1 Thursday, 5 December 2024
2 **(10.00 am)**
3 **LADY JUSTICE THIRLWALL:** Mr Bershadski.
4 **MR BERSHADSKI:** Good morning, my Lady. If I could
5 call Mr Stuart Lythgoe, please.
6 **LADY JUSTICE THIRLWALL:** Mr Lythgoe, would you like
7 to come forward?
8 MR STUART LYTHGOE (affirmed)
9 Questions by MR BERSHADSKI
10 **LADY JUSTICE THIRLWALL:** Do sit down.
11 **A.** Thank you.
12 **MR BERSHADSKI:** Could you state your name for the
13 Inquiry, please?
14 **A.** Stuart Lythgoe.
15 **Q.** Thank you. Have you made statements dated
16 31 January 2024 and 24 October 2024?
17 **A.** I did.
18 **Q.** Are those statements true and accurate to the
19 best of your knowledge and belief?
20 **A.** They are.
21 **Q.** Is it correct that you are the Director of
22 Operations for the HCSA?
23 **A.** That's correct.
24 **Q.** Is that the Hospital Consultants and
25 Specialists Association?

1 **A.** It is.
2 **Q.** Could you just give us a little bit of
3 background, please, to how many members you have, and
4 the sort of make-up of your membership of your Union?
5 **A.** Yes, we have approximately 3,500 members,
6 two-thirds which are in approximate terms Consultants.
7 All members are hospital doctors and hospital doctors of
8 all grades and some student associates, medical student
9 associates.
10 **Q.** Thank you. The Inquiry understands that one
11 of the people who raised concerns about Lucy Letby
12 approached the HCSA around the time that Letby raised
13 a grievance; is that correct?
14 **A.** It is.
15 **Q.** Could I start by asking you a few questions
16 about the scale of the problem regarding whistleblowing
17 and the way it's treated in the NHS from your
18 perspective.
19 You have exhibited to your statement a survey that
20 I understand that your Union has done, if I might ask
21 for that to be put up on screen first, please, it's
22 INQ0013295. Could you just tell us a little bit about
23 what prompted this survey and how it was carried out?
24 **A.** Yes. HCSA has had a concern with the way in
25 which NHS whistleblowers, in particular doctors, have

1 been treated over a number of years and that led in 2019
2 to a motion being put before the TUC Congress, another
3 one was attempted in 2023 and although it's not in my
4 most recent statement, there was a successful further
5 motion with different recommendations in 2024.
6 So there is a background of concern and that
7 derives principally from the role of HCSA to support and
8 represent its members and the focus of that
9 representation is usually employment law issues. And
10 what we found over a number of years is that doctors who
11 have come to us for support on employment law issues,
12 those issues have often -- the grounding or the sort of
13 sequel for them has been a whistleblowing issue where
14 they have raised a protected disclosure, although they
15 usually don't appreciate that what they are raising is
16 a protected disclosure when they first respond to
17 a concern regarding usually patient safety, but -- and
18 in accordance with their obligations.
19 Now, that's a pattern of -- or a consistent problem
20 that we have had and with doctors over a number of
21 years.
22 I joined HCSA in 2020 and when I joined, although
23 I am Director of Operations, I happened to take on
24 a number of cases. I had direct involvement with
25 doctors through the UK, that is Scotland, Northern

1 Ireland, Wales and in England, where this was a problem,
2 namely that disciplinary action was being against them
3 but the origin of that action appeared to be them having
4 raised a concern.
5 And so this survey that you have displayed here is
6 part of the ongoing work of HCSA to identify the extent
7 of the problem, both in terms of how widespread it is,
8 the impact it has and the -- the -- to move on from that
9 to try and work out ways to protect members.
10 **Q.** Is it correct that the conclusions of this
11 survey were that over 70% of hospital doctors believe
12 it's not possible to raise patient safety concerns
13 without detriment to their careers?
14 **A.** That -- yes, that was the outcome of the
15 survey that was conducted between 20 October and
16 2 November of last year.
17 **Q.** If I might just ask you a few questions about
18 your experience of the sorts of detriments that befall
19 doctors who raise concerns, to get a little bit more
20 detail about those.
21 One of the issues that I think you mention in your
22 statement is a referral to a regulator which can follow
23 or a threat of such a referral or even the notion that
24 a referral might be made following the raising of
25 a concern.

1 How frequently do you see that sort of action being
2 mooted?
3 **A.** It's very common that it's in conjunction with
4 disciplinary action, yes. It's usually a two-pronged
5 approach.
6 **Q.** Thank you, that document can come down off the
7 screen now, thank you.
8 In your experience, where a referral is made in
9 response to a concern being raised, how good are
10 regulators such as the GMC at recognising that that is
11 the situation that's arisen and dealing with it
12 appropriately?
13 **A.** We consider it's very poor in terms of
14 a number of reasons.
15 One is the -- there's been a problem with
16 recognising that there is or a whistleblowing aspect to
17 the referral. The second is, and it's a more general
18 problem for the GMC, the time that it takes the GMC to
19 investigate matters. They are very elongated, very
20 delayed; in fact that's a feature and one of the
21 problems of the internal disciplinary processes.
22 And the other issue that's of real concern to us is
23 that many of these referrals are malicious/vexatious,
24 but the GMC, if those referrals are made by doctors, and
25 it's not uncommon for that to be the case, the GMC

1 appears to have -- appears to fail to then go on to use
2 good medical practice to undertake an investigation into
3 such vexatious or malicious referrals.
4 This is an issue that we have taken up with the
5 GMC. We haven't so far received a satisfactory answer
6 and we are continuing to pursue that concern.
7 **Q.** Thank you. The Inquiry has also heard from
8 another witness about the use of the Datix system being
9 invoked in response to doctors who have raised concerns.
10 Is that something that you are aware of?
11 **A.** Well, in my experience the Datix system is
12 often used by doctors to log concerns. It's one of the
13 means which they would do that and that's an appropriate
14 way of doing that.
15 I don't have any direct experience of using Datix
16 myself because I am not a doctor and only occasionally
17 have I see a copy of a Datix entry, a relevant one.
18 But I -- it -- my understanding would be that it
19 would be as a result of a doctor logging a concern in
20 Datix that some sort of victimisation is initiated.
21 I don't have experience of Datix system itself being
22 used as a means to victimise doctors.
23 **Q.** Thank you. One of the main detriments or type
24 of detriment that you discuss in your statements is the
25 use of local disciplinary measures, in particular the

1 MHPS process, which stands for Maintaining High
2 Professional Standards, in response to doctors who raise
3 concerns.
4 Can you just describe what that process is and how
5 frequently you see it being used in response to concerns
6 being raised?
7 **A.** Yes. So, the MHPS process is a policy issued
8 by NHS in I think it was 2003/2005 to create
9 a particular disciplinary framework for doctors that
10 falls within the ordinary employment law context.
11 Although that policy was issued by NHS England
12 I believe, or the regulator, it's been adopted and it's
13 usually incorporated in the policies of particular
14 Trusts.
15 There's essentially three major sections to it.
16 One is conduct, and misconduct allegations which has its
17 own procedure. Then there is capability actions,
18 a section which deals really with the competence of the
19 doctor, clinical competence. And then finally there is
20 the health section. That's the -- and the area that is
21 most commonly used in whistleblowing cases is
22 misconduct.
23 Now, although a case might start and the reason for
24 that is because it gives a route to, it gives a route to
25 a dismissal which won't always happen, but it is a -- in

1 effect a shot across the bows of a doctor, even if it
2 doesn't lead to dismissal. And because of the nature of
3 hospitals, it's seldom -- although it should be
4 a confidential process, it's seldom that it is
5 restricted merely to those that are involved in the
6 process and the doctor concerned.
7 Often the knowledge that MHPS is being used against
8 a particular doctor will be fairly widespread.
9 Now, the problems with the MHPS process are the
10 failure to adhere to the guidance that's set out in it
11 and the relevant ACAS guidance as well. The inordinate
12 delay that's often applied in these processes I have
13 dealt with several cases that have gone on for three or
14 four years and you can imagine the pressure that's put
15 upon doctors in that type of situation.
16 And then linked to this is that it's not uncommon
17 for doctors to either be excluded or have -- from the
18 hospital or have their practice restricted. If it's
19 restricted, it's generally restricted in a way that will
20 inhibit them from undertaking clinical duties.
21 Now, the consequence of such exclusion or
22 restriction of practice is a skill fade and the longer
23 it goes on, and if we are talking about years, it
24 becomes a very serious issues in terms of the doctor
25 being able to resume their practice.

