Witness Name: Shaun Daniel Gallagher
Statement No.: 1
Exhibits: 9
Dated: 21 March 2025

LAMPARD INQUIRY

WITNESS STATEMENT OF SHAUN DANIEL GALLAGHER

I, Shaun Daniel Gallagher, of the General Medical Council, 3 Hardman Street, Manchester, M3 3AW, will say as follows:

1. My name is Shaun Daniel Gallagher. I am the Director of Strategy and Policy at the General Medical Council ('the GMC'), and I have held this role since 1 December 2020. I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 13 March 2025.

2. This is my first witness statement for the Lampard Inquiry ('the Inquiry') into the deaths of mental health inpatients under the care of NHS Trust(s) in Essex between 1 January 2000 and 31 December 2023 ('the Relevant Period').

About the GMC and our response to the Inquiry

3. The GMC is the independent regulator of doctors, physician associates (PAs) and anaesthesia associates (AAs) in the UK. We work with registrants, their employers, their educators, and others to:
    a. set the standards of patient care and professional behaviours registrants need to meet;
    b. make sure registrants get the education and training they need to deliver good, safe patient care;
    c. check who is eligible to work as a doctor, PA and AA in the UK and check they continue to meet the professional standards we set throughout their careers;
    d. give guidance and advice to help registrants understand what is expected of them;
    e. investigate where there are concerns that patient safety, or the public's confidence in registrants, may be at risk, and take action if needed.
4. The GMC is independent of government and the medical profession and accountable to Parliament. Our powers are given to us by Parliament through the Medical Act 1983 ('the Act') and the Anaesthesia Associates and Physicians Associates Order 2024.

5. We welcome the opportunity to contribute information to the Inquiry's investigation into the deaths of mental health inpatients under the care of NHS Trust(s) in Essex between 1 January 2000 and 31 December 2023. We would like to extend our deepest sympathies to all the families affected by these tragic events.

6. We note the Inquiry's interest is in the period up to December 2023 and since we did not start regulating PAs and AAs until December 2024, the focus of our statement and supporting evidence (except where otherwise stated) relates to our regulation of doctors.

7. This statement and the accompanying exhibits focus on the GMC's role in investigating and acting on concerns about doctors' practice, providing an overall summary of our processes and details of cases relating to mental health inpatients under the care of NHS Trust(s) in Essex.

The following section provides an overview of how our fitness to practise processes work, including the different stages of a GMC investigation and the application of thresholds, as requested by the Inquiry.

When and how we investigate concerns about doctors

8. When a serious or persistent concern is raised about a doctor's performance, behaviour, or health, we can take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.
9. We have a legal duty under the Act to protect the public. The Act splits public protection into three distinct parts. It says that we must act in a way that:
    a. protects, promotes and maintains the health, safety and wellbeing of the public;
    b. promotes and maintains public confidence in the profession;
    c. promotes and maintains proper professional standards and conduct for members of the profession.[1]
10. We can act on information we receive from any source that raises a question about a registered doctor's fitness to practise. Common sources of information include patient complaints, referrals from responsible officers[2] (ROs), employers, media reporting, and notifications from the police and other bodies acting in a public capacity.
11. As set out in the Act, we will only take forward a concern relating to a doctor if it falls into one of the following:

[1] Section 40A(4) of the Act.

[2] Responsible officers (ROs) are accountable for the local clinical governance processes in their respective healthcare organisations, focusing on the conduct and performance of doctors. Their duties include evaluating a doctor's fitness to practise and liaising with the GMC over relevant procedures.

a. misconduct[3];
b. deficient professional performance;
c. a criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England or Wales);
d. adverse physical or mental health;
e. not having the necessary knowledge of English;
f. a determination (decision) by a regulatory body either in the UK or overseas to the effect that fitness to practise as a member of the profession is impaired.[4]

12. We will take action where the matter raised is sufficiently serious to raise a question about a doctor's fitness to practise. There are a variety of ways in which we can do this, and these are further outlined below. Further information on what we can and cannot investigate can be found on our website[5] and in our GMC *threshold guidance* [CM/1].

