Witness Name: Charles Hamilton Massey
Statement No.: 2
Exhibits: CM/1 – INQ to CM/16 – INQ
Dated: 19 December 2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF CHARLES HAMILTON MASSEY

I, Charles Hamilton Massey, of the General Medical Council, 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 General Medical Council ('the GMC'), and I have held this role since 1 November 2016.
2. I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 11 December 2024.
3. This is my second witness statement for the Thirlwall Inquiry ('the Inquiry') into the events at the Countess of Chester Hospital ('CoCH') and their implications.
4. I have been asked to address eight further questions for the purpose of my second statement. I will address these questions in turn.

1. Is it common in your experience for doctors to be threatened with referral to the GMC in the course of either: (i) a grievance process; or (ii) when they have raised patient safety concerns?

5. We know that there are instances where doctors have been threatened with referral to the GMC because they have raised a grievance or patient safety concerns. We also know that there have been cases where this same threat can be used as a mechanism to intimidate doctors who are trying to raise concerns. However, we would not consider this to be a common experience for all doctors. We are very clear that our fitness to practise processes must not be weaponised as a mechanism to deter, intimidate, or punish whistleblowers.
6. In 2015 we commissioned Sir Anthony Hooper to carry out an independent review of whistleblowing cases [CM/1 - **INQ0007342** and have implemented his recommendations, introducing a range of safeguards to prevent the misuse of our complaints system to make

sure only complaints requiring GMC action are referred to us in the first place. The safeguards we introduced included a new referral form where the referrer is required to confirm whether the doctor in question has previously raised concerns in the public interest, and whether those concerns have been investigated. The referrer must also declare that the referral is made in good faith and is both accurate and fair.

7. Where we are aware that a referred doctor has previously raised concerns in the public interest about the organisation that has referred them, we carry out provisional enquiries ('PE'). Those enquiries seek information to independently corroborate the allegations that have been referred to us before we decide whether to open a full investigation, to avoid our procedures being used to retaliate against doctors who raise concerns. Responses to those enquiries are overseen by a review group to monitor the safeguards in these cases. I further outline the PE process in my response to question two.

8. Where we need to open a full investigation, or have done so before we are aware of the history of raising concerns, we focus the investigation plan on obtaining information to independently corroborate the allegations and ensure that our decision makers are aware of that history so they can decide what weight to give to the evidence that is put before them.

9. We are clear in our conversations with and guidance to employers that they should provide appropriate and effective support to doctors who raise concerns. We have also been clear that a system wide approach is needed to tackle the fear of raising concerns within healthcare so that all doctors and their colleagues feel confident to speak up without fear of reprisal.

10. Employers have a responsibility to refer a doctor to the GMC where there is a risk to patient safety or public confidence that cannot be managed locally. This should only happen following a discussion with one of our Employer Liaison Advisers ('ELA')[1] unless there is an immediate risk to patient safety, in which case this risk should be reported to the GMC or another body with authority to investigate the issue.

11. Our core guidance on professional standards, *Good medical practice* [CM/2 - **INQ0108730** is clear that patients must be able to trust doctors with their lives and health.[2] To justify that trust, doctors must make the care of patients their first concern and meet the standards

[1] I detailed the role of our ELAs in my first statement to the Inquiry. Witness Statement of Charles Hamilton Massey, paragraphs 77-88, (4 March 2024).

[2] I provided further information on the standards and more detailed guidance we publish for doctors on raising concerns in my first statement. Witness Statement of Charles Hamilton Massey, paragraphs 37-56, (4 March 2024).

expected of them. *Good medical practice* also states that doctors create a working and training environment that is compassionate, supportive and fair, where everyone feels safe to ask questions, talk about errors and raise concerns.

12. Our more detailed guidance, *Leadership and management for all doctors* [CM/3 - **INQ0108731** sets out in paragraph 66 how doctors 'should understand the difference between a personal grievance, that is a complaint about your own employment situation, and a concern about a risk, malpractice or wrongdoing that affects others.' We also say that this is particularly important if patients or members of the public are at risk of harm. The guidance is clear that if these overlap doctors should acknowledge any personal grievance that may arise from the situation, but focus on patient safety by using the correct procedure to make their personal grievance known or raise their concern.