1 The other issue about this I -- is that if the
2 doctor is dismissed, it's a challenging situation in
3 bringing a case to an Employment Tribunal, whether it's
4 a whistleblowing one or whether it's an unfair dismissal
5 one, and the challenge that I am talking about in this
6 particular case is that it's very seldom that a doctor
7 or very seldom that anyone will be reinstated at an
8 Employment Tribunal during the process.
9 And so that -- these factors have a significant
10 impact upon a doctor's ability to resume their practice
11 because if they are dismissed and not reinstated but
12 there's been significant skill fade, there are very
13 significant problems in trying to arrange appropriate
14 reskilling in order for them to return to practise and,
15 therefore many don't.
16 There is one other thing I would just like to say
17 is that a problem with the processes -- I mean there's
18 more detail assessed in the playbook that you may ask
19 questions about later on and partly in this research
20 here, but one of the problems is that the internal
21 investigation process often creates divisions within
22 departments in a hospital. It's common for the doctor
23 to end up being isolated.
24 And this process and the evidence-gathering process
25 and often it's a -- it's a -- I have direct experience

1 of seeing evidence gathered by managers going to, for
2 instance, secretaries or people in other departments,
3 not just fellow doctors, asking if they know of problems
4 with X doctor. So it's not simply responding to people
5 that come with concerns to management, it's eliciting,
6 inviting adverse -- adverse evidence.
7 Now, the problem with this is it creates a division
8 within departments. It polarises situations, which
9 would be a challenge in itself to reintegrate a doctor,
10 but the -- the real concern is that often it -- it
11 creates a situation whereby although the original
12 investigation may have been a misconduct one, which is
13 usually in the cases that we are talking about
14 completely flawed because it raises allegations that are
15 without substance, it nevertheless -- that polarisation,
16 that division, creates a situation where it sets up the
17 potential for the employer to dismiss for some other
18 substantial reason and often that is on the basis of an
19 inadequate investigation.
20 But -- I am probably going on for quite a long
21 time, I hope that sets the tone --
22 **Q.** Can you just explain that link? How is it
23 that an investigation under the MHPS process, even if it
24 doesn't find misconduct, then leads to a situation where
25 it can be said --

1 **A.** Because the whole -- the whole process of
2 these investigations, you tend to have a situation where
3 the evidence gathering is directed towards gathering
4 evidence that is against the doctor. In these types of
5 cases, it's not common to find an impartial and fair
6 investigation. And that -- what happens is and the
7 background to this is the whistleblowing context, and in
8 the whistleblowing context one tends to find there are
9 those that aligned, as in doctors, that aligned with
10 management, whether it is clinical management or lay
11 management in terms of supporting the initiative to
12 victimise the doctor.
13 There are -- most of the other doctors will not
14 align themselves with the doctor who's -- who's being
15 victimised because of the concern they have that they
16 might be the next in line for something that happens.
17 And so that's why one gets the isolation and you have
18 a situation where it's seldom that those that are not
19 aligned with the management case will go forward and
20 speak in favour of the doctor and the concerns that he's
21 got in that disciplinary process because in effect they
22 are concerned they may be seen as challenging management
23 and risking either victimisation themself and/or damage
24 to their own career prospects.
25 And so what happens is then -- and it's not just

1 doctors but I have seen this -- that a -- rather than
2 pursuing the misconduct allegations which are usually
3 flawed, and usually without substance and which we as
4 a -- as a representative can challenge over an extended
5 period by gathering evidence, what tends to happen is
6 that the doctor ends up being isolated, people pull away
7 from the doctor but there might be a strong, albeit very
8 small, opinion of a few colleagues who are strongly
9 supportive of management and then if there's an
10 investigation to see if there is some other substantial
11 reason to dismiss the doctor and that itself is not
12 a thorough investigation.
13 The weight of the evidence will suggest that the
14 doctor simply can't work in that department because
15 no one will work with that doctor and therefore the only
16 route that the employer has is to dismiss.
17 And we are seeing dismissals based on some other
18 substantial reason becoming more frequent than -- well,
19 becoming more frequent.
20 **Q.** Thank you. You mentioned the quality of
21 investigations under this process?
22 **A.** Yes.
23 **Q.** The Inquiry has heard evidence recently from
24 a witness who has suggested that those conducting
25 investigations are often very busy managers who have

1 a day job to do and who aren't qualified or trained to
2 undertake investigations and therefore her
3 recommendation is that there be a centralised body which
4 can be called upon by NHS organisations which has a pool
5 of trained investigators to come in with the idea that
6 they would be a better resource, better qualified and
7 more independent to conduct investigations.
8 Do you have any observations on whether that is
9 a sound suggestion?
10 **A.** I have some observations, yes.
11 Sometimes it is the case that managers are very
12 busy and have difficulty in managing it, though my
13 experience is that's usually not the problem. Usually
14 these investigations go on for a long period of time and
15 in supporting the doctor concerned we as a Trade Union
16 raise all sorts of points, usually it's objecting to the
17 procedure but referring to ACAS guidance, referring to
18 MHPS, referring to the general principles of fairness
19 that were they minded to, they could take on board and
20 correct the process and they certainly have enough time
21 to do it.
22 The time periods set out in MHPS for undertaking
23 and completing an investigation of four months is almost
24 never adhered to, it's usually breached by excessively
25 protracted periods. So -- but an independent body or

1 a body outside the particular hospital would definitely
2 be of assistance in combating that but also in combating
3 those or addressing those situations where the problem
4 is insufficient time or insufficient experience.
5 In terms of what external body there might be,
6 well, there exists one although its remit doesn't
7 directly cover this situation and that is the Health
8 Services Safety Investigation Board.
9 Generally it appears to undertake investigations
10 of, where there are systemic problems rather than
11 individual ones. But the interesting feature about its
12 approach to investigations is the sort of holistic
13 approach and much more aligned to the principles of just
14 culture. Interestingly enough, although it's, it's
15 widely referred to as having been adopted by the Civil
16 Aviation Authority, it's also a policy of the NHS,
17 although frankly seldom adhered to. So I can see an
18 advantage in that.
19 Another advantage -- it's not a direct answer to
20 your question and -- is access to legal advice. Now,
21 one of the problems that I have detected is that often
22 legal advice is not sought and when it's sought, it's
23 often obtained from an external body, a firm of
24 solicitors or something like that.
25 Now, I have only worked in the Trade Union movement

1 for five years, my previous experience was as a lawyer
2 working for the Army and I think that my experience
3 there where you have lawyers that are understanding
4 the -- the ethos and the values of the organisation and
5 that linked to their professional obligations is
6 probably more likely and certainly was in the case of
7 the Army to lead to a situation where impartial and
8 well-reasoned advice is given to managers, or in the
9 case of the Army, the chain of command.
10 I personally -- that is a personal opinion.
11 **Q.** I am going to just you a few questions, if
12 I may, about the Freedom to Speak Up Guardian system.
13 Now, I appreciate that you joined the HCSA in 2020 by
14 which time the Freedom to Speak Up Guardian system was
15 already in place, so am I right in saying that you are
16 not in a position to compare directly the system as it
17 was prior to that with the Freedom to Speak Up system?
18 **A.** That's correct.
19 **Q.** But can you just tell us your experience of
20 how effective Freedom to Speak Up Guardians appear to be
21 when concerns are raised by doctors with them?
22 **A.** They are largely or very often ineffective or
23 substantially ineffective. But that's not a criticism
24 of them as individuals. It's about the circumstances in
25 which they operate.