How patients, families, and the public and employers can raise concerns about patient safety and managing concerns locally

13. Anyone can raise a concern with the GMC. Those raising concerns might include patients or their families, employers, doctors or other healthcare professionals. It is vital that anyone can raise concerns about patient safety promptly, easily, and feel listened to. We provide a range of channels and support (further described below) to help anyone who raises a concern to understand how to disclose information so we can consider whether action needs to be taken.
14. There are many organisations responsible for the health, safety, and wellbeing of patients in England, including employers, the NHS and the Care Quality Commission (CQC). Over the past several years, we have received a high number of enquiries from patients and the public that do not meet our fitness to practise thresholds and/or are not issues the GMC can address. For example, since 2017 approximately 23% of complaints raised with us were not promoted to an investigation since they were not about a doctor. Often these concerns do not raise questions about a doctor's fitness to practise and should be more appropriately dealt with locally by the doctor's employer or contracting body.
15. We provide advice for patients, families, and the public on our website[6] to make sure that we are the right organisation to deal with their concern. We also signpost to other

[3] Examples include but are not limited to: sexual assault; violence; improper sexual or emotional relationships; serious clinical concerns; knowingly practising without a licence; unlawful discrimination; dishonesty; gross negligence or recklessness.
[4] Section 35C(2) of the Act.
[5] Further information can be found at: https://www.gmc-uk.org/concerns/supporting-you-with-your-concern/can-we-help-with-your-concern.
[6] Further information can be found at: https://www.gmc-uk.org/concerns/supporting-you-with-your-concern/local-help-services/help-services-in-england.

organisations who may be better suited to help. This includes, where appropriate, the doctor's employer, trust, or other regulators, such as the CQC.

16. To support patients and the public raising their concerns, we have implemented several initiatives, including updating the Local Help pages[7] on our website to help patients direct their complaint to the relevant organisation.
17. Patients and the public can raise concerns with us by completing our online form or by speaking to one of our contact centre advisers. We also provide a guide to help people decide where and how to raise their concern. This includes information about the support available to them. A copy of this guide, *Supporting you with your concern*, is included at [CM/2]. If we decide to investigate a concern raised by a patient, we will invite them to a meeting either online or in person at one of our offices in Belfast, Cardiff, Edinburgh, London or Manchester to explain our investigation process and answer any questions they might have. Once we have finished our investigation, we will offer another meeting to talk to the patient about the outcome.

Outreach and referral of concerns at the local level

18. In 2012, we set up a team of Employer Liaison Advisors[8] ('ELAs') to facilitate more effective working between the GMC and healthcare providers, predominately in connection with fitness to practise and revalidation.[9]
19. Revalidation is the process through which licensed doctors are required to demonstrate to the GMC on a regular basis that they remain up to date and fit to practise. For most doctors this is achieved through participation in workplace annual appraisal, and a recommendation from their RO to the GMC that they can be revalidated.
20. ELAs work in partnership with employers to improve patient safety and ensure high standards of medical practice through:
    a. providing advice on GMC thresholds and revalidation recommendations;
    b. improving the quality and fairness of fitness to practise referrals; and
    c. encouraging robust local investigation of concerns, performance management, and clinical governance.
21. One of the primary roles of an ELA is to provide ROs with advice on whether the thresholds for referral of concerns to the GMC are met. The role of the RO was established by the UK government to enhance the effectiveness of local handling of concerns. Our ELAs work

[7] Further information can be found at: https://www.gmc-uk.org/concerns/supporting-you-with-your-concern/local-help-services
[8] ELAs are now part of our outreach team.
[9] Further information on the revalidation process can be found on our website Revalidation and the licence to practise - GMC

closely with ROs to support effective local handling and referral to the GMC in appropriate cases.