2. How does the GMC deal with referrals which have been made as a result of the registered doctor in question raising patient safety concerns? Please explain in particular:

a. The relevant process(es) to investigate a complaint against a registered doctor where they have raised patient safety concerns.

b. Any process in place to inform third parties about the patient safety concerns.

c. The likely timescales involved in dealing with a referral.

d. Any relevant guidance in this regard.

13. I outlined in my first statement our legal duty under the Medical Act 1983 ('the Act') to protect the public.[3] We are required in law to consider all concerns raised with us and only take action under our fitness to practise procedures where a doctor poses a current and ongoing risk to one or more of the three parts of public protection. 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.

[3] Witness Statement of Charles Hamilton Massey, paragraphs 63-68, (4 March 2024).

14. We are aware that referrals in relation to doctors who have raised patient safety concerns raise particularly complex issues and that doctors may hesitate to speak up due to concerns about potential consequences and the risk of facing detrimental professional outcomes or treatment. We therefore use a bespoke approach to consider these referrals and guard against them being used by employers to retaliate against a doctor for raising patient safety concerns.

15. Our aim is to prevent doctors from undergoing an unnecessary and stressful investigation linked to their whistleblowing history where the referrer's allegations cannot be substantiated by independent evidence. We do this through a PE when one of the following applies:

    a. The referrer has either declared that the doctor has raised public interest concerns[4] or failed to provide this information within the necessary timescale;

    b. There is evidence either from the doctor or a third party source that the doctor has raised public interest concerns about the referring organisation; or,

    c. The circumstances of the complaint/referral lead to a material risk that it may be linked to the doctor's history of raising public interest concerns even though it is from a patient, a third party organisation, or a third party person acting in a public capacity.

16. We would consider a doctor to have raised public interest concerns if they formally reported their concerns to the management team and/or recorded them on a local reporting or risk management system.

Gathering further information

17. A PE usually involves obtaining limited and targeted information to help us inform a decision about whether a concern raised amounts to an allegation that a doctor's current fitness to practise is impaired and therefore requires a full investigation. We include further information on PEs and the circumstances in which a PE should be undertaken in Parts A and B of our guidance for decision makers [CM/4 – INQ0108732 and [CM/5 – **INQ0108733**

18. Where the doctor has raised public interest concerns (known as 'PIC PE') we use the PE process to independently corroborate the allegations about the doctor's fitness to practise using objective sources of evidence to support a decision about whether a full investigation should be opened. Paragraphs 6-30 of Part D of our guidance for decision makers on

[4] As part of the referral process, the employer is required to confirm whether the doctor in question has previously raised concerns in the public interest, and whether those concerns have been investigated.

carrying out a PE relate to PIC PEs and set out steps that may need to be taken by GMC staff to obtain further information [CM/6 – **INQ0108734**

Deciding whether to promote a PIC PE for a full investigation

19. We strive for the decisions we make when considering whether to promote a PIC PE for full investigation to be rooted in openness and transparency. Therefore, we have published bespoke guidance to support decision makers in deciding the outcome of a provisional enquiry [CM/7 **INQ0108735**

20. The guidance prompts our decision makers at paragraphs 17 to 38 to consider the context of referrals or complaints where the doctor has raised patient safety or public interest concerns [CM/7 – **INQ0108735** Paragraph 22 states:

    'Some types of concern may be more likely to be linked to a doctor's whistleblowing history. These include allegations of poor clinical practice identified by a detailed records review instigated after the doctor has raised public interest concerns. Or allegations of rudeness, bullying, poor teamworking or failure to work with colleagues which arose after the doctor acted as a whistleblower. Decision makers should treat concerns arising solely after the doctor raised patient safety issues with particular caution.'

21. The decision maker must decide if the enquiry should be closed or promoted for a full investigation after they consider the context. An investigation should only be opened if the decision maker is satisfied that sufficient independent evidence has been obtained to corroborate the concerns about the doctor's fitness to practise.

Timescale for a PIC PE

22. Unlike other types of PE, PIC PE does not have a set timeframe for when we decide on whether to open a full investigation. This is because of the complex nature of these referrals and the longer time it may take to gather the information. However, we do keep timescales under review and escalate any excessive delays or difficulties in obtaining the information needed to a senior member of staff to determine the best way forward.

23. We also protect time every fortnight for our internal Public Interest Concerns Group to meet and discuss any enquiries or cases where there is a potential whistleblowing context to ensure these referrals are dealt with in the best way.