1 Issues that seem to be relevant are the time that
2 they have, the range of issues that they have to look
3 at. They don't just address Freedom to Speak Up and in
4 the whistleblowing context it may be more broader
5 concerns are brought to them such as bullying or
6 something along that nature, so there's a vast range --
7 array of cases are brought to them.
8 The -- they usually -- often they are sort of
9 part-time. Their experience is probably not as much as
10 one would like, I accept they have some training, but
11 often they are being called upon to look at difficult
12 cases with a range of different concerns and navigating
13 the way through that and investigating it is difficult.
14 Another very significant problem is where they
15 report to or who they report to. Very often they are
16 reporting into middle management. They don't have the
17 access that's necessary to draw attention to cases and
18 really to be effective they would need to have access to
19 board level and that's one of the -- it links in with
20 one of the recommendations that we made and was adopted
21 by the Trade Union Council in September this year that
22 boards should be held accountable for this and there
23 ought to be -- although that wasn't a part of the
24 recommendation, it's very short, there ought to be
25 someone nominated on a board who has direct access to

1 and vice versa the Freedom to Speak Up Guardian.
2 **Q.** The Inquiry understands that there is already
3 a requirement that there be an Executive and
4 Non-Executive lead for whistleblowing who liaises with
5 the Freedom to Speak Up Guardian. Firstly, is that your
6 understanding and secondly, if that system isn't
7 operating sufficiently well, then why do you think that
8 is?
9 **A.** I -- I don't know that directly. It may be
10 the case. But I don't see it as operating very well.
11 I mean, there is a role for a nominated designated, it's
12 called Non-Executive Director, that's specified in MHPS.
13 But we seldom find the situation where representations
14 to that Non-Executive Director are effective in terms of
15 speeding up the process or ensuring that there is a fair
16 investigation and so my sense is that Non-Executive
17 Directors at present do not either fully appreciate the
18 extent of their responsibilities or they are not
19 sufficiently well-equipped to undertake them and that
20 might be because they haven't been trained or it might
21 be because they don't have sufficient support.
22 But -- and it can be challenging, my sense is, for
23 a Non-Executive Director to effectively challenge
24 a Chief Executive Officer, an Executive officer.
25 **Q.** I understand that one of the recommendations

1 that you support is the creation of an independent
2 agency which will deal with whistleblowing complaints.
3 Firstly, is that correct?
4 **A.** It is.
5 **Q.** Do you or does your organisation have any
6 experience of the Independent National Whistleblowing
7 Officer in Scotland, which has been in place since 2021
8 and if so, what is your experience of how effective that
9 system has been there?
10 **A.** I -- I have experience with one case and we
11 have experience as an organisation with several. In
12 terms of the general view of that it's led to an
13 improvement of the situation in Scotland overall.
14 I think it's from my personal experience I can see the
15 value of it, though the recommendation that we make if
16 we were given an opportunity to flesh it out in more
17 detail would seek to build upon that initiative.
18 So the Independent National Whistleblowing
19 Officer's office in Scotland, they -- it was useful in
20 the case that I was dealing with in terms of leading to
21 the Health Board investigating or reinvestigating or
22 reviewing concerns. But the problem is that the INWO
23 does not have an authority to undertake investigations
24 of the substantial complaint, that is the whistleblowing
25 allegation itself.

1 It can, as I understand it, I may be mistaken, but
2 it can undertake investigations of the nature of the
3 investigation undertaken by the health board. But it
4 can't go further than that and, yes, I have seen it
5 publish reports which are critical of health boards and
6 that's good.
7 But I sense that it's a good base but it would need
8 to be developed but certainly something along those
9 lines is definitely required for England, Scotland --
10 sorry, England, Northern Ireland and Wales.
11 **Q.** Now, I think one of your other recommendations
12 is that Trade Unions should be designated as prescribed
13 bodies. Can you just explain what that recommendation
14 is and what its purpose would be?
15 **A.** Yes. Well, it's a relevant factor in this
16 particular case because in this case the national
17 officer who was advising the doctor member who came with
18 concerns was constrained with what she could do in
19 support of that person because a -- a disclosure to
20 a Trade Union does not provide the protection that
21 a disclosure to a prescribed organisation does. So when
22 a member comes to us raising a concern it inhibits what
23 we can do.
24 So for instance we could not go directly to the
25 employer and say: Dr X has said this and that because

1 that would be disclosing -- this is what we understand
2 the situation to be, disclosing that the doctor had
3 released or made a disclosure to us even if it was
4 a qualifying one, but we are not protected. And
5 therefore in the context of a situation where there my
6 be a real risk of detriment being inflicted, then it's
7 a risk of that detriment being inflicted and then the
8 doctor not having recourse in an Employment Tribunal to
9 bring a case.
10 And therefore it -- it means that Trade Unions are
11 inhibited in the support that they can provide to their
12 members.
13 **Q.** Now, have you already made requests for your
14 Union or any other Unions to become prescribed bodies
15 and, if so, what has the response been to that thus far?
16 **A.** No, we haven't actually made, to my knowledge.
17 That may have happened but not yet and I don't believe
18 the TUC has yet either. But it -- it may have done.
19 **Q.** A connected question. Can you just explain
20 what policies there are, if any, in your organisation or
21 in any other Trade Unions, if you have knowledge of
22 them, of what somebody in the Trade Union is supposed to
23 do if they receive a disclosure from one, from a member
24 who calls them up or, for example, something like
25 a sexual assault having been committed, are there any

1 policies about what the Union is and is not supposed to
2 do that in that sort of situation?
3 **A.** Well, I can't speak for other Trade Unions, so
4 far as our Union is concerned the -- going -- our --
5 it's partly a campaign, it's partly linked to policy.
6 Our approach is what might be called a sort of
7 wrap-around type protection and the thing that we have
8 identified is that doctors seldom realise at the start
9 that they are making what qualifies as a protected
10 disclosure or the risk that's likely to befall them by
11 raising the issue even, and I am not talking about
12 situations where doctors whistleblow by going to the
13 media. I am talking about situations where they raise
14 a concern in, for instance, a Datix or by other means to
15 their managers.
16 So what we are telling our members to do is
17 preemptively in effect come to us for advice before they
18 make any disclosure and, at that point, we then have to
19 look and this is the -- this links into the way in which
20 we manage such cases, is from the local knowledge that
21 we have of the particular hospital that the doctors'
22 working at to identify whether there is a real risk of
23 them being victimised or not because I am not saying
24 this happens in every hospital, there are hospitals that
25 are receptive to these concerns and do act

