Witness Name: Charles Hamilton Massey
Statement No.: WITN0067001
Exhibits: WITN0067002 to WITN0067019
Dated: 21 October 2025

NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF CHARLES HAMILTON MASSEY

I, Charles Hamilton Massey, of the General Medical Council ('the GMC'), 3 Hardman Street, Manchester, M3 3AW, will say as follows: -

1. My name is Charles Hamilton Massey. I am the Chief Executive and Registrar of the GMC, and I have held this role since 1 November 2016. Prior to this, I worked in a variety of roles across government and the wider public sector.

2. I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 26 August 2025.

3. This is my first witness statement for the Nottingham Inquiry ('the Inquiry') into the circumstances that led to Valdo Calocane's actions in June 2023, including his interactions with health services for the management of mental health conditions and the police.

Background to the GMC and our response to the Inquiry

4. The GMC is the independent regulator of doctors, physician associates (PAs) and anaesthesia associates (AAs) in the UK. We maintain a public register of doctors, PAs and AAs. And 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 or 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; and

e. investigate where there are concerns that patient safety, or the public's confidence in doctors, may be at risk, and take action if needed.

5. The GMC is independent of government and the professions it regulates, and accountable to Parliament. Our powers are given to us by Parliament through the Medical Act 1983 ('the Act') and the Anaesthesia Associates and Physician Associates Order 2024.

6. We welcome the opportunity to contribute information to the Inquiry's investigation into the events, acts or omissions in the lead up to Valdo Calocane's actions on 13 June 2023 when he tragically attacked and killed three people, and seriously injured another three, in Nottingham city centre. I would like to extend my deepest sympathies to the families of those affected by his actions.

7. We note the Inquiry's interest is in the period between 2019, when Mr Calocane first presented with mental health issues, and the attacks on 13 June 2023.

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.

8. This statement and the accompanying exhibits focus on the GMC's role in setting standards for education and training. As set out at paragraph four above, setting standards for education and training is one of the GMC's key functions. These standards are then used by bodies, such as the royal colleges, to develop specialised curricula, including curricula for general practice and psychiatry. We approve the curriculum produced by each medical royal college.

9. The GMC also sets the principles, values and standards of professional behaviour expected of doctors ('professional standards'), set out in General Medical Practice (GMP) and other detailed guidance. Our professional standards are covered in further detail at paragraphs 31 to 46.

10. This statement lastly explains how the Inquiry's areas of interest map to and interact with our standards and sets out areas that the Inquiry may wish to consider as part of its recommendations.

11. We have structured the statement according to the headings the Inquiry provided in its Rule 9 request for ease of reference.

Mental health provision

12. In this section, I have first set out background information about our standards for education and training and our professional standards. I have also detailed how these were developed, including how we make doctors aware of them, and our processes for ensuring they are regularly reviewed and updated to remain fit for purpose.

13. For each area of our work, I have also explained the level at which our standards operate, and how these interact with standards and guidance produced by other bodies, including medical royal colleges, faculties and other clinical and regulatory organisations, to form a coherent, comprehensive system for medical education and training, and clinical practice. I have then outlined the different types of standards relating to each area of interest to the Inquiry, including what is set out in the relevant specialised curricula, approved by the GMC, to train as a GP or psychiatrist.

14. After considering the different areas of interest identified by the Inquiry, I have set out our position on the Inquiry's request for views on areas where further guidance, training or support may be needed on a national level to ensure safe and effective mental health care.

Education and training standards

How our education and training standards work

15. Part of the GMC's role is to ensure that registrants receive the education and training they need to deliver good, safe patient care across the UK. We set the standards that medical schools are expected to meet in delivering education and the outcomes that we expect our students at UK medical schools to achieve in readiness for joining our register.

16. Our legislative remit covers both undergraduate and postgraduate medical education. However, the Act gives us different powers for regulating each of these areas, and therefore our approach to approving and quality assuring each of these also differs as a result.

