General Medical Council

Gosport War Memorial Hospital Report: GMC response

Introduction

1 We welcome the report of Bishop James Jones and his panel. The report was widely critical of both individuals and organisations, the GMC among them. We recognise that the length of time which the families had to pursue action over these tragic events was wholly unacceptable and for our part in that, and the other areas of criticisms directed at us, we are deeply sorry.

2 We cannot undo the failings of the past but we can honour the families and those they have lost in our current and future actions. Though much has changed since the events covered in the report, it remains vital that all concerned consider the lessons that can still be learned and the actions that should now be taken.

3 This report sets out the work that we have done since the events described in the Gosport Independent Panel ('the Panel') report, and the further actions we are now taking. The Panel report detailed an appalling and disturbing series of events, raising very serious questions for us and others in how we respond to significant patient safety risks in a robust and timely manner.

4 This cannot undo the past but we hope it can go some way in assuring the families that change has and continues to happen to prevent tragedies like this in future.

Our role

5 The General Medical Council ('GMC') is an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training.

- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.

- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

Executive summary: changes and actions

6 The publication of the report has reinforced for us as an organisation that whilst much has changed, we need to pause for reflection and determine the further action we can take. In the section below, we have summarised the major changes that have occurred since the events at Gosport War Memorial Hospital occurred and the action we are now taking in response to the Panel report.

7 Key changes since the events at Gosport War Memorial Hospital:

- Since the terrible events at Gosport Memorial Hospital occurred, we have made substantial changes in the way we work with families, patients and witnesses that engage with our processes. Our Patient Liaison Service, set up as a pilot in 2012 and fully rolled out in 2015, invites complainants to meet with us to ensure we have properly understood their concerns, discuss our processes and answer any questions that they may have. Our 'patient voice' project ensures we communicate in a timely manner with family, or those close to the care of a patient, where we are investigating concerns about a patient who would otherwise lack a voice in our process because they lack capacity or because they have died. Our ongoing witness experience review is also aimed at improving the experience of GMC witnesses by better understanding witness needs, more frequent and direct interactions with named points of contact throughout our processes and signposting to other support services if necessary.
- Established in 2012, our Employer Liaison Service advisers build strong relationships with employers, advising them on timely fitness to practise referrals, and greatly improving our local intelligence about issues or individuals who may be of concern. They also help us support more robust local processes for dealing with concerns in a way that is in the interests of patients, healthcare providers and doctors.

  In addition, our Regional and Devolved Office Liaison Advisers work in hospitals, GP surgeries, medical schools and communities in partnership with the medical profession, medical schools, postgraduate education bodies, employers, health care regulators and patients to support doctors and medical educators in their practise in the interests of patients and the wider healthcare system.
- We liaise directly and more frequently with police forces across the country to ensure we are sighted early about any doctor who becomes the focus of any police investigations. These types of cases are also subject to regular review by senior members of staff to ensure they cannot simply stall indefinitely. If a current

patient safety risk is posed by the doctor continuing to remain in unrestricted practice, we will now always act swiftly to apply for immediate action through the Medical Practitioner's Tribunal Service's ('MPTS') Interim Orders Tribunal.

- To ensure timely disclosure of any documentation or material we deem necessary for our fitness to practise investigations, we are now far more proactive in our use of section 35A (Medical Act 1983 – as amended) enforcement powers. These powers allow us to require any person who is able to supply information or produce a document that appears relevant to our enquiries to provide that information.
- Today, as a matter of course, we will always seek clear written evidence from employers or other witnesses who provide us with information directly relevant to our investigations. We will never solely rely on verbal confirmation of local restrictions on practice.
- We also work closely with other organisations in the system, such as other professional and systems regulators, to ensure we are sharing information about any emerging concerns across the healthcare system in a swift and robust manner. The *Emerging Concerns Protocol*, signed in 2018 and coordinated by the Health and Social Care Regulator forum in England, greatly strengthens our ability to act in a unified and coordinated way when information and intelligence suggests there is a risk to patients, their carers, families, trainees or other healthcare professionals. We know we cannot act alone in preventing harm to patients and we are committed to working with others to better coordinate and prioritise activity where rapid action is needed. We are also exploring the establishment of similar escalation processes, building on existing protocols where these exist, with partners in Northern Ireland, Wales and Scotland.
- Our guidance around whistleblowing implements a clear professional responsibility on doctors to raise and act on concerns, highlighting managers' responsibilities to ensure there are systems in place to allow concerns to be raised and investigated. Our confidential hotline, launched in 2012, also allows doctors to raise serious concerns with us where they feel they cannot do so through local channels.