1 appropriately.
2 In that case, one would support the member in going
3 to management.
4 If the concern -- if we have a real concern that
5 the doctor is going to be victimised then it may be --
6 and we have gone and sought advice from Protect on cases
7 and Protect has been very helpful and of course it
8 comes -- as I understand it, it comes under the --
9 partly because it's legal advice that's given, the
10 doctor remains protected in speaking with Protect.
11 But the next thing would be perhaps going to
12 a regulator, CQC or something along those lines, and
13 there are ways that can do that. Now, it may not be the
14 most effective of action in terms of going to the
15 regulator. But it -- it would ensure that the doctor
16 had complied with their obligations on -- under good
17 medical practice because I'm sure you have heard already
18 the problem that doctors are faced with is that they
19 have a professional obligation to raise these concerns
20 but in doing so it often results in the victimisation
21 that I have talked about being visited upon them.
22 So our obligation, though we have a concern for
23 patient safety and the functioning of the NHS that's in
24 built into the structure of HCSA and the way it operates
25 we also have -- and our most immediate concern is the

1 doctor and we are having to think both of the potential
2 internal and disciplinary processes and also the
3 potential risk of adverse action being taken by the
4 regulator, the GMC.
5 **LADY JUSTICE THIRLWALL:** So just following up on
6 that, if you don't mind, Mr Bershadski. So far as the
7 situation where an allegation is made by a doctor of
8 something going on, in this example it's sexual assault
9 or sexual assaults, is there any obligation on the
10 hearer of that information within the Union doing
11 anything about it independently?
12 **A.** Oh, well, part of the problem is the
13 constraint in terms of whistleblowing that I mentioned
14 before and not being a prescribed organisation.
15 **LADY JUSTICE THIRLWALL:** Yes.
16 **A.** We -- not independently but with the support
17 of members, we would and so I might have done -- written
18 to NHS England, I have written to the GMC on behalf of
19 members in particular cases with their authority.
20 Another thing that a Trade Union -- the reason that
21 Trade Unions --
22 **LADY JUSTICE THIRLWALL:** Sorry to just cut across
23 you: you might write a letter with the agreement of the
24 person who's made the disclosure to you?
25 **A.** Yes.

1 **LADY JUSTICE THIRLWALL:** But that would -- just
2 help me about this: would that presumably be informed by
3 your advice in relation to the consequences for the
4 doctor?
5 **A.** Yes. We would have to think --
6 **LADY JUSTICE THIRLWALL:** So it's not an independent
7 thing, it's part of that --
8 **A.** Yes, it's not independent and it's not that
9 frequent for the reasons --
10 **LADY JUSTICE THIRLWALL:** No.
11 **A.** -- that I have said.
12 **MR BERSHADSKI:** So would there be -- sorry,
13 my Lady?
14 **LADY JUSTICE THIRLWALL:** No, I have finished thank
15 you.
16 **MR BERSHADSKI:** On the same theme, would there be
17 any circumstances where the information that the hearer
18 receives is -- is such that regardless of the consent of
19 the person who has given that information to them that
20 they would approach an external agency with a concern,
21 or does that simply never happen?
22 **A.** It's not happened in my experience. It would
23 be based upon the consent of the member and that's the
24 way we operate.
25 The other thing -- just whilst I have this

1 opportunity, one of the other things that Trade Unions
2 can do is collective grievances. A member can raise an
3 individual grievance but part of the problem that I've
4 referred to already is the isolation of the doctor and
5 one of the policy approaches that we have and one of the
6 reasons for this sort of pre-emptive approach is to try
7 and build alliances for the doctor if we think there is
8 risk of victimisation before they blow the whistle. So
9 that rather than the management being able to focus on
10 an individual doctor, it's a situation where actually
11 there are several doctors, they are mutually supportive
12 and it makes it a much more challenging situation.
13 That has assisted in at least one case that I have
14 dealt with. The other aspect and advantage of Trade
15 Unions is that Trade Unions can co-operate and so
16 although this evidence that I am giving is focused on
17 the concerns of doctors, because it's a doctors'
18 Trade Union, there are other staff groups, in particular
19 nurses, sometimes they suffer in linked situations and
20 I have one experience of that, with the doctor that we
21 are representing.
22 So if one can bring together several Trade Unions
23 representing different staff groups, the position in
24 terms of responding to the safety concern and protecting
25 the people that are being treated adversely, employees,

1 doctors or nurses, is stronger.
2 **Q.** So is there a system between Trade Unions that
3 somehow encourages sharing of information to allow that
4 sort of combined approach to take place or is it just
5 a purely informal --
6 **A.** Yes, I don't know of any formal system, it's
7 an informal one based upon knowing people and other
8 Trade Unions in a particular hospital or region.
9 **Q.** While you mentioned the subject of grievances,
10 the Inquiry has heard evidence from other, from experts
11 that there are frequent occasions or certainly there are
12 occasions where people about whom concerns have been
13 raised then utilise HR policies, including grievance
14 policies, as a sort of defensive manoeuvre, to try and
15 divert attention away from the concern that's been
16 raised about them, if you see what I mean.
17 Is that a situation that you have come across?
18 **A.** I -- I don't have direct experience of that
19 myself, although I -- from the national officer who was
20 representing the doctor in this case that was our
21 member, I understand that was the case and it wouldn't
22 surprise me. Of course, I mean, someone may do it in an
23 obstructive way, a protective way, it might be that they
24 are advised to do that by that are Trade Union and the
25 Trade Union itself is looking after the interests of the

1 person concerned and doesn't appreciate the genuine
2 background safety concerns.
3 So the fact that one a person raises such
4 a grievance in such a situation, it's not necessarily
5 because there is some advice by their representative to
6 do something that's obstructing an appropriate process,
7 they might simply not be aware of the full background.
8 I don't -- I simply can't speak with any knowledge
9 so far as this case is concerned.
10 **Q.** Do you think there is a necessity to regulate
11 managers in the NHS?
12 **A.** Yes, we do. And HCSA does and I do as well.
13 And I note actually that there's -- the Department
14 of Health and Social Care has initiated a consultation
15 that's likely to lead to that and although I don't
16 believe it's mentioned in there, it might be, but the
17 model of the Financial Conduct Authority of a fit and
18 proper person something along those lines, I think is an
19 essential requirement.
20 Now, we -- the NHS needs -- and I worked in the NHS
21 for a short period of time myself for NHS England, it
22 needs a leadership that genuinely embraces this issue.
23 There is quite a policy in the NHS, as I mentioned, just
24 culture, there is other documents as well, but it does
25 not appear to impact upon senior Executives or senior or

1 even middle management to the extent that's necessary to
2 bring about the change that's required for -- not just
3 for doctors and not just for nurses, but for patients
4 and the safety of the NHS, those that work and are
5 treated by the NHS.
6 **Q.** The Inquiry heard evidence yesterday from
7 somebody with significant experience of the Freedom to
8 Speak Up Guardian system who said that one of the
9 problems from her perspective is a culture of secrecy
10 and lack of sharing of information once a concern has
11 been raised and following an investigation.
12 Is that something that you have experienced and do
13 you have any views on that?
14 **A.** It -- a lack of adequate sharing of
15 information is a problem. It's partly a problem I think
16 due to access of the Freedom to Speak Up Guardians.
17 The -- but also one has to bear in mind the
18 context.
19 One doesn't necessarily need to publish this widely
20 and broadly. If a concern is raised initially what's --
21 from my opinion, what's required is that it's
22 investigated appropriately and then if something -- the
23 result of the investigation, if there is a foundation to
24 the concern should lead to remedial action.
25 Now, it, it wouldn't and because that remedial

1 action may involve for instance retraining of a member
2 of staff, which could be a doctor or something along
3 those lines, because some of the problems, it has to be
4 said, are substandard performance by clinical staff.
5 That would be doctors and nurses, some are, yes.
6 One should be able to have a system whereby the
7 information is only shared with those who absolutely
8 need to do it and have the authority to address the
9 problem which might be a retraining. One wouldn't
10 necessarily want a situation, for instance, where there
11 was -- there ended up being a public -- might end up
12 humiliation of a clinical practitioner, whether it is
13 a doctor or nurse, if they can be adequately retrained
14 and restored to effective practise in the health
15 service.
16 So I think it's like many things, isn't it, it's
17 a matter of degree as to how much publicity there needs
18 to be, but my sense is that there is an inadequate
19 passage of information from a number of reasons and
20 that's one of the problems.
21 **MR BERSHADSKI:** Thank you. My Lady, those are my
22 questions. I don't believe there are any questions from
23 the Bar in relation to this witness.
24 Questions by LADY JUSTICE THIRLWALL
25 **LADY JUSTICE THIRLWALL:** Thank you, Mr Bershadski.

