

Witness Name: Charles
Hamilton Massey
Statement No.: 3
Exhibit: CM/1 – INQ
Dated: 22 January 2025

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 9 January 2025.
3. This is my third 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 three further questions for the purpose of my third statement. I will address these questions in turn.

1. Have fitness to practise or interim order proceedings been conducted in relation to a registrant when acting as a board director (as opposed to in a clinical role or as a department head) in the last 10 years?

2. If yes, please provide this information by reference to:

a. the number of referrals raising a concern for initial assessment?

b. Of those, how many were accepted for further investigation and how many were dismissed by case examiners? The number of interim order applications and, of those, how many resulted in interim orders being made?

c. The number of investigations which (i) found a case to answer and (ii) found no case to answer?

d. For those investigations where there was no case to answer, please indicate whether that was based on insufficiency of evidence to establish the facts or insufficient evidence to make a finding of current impairment?

e. The number of fitness to practise proceedings ('FTP')?

f. Please provide a breakdown of the outcome of the FTPs by reference to whether there was no further action, caution or advice, conditions of practice, suspension or removal from the register.

5. We have considered the Inquiry's request regarding whether fitness to practise or interim order proceedings have been conducted in relation to a registrant when acting as a board director (as opposed to a clinical role or as a department head) in the last 10 years.
6. There is unfortunately no reliable way of providing this information because we do not routinely hold data about whether doctors on our register are in board director positions and because of the way our fitness to practise data is categorised.
7. Our fitness to practise data is structured around a list of allegation types [CM/1 – INQ0108836] linked to the domains of our core guidance on professional standards, *Good medical practice*. There are no allegation types directly related to a doctor's position. The allegation types most relevant to this request are 'Inadequate leadership' and 'Failure to appropriately supervise'. However, any manual review of all cases under these allegation types would not reliably identify the information that the Inquiry is seeking.
8. We do, however, have some related information which may be of interest to the Inquiry as it concerns doctors in Chief Executive, Medical Director, or Responsible Officer roles which are often at Board level positions. Part of this was compiled in response to a previous stakeholder request. Through feedback, we have identified seven cases in relation to doctors in Chief Executive, Medical Director, or Responsible Officer roles. As mentioned, our systems do not capture this information and so it may not be a complete record of all cases relating to doctors in these roles. The outcomes of these seven cases are listed below.
 - a. All seven cases were investigated.
 - b. Five of the cases were referred to a hearing at the Medical Practitioners Tribunal Service.

- c. The first four cases referred to a hearing concluded with a finding of no impairment based on insufficient evidence. The fifth case promoted to a hearing concluded with a finding of impairment and a sanction of erasure from the medical register.
 - d. The sixth case was closed by the Case Examiners with no further action after an investigation.
 - e. The final case concluded with a warning after an investigation.
9. Some of the allegations in these cases included failing to appropriately supervise and provide adequate leadership; failing to raise concerns or respond to complaints about patient safety; unprofessional behaviours, including bullying and dishonesty; and failing to put in place or use systems to raise concerns. Not all of these allegations were found proved.

3. Do the GMC retain subject matter experts in relation to this issue?

10. We have independent expert witnesses who provide us with expert evidence to enable us to investigate fitness to practise cases. We may instruct an expert with experience in leadership roles such as Medical Director or Responsible Officer where relevant to a particular case.
11. I mentioned in my second statement to the Inquiry that we will review our more detailed guidance on *Leadership and management for all doctors* in 2025.¹ We will consult with subject matter experts in this area to inform changes to the guidance.

Concluding remarks

12. I am sorry that I cannot provide exactly what the Inquiry is seeking but hope that the information provided is of some assistance. Please do not hesitate to contact us should you wish to discuss any of the above.

¹ Witness Statement of Charles Hamilton Massey, paragraph 34, (19 December 2024).

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:

Personal Data

Dated: 22 January 2025

Annex A

Table of exhibits: (1 exhibit)

	Date	Notes/Description	Exhibit number
1	February 2024	GMC Allegations Handbook	CM/1 – INQ