Minh,

I didn’t keep contemporaneous notes recording our phone conversation, but your notes seem a reasonable reflection of it. BW. Kevin

Sent from my iPhone

On 7 Apr 2017, at 11:58, Minh Alexander wrote:

Hi Kevin,

I have not heard from you in regards to my emails of 31 March and 3 April.

This is now a note to say that I will be publishing my records of our telephone meeting of 24th March this weekend.

Obviously if you get time to drop me line to say whether you agree with the meeting records - or not - before then, that would be helpful.

If not, I will publish them with the rider that HSIB has not commented on my meeting records.

Notwithstanding, it would be useful to abide by the best practice convention that meetings involving public bodies are properly documented, and for records to be agreed.

 Agreeing a record is an important part of accountability.

Best wishes,

Minh

From: Minh Alexander
Subject: Telephone meeting 24 March 2017 on HSIB & whistleblowing, and matters arising
Date: 3 April 2017 at 15:33:17 BST
To: Kevin Stewart
Thanks ********.

It is indeed punitive and unfair that doctors are obliged by the GMC to raise and escalate concerns, but face a good chance of victimisation and lack of protection when they do so.

Kevin -

1) I’ve taken a look at HSIB’s published documents now that HSIB is operational.

I could find no specific reference to whistleblowing or any external whistleblowing policy. A question that I raised a few emails back has not yet been clearly answered - that is, does HSIB accept that it has prescribed person functions under the Public Interest Disclosure Act, on account of being constituted as part of NHS Improvement, which is a prescribed person under PIDA.

Could someone help with this, and also obviously, correct me if I have missed any relevant documents.

If however it is correct that HSIB has no external whistleblowing policy of its own, could it be clarified whether HSIB intends to produce one, or to just use NHSI’s external whistleblowing policy?

2) I’ve been asked to write an article about NHS whistleblowing governance and I will focus on the lack of investigation and poor investigation of NHS whistleblowers’ concerns. If HSIB can respond to the substantive issues that I raised in my email below of 31 March 19.13 in the next few days, even if only partially, that would be very helpful.

I am submitting the copy on 6 April and an indication from HSIB by that date about whether it agrees to hold an open consultation with whistleblowers about NHS failures to investigate their concerns properly or at all, would be helpful.

Thanks and best wishes,

Minh

From: ****************************
Subject: Re: Telephone meeting 24 March 2017 on HSIB & whistleblowing, and matters arising
Date: 1 April 2017 at 09:25:40 BST
To: Minh Alexander <**********************>
On 31 Mar 2017, at 19:13, Minh Alexander <***************************> wrote:

Dear Kevin,

**Telephone meeting 24 March 2017 on HSIB & whistleblowing, and matters arising**

Thank you for meeting with me by telephone on Friday 24 March.

As promised, I write to provide:

1) summary notes of our meeting for your agreement – see appendix below

2) A concise summary of how the system is designed NOT to investigate whistleblower’s patient safety concerns

I believe that whistleblowing should be central to HSIB’s core business because:

- **Whistleblowing cases often feature very poor safety investigation practice by the NHS**

  Many, if not the majority, of NHS whistleblowing disclosures are poorly to very poorly investigated by the NHS. Quite often, whistleblowers’ disclosures are not even investigated at all, for obvious reasons. HSIB needs to get a grasp of the extent of failure in this area if it is to fully discharge its remit for leading improvement on NHS safety investigation practice. Some research and
measurement would be necessary to establish a baseline on current standards of practice, as far as I am aware, that remains a gap in the evidence.

- **Whistleblowing is an important source of intelligence that can help guide efficient prioritisation of HSIB investigatory activity**

- **Whistleblowers’ disclosures may sometimes be the only source of evidence that can show a cover up has taken place.**

For example, whistleblowers may be the only people who know and can reveal that important evidence has been destroyed by organisations. As you acknowledged in our meeting, in such situations of deliberate concealment, it may not be possible for HSIB to detect that there has been a cover up. Unless of course, whistleblowers are willing to entrust you with relevant evidence.

The current regulatory and legislative landscape presents obstacles to investigation of whistleblowers’ concerns.

- **Current whistleblowing law misdirects focus away from whistleblowers’ concerns, and towards ensuing employment disputes.**

- **There are oceans of ineffective good practice guidance which says that whistleblowers’ concerns should be investigated, but no actual legal compulsion on employers to investigate whistleblowers’ concerns.**

- **NHS regulators currently largely refuse to investigate individual whistleblowers’ concerns, and they claim that they have no remit to do so. This is arguable depending how their remit is interpreted. Regulators could certainly conduct more thematic reviews, which are definitely within their gift, where there are clusters of whistleblowers. However, there has been a lack of political will to do so. The evidence is that the Care Quality Commission in fact fails to act on even the most serious, multiple whistleblower disclosures.**

- **Local trust Speak Up Guardians and the National Guardian’s office have controversially been designed NOT to investigate whistleblowers’ concerns.**

If you need me to expand on the evidence for each of the above points regarding NHS whistleblowing investigatory failure, please let me know.

In short, there is STILL no safe place for NHS whistleblowers to go, despite the DH propaganda.
Despite government claims, current UK whistleblowing law also confers no protection. It only gives whistleblowers the right to sue for compensation after they have been harmed.

If HSIB is to fully discharge its remit to identify serious systemic risks and improve NHS safety investigation practice, I think it must address the above systemic failures that collectively mitigate against the proper investigation of NHS whistleblowers’ concerns.

This is particularly as whistleblowers’ concerns often relate to the most serious patient safety risks.

