

BRITISH BROADCASTING CORPORATION

RADIO 4

TRANSCRIPT OF "FILE ON 4" – "*SPEAKING UP – WHISTLE-BLOWING IN THE NHS*"

CURRENT AFFAIRS GROUP

TRANSMISSION: Tuesday 7<sup>th</sup> February 2017 2000 – 2040  
REPEAT: Sunday 12<sup>th</sup> February 2017 1700 - 1740

REPORTER: Simon Cox  
PRODUCER: Nicola Dowling  
EDITOR: Gail Champion

PROGRAMME NUMBER: PEL44001246/AAA

THE ATTACHED TRANSCRIPT WAS TYPED FROM A RECORDING AND NOT COPIED FROM AN ORIGINAL SCRIPT. BECAUSE OF THE RISK OF MISHEARING AND THE DIFFICULTY IN SOME CASES OF IDENTIFYING INDIVIDUAL SPEAKERS, THE BBC CANNOT VOUCH FOR ITS COMPLETE ACCURACY.

“FILE ON 4”

Transmission: Tuesday 7<sup>th</sup> February 2017

Repeat: Sunday 12<sup>th</sup> February 2017

Producer: Nicola Dowling

Reporter: Simon Cox

Editor: Gail Champion

---

MUSIC

HAMILTON: It was tragic and avoidable. If that service had been properly established and run, I think the chances are that they'd be maybe alive.

COX: That must be a very hard thing to accept.

HAMILTON: Terrible, terrible.

COX: This is what can happen when whistle-blowers say their concerns are ignored, and for NHS staff who do choose to break cover, there can be retribution.

FERRY: That night, when I went to my car, there was a sticker on my car that said, 'Death to the bastard Geordie whistle-blower.'

COX: These reprisals are supposed to be a thing of the past. It was the inquiry into failings at Mid Staffordshire Hospital Trust which first found staff had been scared to raise concerns. This led to a further review by Sir Robert Francis into giving NHS workers the Freedom to Speak Up, which was published two years ago this week.

FRANCIS: I think that the Freedom to Speak Up review showed that the sort of problems I identified in Stafford were not limited to that particular hospital.

COX: What did you recommend to try and improve things?

FRANCIS: People like me can pontificate from on high and so can, frankly, the Secretary of State, but the culture of each individual organisation has to change and that requires the leadership of that organisation to adopt the principles necessary for an open learning culture.

MUSIC

COX: So two years on, is it changing?

#### ACTUALITY IN INTENSIVE CARE

DAY: Intensive Care is an amazing place to work; it's where the sickest patients in the hospital come and the whole idea with an Intensive Care Unit is it takes over a patient's organ function when they're not able to do it themselves, with the intention of the organs returning to normal and the patient leaving the Intensive Care Unit to a normal life, so that's really, really good stuff for medicine. A very, very fulfilling working environment.

COX: Junior doctor Chris Day thought that working in Intensive Care would help his path to eventually becoming an Accident and Emergency consultant. It would provide financial stability for a young dad with a wife and two small children. Shortly after he started in the unit at Queen Elizabeth Hospital in south east London in 2013, he had concerns about how it was run.

DAY: The Intensive Care Unit that I worked in at night departed quite significantly from what the standards said should be the right number of doctors for the right number of ICU patients. It should be one Intensive Care Unit doctor on site with eight ICU patients.

COX: So it should be one to eight - what was it in your unit?

DAY: So at night it varied between one doctor and fifteen to eighteen ICU patients.

COX: So almost double the number of patients from what it should be? So when you see that, what do you do about it?

DAY: Well, very early on, after discussion with my colleagues and actually another consultant, we decided to send an email, setting out that we thought the night time staffing was unsafe, particularly like me and many of my other colleagues, who had no previous experience in Intensive Care, we thought it was unreasonable to leave one of us alone without onsite supervision, especially when you were departing from the numbers of ICU beds to doctor ratios to the extent they were. And so we sent that email to Trust management.

COX: Despite this, he says the staffing levels remained the same. Several months later, in January 2014, he was on a night shift when he was told about staffing problems that raised alarm.