22. Many local concerns do not result in a referral to the GMC, but our guidance emphasises that our ELAs are there to offer advice and support at any stage. We have published *RO referral guidance* exhibited at [CM/3]. When filling out a referral form, we ask ROs to include information such as the doctor's details, an account of the events or incidents with dates, copies of any relevant papers and/or any other evidence. They are also expected to provide details of any local action that has been taken already.
23. Once they have filled out the form and are ready to make their referral, we ask ROs to make a referral declaration. This confirms the referral was made in good faith, based on the information available at the time, and that the RO has taken reasonable steps to ensure that the information contained is accurate and fair.
24. Our thresholds guidance at [CM/1], aims to provide clarity for ROs, medical directors and others involved in the employment, contracting and management of doctors about what matters we can and cannot take action on.
25. The ELA maintains a relationship with the RO through regular meetings and responds to ad-hoc requests for support. The frequency of these meetings depends on a range of factors including, but not limited to, the level of experience of the RO, the presence of any concerns or unusual fitness to practise or patient safety issues. ROs will discuss with their ELA emerging concerns about doctors that are being handled locally. These discussions provide the RO with an opportunity to discuss local problems, thresholds for referral to the GMC, local management, and patient safety issues.
26. The GMC is not responsible for local clinical governance or investigation processes. We encourage ROs to reflect on the effectiveness of the systems for which they are responsible and manage local responses to concerns. The responsibility for taking action on issues, whether by referring to the GMC or dealing with the matter locally, sits with the RO. Paragraph nine of the guidance to RO's at [CM/3] states:
    a. 'you must exercise your professional judgement when considering whether to make a referral;
    b. any referral should be made in good faith, based on all the information that is available to you;
    c. you should take reasonable steps to ensure that any referral you make is accurate and fair;
    d. you may choose to delegate the administration of the referral, but you remain accountable for the referral.'

27. The guidance to ROs also states that they should seek advice from the ELA before making a referral, unless delaying the referral would present an imminent risk to patient safety. To make sure that referrals are accurate and fair ROs may first need to:
    a. complete their own local investigation and consider the conclusions;
    b. understand the outcomes of any external investigation; and/or
    c. take any other reasonably practicable steps necessary to understand whether the concerns raise a question about the fitness to practise of the doctor.

The operation and management of our fitness to practise investigations

28. When we receive a concern or complaint our triage team first identifies whether the concern is about a registered doctor and, if it is, considers whether it meets our threshold for investigation.
29. We are legally required to assess if the doctor may pose any current and ongoing risk to one or more of the three parts of public protection outlined above. We do this by considering the following, which is often referred to as an assessment of a doctor's fitness to practise:
    a. a doctor's overall ability to perform their individual role;
    b. their professional and personal behaviour;
    c. the impact of any health condition on their ability to provide safe care.
30. As part of assessing fitness to practise concerns, and to reach a decision on whether a doctor poses any risk to public protection, we consider:
    a. the seriousness of the concern – this includes looking at how far a doctor has departed from the professional standards set out in *Good medical practice.* Or, if relevant, it includes considering if a health condition is having an impact on their ability to practise safely;
    b. any relevant context – we consider any relevant context of which we are aware. By 'context', we mean the specific setting or circumstances that surround a concern;
    c. how the doctor has responded to the concern.
31. If the concern does not meet the threshold for investigation, we may consider that the complaint should be disclosed to the doctor and the doctor's RO to be reflected on as part of their workplace annual appraisal (this is called the 'Notify RO process').
32. For some concerns we conduct a provisional enquiry.
33. Full investigations are disclosed to the doctor, the doctor's RO and any other employers or contracting bodies. The nature of the concerns will determine what investigatory steps need to be undertaken. Most commonly these involve obtaining:
    a. expert report(s);

b. witness statement(s);
c. any other documentary evidence that may be available (e.g. information from police files, health assessments, or local investigation reports).