17. We set the outcomes that all medical students must be able to meet on successful completion of their undergraduate medical education. We do not prescribe the full detail of medical school curricula, which is determined by individual medical schools in the UK. However, to be approved, medical schools must ensure that education and training is delivered in line with our high-level 'Outcomes for graduates' [WITN0067002], which prioritises themes around mental health, safeguarding vulnerable patients, and working effectively within a multi-professional and multidisciplinary team and across multiple care settings (including the community setting).

18. We maintain, and publish, a list of approved medical schools that can award a primary medical qualification. To grant approval, we subject these bodies to an extensive period of quality assurance in line with the standards set out in 'Promoting Excellence: standards for medical education and training' [WITN0067003].

19. We introduced the Medical Licensing Assessment (MLA) in 2024. The MLA creates a two-part test which sets a threshold for safe medical practice in the UK. All students graduating after summer 2025 from UK medical schools must pass the MLA as part of their degree to apply to join the medical register. The MLA tests the core knowledge, skills and behaviours required for entry to UK practice. These are set out in the MLA content map [WITN0067004], developed in collaboration with clinical experts and education leaders through multiple rounds of engagement.

20. The MLA content map is designed around what a doctor can reasonably be expected to encounter in their early practice, particularly during the UK

Foundation Programme. The Foundation Programme, a two-year programme of medical training undertaken by doctors after undergraduate training before further specialist training (such as training to become a GP or psychiatrist), includes areas of mental health such as schizophrenia, threats to harm others, struggling to cope at home, and the capability to assess and manage risk. It also covers cross-cutting skills such as understanding patient capacity, consent and confidentiality, prescribing and monitoring medicines safely, safeguarding vulnerable patients, and communicating effectively with colleagues, patients and families.

21. The MLA content map does not extend to more advanced psychiatric care, for example, detention under the Mental Health Act 1983 ('the MHA') or the use of depot injectable antipsychotics. These areas fall outside the scope of the MLA, which is designed for newly qualified doctors, and these skills are taught in postgraduate training.

22. Our approach to postgraduate medical education is wider reaching. We are responsible for approving curricula developed by royal colleges and faculties, and we maintain a list of approved postgraduate programmes and sites. The medical royal colleges and faculties design curricula in line with our requirements set out in 'Excellence by design: standards for postgraduate curricula' [WITN0067005]. These standards require curricula to be mapped against our Generic professional capabilities framework of shared generic and specialty specific outcomes [WITN0067006] ('The GPC Framework'). This sets the essential capabilities which underpin professional medical practice and are a fundamental part of all postgraduate training programmes, which includes some generic areas of mental health treatment, such as recognising and

managing the care of patients with common mental health conditions, assessing mental health and wellbeing, and having an understanding of mental capacity legislation. As with our MLA content map, it does not set out more detailed expectations for what a GP or psychiatrist must know in detail, remaining purposely high level to ensure uniform development of professional capabilities across different specialties.

23. Doctors who have qualified overseas and wish to practise in the UK are also able to join our register without having attended a UK medical school. We instead require them to provide evidence that they have the knowledge, skills and experience to practise in the UK and that their fitness to practise is not impaired. In practice, this will involve us verifying that their medical degree, or primary medical qualification, is from a medical school that the GMC has approved, and the doctor passing our Professional and Linguistic Assessments Board Test or a higher-level postgraduate exam, such as those delivered by the medical royal colleges.

24. Doctors who have undertaken their specialist or GP training outside of a formal UK training programme but wish to practise as a consultant in the UK are eligible to apply for specialist or GP registration via the Portfolio pathway. Doctors using this pathway need to provide evidence that they have the relevant knowledge, skills and experience to practise as a specialist or GP in the UK which we map against the high-level learning outcomes of the GMC-approved UK curriculum. When the doctor submits their application to us, we check that the application and supporting evidence meet our requirements. The application is then subject to clinical evaluation either through the royal college or faculty responsible for the specialty in which the applicant is applying or by

GMC associates. The royal college or faculty or GMC associates will make a recommendation, following which we will decide whether to grant registration.