DAY: I was in the heart attack centre and I encountered two of the most experienced nurses in the hospital. Both seemed to be quite rightly concerned that two doctors that would normally be working very, very hard, covering all the wards in the hospital, were not present because two locums didn't show up. We'd already discussed the staffing levels in the Intensive Care Unit routinely at night, so the combination of those two things and the thoughts of my colleagues made me think that this was a very dangerous situation indeed and a clear threat to safety, and also one that could potentially be changed if an assertive effort was made to get two locum doctors to work that night, so that all meant that I phoned the duty manager.

COX: You thought it was serious enough that it could be dangerous for patients?

DAY: I think it was very, very likely to be dangerous for patients. If you have two doctors that should be there covering the wards that aren't there, how can that not be dangerous? And when you combine that with an understaffed Intensive Care Unit at night, that to me seems a logical step to try and get two doctors to come into the hospital.

COX: Lewisham and Greenwich NHS Trust told us in recent years it has significantly improved medical and nursing staffing on the Intensive Care Unit at Queen Elizabeth Hospital and new doctors are now closely supported by more experienced doctors. But back then, as a junior doctor, Chris Day was in limbo - on a temporary contract at the hospital, his training was overseen by Health Education England - or HEE - which decided where he would go next. After his annual appraisal with HEE, he found that his file said he had professional and personal conduct issues and wasn't engaging with supervision. Was there any truth in those allegations?

DAY: My position is, they are absolutely false and have no basis in evidence. My supervisor reports are very, very good supervisor reports. They extend past satisfactory reports into good reports, to very good reports.

COX: Did it make any sense to you, these allegations?

DAY: No, I mean, allegations that I had personal, professional conduct issues would, I assume, need to be related to some kind of incident. I could only assume it related to the views expressed about the Intensive Care Unit or that phone call and interaction with management. It really is up to Health Education England to provide another explanation, which they so far haven't been able to do.

COX: Chris Day tried to find out more about the allegations and ended up in a dispute with the hospital and Health Education England. Unable to come to an agreement, his training stalled and he can't progress to the next level. He took his case to an employment tribunal, claiming the allegations raised about his behaviour were linked to

COX cont: his whistle-blowing. In a statement, Professor Wendy Reid, Director of Education and Quality at Health Education England, told us:

READER IN STUDIO: We carefully considered Dr Day's allegation that we had discriminated against him because of his whistle-blowing. Having looked at the facts relating to his allegation, we are convinced that this was not the case and that we acted properly towards him.

COX: The tribunal never got to hear the full details of Chris Day's case. In legal arguments, the HEE successfully argued they didn't employ him, so the case couldn't proceed.

#### ACTUALITY WITH CHILDREN

DAY: Shall we do Play Dough? Do I put it in there like that? How do you do it? I've forgotten.

COX: Unhappy with this outcome, Chris Day decided to challenge this. With a young family to support and now working as a locum doctor, he couldn't afford it, so he turned to crowdfunding. He has raised over £100,000 from over 3,000 donors to take his case to the Court of Appeal next month. He believes his case has opened up a fundamental gap in employment law, which means that 55,000 junior doctors like him aren't fully covered by whistle-blowing legislation.

DAY: So instead of defending themselves on the facts, they used taxpayer money to essentially argue me - and more importantly, every other junior doctor in the country - out of statutory whistle-blowing protection, which meant that the facts of my case couldn't be heard by an employment tribunal.

COX: Health Education England told us they have created a new legal route that allows junior doctors to bring a whistle-blowing claim against them in the county or high court rather than at an employment tribunal. Chris Day's case is typical of the doctors and nurses in contact with Dr Minh Alexander, who is a former whistle-blower, who





DUTT: I don't think it fares very well, unfortunately, and my benchmark is that I also have a financial services practice, and we recently advised a whistleblower who had whistleblown on some serious issues inside a bank. And so in this instance, they'd addressed the issue, they'd investigated, they were putting it right and they were seeking to look after the individual to ensure that no harm or victimisation was being done. Now that's a bank. And if I compare it to, quite frankly, some of the Machiavellian circumstances that I hear of within the NHS, a caring healthcare service, actually the whistleblowing processes in banks seem to be more rigorous and robust than they are in the NHS.