34. At the conclusion of the majority of investigations, draft allegations are sent to the doctor. Doctors are given 28 days to respond with any comments or supporting evidence that they would like us to be aware of, after which our Case Examiners[10] will make a decision. Investigations can be referred to the Case Examiners for a decision without draft allegations being sent to the doctor if, for example, we are unable to collect the evidence to support the concerns raised to us.
35. We can take action to make sure we protect patients, maintain confidence in the medical profession, and uphold the standards we expect of doctors. We can give doctors a warning when a doctor's behaviour or performance is significantly below the standards expected of doctors and should not be repeated, but when restricting a doctor's practice is not necessary. In certain cases, we can agree undertakings, which are agreements between us and a doctor about the doctor's future practice (for example, limiting a doctor's practice in some way or committing to only working while supervised).
36. We can also refer them to the Medical Practitioners' Tribunal Service (MPTS), which provides a tribunal service. The MPTS was created in June 2012 to separate the GMC's adjudication function from its investigatory function, and to promote greater confidence in the independence of the tribunals conducting medical fitness to practise hearings. The MPTS is a statutory committee of the GMC.
37. Medical Practitioners Tribunals (MPT) have the power to restrict by way of conditions, suspend, or erase a doctor's registration in the UK. Where a referral to a Tribunal is made further evidence may need to be gathered prior to the hearing at the MPTS.
38. If a doctor's fitness to practise is found to be impaired, the MPT will decide whether to impose a sanction, and if so, what sanction to impose. Our current sanctions guidance setting out further advice for decision makers is available at [CM/4].
39. Further information on how we assess concerns can be found either on our website[11] or our *Guidance for decision makers on deciding whether an investigation is needed*, available at [CM/5].

[10] The Case Examiners are our fitness to practise statutory decision makers. They comprise both medical and non-medical members in various fields and their primary role is to make a decision at the end of a fitness to practise investigation. They can also assist with the investigations process and make recommendations on the progression of a case. At the end of an investigation the case examiners must decide unanimously on an appropriate outcome based on the evidence according to the relevant burden of proof, taking into account our statutory objective to protect the public.

[11] Further information can be found at: https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/fitness-to-practise-explained/how-we-assess-and-respond-to-fitness-to-practise-concerns.

A summary of changes made to our fitness to practise process from 2015 to present

40. The Inquiry has specifically asked for details of any changes to our processes during the Relevant Period. We are continuously looking for ways to improve our fitness to practise processes. While we have provided details below of recent changes, we think are most relevant to the inquiry's terms of reference, we can provide details of changes made before 2015 if helpful.

Supporting vulnerable doctors

41. In 2015, we commissioned Professor Sir Louis Appleby to undertake an independent review to identify how we can improve our investigation process to reduce the impact and stress for doctors, particularly those with health concerns. In response to the review findings, we implemented our safeguarding vulnerable doctors' programme. This includes:
    a. coordinating our approach so doctors under investigation have a single point of contact throughout the process;
    b. new guidance for staff to help them recognise signs that a doctor may be unwell and manage interactions with doctors displaying challenging behaviour;
    c. establishing a specialist team to handle cases where doctors are unwell, with a process to pause an investigation to allow a very unwell doctor to get treatment;
    d. introducing procedures to identify and address health concerns more quickly and reduce the number of unnecessary investigations through the effective use of provisional enquiries.

Expansion of the provisional enquiries (PE) process

42. A provisional enquiry involves obtaining limited, targeted information at triage to help inform a decision about whether the concern raised amounts to an allegation that a doctor's current fitness to practise is impaired and therefore requires a full investigation. This helps us to be proportionate in our regulatory activity and mitigate the risk of unfairness, for example, to prevent employers using our fitness to practise procedures to retaliate against whistleblowers. The use of provisional enquiries was tested in a pilot in 2014 and subsequently implemented soon after. It has been extended in phases from 2015 onwards.
43. We now undertake provisional enquiries where:
    a. the doctor who is the subject of the complaint has a history of whistleblowing[12];

[12] If a concern is promoted for an investigation and we later learn from the doctor that they are a whistleblower, we would focus our investigation on independently corroborating the allegations to avoid unfairly disadvantaging that individual in our procedures.

b. it is likely that one or two pieces of information can be swiftly obtained which will clarify the seriousness of the matters raised;
c. the concerns relate to a single clinical incident (one-off clinical mistake) or a single clinical concern (more than one incident about a single patient involving a single course of treatment);
d. there are concerns about a doctor's health (concerns relate solely to a doctor's health and we need more information about their condition); or
e. events that arose during the Covid-19 pandemic (concerns relating to a doctor's practice and/or conduct in a clinical setting during the pandemic and the circumstances of the pandemic are likely to be a key factor in explaining the doctor's actions).