Safeguards where a full investigation is opened

24. If the outcome of our PE is that a full investigation is needed, or if we only received notification of the history of public interest concerns after a full investigation has opened,

we have incorporated further safeguards for the doctor into the investigation process. These safeguards ensure that case owners and decision makers are aware of the doctor's history of raising public interest concerns and, if further information is needed, we focus on ensuring that this is independent of the referrer, or anybody involved in the doctor's whistleblowing history where possible.

25. We also provide the Case Examiners to whom the case is referred for a decision at the end of the investigation stage with details of the whistleblowing history so they can take this into account when deciding what action to take. This is outlined at paragraphs 7 to 10 in our *Guidance for Case Examiners on deciding the outcome of a case where the doctor under investigation has raised concerns locally*, exhibited at [CM/8 – **INQ0108736**

Informing third parties about patient safety concerns

26. We may come across information during an investigation which indicates that there may be concerns about the systems and environment in which doctors work and healthcare is delivered. A systems concern is one that goes beyond an individual doctor or group of doctors and suggests a wider failing within an organisation. Serious systems concerns are likely to affect patient safety and wellbeing and it is important that we share information appropriately so action can be considered by the relevant organisation.

27. Our fitness to practise teams can share information which suggests there may be concerns about the systems within a healthcare provider with relevant organisations. In England, the regulation of healthcare systems is primarily the responsibility of the Care Quality Commission ('CQC') which monitors and inspects healthcare services in England against national standards of quality and safety. Our information sharing approach builds on a joint operational protocol [CM/9 – **INQ0108737** that we have agreed with the CQC to effectively work together.

28. We also have guidance for staff on sharing information with the police [CM/10 – **INQ0108724** where we receive information that gives us reasonable grounds to believe that a criminal offence may have been committed but that the police are not aware of. Separate guidance on sharing safeguarding concerns with social services [CM/11 – **INQ0108725** is also available.

3. What support, if any, is provided to a registrant who is subject to a complaint in this situation?

29. The PIC PE process that I explained in response to question two is designed to ensure we take a proportionate and fair approach to any referrals of this nature and seek to avoid our investigation procedures being used to retaliate against whistleblowers.

30. We know that being investigated by the GMC is a stressful experience. This stress is likely exacerbated where a doctor may have been referred to us because they raised patient safety concerns. We have a range of supportive resources to support doctors in these situations.

31. I outlined in my first statement the measures we have introduced over recent years to reduce the impact and stress for doctors who are subject to our fitness to practise processes. These were informed by the recommendations of the independent review we commissioned by Professor Louis Appleby in 2015.[5] For example, we now ask doctors at the start of each investigation if we can call them rather than just write them a letter. During the phone call, we let them know we are investigating a concern that has been raised with us and outline what will happen next. This also gives the doctor the opportunity to ask questions about the process as we know that the uncertainty of an ongoing investigation causes stress. We also give every doctor a single point of contact so they can speak to the same person about their case throughout the process.

32. We also commission and fund the British Medical Association ('BMA') to run the Doctor Support Service[6] on our behalf. The Service is free, confidential, and available for all doctors under investigation and offers emotional support from another doctor who has peer support experience. The Medical Practitioners Tribunal Service ('MPTS') also provides a support service for doctors appearing before a tribunal.[7]

33. The resources and support we signpost to on our website for whistleblowers before and after they raise concerns include:

    a. Ethical guidance on *Raising and acting on concerns about patient safety.*[8]

    b. An ethical hub on Speaking Up with up-to-date resources to support the raising of concerns.[9]

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[5] Witness Statement of Charles Hamilton Massey, paragraph 96, (4 March 2024).

[6] GMC, *Doctor Support Service,* (2024). Available at: https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/support-for-doctors/doctor-support-service.

[7] MPTS, *Hearing Support Service,* (2024). Available at: https://www.mpts-uk.org/parties-and-representatives/support/mpts-support-service.

[8] I provided further information on the standards and more detailed guidance we publish for doctors on raising concerns in my first statement. Witness Statement of Charles Hamilton Massey, paragraphs 37-56, (4 March 2024).