COX: So what's being done to try and change this? The key measure in England has been the creation of a national Freedom to Speak Up Guardian to make the culture within the NHS more open. The Guardian is planning to review cases so lessons can be learned and suggest improvements that need to be made. It has been a stuttering start - the first Guardian resigned after just two months. Her replacement, Henrietta Hughes, a GP and former NHS manager, says there is still a lack of confidence among whistle-blowers that their concerns will be taken seriously.

HUGHES: I still think that whistle-blowing is a problem in the NHS, because we know from the situations that have been there in the past that staff do have a real concern about this, and not all staff would feel comfortable to raise a concern, even when it was affecting patient safety.

COX: And what are the common themes that you've noticed?

HUGHES: So the common themes are counter allegations and then sometimes staff suspensions, which can go on for a very long time, leading to sometimes dismissal, with concerns about independence - not only of investigations, but also appeals. And so these are all different parts of the process, quite apart from, you know, the actual point where people do raise a concern, and these are all areas that I'm interested in.

ACTUALITY OUTSIDE HOSPITAL

COX: I've come to the heart of the Lake District, to Kendal, on a beautiful but very frosty day. So the Westmoreland General Hospital, this is part of the Morecambe Bay Hospitals Trust. They were in the headlines a couple of years ago because of their maternity services, which were heavily criticised for the numbers of mothers and babies dying in their care. It led to a big inquiry and since then the Trust has tried to turn things round. And part of that has been setting up a local Speak Up Guardian – one of the first in the country. And I'm going to go inside and meet her and find out what she does.

#### ACTUALITY WITH AMBULANCE

MAN: There we are, okay ...

COX: Heather Bruce is a radiographer and one of a network of local Guardians set up to support the national Guardian - she has been doing the job for just over a year, dealing with about one case a week.

BRUCE: Well, the role is Freedom to Speak Up Guardian, so it's to support staff, students, volunteers, governors and locums as well, who want to raise any concerns that they might have. Some people, they don't want their names to be known, in which case I can bring that to the attention of the directors involved. Quite often their names will be known, but the main emphasis for us is that people are supported to raise concerns, so that those concerns are welcomed.

COX: And what happens with investigating concerns that they raise?

BRUCE: Well, it's not up to me to investigate - that would be impossible. We have got five and a half thousand staff in our Trust. What I have to do is find out what is being done, if the investigation is being done, if the person who has raised the concern is satisfied with that. It might not be the result that they want necessarily, but I have to find out and feed back to them what's happening.

COX: Do you think you are making a difference?

BRUCE: Yes, yes I do actually. Because staff have recommended me, I think that's the main good feedback for me.

COX: So here at least some evidence that staff are willing to come forward. All Trusts were supposed to have Guardians in place by October last year, but some still don't. Sir Robert Francis told us he couldn't understand why this was the case. The Lib Dems' health spokesman and former Health Minister, Norman Lamb, has taken a close interest in whistle-blowing and the Guardian system.

LAMB: Well the principle is good, but in practice it seems to be pretty toothless. The national Guardian doesn't have the power to investigate whistle-blower complaints. It's a very patchy picture around the country as to whether local Guardians have been put in place, whether they're actually paid to do their job or whether they're doing it on top of everything else they're doing, and of course if they're employed in the organisation concerned, then there is ultimately a conflict of interest for those people, so I don't think it's been effective in the way that we wanted it to be.

COX: So do you think those local Guardians should be outside of the hospital Trust, they shouldn't be employed by them?

LAMB: Inevitably if they're employed, there has to be a conflict of interest, it seems to me, and so I think we need to be prepared to look at some form of independence there.

COX: And should the local or the national Guardian be given powers to actually investigate whistle-blower complaints?

LAMB: Yes. I mean, I think there has to be some mechanism to hold organisations - and indeed the leaders of those organisations - to account when people are hung out to dry. We're talking here about people who sacrifice everything, who lose their careers as a result of being brave and doing the right thing,

COX: So does Henrietta Hughes, the national Speak Up Guardian, accept any of the criticisms about local Guardians' independence?