Entwined with this investigatory failure is the lack of protection for whistleblowers. In the same way that there are calls to criminalise obstruction of HSIB investigations,

“Critically, it should be an offence to hide or tamper with evidence or otherwise interfere with an Healthcare Safety Investigation Branch investigation” Macrae & Vincent, 10 March 2017 4

I think HSIB must also recognise that a similar imperative applies to the criminalisation of whistleblower suppression and reprisal, as originally envisaged by Robert Francis 5, and as recommended by experts 6 and by campaigners. There also needs to be a legal duty of pre-detriment protection upon employers. If HSIB does not help to ensure the most robust protection for whistleblowers, it cannot expect full disclosure by NHS staff.

In fact any criminalisation of concealment as suggested by Macrae & Vincent, whilst welcome, could be potentially be counterproductive and unfair to NHS staff if there is not commensurate protection for disclosure. It would be unjust if staff who have been terrified into silence run the risk of a criminal conviction, yet have little hope of protection if they speak up.

I have not had access to HSIB’s draft protocols as requested. But for various reasons, I do not think HSIB has good grasp yet of whistleblowing realities and the complexities that staff must navigate when they speak up. In particular, I do not think HSIB has a grasp yet of the depth of NHS corruption and the negligence and collusion of NHS bodies that are meant to enforce transparency.

As I have mentioned before, whistleblowing is a specialist area but is by its nature under-documented. A little bit of knowledge can do harm to both staff and patients.

I would suggest that HSIB develops in depth expertise, especially of qualitative and experiential aspects, and that as a start to this journey there should be a proper, open consultation with NHS whistleblowers.

Whistleblowers hold much of the real organisational memory on what goes wrong, and the means by which NHS cover ups are achieved.

During our meeting, I suggested an openly advertised event with whistleblowers to start the process. I particularly advise that you do not rely on just the ‘usual suspect’ organisations for whistleblowing advice, as often happens when NHS bodies consult. This is because
whistleblowing organisations, for commons reasons of capture and conflicts of interest, usually do not represent the most challenging voices and are not representative of all whistleblowers. In addition, some of the whistleblowing organisations are also not Health/NHS specialists.

You kindly agreed to consider such a consultation and to hold an event. **Please let me know if HSIB will implement this.** I am happy to help if needed. You may also find it useful to consult the whistleblowing research team headed by Professor David Lewis, Middlesex University, which provided academic support to the Freedom To Speak Up Review.

**Please also let me know if you agree with my notes of our telephone meeting, below, or otherwise.**

Lastly as promised, here is the link to the interesting - not to say diverting – presentation by Peter Wilmshurst which revealed the degree of GMC complicity with some NHS cover ups:

https://www.youtube.com/watch?v=Xze-yPubFIY&feature=youtu.be&a

Here is the Hansard record of a debate led by Rosie Cooper MP about the Liverpool Community Health scandal, which describes collusion by NHS regulators to protect abusers:

https://hansard.parliament.uk/ Commons/2016-07-13/debates/1DEAEDE8-BA1C-4BF7-A16A-7CFB9831CFB2/CapsticksReportAndNHSWhistleblowing

With best wishes,

Minh Alexander

cc Keith Conradi

Prof Charles Vincent

Prof Brian Jarman

Carl Macrae

**APPENDIX**

**Notes from telephone meeting between Minh Alexander and Kevin Stewart 24 March 2017, 4pm – 5.15pm**
These notes are taken from contemporaneous records of the discussion. They represent a broad summary. Some but not all passages are verbatim.

KS Busy. A lot to do. [HSIB] will mold into what we come across, won’t get it right first time. Get good bits from other industries. Good people, right motives.

KS indicated that in addition to heading the HSIB intelligence unit, he will spend a day a week on clinical work. [It’s] one of the stipulations.

MA How will intelligence unit work?

KS As open a view as possible to get referrals…accessible to as many people as possible.

25 investigations a year. [Sources of referral] Families, staff, patients, providers, regulators. Our bag: learning across healthcare. [Choose] areas of greatest impact for improvement, improvement for the largest number of patients. [Should be] representative of the system.

A sifting and preliminary investigation approach. Qualitative as well as quantative for the full picture. [Look at] things that don’t normally get measured. Investigating poor investigations. No recognition of human factors. Develop methodology and get trusts to model it. Keen to get independence. [Staff who have disclosed] had it used against them by GMC and DH.

MA What’s your view on deliberate cover ups, how will you find it?

KS Not right. Issues of perverting course of investigation, not producing evidence or interfering with evidence. Think we will pressurise the system a lot. Don’t blame people for not trusting the system. So much to do. So many unknowns. So many things to trip it up, like political interference.

MA How would you find out things like shredded notes?

KS We might not find it. But perhaps if staff reports don’t correspond. That’s where we should be focussing regulatory and legal stuff. We will publish it if we find it. We will ring police. Learned helplessness – [people may say:] ‘you’re never going to get to the bottom of it. But toxic culture [may be evident] if staff won’t talk or talk in car parks etc…and not on premises.

KS Work where providers agreeable

MA Will providers have a choice?

KS We probably have power to act under direction. eg [where there are] shedloads of deaths and trust says ‘no’. Will it happen like that? I don’t know. Don’t know what will happen on 1 April. I think we need to keep an open mind.

MA Sole focus on human factors won’t do it. If staff still see cover ups, they will understand that there is still no safe culture. Will deter reporting. HSIB needs to 1) develop
understanding of NHS whistleblowing - staff experiences and patterns 2) receive information from staff in a safe way.