[9] GMC, *Speaking Up – Ethical Hub,* (2024). Available at: https://www.gmc-uk.org/professional-standards/ethical-hub/speaking-up.

c. The GMC Confidential Helpline. Our helpline allows individuals to raise public safety concerns or ask for advice if they do not feel able to do so locally. It is staffed by specially trained advisers who can discuss concerns and advise who to speak to if, for example, the concern is not about a doctor.

d. Partnership with Victim Support. We have partnered with Victim support, a specialist independent charity to create the Independent Support Service. The Service can provide emotional support and practical advice by phone throughout an investigation. The support service is free, confidential, and available 24 hours a day, 365 days a year. Whistleblowers can use this confidential free support at any time before, during or after attending a fitness to practise hearing.

e. We also signpost to the charity organisation, Protect, in our policy on whistleblowing [CM/12 – **INQ0007341** who can provide confidential advice on whistleblowing.

34. Over 2025 we will review our more detailed guidance on *Raising and acting on concerns about patient safety* and *Leadership and management for all doctors* as part of a scheduled review cycle. A prominent part of the review will consider the barriers to raising concerns and what we can do to lessen and remove the barriers. We will consider strengthening the section on grievance, performance, and health duties in the current version of *Leadership and management for all doctors*. If there is an evidence base, we could introduce a new duty to make explicit that doctors must never use threats of regulatory actions to silence or intimidate those raising concerns about patient safety.

4. The evidence of Ian Harvey [on 29 November 2024] made reference to the GMC corresponding with registrants about complaints with no regard to the day of the week or time meaning letters could be received late on a Friday or at the weekend when no support is available. Does the GMC acknowledge this happened in the past? Does this still happen? If so, is additional support available during evenings and/or weekends? If not, what processes have been put in place to stop this happening?

35. We acknowledge that our approach to initial disclosure letters to doctors has not always been as considerate as it should have been and understand the ramifications of this on doctors' wellbeing. This is why we offer introductory phone calls to all doctors who are subject to an investigation that I outlined in my response to question three. For many years it has been our custom and practice to refrain from sending any correspondence to a

doctor which may be received on a Friday or at other times when the doctor is unable to access immediate support.

36. We ask our teams to be mindful of the impact of correspondence and the best time to send it. This is particularly important during periods when the doctor is less likely to be able to access support, like over weekends and holidays.
37. We always aim to strike the balance between sensitively progressing cases in a timely way, while providing support to any doctor in our processes, and our duty to protect the safety of the public. We consider when to contact doctors on a case-by-case basis as there will be instances where we will need to imminently progress a case and notify a doctor. For example, when we refer a case to an Interim Order Tribunal ('IOT')[10] for a decision on whether a doctor's practice should be restricted while an investigation takes place due to protect the public or maintain confidence in the profession.
38. Although we have made significant efforts to improve how we handle complaints, we will continue to listen to feedback to identify further improvements that we can make to how we communicate with doctors. Striking a balance between being sensitive to any doctor that interacts with our processes and protecting the public is always at the forefront of our work.

5. The Inquiry also understands that referrals have been made as a result of a registrant raising patient safety concerns but that the basis of the referral has been stated to be something else. Does the GMC acknowledge that this happens? If so, what steps are taken by the GMC to satisfy themselves that a complaint is not being made in response to the raising of patient safety concerns by the registrant who is the subject of the referral?

39. In the small number of referrals about doctors where it is known that the doctor has raised patient safety or public interest concerns, it is often the case that the stated grounds for the employer or responsible officer ('RO') referral are not related to the patient safety concerns the doctor has raised at a local level. We are unable to say what the referrer's motivation was in making the referral. However, the safeguards provided by the PIC PE

[10] IOTs decide if a doctor's practice should be restricted, either by suspension or imposing conditions on their registration, while an investigation takes place. This is most commonly to protect the public or to maintain public confidence in the profession while serious allegations about a doctor's fitness to practise are investigated. At any point during our investigations, the GMC can refer a doctor to an interim orders tribunal at the MPTS.

process enable us to assess whether the concerns the referrer has raised are supported by independent evidence and meet the threshold for investigation.

40. Although we are unable to determine an employer's motivation in making a referral, we have put a number of processes and safeguards in place to seek to assure ourselves that a complaint is not being made in retaliation against the raising of patient safety concerns by the doctor. In my first witness statement, I explained that when a referral is made to us, the employer is required to confirm whether the doctor in question has previously raised concerns in the public interest, and whether those concerns have been investigated.[11] The referrer must also declare that the referral is made in good faith and is both accurate and fair. This declaration of good faith was specifically introduced after the recommendations that were made in Sir Anthony Hooper's review.