HUGHES: Well, I think it's the same with any type of member of staff. You expect them to do the job that they've been appointed to do, and the feedback that we've had so far is that staff are going to these Freedom to Speak Up Guardians. I think the proof is if nobody's going to the Freedom to Speak Up Guardian, it's for the organisation to look at how they've appointed and the type of role that they've appointed into and to make sure that it does meet the needs of their staff.

COX: One of the criticisms of your role is that you're toothless because you don't actually have any powers to investigate.

HUGHES: Well, we're not an investigating body, and we don't have a statute, we don't have regulations, but there are plenty of regulations that already exist across the NHS and in bodies around the NHS as well, and the main thing is that every part of the NHS sees that they have a role to play in this, and brings their powers to bear, where that can be helpful. So for example, the CQC are looking to put this as part of their well-led inspection, and that's just a good sort of example of how other bodies' powers are used to make sure that the culture changes that happen in the NHS that we're looking for.

COX: But many Health Service workers are still scared of doing the right thing. The last NHS survey found a third of staff didn't feel safe raising concerns about patient safety and almost half didn't have confidence their concerns would be addressed. There is also the fear of retribution, which can happen to even the most senior staff - which brings us to a case only recently resolved, but which started a long time ago.

FERRY: My name is Professor David Ferry. I'm a Medical Oncologist.

COX: David Ferry had been working at the Royal Wolverhampton Trust for a decade with an unblemished record when he came across a problem during an audit of patients with colorectal cancer.

FERRY: I noticed that many patients were not having treatment which would be considered standard in the rest of the world. Patients were receiving six months at times of chemotherapy prior to their standard treatment. This was very unusual and it slowly came to light, and the audit findings were very shocking to me, and I took those findings to the regional colorectal committee, and we took action to stop that practice occurring.

COX: Professor Ferry raised this extra gruelling treatment with managers at the hospital and said they should contact the patients who had been given the unnecessary treatment.

FERRY: What was most difficult for me, as an ethical dilemma, was I knew that patients should be informed about the harm of having prolonged intensive chemotherapy, which causes sickness, vomiting and infections.

COX: So you raise these concerns with the hospital. You say, we should contact patients. How does the hospital respond?

FERRY: The hospital said that they didn't feel it was necessary, it would cause upset and they weren't going to do it.

COX: He kept his head down as he had seen how other whistle-blowers had been treated at his hospital and elsewhere. Then the hospital launched an internal investigation into Professor Ferry after he was accused of bullying and harassment - . and things took a more sinister turn.

FERRY: Somebody entered my office and wrote racist graffiti on the wall, smashed my precious family photographs.

COX: When you found out about that, that your office has been trashed, there's this racist graffiti, that must have been pretty worrying?

FERRY: It is very worrying and my eldest daughter was doing her GCSEs at the time and my wife is black, of course, and you have to consider carefully what you do. I think that some people were hoping I would react to that and say perhaps some inappropriate things, which would give them an excuse to suspend me or exclude me, but I think I managed that difficult episode with more control and dignity than I thought I might in the first days after it occurred.

COX: The Trust investigated this incident but couldn't identify who had written the graffiti. Throughout 2013, David Ferry says he witnessed more problems in the Oncology department - and then he was targeted again.

FERRY: Things were deteriorating, and after a particularly difficult day in the department, there was a lot of upset and that night, when I went to my car, there was a sticker on my car that said 'Death to the bastard Geordie whistle-blower.' You think, this is getting very difficult. And shortly after that, it was decided there was going to be an external inquiry into rectal radiotherapy treatments in the Trust. Ultimately, that inquiry by national level experts in rectal cancer supported my perspective.

COX: This report said there was no rationale or explanation as to why the colorectal cancer patients were given extra chemotherapy. It found the hospital failed to pick up what it called 'unsatisfactory practice'. Whilst it said there was concern about the management of one patient who later died, there was no evidence the majority of patients had been significantly harmed - a point emphasised by the hospital Trust, who told us all Professor Ferry's allegations were investigated and all patients and relatives were written to. They added they have an open and transparent culture, and take whistle-blowing seriously. They also now have a dedicated Freedom to Speak Up Guardian. Despite the report backing up some of Professor Ferry's concerns, investigations into him continued. The Trust compiled a huge dossier of evidence, which they sent to the GMC - the General Medical Council.