1 May I just ask one or two questions? I think you
2 told us at the beginning of your evidence just over
3 3,000 members, of whom 2,000, or two-thirds, are
4 Consultants?
5 **A.** In -- in rough terms, yes.
6 **LADY JUSTICE THIRLWALL:** In rough terms yes, and
7 then we looked at a survey where I think the number of
8 Respondents to the survey was 562 or something a bit
9 like that. We can look at that if that helps. Was that
10 a survey that was sent to all your members, some of your
11 members or just a specific group?
12 **A.** It was sent to all our members.
13 **LADY JUSTICE THIRLWALL:** In terms of a response
14 rate, that's one that you would feel you can draw
15 conclusions from the number of responses that you have
16 got?
17 **A.** Yes, it is. It's -- I mean, this is not an
18 official survey of course, it is completely voluntary.
19 **LADY JUSTICE THIRLWALL:** No, I understand.
20 **A.** And that is a sound response rate and not only
21 that, the responses are consistent with the experience
22 of the national officers who advise members on
23 particular cases.
24 So we believe that it is the conclusions that are
25 drawn by it and are a fair representation of the

1 situation.
2 **LADY JUSTICE THIRLWALL:** Thank you. There was just
3 one matter which you touch on very lightly and it's that
4 you do make a suggestion that you say: we would argue
5 that it would send a very strong message of deterrent if
6 we introduced a criminal offence of causing detriment to
7 individuals who have made protected disclosures.
8 Is that something that you have raised beyond your
9 statement here, is that something that's under
10 discussion?
11 **A.** No, at the moment that's been put, that was in
12 that submission and the motion that was adopted by the
13 TUC. In terms of writing to Government and that we
14 haven't put that forward as a particular concern. But
15 the -- there is scope in my mind for the criminal law to
16 be involved in here.
17 Some of the treatment is so abusive that it --
18 it's, it seems an appropriate response and harassment
19 might be another example. There's even a concern about
20 the extent of it and, and it's -- it's -- not only is
21 there a case by one doctor about destruction of evidence
22 and emails or elimination, but that was actually
23 endorsed broadly by the retiring NHS Ombudsman -- Health
24 Services Ombudsman, Rob Behrens, in an interview with
25 the Guardian.

1 **LADY JUSTICE THIRLWALL:** We are hearing from him
2 next week.
3 **A.** Sorry.
4 **LADY JUSTICE THIRLWALL:** We will ask him about
5 that.
6 **A.** I am very glad to hear that --
7 **LADY JUSTICE THIRLWALL:** Sorry, I didn't want to
8 cut you off.
9 **A.** No, no I have answered the question.
10 **LADY JUSTICE THIRLWALL:** Thank you very much
11 indeed.
12 Anybody want to ask anything else?
13 No, well, thank you very much indeed for coming to
14 give us your evidence, Mr Lythgoe, you are free to go
15 now.
16 **A.** Thank you.
17 **MR BERSHADSKI:** My Lady, I believe Ms Raphael is in
18 the room and so we are in a position to carry straight
19 on.
20 **LADY JUSTICE THIRLWALL:** Very good, excellent.
21 MS SYBILLE RAPHAEL (affirmed)
22 Questions by MR BERSHADSKI
23 **LADY JUSTICE THIRLWALL:** Do sit down.
24 Mr Bershadski.
25 **MR BERSHADSKI:** Could you state your full name

1 please for the Inquiry?
2 **A.** Sybille Raphael.
3 **Q.** Have you made a statement dated 4 March 2024?
4 **A.** I have.
5 **Q.** Is that statement true and accurate to the
6 best of your knowledge and belief?
7 **A.** It is.
8 **Q.** Now, Ms Raphael, you are the legal director of
9 a charity called Protect, is that right, and could you
10 just please begin by telling us about what it is that
11 your charity does and what your role within it is?
12 **A.** Protect has three arms, so at the heart of the
13 charity is our free legal advice line where we advise
14 workers on how to raise their concerns in the most
15 effective and the safest way and we also advise them on
16 their legal rights when things go round -- go wrong.
17 We are unusual as a charity because we self-fund
18 and we do that by selling training and consultancy to
19 organisations, to companies, to businesses, to
20 regulators on how to set up and to maintain effective
21 whistleblowing systems.
22 So we help at the microlevel, we help individual
23 whistleblowers but we also help at the macro level
24 because we look at systems and it is very satisfying
25 because we work with the -- these organisations who are

1 leaders in the field with best practice, those who
2 really want to do whistleblowing right.
3 Our third arm is our policy and research arm. We
4 were set up in '93, we have campaigned for the UK to
5 adopt a law to protect whistleblowers which it did in
6 '98, 26 years ago.
7 And we -- we kept its very strong and important
8 policy and campaign function undertaking research and
9 responding to consultations.
10 **Q.** Thank you. Ms Raphael, if I could just ask
11 you to speak up a little bit for the assistance of
12 creating the transcript.
13 How long have you been the legal director of
14 Protect?
15 **A.** I have been the legal director of Protect for
16 four years.
17 **Q.** Prior to that, were you also involved in
18 Protect or was your career elsewhere?
19 **A.** No, I was working for another charity, focused
20 on discrimination and parental rights, so also an
21 employment law charity but not about whistleblowing.
22 **Q.** In your experience firstly, can you just
23 outline for us what your understanding is of how
24 a serious concern that's raised to do with for example
25 patient safety ought to be dealt with by management, if

1 they receive it?
2 **A.** The role of a whistleblower, the role of
3 a worker who spots that something is wrong is to raise
4 it, to raise it to someone who can deal with it. The
5 role of the person who receives the concern is to
6 identify what sort of concern it is and then to
7 investigate it.
8 It's also important we say to be seen to
9 investigate it and to be seen to take remedial action
10 because otherwise the whistleblower and others within
11 the workplace will believe it's pointless to raise
12 concerns, it's pointless to raise issues because nothing
13 is done about them.
14 And of course the role of the person who receives
15 the concern is also to protect the whistleblower because
16 victimisation of whistleblowers is a very common and
17 a very natural default mode for all of us. No one likes
18 being brought a problem. It's far easier and very
19 tempting to blame the messenger and to shoot at the
20 messenger rather than address the message.
21 So the role of the person who receives the concerns
22 we say is also to prevent victimisation from happening
23 in the first place.
24 I would also say more generally the role of
25 management is not just to allow staff to raise concerns,

1 it is to empower them to raise concerns. Whistleblowing
2 is the best risk management tool that organisations
3 have. We know it's far more efficient for instance than
4 internal audit to discover fraud. We know as well that
5 it's absolutely crucial element to patient safety.
6 So why wouldn't an organisation take it seriously
7 and investigate an issue? Crucially, it's not for the
8 whistleblower to investigate themselves. The role of
9 the whistleblower is only to alert management and it is
10 then for management to investigate and that's behind our
11 law which Parliament passed to encourage responsible
12 whistleblowing.
13 It's also behind the NHS Speak Up policies. It
14 says that once you raise a concern, someone else will
15 investigate, someone who is trained and can handle that
16 properly. Whistleblowers only have a tiny angle on
17 an issue. It may well be that this issue has
18 a perfectly honest and innocent explanation but it may
19 look dodgy from the whistleblower's angle.
20 So of course it's not for the whistleblower to
21 determine whether or not there is something dodgy, there
22 needs to be an investigation by someone else.
23 **Q.** Connected to that, is it the obligation of the
24 whistleblower or the person raising a concern to bring
25 evidence forward behind that concern?