KS Referred to cover ups as ‘now and again’

MA It’s more than now and again. Endemic. Referred to example of Peter Wilmshurst attending a GMC hearing to find that the senior GMC official had to recuse himself, as if he had gone to the Old Bailey and the Lord Chief Justice had to recuse himself because he helped to bury the body. Brief reference to an NHS trust trying to evade even a mandatory investigation of a mental health homicide for almost two years. Need to understand what lies beneath superficial NHS respectability.

KS Do bodies like GMC, BMA & RCN help whistleblowers?

MA They’re part of the problem. Unions often dump whistleblowers as like any other insurers, don’t like to pay up for costly legal services. Also conflicts of interests – senior members who are the abusers. HSIB needs to understand the mechanics of NHS cover up. Abusers protected. NHS regulators even lie to MPs when they protect and recycle poor managers – example of Rosie Cooper MP and NHS regulators protecting Liverpool Community Health NHS Trust managers.

KS We can’t do 20 years of whistleblower cases.

MA You don’t have to, but can at least gather intelligence from and consult whistleblowers about their experiences. Try an openly advertised event.

KS [Agreed to consider].

MA Will write.

REFERENCES

1 Whistleblowers unheard by CQC. Alexander, Linton, Sardari and fourth author, 2 December 2016. See pages 17-18 of the report for details of CQC’s inaction in response to even the most serious disclosures about North Cumbria.

https://minhalexander.com/2016/12/05/whistleblowers-unheard-by-cqc/

78 The INO [National Guardian] will have discretion to consider how an existing case is being or has been handled, and to advise an organisation on any actions they should take to deal with the issues raised. The officer would need to operate in a timely, non-bureaucratic way. **He/she would not take on the investigation of cases themselves**, but would challenge or invite others to look again at cases and would need sufficient authority to ensure that any recommendations made were taken seriously and acted upon.”

Page 169:

“7.6.17 The INO [National Guardian] would in essence fulfil a role at a national level similar to the role played by effective Freedom to Speak Up Guardians locally. **They would not take on cases themselves**, but could challenge or invite others to look into cases which did not appear to have been handled in line with good practice or where it appeared that a person raising a concern had experienced detriment as a result of raising the concern.”


3 National Guardian: Letter from Wonderland. Minh Alexander, 20 February 2017


http://journals.sagepub.com/doi/pdf/10.1177/0141076817694577

5 Sir Robert’s Flip Flops, Minh Alexander, 26 September 2016

6 Letter by Prof David Lewis, 15 February 2015

https://www.theguardian.com/society/2015/feb/15/whistleblowers-should-law-punish-hospital-bosses

Article: http://www.sundayguardianlive.com/world/6512-whistle-blowers-should-be-encouraged-protected-law
Dear Kevin,

Thank you for your further email and the suggested time to speak.

**Meeting**

I can’t definitely confirm a telephone meeting at 4pm tomorrow. I will let you know as soon as I can today. 4.30 pm may be better.

As per my previous email, I am available all day today, if you find there is time to call.

**HSIB expertise, in group bias and diversity**

I remain concerned about the fact that HSIB has not consulted openly, and will not allow whistleblowers a meaningful opportunity to comment on its protocols before it goes live in only one week’s time.

The approach so far, based on your and Keith’s comments, suggest to me that HSIB lacks expertise in this important area. HSIB is still treating whistleblowing as a peripheral issue.

You say you hope that Carl Macrae will help HSIB develop a process for "capturing information from whistleblowers” and that you believe he is aware of the academic literature on whistleblowers.

I hope that HSIB’s approach will encompass more than just capturing information.

I do not know exactly what expertise Carl Macrae has on whistleblowing but upon reading his own account of his skills set and experience*, I think it is very unlikely that he has any specialist experience of whistleblowing.

Upon a brief search, I can find no published material by Carl on whistleblowing, other than in a single sentence reference to the Mid Staffs disaster.**

I should point out that a familiarity with the academic literature on whistleblowing does not constitute expertise.

Whistleblowing is a highly complex minefield with many aspects touching on many fields of governance, law and policy. By the nature of suppression and of power, the full history of whistleblowing is not reflected in academic journals.

Powerful experiential aspects of whistleblowing cannot be fully appreciated from the academic literature alone.
There are also sector specific issues. Knowledge of whistleblowing issues in aviation, which I think is the model that HSIB may largely relying on, cannot be simplistically transferred to Health.

As Steven Shorrock recently commented to me:

“But my view is that healthcare is many times more complex & messy than aviation. So experience, e.g. whistleblowing differs.”

I am concerned that HSIB continues to rely on a small club to define policy, and that HSIB is remote from the bloodiness and human realities of NHS suppression of the frontline.

You cannot hope to begin to grapple with safety culture if you do not have proper handle on NHS cover up, an intricately crafted edifice.

HSIB will not win as much NHS workforce confidence as it could, or as much staff disclosure as it could, if it does not demonstrate a high level of competence and insight into the handling of concerns and the protection of staff from reprisal.

You surmise correctly that I “know about” the academic literature on whistleblowing. I campaign in this area and network with academics, and I am a member of an international whistleblowing research network. Added to this is my lived experience, and ongoing contact with current whistleblowers and the intelligence that they supply.

If it is helpful in advance of our meeting, some of my analysis of NHS whistleblowing governance and some of the data that I have been assembling is collated here in a collection of reports and commentary on many aspects of NHS whistleblowing:

MinhAlexander.com

I should point that issues of diversity are important to just culture and good governance, and that there is empirical evidence that NHS BME workers are more likely to be ignored or victimised when they raise concerns.