FERRY: They produced further reports to send to the GMC. Eventually they sent over 5,000 pages.

COX: How long did that take and what was the conclusion of that GMC investigation?

FERRY: Well, I was investigated by the GMC from October/November 2013 - that's when they started - right through to two years later, when they concluded that there was no case to answer. And the lowest level of sanction is a warning. I didn't even receive that. I think that the GMC just dismissed everything - it was clearly a witch-hunt at the end of the day.

COX: After years of investigations, David Ferry was in the clear. He felt the Trust had used the GMC to target him for raising concerns. This was an issue raised by other doctors in a separate report commissioned by the GMC into the NHS, which found a widespread fear that the General Medical Council was being used to punish whistle-blowers. David Ferry left the hospital Trust in 2014, but he wouldn't give up - he asked the regulator, the CQC, to examine the cancer concerns he had raised when they inspected Royal Wolverhampton Hospital in 2015.

FERRY: When the report came out, the CQC report, I read it and it said in the report, the first version of the report, that the chemotherapy the patients had received had been standard. In other words, there was no error made. Now when I raised this issue, there was a lot of fuss, the report had to be rewritten and Sir Mike Richards, who heads the hospital inspection process, stepped in and said there had been a typographical error, so that was very interesting.

COX: So he was worried that, five years after he raised concerns, that even in this new culture of openness, an inspection report still managed to put out incorrect information about cancer treatment. The CQC said it had made a typographical error, which it corrected as soon as it found out. Dr Minh Alexander was interested in concerns brought to them by whistle-blowers. She put in a Freedom of Information request asking for a national breakdown of the issues raised and what action was taken. The CQC said it couldn't provide the national picture, but did provide a smaller sample relating to one Trust.

ALEXANDER: We were quite shocked, because it showed that CQC were marking down even the most serious disclosures as simply information noted for future inspection, and there was no other evidence of outcome or action taken by CQC. This included a troubled Trust where staff have been making allegations that management have falsified performance data, safety data, not acted on serious recommendations from safety reviews. But even some of these very serious disclosures were simply effectively put in a drawer by the CQC, so if that's replicated on a national level, you know, it suggests that there is great exposure to patients from risks not being mitigated.

COX: The CQC told us that it takes concerns raised by staff extremely seriously and acts on them where appropriate. In the last six months of last year, around 50% of concerns raised resulted in either an immediate inspection or were followed up on future inspections. Around 20% were referred to other bodies, and in 10% of cases, no action was required. The remainder remain under review currently. But even if whistle-blowing problems are dealt with now, the failures of the past can have devastating effects much later on.

HAMILTON: I'm Dr Jane Hamilton and I worked as a Perinatal Psychiatrist in Lothian. It was my third consultant post and I came up to a new unit, so this was a brand new service provision, and it subsequently became clear that I was the only person in the entire appointed staff group that had any experience in this specialist field.

COX: Jane Hamilton's job was working with pregnant women and new mums with psychiatric problems in Scotland. She was worried that other staff and managers weren't aware of the mental health needs of pregnant women, but like other whistle-blowers we've heard from, there was one incident that made her think she had to speak up.

HAMILTON: There was one case which absolutely changed everything about how I felt. A woman had been mismanaged in her pregnancy and because of that, had not been seen or treated and no plans had been made and became psychotic in her labour. And because she was psychotic in her labour, obviously it was very difficult to deliver her of the baby safely, and there was a real sense that both her and her baby could



READER IN STUDIO cont: identify women of childbearing age who are at high risk of perinatal mental illness if they become pregnant.

COX: When you're reading that official report, are you struck by the concerns they raise?

HAMILTON: Very struck, because they are almost identical and that is very difficult to accept, that those things that I raised in 2007, despite all these other external inquiries, reviews etc were still an issue all those years later. Oh, it just made me feel absolutely devastated and it just, it was, I mean, tragic and avoidable. And I suppose, you know, it just left me feeling so frustrated that years of effort are put into trying to sort it out and it still didn't get sorted out. And then something like that happens, I mean, there's just no positive way of looking at that.