41. As explained above, where a doctor has raised concerns in the public interest, we will seek independent corroboration of the allegations provided in the employer or RO referral before deciding whether to open an investigation. This is to help us ascertain if there is a genuine question about the doctor's fitness to practise that may raise a risk to patients, public confidence in the profession, or proper professional standards and conduct.

42. If a full investigation is needed, we also make our Case Examiners aware of the whistleblower history, so they can take this into account when deciding what action to take. Further details can be found in paragraphs 7 to 10 our guidance for Case Examiners exhibited at [CM/8 - INQ0108736

43. We continue to deploy our Outreach teams across the UK to improve understanding of our role and when fitness to practise action is necessary by discussing concerns and helping address them at a local level.

44. Our guidance to support employers and ROs [CM/13 - INQ0108726 when they are considering raising a concern helps explain the steps they need to take to ensure referrals are appropriate, fair, and proportionate. The guidance explains that they must tell us:

    a. about all the steps they have taken to make sure referrals are fair and inclusive;

    b. what impartial checks have been carried out and how they have considered systemic issues;

    c. what support they have provided locally to the doctor in question; and,

    d. whether the doctor has raised patient safety concerns.

[11] Witness Statement of Charles Hamilton Massey, paragraph 135, (4 March 2024).

45. We also ask ROs to ensure they speak to their ELA for advice on how to proceed if a doctor connected to their designed body or working for or contracted by their organisations appears to have reached, or be close to, any of our thresholds for investigation and fitness to practise action. Our thresholds guidance [CM/14 - **INQ0108727** provides clarity to ROs, medical directors and others involved in the employment, contracting, and management of doctors on what matters we can and cannot take action on.

46. We continue to work with partners to help ensure local investigation processes are fair and consistent. For example, we have spoken to every employer in the UK about their duty to provide supportive and inclusive working environments. This includes how they are considering the findings of the *Fair to Refer?* research [CM/15 - **INQ0108728**, that we commissioned to explore why employers and healthcare providers refer some groups of doctors to us more than others.

47. Our teams continuously update online resources and information to help improve understanding of the fitness to practise process. This makes it clear what we can and cannot investigate.

6. Do you have any figures or data about:

a. How many referrals are made arising from a grievance process or against registrants who raise patient safety concerns?

b. How many of those referrals are dismissed and how many are upheld?

c. For those that are upheld, please provide details about the sanctions imposed.

d. How long these referrals take to be dealt with?

48. We have searched our fitness to practise records for referrals that have been made which contained investigations:

    a. Where retaliation against a whistleblower has been noted; and,

    b. Where someone might have failed to protect whistleblowers or act on whistleblowing concerns.

49. It is important to note that these figures are non-exhaustive because of the complexity of these types of cases, the way we categorise our data, and how we can search our records. There might be further instances that will not have appeared in our search due to the search terms we used. However, they can be used as an illustration of the levels of vexatious complaints or referrals we have received.

50. Since April 2007,[12] we identified 19 investigations where retaliation against a whistleblower has been noted in the allegation description of the investigation. The median duration from the date the referral was received to closure was 1.6 years. The outcomes of these allegations included:

    a. 15 concluded with no action after investigation.

    b. 2 concluded with advice provided to the referrer.

    c. 1 concluded with sanctions of conditions on practice applied at a hearing.

    d. 1 is still in progress.

51. We also identified 7 investigations which included allegations of someone having failed to protect whistleblowers or act on whistleblowing concerns since April 2007. Each investigation concluded with no action taken. The median duration from the date the referral was received to closure was 2.2 years.

7. How, if at all, does the GMC deal with complaints against registrants involved in a grievance process or who have raised patient safety concerns that it considers are vexatious? Does the GMC have a vexatious referrals policy?

52. The approach we are required to take to referrals is set out in legislation[13]. We do not have a vexatious referrals policy. However, during our initial assessment of concerns, paragraph 6(b) in our guidance on the fitness to practise rules provide that 'where the registrar considers that an allegation should not proceed on grounds that it is vexatious he shall notify the practitioner and the maker of the allegation accordingly' [CM/5 - INQ0108733] It is rare that we will engage this rule in practice because to do so requires that we identify a vexatious motivation and that is incredibly difficult to determine, particularly at the outset when we have limited information.