25. We also have a duty to make sure undergraduate and postgraduate medical education and training in the UK is meeting our standards, and we discharge this duty through our quality assurance activities. We expect organisations responsible for educating and training to meet the standards we set out in 'Promoting excellence: standards for medical education and training' [WITN0067003]. We quality assure medical schools, postgraduate deaneries and their local offices, and local education providers (such as trusts and health boards) to check they are meeting our standards. Our quality activities are risk based, which means we look at the evidence we gather, including data from our annual National Training Survey, quality assurance site visits, and annual self-assessment questionnaires medical providers are required to complete, and decide which areas are likely to be of concern. We provide feedback to organisations on areas of good practice and can take action if they are not meeting our standards.

Development, implementation and review of standards

26. We developed our standards and outcomes in close collaboration with expert clinical and non-clinical stakeholders, including educators, professional bodies, doctors, students, and patients. They were finalised after an extensive policy development process, including formal consultation. We keep our standards and outcomes documents under periodic review, updating them when necessary to reflect changes in practice. We have committed to updating our suite of education standards

and outcomes by 2030. Our standards and outcomes for medical education were published and updated as follows:

- 'Promoting excellence: standards for medical education and training' – published on 15 July 2015 and came into effect on 1 January 2016.
- 'Excellence by design: standards for postgraduate curricula', which require curricula to be kept up to date and redundant content removed - published on 22 May 2017 and came into effect in May 2017.
- 'Generic professional capabilities framework', which sets out the general clinical and professional skills that must be embedded into postgraduate curricula – published in May 2017.
- 'Outcomes for graduates', which sets out the high-level requirements newly qualified doctors must know and be able to do – published in June 2018 and updated in November 2020.

The rationale for high level standards

27. Our education standards are deliberately set out at a high level and are not therefore specific to individual areas of clinical practice. Our focus is on setting the high-level outcomes for all medical students and doctors training in specialties to meet, and the standards that we expect organisations delivering education and training to meet. But it is not our role to set out the more detailed clinical knowledge, skills and experience that doctors training in a particular specialty are required to attain. That is a role for faculties and medical royal colleges.

28. Curricula for GP and psychiatry specialist training are designed respectively by

the Royal College of General Practitioners (RCGP), set out in the RCGP Curriculum 2025 [WITN0067007], and the Royal College of Psychiatrists (RCP), set out in The General Psychiatry RCP Higher Speciality Curriculum 2022 [WITN0067008].

29. It is important that curricula remain up to date to keep pace with medical and societal changes. Medical royal colleges and faculties must regularly review and update their curricula to ensure they remain fit for purpose and provide safe, effective and modern medical training. Updated curricula must meet our standards and we will quality assure them to ensure that this is the case.

30. As part of our work to maintain oversight of postgraduate medical education and training, we convene and chair a Curriculum Oversight Group (COG), with membership invited from the departments of health and statutory education bodies from the four countries of the UK. Where necessary, the COG provide advice on the extent to which proposed changes (proposed by the relevant royal college or faculty) to postgraduate curricula are, and continue to be, aligned to the needs of patients and services.

Professional standards

How our professional standards work

31. Our standards of conduct and ethics define what makes a good doctor by setting out the professional values, knowledge, skills, and behaviours required of all doctors working in the UK. We work closely with doctors, patients, groups representing their interests, and other stakeholders to develop and agree these standards, which are set out in GMP [NUHT0000045].

32. GMP sets out the principles, values, and standards of professional behaviour expected of all registrants. We also publish a range of more detailed guidance which expands on some of the principles set out in GMP such as consent and confidentiality, raising concerns about patient safety, child protection responsibilities, and providing care for people who are dying. Together they form the professional standards we expect all registrants to follow.

33. GMP covers areas that include:

- making the care of patients the first concern;
- providing a good standard of practice and care, and working within competence;
- working in partnership with patients and supporting them to make informed decisions about their care;
- treating colleagues with respect and helping to create an environment that is compassionate, supportive and fair;
- acting with honesty and integrity and being open if things go wrong; and
- protecting and promoting the health of patients and the public.