COX: Do you think if you'd stayed there and they'd made the changes, that you could have saved that baby's life?

HAMILTON: Well that sounds a bit grandiose actually, but I think if that service had been properly established and run and managed, with proper structures and procedures, I think the chances are that baby may be alive, yes.

COX: And that must be a very hard thing to accept.

HAMILTON: Terrible, terrible – yes.

COX: It's impossible to say whether the young baby killed by her mother could have been saved. NHS Lothian said they have taken action to review the service and are working to strengthen communications between the mother and baby unit and other healthcare professionals. They added that the issues raised by Dr Hamilton were taken seriously and investigated at the time, and they encourage staff to raise worries about patient safety. Paul Gray is Chief Executive of NHS Scotland. He met with Jane Hamilton last week to discuss her concerns.

GRAY: Dr Hamilton asked us to consider some issues, which I have agreed to do. I'll be speaking to the Chief Executive of NHS Lothian about that. He's already aware of that, and we've asked Dr Hamilton if she'd be willing to help us with advancing our understanding of the issues faced by whistle-blowers, and of course, if she is willing to do that, we'll be very pleased.

COX: We'd also spoken to Jane Hamilton, and the concerns which I'm sure she has told you she had raised, she said if they were acted upon, she feels that maybe some of those deaths of mothers, and indeed the young baby who was killed by her mother who had postnatal depression, who was badly let down by NHS Lothian, maybe those cases could have been avoided.

GRAY: So every death in these circumstances is a tragedy and I feel very deeply for all those affected by that. I think one of the things that we do need to make clear is that the Mental Welfare Commission investigated the death that you referred to and has made a number of recommendations. The Scottish Government has welcomed these recommendations and I know that NHS Lothian and other health boards are taking steps to implement them. I can't say whether there was a direct correlation, but I do know that Dr Hamilton has expressed that view very firmly and strongly, including to me, and I certainly respect her very deep concerns about the matter. I do think that we have moved on in a number of ways, but I do respect her concerns.

COX: In Scotland, as in England, there is more effort being made to help whistle-blowers to raise concerns, and for those who have won their cases and been exonerated, a promise to put them back into the NHS. But Jennie Fecitt, a nurse from the whistle-blowing group, Patients First, found that doesn't always work in practice.

FECITT: I applied for a number of jobs and was actually successful at interview until HR got involved and then the job was suddenly withdrawn. And when I asked, well why? I was basically told, well, the funds aren't available, the funds aren't there anymore. It was only when a senior HR advisor in the NHS contacted me through Twitter and actually told me that there's blacklisting going on and the blacklisting is taking place on the electronic staff records.

COX: She applied for her electronic staff record and got it back pretty quickly.

FECITT: And to my horror, when I looked, there wasn't an issue with my sickness, disciplinary – no issues there, but when I looked at my reason for leaving, it had SOSR, which basically stands for Some Other Substantial Reason. And when I've asked for more information, on a back screen, I was told that there was a connection that I was a whistle-blower. And it was at that point that I thought, well, that's why HR have been withdrawing the jobs. I could only put two and two together.

COX: A round robin email to other members of Patients First found dozens of others were in the same boat, with incorrect and damning information on their records making them unemployable in the NHS. Jennie Fecitt has now complained to the Information Commissioner's office to get the records changed. We wanted to speak to the Department of Health about this, but no-one was available for interview. So, two years after Sir Robert Francis conducted his inquiry into whistle-blowing, is it easier for staff to speak up?

FRANCIS: Progress in changing culture is always slower than one would like - it's not like turning a light on or a light off - but I do think progress is being made. Firstly, there's been a widespread recognition that things should change. I believe that the principles that I set out have been widely accepted, so I think there's progress being made, but have we got to the end of the road? No, of course we haven't.

COX: Do you think we could ever see a situation that we saw in Mid Staffs again, where concerns are raised and they are not acted upon and then there are terrible consequences for patients?

FRANCIS: I think it is possible for that to happen, it could be an issue, but I would like to think that the alertness for warning signs of serious systemic failure are more easily recognised now than they used to be, and so I would like to think that sort of failure was less likely, but I couldn't possibly rule it out.