Embedding Learning from Sexual Abuse Cases

44. We conducted a review in 2017 of our historic child sexual abuse cases that occurred between 1945 and 2016 in line with current best practice on child protection. We reflected on the wider lessons from the review and in 2018 established the Embedding Learning from Sexual Abuse cases ('ELSA') programme of work to:
    a. improve how we identify, evidence and progress cases involving sexual misconduct and sexual harassment;
    b. improve our support for complainants and vulnerable witnesses to understand and participate in our investigation of sexual misconduct cases, as well as our support for doctors, employers, and our staff in identifying and raising concerns about sexual misconduct and sexual harassment;
    c. raise awareness with our staff, doctors, and the public about our professional guidance and how we deal with cases involving sexual misconduct and sexual harassment.
45. As a result of the ELSA programme, we have delivered the following changes to date:
    a. we updated our guidance on anonymous and confidential complaints to ensure a doctor's fitness to practise history is appropriately considered;
    b. we updated our guidance on dealing with complaints relating to events more than five years ago to introduce clear criteria on when it may be in the public interest to investigate. This gives decision makers greater flexibility to consider factors where a complainant may delay reporting their concerns in, for example, cases involving sexual misconduct, harassment or other traumatic events. We also updated our systems to make it easier to track and report these decisions;

c. we identified areas of good practice in our use of expert reports in clinical cases that involve allegations of inappropriate clinical examinations or behaviour and introduced new guidance to ensure this happens consistently;
d. in response to new research, which revealed concerns about the extent to which chaperones can protect patients from a doctor under investigation, we updated our guidance on imposing interim orders for the Interim Order Tribunal[13] and MPT. This encourages decision makers to give greater consideration to the circumstances where temporary measures requiring the use of a chaperone (conditions) may not be effective.

Fair to Refer

46. In 2019, we commissioned independent research to help us understand why some groups of doctors are disproportionately referred by employers to the GMC. The *Fair to refer?* report pointed to workplace environments and cultures as the causes of this disproportionality. We have committed to eliminating disproportionality in fitness to practise referrals from employers based on ethnicity and place of primary medical qualification by 2026.
47. To address inequalities in how concerns are handled at a local level effectively, commitment from employers and other key stakeholders is required. To achieve this, we are making changes to our own procedures and working with our partners to create more inclusive, supportive, and fair local environments.
48. We have completed phase one of our programme to support delivery of the target, and our activity so far includes:
    a. fairness conversations with all employers to emphasise their duty to provide supportive and inclusive working environments and to explore how they are implementing the findings of the *Fair to refer?* research;
    b. changes to our RO referral form, to include additional questions about how employers have considered systemic issues, the support that they have provided locally, and the impartial checks that have been made to ensure the referral is fair and inclusive;
    c. new training for our staff on the specific risks of bias in employer referrals;
    d. introduced new feedback channels for employers to share information about the outcome of concerns referred to us at the end of an investigation;

[13] Interim orders tribunals decide if a doctor's practice should be restricted, either by suspension or imposing conditions on their registration, while an investigation takes place. At any point during our investigations, the GMC can refer a doctor to an interim orders tribunal at the MPTS.

e. we are also developing a mechanism to provide feedback to employers about concerns that do not meet our threshold for investigation;
f. we support NHS Resolution's Being Fair programme which brings together a range of stakeholders to collaborate on ED&I matters and support a just and learning culture;
g. we support the work of our partners to standardise local investigation processes and how these might address disproportionality at the early stages of a concern being raised, to avoid unnecessary GMC referrals. For example, we worked with Health Education England (prior to its merger with NHS England) to launch a standardised induction process for international medical graduates in 2022.

49. We also introduced a feedback loop between Case Examiners and our outreach team in May 2022 to identify learning where employer referrals do not meet our criteria to open an investigation at triage. This process helps to identify and share lessons for any ELAs who provided advice and support prior to the referral, and lessons for the employer where referrals were made without advice.