1 **A.** Absolutely not. And indeed the whistleblower
2 will probably put themselves at risk if they started
3 doing so because they would probably, you know, collect
4 confidential information that they must not do, you
5 know, it goes beyond their role.
6 The role of the whistleblower is just to alert; not
7 to seek hard evidence that would, you know, prove their
8 concern. It's not for the whistleblower to prove their
9 concern.
10 The law is very clear that the only thing the
11 whistleblower needs to have to be protected by law is
12 a reasonable belief that there is a risk of a wrongdoing
13 happening or that wrongdoing has already happened.
14 It's only the reasonable belief. It's perfectly
15 normal for whistleblowers to be mistaken, indeed if an
16 organisation never has any mistaken whistleblowers we
17 say that's quite worrying, it means that their staff are
18 far too worried to report risk and that the organisation
19 is missing out on -- on using to the full the eyes and
20 ears that the workers have to -- to spot and manage
21 risks.
22 **Q.** Now, Ms Raphael, presumably your organisation
23 deals with whistleblowers from all sorts of industries
24 and not just healthcare sector or the NHS.
25 Can you just tell us in your experience what

1 proportion of healthcare workers find their concerns
2 when they have raised them have been adequately dealt
3 with? I think you deal with some figures on that point
4 at paragraph 28 of your statement, if that assists.
5 **A.** So whistleblowers from the healthcare
6 sector --
7 **Q.** Yes.
8 **A.** -- are the most important categories of our
9 callers and NHS callers obviously represent a big
10 proportion of that particular category.
11 31% of our callers in the NHS tell us that their
12 concern has been ignored. "Ignored" means not even
13 investigated. "Ignored" doesn't mean it has been
14 unsubstantiated, "I was told I was wrong". No, no,
15 "ignored" means no one has done anything about it. It
16 is like throwing a pebble in a dark hole, it is
17 completely pointless to raise that issue because no one
18 took any notice. That is very worrying.
19 The other extremely worrying figure is the 63% of
20 NHS callers who tell us that instead of being thanked
21 for doing what they should do, which is raising
22 a concern, they have been punished for it so they have
23 been victimised, they have been forced to resign, they
24 have been dismissed, they have been ostracised, they
25 have been subject to a disciplinary process because of

1 it.
2 **Q.** How do those figures compare to other
3 industries that you have experience of?
4 **A.** They are not widely different from other
5 industries. Whistleblowing is a dangerous thing to do.
6 It's an absolutely vital thing to do, it's what holds --
7 you know, to me it is a cornerstone of our rule of law
8 and of our Parliamentary democracy, the ability to
9 report wrongdoing. It is key to accountability, it is
10 key to deterrence, it is obviously key to ensure that
11 wrongdoing is detected but it is indeed a dangerous
12 activity.
13 What we find in particular in relation to NHS
14 workers and we usually find those calls painful because
15 there does seem to be a blame culture in the NHS, more
16 of a blame culture in the NHS than in other sectors.
17 Also because the concerns themselves are not
18 necessarily easy. Sometimes a concern is actually
19 a difference in medical opinion and when is it
20 wrongdoing? When is it disagreement as to what's the
21 best treatment for that particular patient is?
22 Even more often it's an issue about resources and
23 no one can do anything about it in a way, you know,
24 there is not enough of us, we have too much to do and
25 that means that the care that we deliver is substandard

1 and we are putting people at risk.
2 What's also obvious to us is that in comparison to
3 at least the financial sector there seems to be a lack
4 of accountability at senior management level, which is
5 very worrying, and although there are a plethora of
6 regulators in the health sector, there doesn't seem to
7 be a single regulator that's actually focused on
8 punishing those who silence whistleblowers, those who
9 victimise whistleblowers and punishes those who don't do
10 what they should be doing ie investigate serious
11 concerns.
12 So our callers tell us that when, for instance,
13 they go to the CQC to alert the CQC that there has been
14 whistleblowers victimisation. The CQC replies that it
15 is not for them to deal with that, there is an
16 Employment Tribunal process if they want to do that.
17 So no one at -- at a senior management level feels
18 responsible for ensuring that whistleblowing is done
19 properly, that whistleblowing is effective, and the NHS
20 has lots of wonderful policies but what matters is not
21 the policy, it's how it's implemented and no one seems
22 to be responsible for ensuring that these policies are
23 indeed implemented and that they work, that they are
24 effective.
25 **Q.** What's your experience of how whistleblowers

1 are -- what detriments befall them in the NHS?
2 **A.** Isolation is a very common one, when you
3 report a concern. By definition you are disagreeing
4 with the rest of the group no one else seems to have
5 said anything about it, maybe, maybe you are wrong
6 because no one else think it's a problem. It's very
7 isolating to blow the whistle. By definition you are
8 separating yourself from -- from the group. But then we
9 see much worse than that.
10 So we see active victimisation. We see the use of
11 Datix, like what you have heard just now, we have had
12 several callers who said that after they reported
13 a whistleblowing concerns, Datix has been used to --
14 against them in a -- in a totally inappropriate way, you
15 know, every single little incident which would be
16 perfectly fine for anyone else was suddenly put on Datix
17 because it was against them.
18 Use of disciplinary threats or use of disciplinary
19 sanctions, referral to the GMC or veiled threats that
20 they are going to be referred to the GMC and -- and of
21 course managing them out and ensuring that they leave
22 that particular Trust.
23 We see the whole gambit.
24 **Q.** You say at paragraphs 45 to 48 of your
25 statement that there are particular problems regarding

1 raising concerns for those with protected
2 characteristics. Can you just tell us a little bit
3 about that and why there appears to be a difference
4 there?
5 **A.** The more vulnerable you are, the more
6 difficult it's going to one, believe that you will be
7 taken seriously, that you will be believed, that you
8 will be listened to; and two, that you will be protected
9 if you blow the whistle.
10 I often say that I have absolutely no problem
11 blowing the whistle as a legal director of Protect to my
12 board because I know the trustees, I feel quite secure
13 in my job. Very, very different if I have just started
14 at the bottom, you know, as the most junior legal
15 adviser and if I don't look like the rest of the group,
16 if I am the only one of my kind. You are already much
17 more vulnerable. So the likelihood is that you are not
18 going to raise speaking up and the likelihood is that
19 also if you do speak up, you are not going to be
20 listened to, people won't pay attention to you because
21 they will think that you are not credible or whatever.
22 So we are very conscious that, yes, increased
23 vulnerabilities -- if you have a protected
24 characteristic that puts you already at an increased
25 risk, both of victimisation when you speak up but also