The NHS Human Factors/ HSIB project has so far looked very male and white to me, with questions about in group bias.

This will make it more difficult for HSIB to understand the experiences and anticipate the needs of others.

It is partly because of this that I urge HSIB to collaborate more openly and widely with all relevant parties.

Access to HSIB documents
I really would prefer to have a copy of your protocols at this stage and before our meeting, no matter how rough, although I find it hard to imagine that they are that rough given that HSIB goes operational in just a week’s time.

It is impossible to make informed comments without seeing what HSIB has in mind, and the principle stands that HSIB should be making all efforts to ensure that it has the best working protocols possible before it goes live.

The purpose of the phone call is to discuss HSIB’s approach and at present I have no specific proposals from HSIB to comment on.

I would be grateful if you would send me whatever you have.

With best wishes,

Minh Alexander

* Autobiographical details on Carl Macrae’s website:

"Carl Macrae is a social psychologist specialising in how organisations achieve high levels of safety, reliability and resilience. His work focuses on aviation and healthcare and is particularly concerned with how safety improvements are initiated, interpreted and organised; how organisations respond to disruptions, manage risk and learn from error; and how organisational and regulatory systems can be designed to support local innovation and improvement.

Carl is a Senior Research Fellow in the Department of Experimental Psychology at the University of Oxford, a Research Associate at the London School of Economics Centre for Analysis of Risk and Regulation and a Chartered Psychologist. His work spans research, policy, regulation and practice in a range of safety-critical industries and he holds a PhD in risk and safety management.

Previously he has held posts including Health Foundation Improvement Science Fellow and Senior Research Fellow at Imperial College London, Special Advisor and Business Architect at the NHS National Patient Safety Agency, Senior Research Fellow at University of Leicester medical school, two ESRC research fellowships at the London School of Economics, and visiting positions at Stanford University, University of California San Francisco, Cranfield University Safety and Accident Investigation Centre and the Australian National University, Canberra. He has also worked as a regulatory and prudential affairs associate in the risk management group of an investment bank.”


** Early Warnings, weak signals and learning from healthcare disasters, Macrae C. BMJ Qual Saf 2014;0:1–6. doi:10.1136/bmjqs-2013-002685

Minh,

Sorry for the delay; I've been flat out. Is Friday afternoon this week any good to you? I have a clinic which runs on until mid afternoon but I can usually free up some time around 3.30 or 4pm. I'd really like to get an understanding of what your concerns are about HSIB; for my part I'm coming at it with a very open mind and a focus on doing things differently. I know that folks who've had very poor experiences of NHS processes in the past will be naturally suspicious of this, but I suspect the only way that we will really be able to counter this is by demonstrating it by our approach to investigation when we start doing them.

I am conscious that most whistleblowers have had very negative experiences and that many other clinicians will have been reluctant to speak up for this reason (I don't know if you've seen our RCP report on this published last week?). I suspect that you also know about the academic literature on treatment of whistleblowers in healthcare and other industries, which I don't know well, but Carl Macrae does. I am hoping that Carl will help us use this to develop our approach to capturing information from whistleblowers. I don't know if any other healthcare system does this well, but we will look at other industries as well. Carl seems to think they have good processes in banking.

Re policies and procedures, we have very rough drafts at the minute but will publish preliminary documents on our website in the first few days of April. Like much else these will not be set in stone and will be subject to change depending on utility, feedback etc. We are very conscious that we are undertaking a new venture that hasn't been done before so expect that we won't get everything right straight away and that our methods and approach will have to grow and develop with us. I appreciate your interest in our work but I don't think that I can share drafts or notes with you at the minute without sharing them with lots of other individuals as well and we really don't have anything that is ready for that.

Anyway, let me know if you can do a call Friday afternoon.

Regards, Kevin

Sent from my iPhone
On 21 Mar 2017, at 06:53, Minh Alexander <***************> wrote:

Hi Kevin,

Can you confirm if a telephone meeting will be possible as suggested?

Thanks

Minh

From: Minh Alexander <***************>
Subject: Meeting
Date: 17 March 2017 at 12:24:21 GMT
To: Kevin Stewart <***************>

Hi Kevin,

Thanks for the invitation to meet face to face.

There are a number of reasons why I would prefer a telephone meeting at this stage.

I am concerned about speed and would like to ensure that there is some semblance of meaningful exchange about whistleblowing matters before HSIB goes live in 2 weeks time.

I am also a carer and travelling to London requires a lot of arrangements. Unusually, I am in London for a couple of matters in the next two weeks but there will not be time on either of those days to accommodate an additional meeting.

So, please can we meet by telephone in the first instance.

I can speak any time today after 1pm, and any time after 11 am on Sunday and Monday. Please let me know a time that suits you.

**Before we speak can you please send me any protocols relevant to whistleblowing and safe space for staff, whatever their roughness.**

I don’t think it would be meaningful to meet without this information.

Thank and best wishes,

Minh
Subject: Meeting

Date: 17 March 2017 at 07:26:01 GMT

To: Minh Alexander *******************

Dr Alexander,

Sorry for the delay in getting back to you. I'm sure we should meet face to face if possible; I'd like to hear directly about your concerns and fears about HSIB, how we might work, your thoughts on how we might avoid some of this happening etc. Hopefully I can reassure you on some of this.

I'm in London a lot over the next couple of weeks so maybe we can meet there if that would work for you? I can probably find us space to meet at RCP.

Could you perhaps let me know any times and dates that might work for you over the next couple of weeks in London?

