

Witness
Name: [Professor Sir
Terence Stephenson]
Statement No.: [1]
Exhibits: [CM/3 –
INQ0007314, CM/5 INQ
INQ0007316 – CM/7
INQ0007318]
Dated: [19/04/2024]

THIRLWALL INQUIRY

WITNESS STATEMENT OF Professor Sir Terence Stephenson

I, Professor Sir Terence Stephenson, former chair of the General Medical Council, 3 Hardman Street, Manchester, M3 3AW will say as follows: -

1. My name is Professor Sir Terence Stephenson. I provide this witness statement in my former capacity as chair of the General Medical Council ('the GMC') between June 2015 and July 2016 when seven babies were tragically murdered at the Countess of Chester Hospital. I would like to extend my deepest sympathy to everyone affected by these shocking events.
2. I served as Chair of the GMC from 2015 to 2018. I am currently Nuffield Professor of Child Health at the Great Ormond Street Institute of Child Health, University College London. I am also Chair of the Health Research Authority for England. Previously I was Chair of the UK Academy of Medical Royal Colleges 2012-2014 and President of the UK Royal College of Paediatrics and Child Health 2009-2012. Prior to that, I was Dean of Medicine for Nottingham University between 2003-2009.
3. I would like to clarify that I do not, and have never held, a role which gives me general oversight of local safeguarding processes and procedures in hospitals in England. My historical role with the GMC relates solely to the professional regulation of registered doctors within the UK rather than the regulation or oversight of healthcare settings. As such, future changes to professional regulation to improve the quality and safety of care for babies in hospital and operational issues such as CCTV monitoring of maternity wards and parents' access to remote footage and local safeguarding procedures for neonates fall outside my knowledge or professional experience.
4. I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 4 December 2023.

5. This is my first witness statement for the Thirlwall Inquiry into the events at the Countess of Chester Hospital ('CoCH') and their implications ('the Inquiry').

Safeguarding in hospitals

6. During the period when I was chair of the GMC, our Employer Liaison Service worked with Responsible Officers for NHS trusts and other designated bodies to ensure that where concerns about a doctor arose, our fitness to practise thresholds were applied consistently; concerns about underperforming doctors were resolved locally where appropriate, and where referrals were made by Responsible Officers to the GMC these should be robust and evidence based.
7. At the time of the events at the Countess of Chester Hospital, *Good Medical Practice* (2013) ('GMP') exhibited at [CM/3 INQ0007314], was the GMC's core professional standards and describes what is expected of all registered doctors. This explains all doctors have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies, and procedures in the organisations in which they work. Doctors must promote and encourage a culture that allows all staff to raise concerns openly and safely. They must take prompt action if they think that patient safety, dignity, or comfort is or may be seriously compromised.
8. GMP 2013 set expectations that doctors must:
 1. immediately tell someone who is in a position to act right away if a patient is not receiving basic care to meet their needs.
 2. raise concerns in line with the GMC's guidance and their workplace policy if patients are at risk because of inadequate premises, equipment, other resources, policies, or systems.
 3. ask for advice from a colleague, their defence body, or the GMC if they have concerns that a colleague may not be fit to practise and may be putting patients at risk. They must report this in line with our guidance and their workplace policy if they are still concerned.
 4. record all steps that they have taken in raising concerns under the points above.¹
9. In addition, the GMC published a range of supplementary guidance on raising concerns:
 1. *Leadership and management for all doctors* (2012) at [CM/6 – INQ0007317]
 2. *Raising and acting on concerns about patient safety* (2012) at [CM/5 – INQ0007316]

¹ GMC, *Good medical practice*, paragraphs 24-25, (2013).

3. *Protecting children and young people: The responsibilities of all doctors* (2012) at [CM/7 – INQ0007318

10. In 2015, Sir Robert Francis QC published *Freedom to speak up: an independent review into creating an open and honest reporting culture in the NHS*. This highlighted the barriers doctors face in raising concerns about doctors and other healthcare professionals. In the same year, the GMC established a confidential helpline to support doctors who wish to raise concerns. In line with the GMC's guidance on *Raising and acting on concerns about patient safety*, if a doctor has concerns about a colleague's ability to practise safely they can also seek advice from a colleague, medical defence body or Freedom to Speak up Guardian. Doctors can also contact the NHS Whistleblowing helpline in relation to concerns about all healthcare professionals.

11. I am very conscious that families affected by these deeply upsetting events rightly expect those in positions of leadership across the healthcare system to reflect and consider how to improve the safety of babies in hospital in the future. As such, I understand the current Chief Executive Charlie Massey has also provided a witness statement which gives a full account of how the General Medical Council has tackled these issues in the period outside my tenure as Chair. My former colleagues at the GMC have also assisted me in the preparation of this short statement.

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:

PD

Dated: ____24th April 2024____