34. The key pieces of more detailed guidance relevant to the Inquiry's areas of interest are:

- 'Decision making and consent' [WITN0067009];
- 'Good practice in proposing, prescribing, providing and managing medicines and devices' ('Prescribing') [WITN0067010];
- 'Leadership and management' [WITN0067011]; and
- 'Confidentiality: good practice in handling patient information' ('Confidentiality') [NUHT0000044].

35. As I identified in paragraph 4(c), we check doctors continue to meet the professional standards we set throughout their careers. We do this through appraisal and revalidation processes, which operate to ensure that doctors are working in line with and hold a good understanding of GMP and the detailed guidance. Revalidation for doctors was introduced in December 2012, and every licensed doctor must revalidate. All doctors who wish to practise medicine in the UK must hold a licence to practise, along with the suitable type of registration for the work that they do (such as specialist registration as a psychiatrist). It is not possible to practise medicine without a licence, but it is possible to hold registration without a licence. Doctors who hold registration only remain in good standing with the GMC but are not allowed to exercise any of the legal privileges of a registered medical practitioner, such as prescribing, signing death certificates or working as a doctor in the NHS. Whether a doctor holds registration only or a licence to practise too, they are required to follow our professional standards.

36. A doctor must revalidate every five years to retain their licence to practise. To do this, they must be connected, known as a prescribed connection, with a designated body (DB), which is normally a healthcare organisation and a doctor's main employer, such as an NHS trust or GP practice. Each DB appoints a Responsible Officer (RO), who is a member of staff accountable for the local clinical governance processes and who is responsible for overseeing revalidation of doctors with a prescribed connection to the DB.

37. Revalidation requires doctors to engage with local clinical governance systems, including undertaking annual appraisal, to demonstrate that they are up-to-date and fit to practise. It supports doctors to develop their practice, drives improvements in clinical governance and helps give their patients confidence

in their skills and knowledge. Whilst appraisal is not a GMC process and is governed locally, the GMC is responsible for setting the UK-wide framework for revalidation and for approving revalidation recommendations from ROs. Their duties include evaluating a doctor's fitness to practise and liaising with the GMC over relevant procedures. This framework is based on information collected through local governance systems, which includes appraisal. In our 'Guidance on supporting information for appraisal and revalidation' [WITN0067012], we specify the six types of supporting information that doctors need in order to revalidate, which they must collect, discuss and reflect on within their appraisal discussions. The expectations set out in GMP are woven through this guidance.

38. The professional standards set out in GMP and the more detailed guidance describe good practice. In instances of departure from our professional standards, we may take fitness to practise action. When a concern is raised with us about a registrant, we must assess if that individual poses any current and ongoing risk to one or more of the three parts of public protection:

    - protecting, promoting and maintaining the health, safety and wellbeing of the public
    - promoting and maintaining public confidence in the medical professions, and
    - promoting and maintaining proper professional standards and conduct for members of those professions.

39. We do this by considering a number of factors, as follows:

    a. How serious the concern is. This includes considering the extent of any departure from the professional standards expected and/or the impact of a medical professional's health condition on their ability to practise safely. It

also includes taking into account any specific factors that may impact on seriousness, such as premeditated or persistent behaviour, abuse of power, and whether the behaviour or poor performance the concern relates to is an isolated incident or has been repeated.

b. Any relevant context that may impact on risk, for example systems factors and interpersonal factors in the medical professional's working environment or their role and level of experience.

c. How the medical professional responded to the concern, including evidence of insight and remediation.

40. Once we've assessed the risk, we will consider if regulatory action may be required in response to the concern.

Development, implementation and review of standards

41. A revised version of GMP was published in summer 2023 and came into effect on 30 January 2024. In the process of revising the guidance, we undertook engagement with a range of health organisations, healthcare professionals, patients, carers and their relatives and members of the public. We also ran a public consultation on the revised guidance, which attracted over four-and-a-half thousand responses from across the UK. Key changes made as a result of the feedback we received related to five themes:

- Creating respectful, fair and compassionate workplaces;
- Promoting patient centred care;
- Helping to tackle discrimination;
- Championing fair and inclusive leadership; and

- Supporting continuity of care and safe delegation.