53. In law, we are required to consider all concerns raised with us, and where the legal threshold is met, we are required to investigate.[14] Once concerns are promoted for investigation, we consider whether the available evidence supports the allegation. When communicating closure decisions made by our Case Examiners, we provide a clear explanation and rationale of our decision to the doctor and the complainant or referrer. It

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[12] 2007 was used as it is the first full year of reliable data that we have on our current data system.

[13] *Health Care and Associated Professions – Doctors – General Medical Council (Fitness to Practise) Rules Order of Council Order 2004.* SI 2004/2608. [Online]. [Accessed 17 December 2024]. Available at: https://www.legislation.gov.uk/uksi/2004/2608/made.

[14] Section 35C(2)(a-d) of the Act.

would be difficult for Case Examiners to determine that a complaint was vexatious as they are considering evidence related to the doctor's fitness to practise in order to determine the outcome of our investigation, and it is very difficult to determine the complainant's or referrer's motive.

8. Is there a timescale for dealing with vexatious complaints? Is there any sanction against any individual or organisation that is considered to have made a vexatious complaint?

54. We do not have separate timescales for vexatious complaints and apply our usual timeframes. The overarching principle remains that all enquiries and cases should be progressed as quickly and proportionately as possible.

55. In terms of sanctions for individuals or organisations that are considered to have made a vexatious complaint, we only have sanction powers relating to doctors (and since 13 December 2024 relating to Physician Associates and Anaesthesia Associates). Our legal powers to impose sanctions are not intended to be punitive and are intended to address the risk a doctor poses to public protection which includes patient safety, public confidence in the profession, and maintaining proper professional standards and conduct. It is possible that this could arise where a registrant had made a vexatious complaint about another registrant, but it is difficult to establish the evidence for this.

56. The opportunity to make our fitness to practise procedures less adversarial through our current programme of regulatory reform[15] will give us more discretion to determine which cases we should investigate, as well as closing cases more quickly when we have confirmed there is no current or ongoing risk to patients. This will better support doctors who are subject to a complaint in this situation.

Concluding remarks

57. I am grateful for the opportunity to provide further information to the Inquiry on how we continue to address these important issues.

[15] More information on regulatory reform is available on our website: https://www.gmc-uk.org/about/how-we-work/regulatory-reform.

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: 19 December 2024

Annex A

Table of exhibits: (16 exhibits)

	Date	Notes/Description	Exhibit number
1	March 2015	The handling by the General Medical Council of cases involving whistleblowers - Report by the Right Honourable Sir Anthony Hooper to the General Medical Council.	CM/1 – **INQ0007342**
2	January 2024	Good medical practice.	CM/2 – **INQ0108730**
3	March 2012	Leadership and management for all doctors.	CM/3 – **INQ0108731**
4	January 2023	Guidance for decision makers on Provisional enquiries (Part A).	CM/4 – **INQ0108732**
5	December 2023	Guidance for decision makers on Provisional enquiries (Part B).	CM/5 – **INQ0108733**
6	February 2023	Guidance for decision makers on Provisional enquiries (Part D).	CM/6 – **INQ0108734**
7	January 2023	Guidance for decision makers on Provisional enquiries (Part E).	CM/7 – **INQ0108735**
8	January 2024	Guidance for Case Examiners on deciding on the outcome of a case where the doctor under investigation has raised concerns locally.	CM/8 – **INQ0108736**
9	March 2024	CQC & GMC operational protocol: a practical guidance for staff.	CM/9 – **INQ0108737**
10	January 2018	Sharing information with the police - guidance for all staff.	CM/10 – **INQ0108724**
11	January 2018	Sharing information with social services - guidance for all staff.	CM/11 – **INQ0108725**
12	May 2018	GMC policy on whistleblowing.	CM/12 – **INQ0007341**
13	December 2024	RO referral guidance.	CM/13 – **INQ0108726**
14	April 2024	Thresholds guidance.	CM/14 – **INQ0108727**
15	June 2019	Fair to Refer? report.	CM/15 – **INQ0108728**
16	December 2023	Guidance to the fitness to practise rules 2004 (as amended).	CM/16 – **INQ0108729**