Changes introduced during Covid-19 pandemic which we have permanently retained to enable better use of resources and more targeted regulatory action to protect patients

50. During the pandemic, it was crucial that we continued to protect patients and investigate serious concerns whilst being sensitive to the exceptionally challenging circumstances in which doctors may be working. We also introduced measures to reduce face to face contact to protect everyone involved in our fitness to practise procedures. Some of those changes delivered additional long-term benefits by allowing us to make better use of resources and deliver more targeted regulatory action. For example, the greater use of remote engagement should enable us to progress cases more quickly and improve the accessibility of these meetings by removing the need to travel. As a result, we have decided to permanently embed these changes in our fitness to practise processes. These include:
    a. new guidance for our decision makers on how to take into account the unique context of the pandemic. It also seeks to ensure that decision makers understand and consider the specific context and individual circumstances surrounding a complaint consistently and fairly, together with the wider system or environmental pressures that are beyond a doctor's control;
    b. expediting how we obtain independent opinion on a doctor's performance and fitness to practise through the introduction of short form performance assessments when appropriate;

c. holding medical supervision and health assessment[14] appointments remotely to allow for greater flexibility;
d. transitioning to remote meetings with doctors and GMC staff where we draw attention to the issues, we are most concerned about in the case;
e. changing our triage guidance to enable us to close matters relating to lower-level violence or dishonesty that occurred outside professional practice and has been investigated by another body, such as an employer or the police, without formal action being taken. This allows us to have a more flexible and proportionate approach where the doctor's behaviour does not pose a risk to patients, to public confidence in the profession, or to proper professional standards and conduct.

Introductory phone calls between investigation caseworkers and doctors who are the subject of concern

51. To reduce anxiety for doctors who are the subject of a concern, we have put in place a new process where the person dealing with the investigation will first email the doctor to arrange a phone call and introduce themselves as the doctor's contact. Our staff will then explain what the immediate next steps in the investigation will be and signpost the doctor to relevant support services and representation. This is aimed at taking a more compassionate approach to our interactions with those who are subject to our fitness to practise processes and reducing the impact of our investigations on doctors.
52. We then follow up the call with written correspondence confirming the details outlined in the initial call and containing the documentation we currently hold relating to the concerns we are investigating. A bespoke communication plan is also created for the doctor during the call, factoring in their communication preferences. The pilot, carried out last year, found doctors felt more supported when initial phone calls were made. A post implementation review is currently ongoing to ensure the process continues to be effective and to tailor our approach where necessary.

Providing ongoing support for people who provide witness statements as part of our investigations

53. Our Legal team introduced the witness needs assessment process in 2017, which is designed to continually assess the communication preferences and/or vulnerabilities of people who provide witness statements as part of our investigations (either in written or

[14] Medical supervision is how we monitor a doctor's health progression during a period of restricted practice. A health assessment is one part of a wider investigation into a doctor's fitness to practise. It helps us understand any concerns about a doctor's health before considering measures we may need to take to protect patients.

oral form). This is particularly valuable for those involved in cases that are referred to a hearing, as these cases generally take longer to resolve and involve more frequent engagement between the GMC and the witness. This new process also aids the transfer of witness contact between investigations and legal colleagues once a decision has been made for an allegation to be referred to a hearing. Additional support is available for any witnesses involved in MPT hearings. This independent support service, run by Victim Support[15], can be accessed before, during or after attending a hearing and is free and confidential. They can also signpost to specialist support organisations to meet a range of needs.

The following section provides an overview of our quality assurance processes which we use to check and monitor postgraduate training and education.

54. We have included this information here as we have enclosed a report and associated correspondence relating to the postgraduate education and training for South Essex University Partnership Trust. While the report relates to the period before 2010 - and before we assumed responsibility for the regulation of postgraduate training, we have set out here how we have regulated this function after 2010. We also regulate undergraduate medical education and training and would be happy to provide additional information on how we do this if the Inquiry would find it helpful.