8 Key action taken in response to the Panel report:

- Having reflected on the Panel's criticisms, we clearly need to do more to learn from the families' experiences in tirelessly seeking justice for their loved ones. To strengthen our work listening and engaging with the voices of patients, families and friends, and the wider public, we are therefore introducing a patient champion role at a senior level at the GMC. We are currently working through operationalising this patient champion role.
- In order to ensure we have identified any fitness to practise concerns within the Panel report, we have instructed leading external counsel to advise us on whether there are any grounds to consider fitness to practise action against any of the

doctors named in the report. Where we identify that there is action to be taken, we will proceed in a robust and timely manner. Once we have made all the decisions in respect of fitness to practise we will publish a further update with more details.

- We are conducting an internal review of our investigations processes where there is an ongoing police investigation and identifying any changes we need to make to our guidance for staff and decision makers and other further improvements we can make. This will ensure we are doing everything we can to progress such investigations in a timely fashion and ensure that we can take action in a timely way where we believe that patients may be at risk. We intend to reflect with other regulators on any further lessons that can be learned as a result of events at Gosport War Memorial Hospital.
- We are also committed to working closely with other professional and systems regulators to ensure any improvements to information sharing protocols or other processes are implemented in a timely fashion.
- In recognition that there were 'shortcomings in the assistance given to the Panel' and that we were involved in a 'coincidence of interests across organisations…including at times… dismissive treatment of the families', we are eager to learn from the exercise and ensure similar mistakes do not occur in the future. We therefore commissioned an independent learning review into the way in which we manage and resource our relationship with both statutory and non-statutory inquiries so that we are better able to support them in their work.

Interactions with families and witnesses

9 A crucial learning point for us from the Panel report has been the way we interact with families and others who bring their concerns to our attention. In recent years we have made substantial changes to the way we engage with complainants and witnesses. We recognise that our processes are complex and can be confusing and stressful for complainants who may have already lost a loved one or suffered harm themselves. Our processes for supporting families and complainants at the time of the events at Gosport War Memorial Hospital were simply not good enough. The changes we have made in the years since are outlined below and we recognise that there is always room for improvement.

Patient liaison service

10 The largest proportion of complaints to the GMC are from the general public (nearly 70% of the total in 2016) and yet only 11% of these complaints lead to the most serious sanctions of suspension or erasure. We appreciate that this can lead to frustrations for patients who will inevitably feel that they have not been listened to. By the time patients/families/complainants engage with the GMC, we recognise that they may have already been through several other investigations such as by the Police, the Trust, the Coroner, the Parliamentary and Health Service Ombudsman or others. We

therefore introduced the Patient liaison service, first as a pilot in 2012 and then rolled out in 2015, to improve how we liaise with patients and their families.

11 The service offers face to face or telephone meetings to complainants at the outset of the investigation process. The purpose of the meetings is to explain our processes and help complainants develop an early understanding of possible outcomes of the investigation, as well as to ensure that we have properly understood their concerns. It also allows the complainant to provide further information and ask any questions about our processes or about their case. At the conclusion of a case, whether or not action has been taken against a doctor's registration, a further meeting is offered to discuss the decisions made and, if appropriate, to direct the complainant to other sources of help. Since we introduced the service, we have seen a third of all complainants engage with the service and this number continues to rise. We seek feedback from every complainant who engages with the service and the feedback is overwhelmingly positive.

Patient voice

12 The aim of our 'patient voice' policy is to ensure that, in cases where a patient may lack the capacity to engage with us, or is deceased, we make timely contact with those close to the care of the patient to notify them of the investigation and invite them to tell us about anything that may be relevant to that investigation. This may be a family member, but could also be a patient's carer or close friend. We recognise that families and those close to the care of a patient can provide important insight into the care received by their loved ones which can be very valuable to an investigation, and we make every effort therefore to ensure that they are properly involved in our investigation process.

Witness experience review

13 Once an investigation process is underway, we will begin to take formal witness statements from those involved. We have recently launched a series of changes that will aim to improve the experience of GMC witnesses ensuring:

- better care throughout an investigation
- seamless communications and regular updates through named points of contact through our processes
- early assessment of witness needs
- signposting to our independent witness support service if necessary (which offers emotional support through our processes)
- improved witness care when attending an MPTS hearing, including regular updates on the hearing and a new witness waiting room.