1 of just not, not feeling empowered enough to speak up in
2 the first place.
3 **Q.** I just want to ask you a few questions, if
4 I may, about the Freedom to Speak Up Guardian system.
5 I think you say in your statement that one of the bits
6 of advice that you give sometimes when you receive calls
7 from NHS workers is to direct them to raise their
8 concerns with the Freedom to Speak Up Guardian in their
9 Trust.
10 But what is your experience of the effectiveness of
11 Freedom to Speak Up Guardians? Dealing with concerns?
12 **A.** On paper, having a Freedom to Speak Up
13 Guardian, having several Freedom to Speak Up Guardians
14 in your place of work is wonderful. This is advice and
15 support by one of your colleagues that should be very
16 accessible and that's indeed something that's extremely
17 valuable, although we give advice legal advice and
18 support to our callers we you know we advise many
19 different kinds of callers we don't have intimate
20 knowledge of that particular place of work, there is
21 particular pressure around it.
22 So having someone to support the whistleblower and
23 be there in that role is great. The main problem we
24 think is that that particular person, the Freedom to
25 Speak Up Guardian, is to provide the sort of more

1 support, common sense, ideas, okay, how -- maybe how can
2 you raise it differently, have you tried using that
3 channel et cetera.
4 But that Guardian is also tasked with holding
5 senior management to account if the concern is not
6 investigated and be basically the sort of Speak Up
7 advocate and we don't think that these two roles are
8 being done properly.
9 We don't even think that the first role, the role
10 of support, is necessarily being done properly, not --
11 obviously I can't speak on individual cases and we know
12 that there are some wonderful Freedom to Speak Up
13 Guardians but on the whole we believe that Freedom to
14 Speak Up Guardians just don't have the resources to be
15 able to help effectively whistleblowers, partly because
16 they are tasked with helping with anything and
17 everything, including eyes rolling, so it is quite hard
18 for them to be able to sort of allocate enough resources
19 to the really important whistleblowing public interest
20 concerns when they -- when they receive those.
21 But on -- you know, holding the board to account
22 you have just heard they don't necessarily have access
23 to the board anyway and they are part of that my -- line
24 management themselves. So it's also very risky for
25 their personal situation if they start making some noise

1 and kicking up a fuss against a Chief Executive who they
2 think has not investigated a concern properly.
3 So we think it's absolutely key that there is
4 someone higher up who should really be there to be the
5 whistleblowers' champion following maybe the model of
6 the financial sector whistleblowers' champion to ensure
7 that critical conversations are held at board level and
8 it's taken really seriously.
9 **Q.** How comfortable do your callers appear to be
10 in contacting their Freedom to Speak Up Guardian with
11 concerns?
12 **A.** We don't necessarily hear of any discomfort,
13 but we hear of: it's pointless, you know. Why would I,
14 if I'm a Consultant, the Freedom to Speak Up Guardian is
15 a nurse, they may not even understand or -- it just
16 doesn't seem to be the natural fit. And if I have
17 contacted my Freedom to Speak Up Guardian, well, they
18 didn't really help, they couldn't do much about it
19 anyway so why would I? So it is not really discomfort,
20 it's more discouragement.
21 **Q.** There has been a proposal by one of the other
22 witnesses that the Inquiry has heard from for the
23 function of the Freedom to Speak Up Guardian to be
24 externalised in effect for them to be employed by an
25 organisation which is not the Trust itself. What do you

1 think about that recommendation and whether it would
2 assist?
3 **A.** Why not? And if indeed it's properly
4 resourced and more importantly if that external person
5 has the ear of the board and therefore can hold senior
6 management to account more effectively then, then great.
7 I mean, as usual with policies it's not the policy
8 that matters, it is how it is implemented in practice,
9 it is how it works in practice.
10 Yes, we are all for it if that means increased
11 accountability and increased access to the board.
12 I suppose it will also mean a ring-fenced set of
13 resources, I think the problem with Freedom to Speak Up
14 Guardians is that they don't necessarily have any
15 resources, the Trust are left free to fund their role or
16 not and we know that some of them are not funded at all.
17 So if there was an external body I imagine then at
18 the very least then there would be some reassurance that
19 something does exist that's probably paid for.
20 **Q.** Have you got any experience of the Independent
21 National Whistleblowing Officer system in Scotland?
22 **A.** We do. We were asked to help to contribute to
23 the drafting of the standards.
24 **Q.** What has been your experience of any
25 differences between the effectiveness of that system

1 versus the system we have in England and Wales?
2 **A.** It's been positive. It's been positive mostly
3 on that accountability piece because INWO, you know, has
4 teeth because INWO will go to the board and will say
5 "this is not good enough, why haven't you investigated?"
6 And if the board doesn't still ignores then INWO will go
7 to the Scottish Parliament and will publish their
8 findings. You know, there is a real threat here.
9 Whereas the poor FtSUG, the poor Freedom to Speak Up
10 Guardian, have none of those weapons at hand.
11 So, yes, we say it's been helpful. It's also been
12 helpful to have much clearer and much more precise
13 standards of what a good investigation looks like and
14 that's detailed in -- in the standard.
15 The Freedom to Speak Up policy in England is
16 actually quite vague, whereas the INWO standard goes
17 into the detail of "this is what you need to do", which
18 we think is helpful.
19 **Q.** One of the legal reforms that I understand
20 Protect is seeking to have implemented is an independent
21 agency to be established in England and Wales. I think
22 you call it the "Whistleblowing Commissioner" in one of
23 your documents. Can you just set out for us what you
24 see the functions of that body being?
25 **A.** Well, a little bit like INWO does but more

1 generally across the piece, more generally for the
2 society.
3 Our law, our UK law, is an "after the event" law.
4 The only thing our law says is: oh, if an employer
5 punishes or dismisses a whistleblower, then the
6 whistleblower can go to the Employment Tribunal and get
7 money and get compensation for it.
8 There's nothing in our -- in our legal system
9 that -- that's actually forces employers to have systems
10 in place and we are at odd with our neighbours because
11 in the EU now there is an EU Directive that says any
12 employer who has more than 50 workers needs to -- you
13 know, needs to investigate possible concerns when they
14 are brought to them, needs to protect the
15 confidentiality of the whistleblowers, needs to feed
16 back, needs to organise an investigation by someone who
17 appears impartial.
18 So we are hoping that if indeed we have
19 a Whistleblowing Commissioner, that Whistleblowing
20 Commissioner will be able to draft those key good
21 practice principles and then will be able to impose
22 civil penalties on those organisations who don't follow
23 those principles and therefore will have teeth and will
24 say it matters: If you don't do it, it matters, there
25 will be a penalty if you don't do it; therefore do it.

1 **Q.** Just to be clear, is Protect's proposal that
2 there be a legal duty on certain employers to
3 investigate concerns that have been raised?
4 **A.** Yes. Because why wouldn't you? I mean, you
5 know, it would be madness not to want to investigate
6 when things have gone wrong. I think it's just common
7 sense. It's -- it feels to us it is madness that
8 organisations don't do it.
9 **Q.** You say at paragraph 43 of your statement that
10 the NHS is trying to implement a just culture which is
11 blame free, similar to the aviation sector, but that the
12 reality on the ground doesn't match this.
13 Can you just explain that to us, please? Firstly,
14 what is the just culture in your understanding?
15 **A.** The just culture is a culture where, when you
16 report that something is not right you are not blamed
17 personally for it. And actually you are thanked for
18 doing that and it's a sort of -- I mean, it's not a no
19 blame culture because if there is evidence that an
20 individual is indeed at fault, you know, there will be
21 remedial action and so on. But it's -- it's a culture
22 where reporting wrongdoing, reporting issues is -- is
23 encouraged and actually not just encouraged but is part
24 and parcel of what you should be doing.
25 What we see in the NHS is that far too often when