Postgraduate Medical Education and Training Board and the merger with General Medical Council

55. In April 2010, the Postgraduate Medical Education and Training Board (PMETB) merged with the General Medical Council (GMC). PMETB was a non-departmental public body responsible for postgraduate medical education and training in the United Kingdom. PMETB was accountable to the Parliament of the United Kingdom and acted independently of the government. New legislation transferred PMETB's regulatory responsibilities to the GMC and the GMC took over the functions of PMETB when the two organisations merged. One of these regulatory responsibilities was as defined in the Medical Act 1983, section 34H:
    (1)The General Council shall—

[15] Victim Support is a charity providing independent emotional support to any witness involved in MPT hearings. Further information can be found on their website at: https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/gmc-and-nmc-independent-support/

a. establish standards of, and requirements relating to, postgraduate medical education and training, including those necessary for the award of a CCT in general practice and in each recognised specialty;

b. secure the maintenance of the standards and requirements established under paragraph (a); and

c. develop and promote postgraduate medical education and training in the United Kingdom.

56. Therefore, from 2010, we assumed responsibility for setting and maintaining the standards of postgraduate medical education and training, taking action when standards were not met through our quality assurance processes. Quality control of these standards was the responsibility of the learning education provider, for example trusts and health boards and the quality management of these standards was implemented by postgraduate training bodies sometimes referred to as deaneries or statutory education bodies.

Reactive quality assurance of postgraduate education and training

57. We have both proactive and reactive quality assurance processes which we use to check and monitor postgraduate training and education. Proactive quality assurance is an annual process that we undertake with postgraduate training organisations (PTOs) and medical schools to check how they are meeting our standards (as set out in our Promoting Excellence guidance, included at [CM/7]) and how they are quality managing medical education and training.

58. Our reactive quality assurance processes enable us to:

    a. address organisations with low level or emerging concerns to stop issues from escalating and therefore ensure training and education meets our standards.
    b. deal with higher level concerns that have escalated and require interventions from the regulator to resolve, therefore ensuring standards are maintained

    Our reactive quality assurance processes have mostly centred around two processes:

    c. reporting via the quality reporting system
    d. enhanced monitoring.

The quality reporting system

59. When a low level or emerging concern becomes one that we need to closely monitor, we discuss it with the PTOs and depending on the risk rating, may request that they add this to our quality reporting system for us to monitor. When we monitor a concern via our quality reporting system, we ask the PTO to provide timely updates on the progress of

the concern. We then assess this update and either accept it and ask for a further update later or we request a further discussion about escalating the concern.

Enhanced monitoring

60. Sometimes there is a potential serious risk to patient and/or training safety. When this is evident, then the concern is deemed to be high level and is escalated to enhanced monitoring.
61. In our enhanced monitoring process, we require more frequent progress updates from those responsible for managing these concerns. Therefore, we ask the trust/health board to provide an improvement plan which the PTOs use to monitor progress against specific actions. We have oversight of this plan to ensure that the plan addresses all the requirements we set. We can provide representation on a locally led visit to investigate a concern or check on progress. We publish information on enhanced monitoring cases on our website and we share information with other healthcare regulators. Additionally, if there are any medical students attending the department for undergraduate placements, we will notify medical schools of the enhanced monitoring status.
62. We work with all organisations concerned; the trust or health board and postgraduate training organisations to address the concern and develop a sustainable solution. Sometimes we need to work with other regulators responsible for service improvement and transformation in the health sector. We regularly review the risk level for each enhanced monitoring case which is informed by the data, intelligence and insights we have internally and information from the deaneries and local education and training boards. We monitor the risk level and adjust our response accordingly.