Other initiatives

14 We are also reviewing the way in which we engage with those involved in our processes who are more vulnerable. We are working to ensure that our investigations staff have the appropriate training and guidance needed to work with particularly vulnerable groups. Specifically, we have made changes to our processes for groups such as individuals with learning difficulties, those that have experienced trauma such as sexual abuse and individuals that have mental health concerns.

15 Furthermore, to support the work mentioned above, we are committed to introducing a responsibility to champion patient issues within a senior role at the GMC. This role will strengthen our work around listening and engaging with the voices of patients, families and friends and the wider public with senior sponsorship within the GMC. We are currently working through operationalising this patient champion role.

Doctors' fitness to practise

16 Dr Jane Barton, the doctor who is the focus in the Panel report, is no longer registered with the GMC. At the time of her hearing before the Fitness to Practise Panel in 2010 we sought her erasure from the medical register. The Fitness to Practise Panel concluded that it was sufficient to impose conditions on Dr Barton's registration. At that time we had no power of appeal against such decisions, although we took the decision, unprecedented at the time, to issue a statement making clear we thought the wrong sanction had been applied. Today, we would seek to immediately appeal any decision where we felt the MPTS had not adequately protected patients or the public (including public confidence in the medical profession). The Council for Healthcare Regulatory Excellence ('CHRE', now known as the Professional Standards Authority) did have a power of appeal, but chose not to exercise that power.

17 The recently published Sir Norman Williams Review looked into the issues relating to gross negligence manslaughter in healthcare. It recommended that the GMC's right to appeal MPTS decisions should be removed. In Dr Barton's case, the findings were very serious and the GMC did not deem conditions sufficient to protect patient safety or confidence in the medical profession. If we had the power of appeal in 2010, we would have appealed the Fitness to Practise Panel's decision. Indeed, part of the rationale for the GMC obtaining the right of appeal was because of the Fitness to Practise Panel's decision in Dr Barton's case and our inability to appeal.

18 We subsequently granted an application from Dr Barton to have her name voluntarily erased from the register, there being no further effective action against her that we could take given CHRE's decision not to appeal. As she is no longer registered, she is beyond our jurisdiction.

19 Following the publication of the Panel report we commissioned leading external

counsel to advise us on whether there are grounds to consider fitness to practise action against any of the other doctors named in the report. We know that some of these doctors are no longer on our register. For those that remain on our register, if there are shown to be serious concerns and we are not prohibited from taking an investigation forward in any way, we will immediately prioritise any action. Protection of patients and the public will always be our first priority.

20 If any of the doctors who are no longer registered were ever to apply to come back on the GMC register, we would first consider whether the criticisms of them in the Panel report are compatible with their restoration to the register.

21 In addition, we are mindful that while a doctor may no longer have GMC registration and so is unable to practice in the UK, they could be registered to work in a jurisdiction outside the UK. Where we have reason to believe a named doctor may be working in another jurisdiction we will make the medical regulator in that country aware of the existence of the Panel report. We will do all we can to ensure they cannot practise in a different jurisdiction without the relevant regulator being aware of the Panel's concerns.

Operation Magenta assessment

22 We are committed to working closely and regularly liaising with the Eastern Policing Region in their new assessment of events at Gosport War Memorial Hospital. We understand they are considering whether any individuals should be subject to criminal investigation. We will ensure that we are sighted early about any doctor who becomes the focus of the police assessment. If we identify a current risk to patient safety, we will push for action to be taken in a swift manner through the MPTS' Interim Orders Tribunal. We will do all we can to ensure we have the relevant evidence to obtain an appropriate order to protect patients and the public while we investigate any concerns.

Regulatory themes and developments

Regulatory and criminal investigations

23 One of the fundamental criticisms in the Panel report was that the GMC and others were too passive in pursuing their own investigations, preferring to allow the police and Crown Prosecution Service' (CPS) criminal enquiries to run their course first. In doing so, we allowed our own processes of accountability to be undermined by deferring to the police's request to place our investigation on hold and for this, we apologise. We also recognise that the delays in investigating Dr Jane Barton's case and delays in obtaining an interim order placing restrictions on her practice contributed to a more lenient sanction at the Fitness to Practise Panel hearing. Whilst the reasons for this delay are multi-faceted, we recognise our failures in this regard and will reflect on any gaps in our internal guidance. We apologise that this was allowed to occur in the first place: it is unacceptable.