Regards,

Kevin Stewart

Sent from my iPhone

From: Minh Alexander <*******************>

Subject: Meeting

Date: 21 March 2017 at 06:57:42 GMT

To: Kevin Stewart <*******************>

Cc: Keith Conradi <*******************>

PS I should say that I’m available any time today and Thursday after 11 am.

Tomorrow and Friday I’m otherwise engaged.
So if you agree to a telephone meeting but today and Thursday are not convenient, it will have to next week, which is not very good because there will be little chance of meaningfully feeding into your process before HSIB goes live.

Minh

From: Minh Alexander <**************>
Subject: Meeting
Date: 21 March 2017 at 06:53:42 GMT
To: Kevin Stewart <**************>
Cc: Keith Conradi <**************>

Hi Kevin,

Can you confirm if a telephone meeting will be possible as suggested?

Thanks

Minh

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To: Kevin Stewart <**************>

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So, please can we meet by telephone in the first instance.

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**Before we speak can you please send me any protocols relevant to whistleblowing and safe space for staff, whatever their roughness.**

I don’t think it would be meaningful to meet without this information.

Thank and best wishes,

Minh

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**From: "STEWART, Kevin (HAMPshire Hospitals NHS Foundation Trust)"
<*************>

**Subject: Meeting**

**Date:** 17 March 2017 at 07:26:01 GMT

**To:** Minh Alexander

Dr Alexander,

Sorry for the delay in getting back to you. I’m sure we should meet face to face if possible; I’d like to hear directly about your concerns and fears about HSIB, how we might work, your thoughts on how we might avoid some of this happening etc. Hopefully I can reassure you on some of this.

I’m in London a lot over the next couple of weeks so maybe we can meet there if that would work for you? I can probably find us space to meet at RCP.

Could you perhaps let me know any times and dates that might work for you over the next couple of weeks in London?

Regards,

Kevin Stewart
Thanks for your email Jane.

**Kevin** - as half of March has already passed, I think it would be best if we could meet by telephone for speed. I would basically like an opportunity to help shape HSIB policy before it is published when you go live on 1st April.

Could you possibly let me know if a telephone meeting is possible, and if so, some times that are convenient for you.

Could you also let me have, as requested, a copy of any draft or interim HSIB protocols so far, no matter how rough? A meeting would be more meaningful if I have information about HSIB’s current thinking.

Thanks,

Minh
Thanks for your email Jane.

**Kevin** - as half of March has already passed, I think it would be best if we could meet by telephone for speed. I would basically like an opportunity to help shape HSIB policy **before** it is published when you go live on 1st April.

Could you possibly let me know if a telephone meeting is possible, and if so, some times that are convenient for you.

Could you also let me have, as requested, a copy of any draft or interim HSIB protocols so far, no matter how rough? A meeting would be more meaningful if I have information about HSIB’s current thinking.

Thanks,

Minh

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**From:** Jane Rintoul  
**Subject:** RE: HSIB and stakeholder involvement  
**Date:** 13 March 2017 at 12:47:24 GMT  
**To:** Minh Alexander  
**Cc:** "Keith Conradi"

Dr Alexander

Thank you for your email.

Can I suggest that Dr Kevin Stewart and yourself arrange to meet, at your convenience?

I think he can then explain where we are with developing protocols, and get your views and thoughts.
I will ask Kevin to get in touch. He is currently moving between roles, so apologies if there is a short delay in hearing from him.

Best Wishes

Jane

From: Minh Alexander [****************************]
Sent: 08 March 2017 08:40
To: Jane Rintoul <*************************>
Cc: Keith Conradi ******************Kevin Stewart <**************************************************************************
***************************************************************************
***************************************************************************

Subject: HSIB and stakeholder involvement

Hi,

Thanks for your email Jane and for the indication that you have consulted with more than one whistleblower.

Your answer still leaves me in a fog about what specifically HSIB has learnt from this contact and how it will shape HSIB’s protocols.

The staff survey published yesterday shows a fairly constant picture of NHS staff reluctance to raise concerns: 30% of over a million NHS staff do not feel secure to raise concerns.

Could you please allow me, and the majority of whistleblowers who have so not been allowed access to your consultation, the opportunity to comment on the relevant draft HSIB protocols before they are finalised?

I would very much appreciate it if you could send me a copy of any relevant draft or interim HSIB protocols that you have so far, no matter how rough?

The dangers of the government - I see this current correspondence as more of conversation with the DH than with HSIB - only consulting those with whom it feels comfortable is that it will not be subject to healthy and effective challenge.

Best wishes,

Minh Alexander
Dear Dr Alexander,

Thank you for your email.

HSIB is, and will continue to consult with more than one whistleblower.

We know that we need to meet with more organisations and individuals representative of both patient/families and whistleblowers.

Our meetings have been very much about listening to issues and experiences.

These and future meetings are helping us to shape our approach, both in relation to safe space, and in drafting protocols that reflect how we work with individuals during investigations. Indeed, listening to people’s experiences confirmed our decision to have an open referral process into HSIB.

We are currently planning further input into our protocol writing.

Kind regards

Jane Rintoul
Hi Jane,

I now understand that you have indicated that HSIB has consulted a single, unnamed whistleblower.

If so, is it possible to share

a) what learning HSIB derived from this

b) how it will shape HSIB’s approach to whistleblowing and the drafting of HSIB protocols?

Many thanks,

Minh

Hi Jane,

Thanks for getting back to me and clarifying that you and HSIB see input from a wide range of stakeholders, including whistleblowers, as key.