42. We published further information online about the key changes made to GMP [WITN0067013]. The changes made in respect of promoting patient centred care, and supporting continuity of care and safe delegation, may be of particular interest to the Inquiry. Changes relating to patient centred care emphasised the importance of encouraging an open dialogue about a patient's health with them and supporting patients in caring for themselves. GMP also included additional detail requiring doctors to share all relevant information about patients with others involved in their care, within and across teams, as well as setting out more detail on what to do when transferring a patient's care.

43. Archived copies of GMP, including those that were in effect during the period to which the Inquiry relates, can be found on our website (https://www.gmc-uk.org/professional-standards/archived- professional-standards).

44. The more detailed guidance, which expands on GMP, were also developed in consultation with patients, the public, and stakeholders. These documents came into effect as follows:

- 'Confidentiality' came into effect on 25 April 2017 and was updated on 25 May 2018 to reflect requirements under the General Data Protection Regulation and Data Protection Act 2018;
- 'Decision making and consent' came into effect on 9 November 2020;
- 'Prescribing' came into effect on 5 April 2021 and was updated on 15 March 2022 to include a section on reporting adverse drug reactions, medical device incidents and other patient safety incidents, reflecting arrangements and terminology for reporting adverse incidents and near misses across the UK; and

- ‘Leadership and management’ came into effect on 12 March 2012, and is currently undergoing review, with a public consultation planned for late 2025.

The rationale for high level standards

45. As with our education and training standards, our professional standards are high level and apply to all registrants (doctors, PAs and AAs). They are necessarily high level to be widely applicable. As they cannot cover all the situations a doctor might face in practice, we expect them to use their professional judgment to apply professional standards to their day-to-day practice. This means identifying and applying the professional standards that are relevant to the specific circumstances they face and using their knowledge, skills and experience to follow them in that context.

46. Our guidance on professional standards sets out our expectations of doctors. We cannot advise doctors what to do in individual cases, on matters of clinical practice or in a particular situation. However, in our role we can advise on the relevant principles in our guidance which might help them decide how to proceed. We also cannot approve or endorse guidance, training or other content which we have not developed and consulted on ourselves. The responsibility to set clinical standards of practice sits with systems partners including the royal colleges and faculties, the Care and Quality Commission, NHS bodies, the National Institute for Health and Clinical Excellence (NICE), and additional specialist societies which may produce additional guidance for sub-specialities or advanced practice.

Inquiry areas of interest

47. In considering the Inquiry's areas of interest, I have considered the following documents setting out our education standards, alongside the specialist curricula for general practice and psychiatry, and mapped these to the Inquiry's areas of interest:

    a. Outcome for graduates (mapping at WITN0067014)
    b. The UK Foundation Programme Curriculum 2024 (mapping at WITN0067015)
    c. The GPC Framework 2017 (mapping at WITN0067015)
    d. The RCGP Curriculum 2025 (mapping at WITN0067015)
    e. The General Psychiatry RCP Higher Speciality Curriculum 2022 (mapping at WITN0067015).

48. I have also reviewed the following professional standards documents, drafted and maintained by the GMC, and have mapped these to the Inquiry's areas of interest:

    a. GMP (mapping at WITN0067016)
    b. Various detailed professional standards guidance detailed at paragraph 34 above (mapping at WITN0067016).

Areas not covered by GMC guidance or standards

49. As set out at paragraphs 27 to 30, 45, and 46, our standards are deliberately and necessarily high level to ensure they have overarching applicability across all clinical areas — including mental health. In practice, these standards are interpreted and applied with support from clinical guidance from other organisations, like the royal colleges, as well as local trust or organisational

policies on risk management and safeguarding. This guidance provides the clinical input that is outside the GMC's remit to advise on.