24 Our regulatory investigations do not seek to punish doctors: our clear priority is to protect patients and the public. We will therefore make our decisions about a doctor's fitness to practise looking forward, not backwards. The police, however, make their decisions looking backwards and to a different (and higher) standard of proof. The two investigations are therefore very different, but have the joint overarching aim of public protection. Today, we work closely with the police to understand their criminal investigations and to ensure we are not unnecessarily prohibited from conducting our own regulatory investigations in a timely manner.

25 Since the 1990s and 2000s, much has changed in the way we work with the police, and other authorities, where we have a live investigation. Today we would expect to run our own investigations in parallel with those of the police. During the course of an investigation there may be circumstances in which the police ask us to place some elements of our own enquiries on hold in order not to prejudice their criminal investigation. For example, they may wish to speak to certain witnesses before we do. But whilst it is important that we do not impede their investigations, we will work with them to understand the reasons for their request and establish whether there are other aspects of our own enquiries with which we can safely press ahead without jeopardising a criminal investigation. Cases where there is a judicial process running alongside our regulatory investigations are subject to regular review by senior colleagues so that they cannot simply stall indefinitely. We may also seek external legal advice to allow us to progress a case in a more timely fashion.

26 Another factor in our interactions with the police in the case of Dr Barton concerned problems with the disclosure of information to us. As the Panel report outlines, we made several unsuccessful approaches to the police to request disclosure in an attempt to gain further information to support our investigations. Part of our disclosure process involves section 35A of the Medical Act 1983 (as amended), our power to compel disclosure from the police and others. Further details are provided below.

GMC's power to require disclosure of information

27 Section 35A of the Medical Act 1983 was introduced in 2000. In short, this power enables the GMC to require any person who is able to supply information or produce a document which appears relevant to our enquiries to provide that information or document.

28 Our enforcement powers as per section 35A of the Medical Act should have allowed us to seek information from the police and other parties where delays had occurred and normal channels of disclosure had failed to produce the evidence we required. We recognise that in the case of Dr Barton, we were not sufficiently proactive and robust in enforcing these powers and regret that this led to delays in obtaining key evidence from the police and Trust.

29 Whilst we have made great strides in the enforcement of this power, the Panel report

has reinforced our need to be vigilant about the way in which we do this. Today, every request to the police for disclosure of information is made under our section 35A powers. If we do not secure full disclosure of the necessary evidence within agreed timeframes, there is now a clear escalation protocol to assist staff with the enforcement of section 35A. If the lack of evidence is impeding our ability to investigate a matter properly and in a timely fashion, we will always consider the use of our enforcement powers.

30 In general, our liaison with police forces across the country has much improved since the events at Gosport and we continue to learn from our historic mistakes. Earlier this year we met with the Metropolitan Police's disclosure unit to improve our understanding of our respective needs regarding the communication and disclosure of information. This resulted in agreement on new approaches to disclosure requests and a better understanding, on both sides, of why we make requests in the first place and situations in which we will enforce our section 35A power. We will be meeting them again to keep the dialogue open and we continue to explore ways to expedite disclosure requests with other police forces.

Use of unverified information

31 The Panel report criticised our failure to verify the accuracy of what we were told by police and employers about the local restrictions on Dr Barton's practice in relation to her prescribing. It is, of course, reasonable for us to expect such authorities to be honest, accurate and open in their dealings with us as we should all be working in the public interest.

32 Nonetheless, we each have a duty to exercise due diligence in the way we carry out our responsibilities. As described elsewhere in this response, our current relationships with the police and employers mean we are much better placed to ensure we have a full understanding of the facts of a case and of local developments and better sharing of key information. In particular, the establishment of our Employer Liaison Service ('ELS') and Regional Liaison Service ('RLS') in 2012, as well as our Devolved Office Liaison Advisers ('DO LAs'), have enabled us to build strong relationships with stakeholders across the United Kingdom. Further detail about the ELS, RLS and DO LAs are provided below. Today, as a matter of course, we will seek witness evidence or written confirmation of the information we are given from various sources about things such as local restrictions on practice. We regret that this was not done in a more robust way in Dr Barton's case.

GMC Liaison Services: the ELS, RLS and DO LAs

33 The ELS has been crucial in creating and developing better relationships with employers, improving our local intelligence about issues and individuals who may be of concern and enabling more effective sharing of information. Most notably, the ELS provides support and advice for Medical Directors (Responsible Officers) in

Trusts/boards in investigating concerns about a doctor's practice, even before a case is formally referred to us for consideration. This also helps to support more robust local processes for dealing with such concerns in a way which is in the interests of doctors, patients and healthcare providers.