I remain unclear who exactly is being consulted at this stage - I am aware only of some of the parties - and I do not understand why there is not an open process. Issues of equity arise as those involved at an earlier stage have a greater voice.
My specific question about whether whistleblowers will be invited to contribute to the drafting of HSIB’s protocols where they impact on whistleblowers (as opposed to HSIB producing a finalised protocol as a fait accompli - which appeared to be what Keith was proposing in his email below of 6th January 11.16) remains unanswered, I think.

With best wishes,

Minh

Minh Alexander

From: Jane Rintoul <************************>

Subject: RE: HSIB and stakeholder involvement

Date: 28 February 2017 at 09:10:37 GMT

To: Minh Alexander <************************>

Cc: **********************************************
************* "Keith Conradi" <****************>, Kevin Stewart <****************>,
************* **********************************************

Dear Dr Alexander,

Thank you for your email.

As I said in my previous email, we are working and will continue to work with a wide range of stakeholders. We are still very much in the design phase and will continue to refine our protocols after going live. We see the input of a broad range of stakeholders, including whistleblowers, as key.

Referrals to HSIB will be open to all. We are currently working on how this system will work and deciding on how our Advisory Board function will work.

More information will be available on our website, when it goes live at the end of March.

Thank you for your interest in HSIB.

Kind regards

Jane
Hi Jane,

Just checking if you received my email below of 6 February?

I gather that a meeting with stakeholders is taking place on Monday.

I would very grateful for clarification, as requested, of whether and how HSIB will be ensuring that its frameworks and protocols are designed with whistleblower input.

With best wishes,

Minh

Minh Alexander
Hi Jane,

Thanks very much for your email.

To recap,

I first wrote to Keith last summer about regulatory failures that allowed poor NHS incident handling, and I sought a response at the New Year.

I also asked HSIB a month ago if it would involve whistleblowers, patients and families in drafting its protocols.

The answers that I received from Keith and Kevin implied that the answer might be 'no', so I therefore asked for clarification.

I then learnt that HSIB subsequently approached a few individuals and organisations to offer access to its process (with a patient and family focus).

You now advise that HSIB is consulting informally and using existing stakeholder groups. But this does not fully answer my question.

I do not know how equitable or representative your approach is. I think there is a risk that it is not, and that it lacks the transparency needed for the culture change that HSIB is tasked with driving.

However, to my knowledge, whistleblowers were not represented in the establishment of HSIB to date. Therefore, if HSIB relies on the existing club which helped to establish it, it will exclude a major slice of intelligence and insight into how serious and deliberate NHS investigative failure happens.

I would have thought that this something which HSIB would seek to understand.

On 6 January Keith referred below to HSIB protocols for "dealing with whistleblowers".

This suggests that there is work to be done on how HSIB conceptualises and understands the issues around whistleblowing. The operation of so called 'safe space' is likely to be mechanistic and flawed without fundamental understanding of how the NHS silences staff. The change required is infinitely more complex than simply designating a space 'safe'.

There are so many ways in which the NHS can intimidate staff from telling the whole truth. I am shortly speaking to yet another staff victim of current NHS suppression. And I have just heard literally moments ago from someone who has decided that they have no choice but to submit to a restrictive compromise agreement. I am also today helping another ex
member of NHS staff to search for personal data about likely blacklisting for speaking up. These are typical scenarios and they continue all the time.

Please advise more clearly if HSIB will involve whistleblowers in drafting any protocols that relate to whistleblowing and the related but different matter of 'freedom to speak up'.

I also copy this to the National Guardian, Sir Robert Francis who will be chairing the Accountability committee for the National Guardian office and the relevant select committee chairs.

With best wishes,

Minh

Minh Alexander

Sent from my iPhone

From: Jane Rintoul <********************************************>
Date: 6 February 2017 at 08:43:07 GMT
To: Minh Alexander <********************************************>
Cc: Kevin Stewart <********************************************>, "Keith Conradi" <********************************************>,
********************************************

Subject: Re: CQC checks on the accuracy and quality of providers’ incident investigations

Dear Dr Alexander,

I am replying for Kevin, as he is on leave this week.

We are keen to learn from people's experiences and to get their views as we develop HSIB.

In establishment, we are going about this in an informal way and are using organisations and existing stakeholder groups where possible.

Longer term, as set out in the directions for HSIB establishment, we will have some form of advisory "board". We are currently working through options for this.

We are always happy to receive your views on HSIB and thank you for your interest.

Kind regards

Jane Rintoul
On 3 Feb 2017, at 16:43, Minh Alexander <***************> wrote:

Hi Kevin,

I am sorry to chase as I realise you must all be busy trying to get HSIB operational by April. However, as there is very little time to go, could you or another colleague get back to me regarding the question of whether HSIB will involve whistleblowers, patients and families in drafting its protocols?

I understand that you may be starting to invite individuals but it would be good to hear more about how you may be approaching these issues.

Many thanks,

Minh

Minh Alexander

From: Minh Alexander <***************>

Subject: CQC checks on the accuracy and quality of providers’ incident investigations

Date: 18 January 2017 at 17:05:22 GMT

To: Kevin Stewart

Cc: Keith Conradi <***************>, Jane Rintoul ***************

Hi Kevin,

Thanks very much for your email this afternoon, copied below, which I am guessing is a response to my email to Keith Conradi of 6 January at 11.45, also copied below.

I’m glad that HSIB views favourably the principle of using intelligence from staff and families. I may have to quibble with you a little about characterising the intelligence as
“soft”, as it is often very “hard” and well evidenced. It is just that the NHS may brazenly ignores serious concerns and tries to dismiss them as misconceived.