50. Although our standards may not specifically provide for some of the scenarios set out in the Inquiry's areas of interest, these scenarios will be covered by the high- level principles set out across our education and professional standards. We expect doctors to have a good understanding of our professional standards and to use their professional judgement and expertise to apply them in specific contexts, including the areas highlighted by the Inquiry. We also provide additional learning materials and guidance to help doctors do this, such as a legal factsheet to support our 'Decision making and consent' guidance [WITN0067017].

51. In some areas, they may also be covered by relevant specialist postgraduate curricula – for example, in respect of psychosis and schizophrenia, and the use of injectable antipsychotics such as depot, the General Psychiatry RCP Higher Speciality Curriculum 2022 requires doctors to apply advanced knowledge of the pharmacodynamics, pharmacokinetics, efficacy, tolerability, interactions, and short and long-term side effects, of all relevant psychotropic medications as appropriate when initiating, reviewing, changing or discontinuing regimes. The GP curriculum also requires doctors to be able to monitor people on medication such as anxiolytics and antipsychotic medication, and to demonstrate safe and appropriate prescribing, repeat prescribing, medication review and medication management in the community context. This would otherwise be too specific to be covered explicitly in our education or professional standards.

Areas for further national training and/or guidance

52. We are an independent regulatory body. Our mandate is to uphold professional standards and protect patient safety. Commenting on gaps in wider national healthcare training and/or guidance, and the structures for managing mental health care sits outside of our remit.

Recommendations

Internal reviews

53. While the GMC has not undertaken any formal reviews in light of the events of 13 June 2023, we continue to liaise with the Nottinghamshire Healthcare NHS Foundation Trust ('the Trust') through our Employer Liaison Advisers (ELAs) working within our Outreach team.

54. For context, we set up a team of ELAs in 2012 to facilitate more effective working between the GMC and healthcare providers, predominately in connection with fitness to practise and revalidation. ELAs work with employers' ROs to improve patient safety and ensure high standards of medical practice through:

- providing advice on GMC thresholds and revalidation recommendations;
- improving the quality and fairness of fitness to practise referrals; and
- encouraging robust local investigation of concerns, performance management, and clinical governance.

55. Alongside being responsible for overseeing revalidation at their DB, as described in paragraphs 35 to 37 above, ROs monitor the fitness to practise of

doctors connected to their DB through their involvement in local clinical governance. One of the primary roles of an ELA is to provide an RO with advice on whether a concern they may have about a doctor meets the thresholds for referral to us, and to support effective local handling where they do not. 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.

56. Our ELA responsible for the North Midlands maintains regular contact with the RO for the Trust and is providing ongoing support in relation to fitness to practise matters. We will continue to closely monitor local developments and take action where appropriate and necessary.

Inquiry recommendations

57. Given the limits of our regulatory remit, we are not able to suggest recommendations for the Inquiry. However, we take this opportunity to reinforce the importance of good clinical governance for effective and safe clinical practice. Clinical governance is a framework for holding healthcare organisations accountable for the ongoing improvement of services and safeguarding of high standards of clinical care. It is predicated on effective, joined up leadership and effective systems across all areas of governance, including people management, incident reporting, internal audit, complaints management, and record keeping.

58. Recognising the importance of effective clinical governance, the GMC developed its clinical governance handbook 'Effective clinical governance to support revalidation' [WITN0067018] in 2012, which was revised and expanded

in 2018 and again in late 2024 to accommodate the introduction of PAs and AAs to regulation. This is a tool intended to support the development of good practice by outlining four key principles for effective clinical governance, alongside outcomes that describe how each principle is achieved in practice. ELAs may use this, alongside providing tailored support, in their regular discussions with healthcare providers to support ROs with developing and maintaining good organisational clinical governance arrangements. It also provides a helpful framework when thinking about how local clinical governance processes support revalidation.

59. Numerous high-profile inquiries have exposed failings in local clinical governance systems. We would therefore suggest that the Inquiry may wish to consider local clinical governance arrangements at the Trust and if these may have had an impact on the joined-up delivery of care for Mr Calocane in the lead up to June 2023.