34 Additionally, Regional and Devolved Office Liaison Advisers work in hospitals, GP surgeries, medical schools and communities in partnership with the medical profession, medical schools, postgraduate education bodies, employers, health care regulators and patients to support doctors and medical educators in their practise in the interests of patients and the wider healthcare system. Our advisers:

- Promote understanding of the role and value of the GMCs work with medical students, doctors, patients, employers and other health regulators
- Support high professional standards in medical education, training and practice by identifying concerns about patient safety and the quality of training doctors are receiving and collaborate with others to drive improvement
- Deepen the GMC's understanding of the issues affecting doctors, employers, medical students and patients so that our work is informed by and responsive to these challenges
- Develop training interventions to support high standards of professional practise.

35 These liaison services did not exist at the time of the events at Gosport War Memorial Hospital. Had they done so, this would have enabled greater openness, as well as better and timelier information sharing.

Information and intelligence sharing with other organisations

36 The concerns at Gosport War Memorial Hospital were not identified systematically or at an early enough stage. Furthermore, it is deeply disturbing that the scale of patient harm was not fully understood until the Panel's report. We cannot act alone in identifying and addressing patient safety concerns and we are committed to coordinating with others to take swift action where necessary. A number of other developments in recent years are also helping to create more robust local clinical governance, readiness to raise concerns and better information sharing.

37 We are working closely with system regulators and improvement bodies to update the Effective governance handbook to support revalidation. The core elements of effective governance (incorporating clinical governance and medical appraisals) as set out in the handbook, are aimed at helping healthcare organisations (via their boards, governing bodies and responsible officers) review the robustness and effectiveness of local systems supporting high quality patient care and medical revalidation. Providers of

healthcare services have a clear duty of care to patients. To satisfy this duty, they must ensure that all doctors they engage with are supported in keeping up to date and are fit to practise, and that where a doctor's performance is in question there are effective mechanisms for investigating and managing this.

38 As outlined above, we cannot identify concerns alone and we are sometimes faced with a difficulty in identifying where or when issues arise. Intelligence and data from a local level and from other organisations help us identify abnormal practice. To further our ability to identify risk and take action where needed, we need to work closely with others and share our own intelligence and information. With this goal in mind, we recently signed the *Emerging Concerns Protocol*, coordinated by the Health and Social Care Regulator forum in England. The protocol is a strengthening and formalisation of existing arrangements for sharing emerging concerns between regulators. It provides a clear mechanism for organisations with a role in the quality and safety of patient care to share information and intelligence that may indicate risks to patients, their carers, families, trainees or other healthcare professionals, including doctors. It also enables signatories to better co-ordinate and prioritise activity where further action is needed. If further work is required and deemed necessary, it can be prioritised and coordinated across all those attending. We are also exploring the establishment of similar escalation processes, building on existing protocols where these exist, with partners in Northern Ireland, Wales and Scotland.

39 To ensure our information sharing and data collation systems are robust and that we capture any relevant improvements and learning in the wake of the Panel report, we intend to reflect with other regulators on any further lessons that can be learned as a result of the events at Gosport War Memorial Hospital.

Whistleblowing and raising and acting on concerns

40 It is deeply unfortunate that concerns were raised at Gosport War Memorial Hospital as early as 1991 by nursing staff but were not taken seriously, supported, or appropriately actioned. We recognise that we have a role to play, alongside others in the healthcare sector, in helping to develop a culture in which openness and honesty is the norm, ensuring that concerns are shared at an early stage and acted on as soon as possible.

41 As well as organisational duties, there is an individual professional responsibility on all doctors to raise and act on concerns. Our guidance *Raising and acting on concerns about patient safety* sets out managers' responsibilities to ensure there are systems in place to allow concerns to be raised and investigated and that staff who raise concerns are protected from unfair criticism or action.

42 Our confidential helpline (established in 2012) gives doctors across all four countries of the UK a means to raise serious concerns with us. Since 2014 we have received over 200 calls to the helpline from across the UK, the majority of which have led to further

investigation. Via our liaison advisers, we proactively raise the profile of this guidance especially with doctors new to UK practice and doctors in training. In England we are working closely with Freedom to Speak Up Guardians whose role is to lead culture change within NHS organisations so that speaking up becomes business as usual.