In my own experience, the NHS was capable of even ignoring a fully evidenced report of a mental health homicide (and even though the homicide was acknowledged, investigated by all the other agencies involved and subject to a criminal prosecution).

My question to Keith Conradi of 6th January was whether HSIB will be involving whistleblowers, patients and families:

“Will it be possible for whistleblowers, patients and families to contribute to the development of HSIB’s protocols where these have an impact on these stakeholder groups?”

May I just double check if HSIB’s intention is to involve us in the drafting of HSIB’s protocols?

From the perspective of whistleblowers, it would be helpful if we can contribute to the development of your external whistleblowing policy and standards for how you interact with whistleblowers and act upon their disclosures.

I presume HSIB will have legal Prescribed Person functions under the Public Interest Disclosure Act as it is part of NHS Improvement. It would also be useful to know what HSIB’s approach to this will be and also to know if HSIB will have or seek Prescribed Person status if it gains the statutory independence that it is reportedly seeking at present.

Many thanks and best wishes,

Minh

From: "STEWART, Kevin (HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST)"
<<<<<<<<<<<

Subject: Contact with Keith Conradi

Date: 18 January 2017 at 15:27:56 GMT

To: Minh Alexander ************

Cc: Keith Conradi ************, Jane Rintoul <<<

Dear Dr Alexander,

Hello again; Keith Conradi has asked me to respond to you on his behalf. As I said in my last email, I am in the process of transitioning between my RCP job and HSIB, so I can’t really give you a lot of specific replies at the minute. As a general comment however, HSIB will be looking to gather information and intelligence from all possible sources in order to
inform our focus.

To me this means being open to the possibility that helpful information may come from "soft intelligence" gained from staff members or from patients' families that might not be detected by formal data reporting, inspections, reports or other systems.

I certainly appreciate that in the past there have been too many individuals (staff members, patients, families) who have tried to raise legitimate concerns but found that these have been ignored, or worse that they have been treated in punitive fashion (at the College we hear these stories quite a lot as you might imagine). By contrast I have been impressed with the approach that Keith has brought with him to HSIB from his air accident investigation experience, which really does focus on the just, respectful culture that we have been lacking in healthcare.

The caveat for HSIB I guess is that we are a small organisation with limited resources and so will be fairly restricted in what we can investigate ourselves, at least initially, but our principles, which we hope to spread throughout the NHS, will be to deal with patients, families and staff in a just, open and respectful manner.

I will get back in touch with you when I perhaps have a bit more detail to share.

Best wishes,

Kevin Stewart

From: Minh Alexander <***************>

Subject: CQC checks on the accuracy and quality of providers’ incident investigations

Date: 6 January 2017 at 11:45:47 GMT

To: Keith Conradi <***************>

Cc: **************************************************************

Hi,

Many thanks for getting back to me.

I appreciate this must be a busy time for you.

1) Will it be possible for whistleblowers, patients and families to contribute to the development of HSIB’s protocols where these have an impact on these stakeholder groups?
Whistleblowing is an especially complex, specialist area and I hope that there can be input by whistleblowers to help ensure that HSIB gets it right.

Whistleblowers are largely currently excluded from the National Freedom to Speak Up Guardian’s processes, despite concerns raised about this, and I very much doubt that you will get a complete insight from the collaboration with the National Guardian’s office.

2) I don’t see the issues about CQC as separate to the establishment of your operational framework. Rather, regulatory failure to inspect the quality of incident investigations (and related to this, the Duty of Candour*) it is a core issue that is holding back improvement and safety in the NHS. CQC is also continuing to failing whistleblowers, as recently highlighted by a report that I co-authored, which was reported by the Times:

https://minhalexander.com/2016/12/05/whistleblowers-unheard-by-cqc/

I was very glad therefore to see that HSIB is seeking powers, which will extend to NHS regulators.

Would it be possible to discuss some of these issues?

I copy this to Inquest as I promised to share the response from my correspondence to you of June 2016, and I copy this to AvMA as regards the issues of candour. I also copy this to fellow campaigners who I am aware are also interested in how HSIB develops.

Best wishes,

Minh

* Regulating the Duty of Candour. AvMA August 2016


From: "Keith Conradi" <*************>
Subject: RE: CQC checks on the accuracy and quality of providers’ incident investigations
Date: 6 January 2017 at 11:16:29 GMT
To: Minh Alexander <*************>

Dr Alexander,
Thank you for your email. I note your concerns regarding the CQC; however please understand that my current priority is to establish an investigation capability that will become operational on 1 April 17. We are currently working on criteria to select our 30 investigations a year and also our protocols on dealing with whistleblowers. The criteria will be published on our website when it becomes fully functional.

Regards,
Keith

Keith Conradi | Chief Investigator
HSIB – Healthcare Safety Investigation Branch

From: Minh Alexander [***************]
Sent: 03 January 2017 16:41
To: Keith Conradi <***************>
Subject: CQC checks on the accuracy and quality of providers’ incident investigations

BY EMAIL

Keith Conradi
Chief Investigator HSIB

3 January 2017

Dear Mr Conradi,

1) I wrote to you in June and was informed by the IPSIS secretariat that you would receive my correspondence no later than September 2016, when you took up post. As I have not heard from you, I would be grateful for your response on the concerns raised about CQC’s approach and omissions.