60. One way in which local clinical governance processes could be strengthened is through bolstering the position of ROs and their role within local systems. Changes to the Medical Profession (ROs) Regulations 2010 [WITN0067019] ('the Regulations') could help achieve this and provide better local clinical governance. In particular, we would suggest the Regulations could be changed in the following ways:

    - Clinical governance responsibilities should be moved from the individual RO to the DB and its Board or Executive. This would mean that organisations would have the statutory responsibility for providing clinical governance systems and the RO would have the responsibility for

ensuring the systems were implemented and running effectively;

- An organisation's responsibilities for clinical governance should be extended to cover all doctors working there, not just those who have a prescribed connection (the way in which this currently works having been explained further at paragraph 36 above); and
- Information sharing between DBs should be a statutory requirement to develop a better understanding of risk for doctors working for different organisations – focusing in particular on circumstances when concerns arise about a doctor or when a doctor is not engaging in clinical governance processes (including appraisal).

61. While we are not in a position to make specific recommendations ourselves, we are fully committed to supporting the Inquiry's work and to constructively engaging in the development of its recommendations at the appropriate stage. And when these recommendations are published, we will closely consider their implications for our processes and make changes where necessary. In particular, we will log the Inquiry as an area of consideration when undertaking periodic reviews of our guidance, such as our upcoming review of our education standards and outcomes, and consider if there are areas to strengthen in light of the Inquiry's recommendations.

Improvements to multiagency working

62. Given our regulatory remit, we are again unable to comment on specific improvements that could be made locally and nationally to multiagency working. That said, we would like to emphasise the importance of cooperation and collaboration between organisations to ensure public protection and patient

safety is upheld. The Act explicitly sets out a legal duty for us to cooperate with a range of organisations set out in the legislation, which supports our ability to work collaboratively with systems partners, such as through reciprocal data sharing. Other organisations and agencies may benefit from a similar duty, where appropriate, to ensure that relevant information can be effectively shared and minimise the risk of gaps in communication arising.

63. From our work supporting other inquiries, we are aware that such gaps may exist in effective information sharing across service boundaries that have the effect of risking the safety of patients, other vulnerable people, and the public at large. The legal landscape for sharing confidential patient information, particularly across different agencies, is complex and often poorly understood within health and social care and policing. While our 'Confidentiality' guidance seeks to support doctors to feel empowered to make disclosures to other professionals in the public interest, we recognise that this can be an area of challenge for doctors. This may be an area the Inquiry wishes to reflect on further.

Concluding remarks

64. 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. We hope that the information that we have provided will assist the Inquiry in its work and contribute towards ensuring such tragic events 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:

GRO-B

Dated: 21 October 2025

Table of exhibits: (20 exhibits)

No.	Inquiry URN	Document Description
1.	WITN0067002	Outcomes for graduates
2.	WITN0067003	Promoting Excellence: standards for medical education and training
3.	WITN0067004	MLA content map
4.	WITN0067005	Excellence by design: standards for postgraduate curricula
5.	WITN0067006	Generic professional capabilities framework of shared generic and specialty specific outcomes
6.	WITN0067007	The RCGP curriculum
7.	WITN0067008	The General Psychiatry RCP Higher Speciality Curriculum
8.	NUHT0000045	Good medical practice
9.	WITN0067009	Decision making and consent
10.	WITN0067010	Good practice in proposing, prescribing, providing and managing medicines and devices
11.	WITN0067011	Leadership and management
12.	NUHT0000044	Confidentiality: good practice in handling patient information
13.	WITN0067012	Guidance on supporting information for appraisal and revalidation

14.	WITN0067013	Key changes to Good medical practice 2024 - GMC
15.	WITN0067014	Mapping – Undergraduate Education standards
16.	WITN0067015	Mapping – Postgraduate Education standards
17.	WITN0067016	Mapping – Professional Standards
18.	WITN0067017	Legal factsheet to support our Decision making and consent guidance
19.	WITN0067018	Clinical governance handbook
20.	WITN0067019	The Medical Profession (Responsible Officers) Regulations 2010