Our guidance: anticipatory prescribing

43 One of the issues described in the Panel report was that anticipatory prescribing of pain medication (not in itself a bad practice) became 'routine' every day practice, as a convenience for Gosport clinicians rather than based on proper assessment of the clinical needs of individual patients. This poor practice was compounded by the medicines then being routinely administered without proper clinical review of the patients concerned, in part because an expectation was created that the drugs would be given to those patients at some point. The culture of deference to clinical decision-making that pervaded the hospital meant that attempts to question this practice were ignored or silenced.

Guidance in place at the time

44 Routine anticipatory prescribing without consideration of the individual patient's clinical condition and clinical needs was not good clinical practice in the period concerned.

45 Our guidance to doctors, *Good Medical Practice,* during the key period (1995, 1998 and 2001) set standards for good clinical care. *Good Medical Practice* 2001 stated that doctors must:

- [carry out] an adequate assessment of the patient's conditions, based on the history and symptoms and, if necessary, an appropriate examination
- provide the necessary care to alleviate pain and distress whether or not curative treatment is possible
- prescribe drugs or treatment, including repeat prescriptions, only where you have adequate knowledge of the patient's health and medical needs. You must not give or recommend to patients any investigation or treatment which you know is not in their best interests, nor withhold appropriate treatments or referral.

Prescribing guidance – shared responsibility

46 The Panel report comments critically on the fact that some clinicians in the period in question, accepted/complied with their colleagues' routine use of anticipatory prescribing for large numbers of patients, for example by administering prescriptions, without any consideration as to whether the prescribing was clinically appropriate for the patient at that time (or at all).

47 There are principles in our prescribing guidance which are relevant to questions around

individual responsibility in circumstances where many professionals are involved in providing treatment and care. In particular the paragraphs on 'shared care', repeat prescribing and reviewing prescribing decisions:

- If you share responsibility for a patient's care with a colleague, you must be competent to exercise your share of clinical responsibility. You should:

    a. keep yourself informed about the medicines that are prescribed for the patient
    b. be able to recognise serious and frequently occurring adverse side effects
    c. make sure appropriate clinical monitoring arrangements are in place and that the patient and healthcare professionals involved understand them
    d. keep up to date with relevant guidance on the use of the medicines and on the management of the patient's condition.

- Reviewing medicines will be particularly important where:

    a. patients may be at risk, for example, patients who are frail or have multiple illnesses
    b. medicines have potentially serious or common side effects
    c. the patient is prescribed a controlled or other medicine that is commonly abused or misused
    d. the BNF or other authoritative clinical guidance recommends blood tests or other monitoring at regular intervals.

- You are responsible for any prescription you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any repeat prescription you sign is safe and appropriate.

- When you issue repeat prescriptions or prescribe with repeats, you should make sure that procedures are in place to monitor whether the medicine is still safe and necessary for the patient.

48 Our guidance on these issues is therefore clear. The challenge for us going forward is to promote it as widely as possible, using all the channels available to us including our new website, our social media channels, our liaison services and communications such as *GMC News for doctors*.

Interactions with the Gosport Independent Panel

49 From the outset we sought to co-operate fully and openly with the Panel, at the most senior levels in the GMC. We were keenly aware that we had a public duty to do so. We also felt we had a specific responsibility to the Gosport families to help make sure they were able find the truth about what had happened to their loved ones.

50 The fact that the Panel was not established as a statutory inquiry under the provisions of the Inquiries Act imposed a number of challenges in our efforts to support the work

of Panel. In particular, it meant that we could not legally hand to the inquiry every document requested by the Panel without first ensuring that we were acting in compliance with the provisions of the relevant data protection legislation in respect of each and every document disclosed.

51 In the event, it was necessary for us to identify, locate, where necessary obtain permission to disclose information from data subjects, and redact sensitive personal data as appropriate, across approximately 330,000 pages of material dating back over 20 years of records. It was a significant, time consuming and resource intensive undertaking. Inevitably, administrative mistakes were made, for example in the way the redaction of some material was carried out. The scale of the disclosure and redaction exercise meant we were not always able to help the Panel as expeditiously as we would have wanted. This may have given the impression that we were not sufficiently sensitive to the scale of the families' distress and concerns and that we were not cooperating as fully as we should have been and for this, we sincerely apologise.

52 We are keen to learn from this exercise and we commissioned an independent learning review into the way in which we manage and resource our relationship with both statutory and non-statutory inquiries so that we are better able to support them in their work.