The following section provides an overview of our data relating to the deaths of mental health inpatients under the care of NHS Trust(s) in Essex between 1 January 2000 and 31 December 2023

Data related to the deaths of mental health inpatients under the care of NHS Trust(s) in Essex

63. We carried out a search of our electronic case management system (Siebel – which was introduced in April 2006) for complaints received since 1 April 2006 with a recorded connection to Essex Partnership University NHS Foundation Trust (including former trusts South Essex Partnership Trust and North Essex Partnership Trust) and North East London Foundation Trust (previously known as North East London Mental Health NHS Trust). We have identified 29 complaints which may be relevant to your terms of reference, and we summarise these in the provided spreadsheet [CM/6].
64. Where 'a recorded connection' is referenced, this is where the referring body, incident location, the doctor's designated body or employment history is recorded as one of the Trusts.
65. The above initial search may not have identified all cases relevant to your terms of reference for two main reasons:

    a) Our records are primarily organised by doctor name, and this is the most reliable way to search our records. Fitness to practise complaint records prior to 1 April 2006 are paper files held in storage and a doctor's name is the most reliable way to search these records for any relevant complaints. A search using patient names may be possible for records since April 2006, however a doctor's name remains the most accurate way to search these records.

    b) We are aware other Trusts and service providers may have provided services to patients, the most efficient and reliable way to search these would be using a doctor's name and/or patient name.
66. Following the further request from the Inquiry, which includes a list of known providers and a preferred search strategy, we will now begin conducting the searches to collate relevant cases for additional providers.

Data related to meetings between our outreach teams and relevant Trust(s) which touch upon provision of Mental Health inpatient care during the relevant period.

67. As per the Inquiry's further request, we have initially identified meeting notes between the ELA and RO of North Essex University Partnership University Foundation Trust, Essex Partnership University Foundation Trust and South Essex Partnership Foundation Trust spanning the period between 2012 – 2023. Now that we have received the list of additional providers of interest, we will need to conduct further searches of meeting notes for those providers.
68. These minutes will cover a range of issues and sensitive information, including but not limited to cases involving doctors that fall out of the scope of the terms of reference. Thus, we would need to review the notes and apply appropriate redactions.
69. Due to the volume of notes and redactions that will need to be applied, we will not be able to disclose these by the 21st of March. However, we aim to exhibit these materials with an accompanying supplementary statement to the Inquiry by Friday 4 April 2025.

Data related to education quality assurance materials which touch upon provision of Mental Health inpatient care at relevant Trust(s) during the relevant period

70. We have provided information about concerns in South Essex Partnership NHS Foundation Trust. The report [CM/8] and associated correspondence [CM/9] pre-dates the merger of PMETB and the GMC. Therefore, these records were transferred to us from PMETB. The report contains detail about how the concerns were monitored at the time. Although we have made some changes to our processes since the merger, and are described in the section above, essentially the principles are the same. The concerns would have been monitored by PMETB working closely with the quality management organisation at that time, which was the East of England deanery.
71. The report [CM/8] and associated correspondence [CM/9] have been provided in redacted form to safeguard sensitive information. We are happy to provide unredacted versions by the 4th of April with a further Section 21 Notice.
72. As we now have the additional providers of interest, we will need to undertake further checks to identify whether we hold similar information. We will share that with the Inquiry where it is relevant to the terms of reference.

Concluding remarks

We want to thank the Inquiry for the opportunity to provide information and would be happy to discuss any of the information contained within this statement and provide further information should that be required. We hope that the information that we have provided will assist the Inquiry in its work and contribute towards ensuring tragic events like these never

happen again.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed [I/S]

Dated: 21.03.2025

Annex A

Table of exhibits: (9 exhibits)

	Date	**Notes/Description**	**Exhibit number**
1.	April 2024	GMC Thresholds	CM/1
2.	July 2023	Supporting you with your concern	CM/2
3.	December 2024	RO Referral Guidance	CM/3
4.	February 2024	Sanctions guidance: for members of medical practitioners' tribunals and for the General Medical Council's decision makers	CM/4
5.	March 2022	Guidance for decision makers on deciding whether an investigation is needed	CM/5
6.	February 2025	Data related to the deaths of mental health inpatients in Essex.	CM/6
7.	July 2015	Promoting Excellence: standards for medical education and training	CM/7
8.	January 2008	Progress Report Quality Assurance ST4 Placements East of England	CM/8
9.	February 2008	Education Quality Assurance Report: PMETB and South Essex Partnership Trust on experience of Psychiatry Trainees.	CM/9