For completeness, I attach a further email that I sent you on 14 July 2016 about the CQC, and I copy below a link to a published summary of concerns about CQC’s recent so-called “Deaths Review”:
2) I also notice that you have been invited to the National Freedom To Speak Up Guardian’s consultation event on 20 January, about the establishment of a stakeholder advisory group which the National Guardian has told the press will select cases for review by her office.

May I ask if HSIB has developed any policy or protocol yet on how whistleblowers will feature in its operations, and how HSIB may respond if contacted by NHS whistleblowers?

Many thanks.

Yours sincerely,

Dr Minh Alexander

From: Minh Alexander <***********************>
Subject: CQC checks on the accuracy and quality of providers’ incident investigations
Date: 10 June 2016 at 10:02:41 BST
To: ipsis.sec@dh.gsi.gov.uk, enquiries@improvement.nhs.uk
Cc: rfrancis@serjeantsinn.com, Katherine Murphy <katherine@patients-association.com>, pubaccom@parliament.uk, meghilliermp@parliament.uk, richardbaconmp@parliament.uk, harriett.baldwin.mp@parliament.uk, deidre.brock.mp@parliament.uk, kevin.foster.mp@parliament.uk, stewart.jackson.mp@parliament.uk, clive.lewis.mp@parliament.uk, nigel.mills.mp@parliament.uk, david.mowat.mp@parliament.uk, teresa.pearce.mp@parliament.uk, stephen.phillips.mp@parliament.uk, pughj@parliament.uk, nick.smith.mp@parliament.uk, karin.smyth.mp@parliament.uk, annemarie.trevelyan.mp@parliament.uk, Health Committee <healthcom@parliament.uk>, sarah.wollaston.mp@parliament.uk, philippa.whitford.mp@parliament.uk, thornberrye@parliament.uk, maggie.throup.mp@parliament.uk, liz.mcinnes.mp@parliament.uk, andrew.percy.mp@parliament.uk, james.davies.mp@parliament.uk, andrea.jenkyns.mp@parliament.uk, paula.sherriff.mp@parliament.uk, bradshawb@parliament.uk, julie.cooper.mp@parliament.uk, bernard.jenkin<bernard.jenkin.mp@parliament.uk>, ronnie.cowan.mp@parliament.uk, oliver.dowden.mp@parliament.uk, paulflynnmp@talk21.com, hoeyk@parliament.uk, cheryl.gillan.mp@parliament.uk, hopkinsk@parliament.uk, officeofdavidjonesmp@parliament.uk, gerald.jones.mp@parliament.uk, tom.tugendhat.mp@parliament.uk, mail@islandmp.org, louis.appleby@manchester.ac.uk, alistair.burt.mp@parliament.uk, suella.fernandes.mp@parliament.uk, smithad@parliament.uk, norman.lamb.mp@parliament.uk, luciana.berger.mp@parliament.uk, "Docherty, Matthew" <Matthew.Docherty@cqc.org.uk>
To Keith Conradi, Chief Investigator, Healthcare Safety Investigation Branch 10 May 2016

Dear Mr Conradi,

**CQC checks on the accuracy and quality of providers' incident investigations**

Congratulations on your appointment. With regards to HSIB’s remit for leading improvement in NHS incident handling, I write to suggest that HSIB seeks and reviews quantitative assurance data from CQC on its previous claim that it checks whether providers are “writing truthful” incident reports. (1)

Indeed, current CQC inspection frameworks include assessment of investigation quality:

“When things go wrong, are thorough and robust reviews or investigations carried out? Are all relevant staff and people who use services involved in the review or investigation?” (2)

However, CQC inspection reports give little data about such inspection activity and the continuing experience of many patient complainants, families and whistleblowers is that CQC in fact resists exploration of their reports that incident investigations are flawed, even where there is concern about falsification.

It would be useful if there is transparency about CQC’s methodology, and published evidence on whether CQC is consistently reviewing meaningful samples of incident reports for reviews to be effective.

As a very serious example, CQC’s report of its inspection of Southern Health in 2014 (3) did not convey the full scale and gravity of the trust’s governance failings around serious incident investigations. My reading of CQC’s report is that CQC commented on matters of process, and noted external stakeholder’s perceptions of investigation quality, but gave no assessment of its own on whether trust investigation reports were ‘truthful’, bar a comment on the incorrect classification of a single Never Event and a general observation that there was a lack of staff understanding about incident grading and related issues. This apparent lack of direct assessment of investigation quality by CQC was despite the fact that CQC’s report gave several examples of organisational failure to learn from risks and incidents that logically, ought to have prompted closer scrutiny of investigation quality. Nor could I find clear comment in CQC’s report on the trust’s failure to investigate deaths that should have been investigated. I found one reference to a failure to arrange an external review in a single case. CQC concluded that the trust merely ‘Required Improvement’ as opposed to being ‘Inadequate’ on the safety domain.

A question arises about the degree to which CQC has failed to adequately flag serious governance failure elsewhere.

I would be grateful to hear from you regarding this.

Yours sincerely,
Dr Minh Alexander

1) CQC annual report 2014/2015
http://www.cqc.org.uk/content/annual-report-201415

2) CQC inspection frameworks January 2016 http://www.cqc.org.uk/content/inspection-frameworks-hospital-and-ambulance-core-services


cc Public Administration and Constitutional Affairs Committee

   Public Accounts Committee

   Health Committee

   Norman Lamb MP

   Luciana Berger MP

   Suella Fernandes MP

   Andrew Smith MP

   Alistair Burt Minister of State for Community and Social Care

   Sir Robert Francis QC

   Katherine Murphy CEO Patients Association

   Peter Wyman CQC Chair

   Prof Louis Appleby CQC NED
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