1 you report -- when you report something, you know, you
2 become the subject of the blame, the narrative turns
3 against you instead of the underlying cause of the issue
4 partly because the underlying cause of the problem that
5 you report is far too painful to deal with, much easier
6 to try to silence you. But that's certainly our
7 experience.
8 Now, we don't hear about all the many happy ending
9 whistleblowing stories necessarily because although some
10 of our callers call us before they raise a concern, a
11 lot of our callers call us after they have raised
12 a concern because they have been ignored or because they
13 have suffered because they have raised a concern. So we
14 have a slightly skewed view on -- on, you know, how
15 happily whistleblowing takes place in the NHS.
16 But it's fair to say that, from where we stand,
17 it's -- it's a painful picture.
18 **MR BERSHADSKI:** My Lady, I see the time. I don't
19 have many more questions for this witness so it may be
20 convenient.
21 **LADY JUSTICE THIRLWALL:** I think we will take the
22 break now and we will come back in at 20 to 12. Thank
23 you.
24 **(11.18 am)**
25 **(A short break)**

1 **(11.40 am)**
2 **LADY JUSTICE THIRLWALL:** Yes.
3 **MR BERSHADSKI:** Ms Raphael, we talked a short while
4 ago about the notion of externalising Freedom to Speak
5 Up Guardians to take them outside of the Trust so that
6 they are employed by another body and that that's one
7 potential way the current system could be changed. The
8 other way or another option is the Scottish model where
9 there is the Independent National Whistleblowers Office
10 which, as we understand from another witness, is mainly
11 there to come in after the event if there is a worry
12 that a concern has not been dealt with appropriately and
13 to then come in and make recommendations.
14 Which of those two models or some sort of hybrid of
15 the two is it that you think would be most effective in
16 the NHS setting in England and Wales?
17 **A.** I would argue you need both. You need both
18 a Freedom to Speak Up Guardian who can be effective
19 during, during the investigation and can and have better
20 resources, better access, better gravitas maybe, to help
21 the whistleblowers more effectively and you also need an
22 INWO type body who is able to come and mark the homework
23 of the organisation and say: look, you have not -- you
24 know, you have not done it properly. You need to -- you
25 have not respected the standards, you need to redo it or

1 you need to look into what went wrong here.
2 **LADY JUSTICE THIRLWALL:** Can I just ask. So that
3 would you two new organisations, for want of a better
4 word, which obviously would require money to pay for
5 them. And is there a way, do you think, of sort of
6 amalgamating the two, or do you think actually they are
7 usefully kept separate, so you would have the
8 independent investigators and then the reviewing body?
9 **A.** I think if I were to choose between the two,
10 maybe the reviewing body, because it really strikes me
11 this sort of lack of accountability. I mean, you know,
12 in the Countess of Chester Hospital, we know that the
13 CEO openly and expressly discussed plans to retaliate
14 against whistleblowers because they had blown the
15 whistle and we know that HR did not find those plans
16 reprehensible, only disappointing. That is despite us
17 having a law for the last 26 years which says very
18 clearly that whistleblowing victimisation is illegal.
19 There doesn't and we -- we put a Freedom of
20 Information Request to the Countess of Chester Hospital
21 to ask if they had reviewed their policies and processes
22 after the conviction of Lucy Letby into what, if
23 anything, went wrong in their treatment of
24 whistleblowing and they said: no. We have, you know,
25 updated it along with the guidance but no, we haven't

1 changed anything following anything that happened
2 specifically within the Trust.
3 **LADY JUSTICE THIRLWALL:** So just pausing there, of
4 course I have to make decisions about what happened and
5 who did what, when and I will be doing that in due
6 course and in my report.
7 But going back to the accountability point, which
8 I understand is an important one, what about -- would
9 the CQC be a suitable body that could look at the
10 whistleblowing policies?
11 **A.** Yes, yes. Potentially. We say it's -- it's
12 not just having a policy. You really need to look at
13 your governance, you need to look at your senior
14 management because of course if you have senior leaders
15 who don't model the behaviours they want to see that set
16 the tone for the whole organisations, you need to look
17 at your engagement, your communication, your training:
18 Do people know how to blow the whistle? Do they know
19 what to do? Do they know what is whistleblowing? Are
20 managers trained on how to receive those concerns? And
21 you need to look at your operation, how do you
22 investigate concerns, how do you keep records? Do you
23 feed back to the whistleblower? What is it that you do?
24 You really need to, yes, check the effectiveness of --
25 of your systems and we in an ideal world would want each

1 organise to do it and to do it voluntarily but if they
2 don't do it then having a regulator that says: look, if
3 you don't do it, we will come after you is -- is
4 obviously important.
5 **LADY JUSTICE THIRLWALL:** Yes, thank you very much
6 indeed.
7 **MR BERSHADSKI:** Thank you, my Lady, I have no
8 further questions for this witness. Thank you.
9 **LADY JUSTICE THIRLWALL:** Anyone have any questions?
10 No, well, thank you very much indeed, Ms Raphael
11 for coming to enlighten us today. It's been very
12 helpful evidence. Thank you, and you are free to go.
13 **A.** Thank you.
14 **MR BERSHADSKI:** Yes, my Lady, Mr De La Poer,
15 King's Counsel, will be taking the next witness.
16 **LADY JUSTICE THIRLWALL:** Very good. Don't wait,
17 Mr Bershadski, unless you want to.
18 (Pause)
19 There's no rush, Mr De La Poer, I think we finished
20 more speedily than you had been warned. Now it is
21 Mr Bowers next.
22 **MR DE LA POER:** It is, I think he is just being
23 brought up.
24 **LADY JUSTICE THIRLWALL:** Professor Bowers.
25

1 PROFESSOR JOHN BOWERS (sworn)
2 **LADY JUSTICE THIRLWALL:** Do have a seat and get
3 your breath back, we reached your evidence a bit more
4 swiftly than we expected.
5 **A.** Yes.
6 **LADY JUSTICE THIRLWALL:** Mr De La Poer.
7 Questions by MR DE LA POER
8 **MR DE LA POER:** Please could you give us your full
9 name?
10 **A.** John Simon Bowers.
11 **Q.** Is it correct that although, strictly
12 speaking, you are Professor Bowers, you generally go by
13 Mr Bowers?
14 **A.** Yes, 99% of the time. So yes.
15 **Q.** Mr Bowers, you have provided two expert
16 reports to the Inquiry. Can we begin by inviting you to
17 confirm that their content is true to the best of your
18 knowledge and belief?
19 **A.** Yes, they are.
20 **Q.** Now, in terms of your background and in due
21 course, your CV will be published, can I just take you
22 through some of the highlights.
23 Were you called to the Bar in 1979?
24 **A.** Yes.
25 **Q.** Did you take silk in 1998?

1 **A.** Yes.
2 **Q.** In that same year, were you appointed as
3 a part-time employment judge?
4 **A.** Yes.
5 **Q.** Were you promoted to the Employment Appeals
6 Tribunal in 2000?
7 **A.** Yes.
8 **Q.** Appointed a Recorder of the Crown Court in
9 2002?
10 **A.** Yes.
11 **Q.** Appointed Honorary Visiting Professor in Law
12 at the University of Hull in 2008?
13 **A.** Yes.
14 **Q.** Deputy High Court Judge in 2011?
15 **A.** Yes.
16 **Q.** And in 2015, appointed Principal of Brasenose
17 College, Oxford?
18 **A.** Yes.
19 **Q.** Is that a position you hold to this day?
20 **A.** I do.
21 **Q.** In terms of your private practice, firstly
22 academically, are you a frequent lecturer in employment
23 law?
24 **A.** Yes.
25 **Q.** Are you the author of 15 books?

1 **A.** I think 16 now.
2 **Q.** 16 and no doubt numerous regardless in
3 publications?
4 **A.** Numerous, yes.
5 **Q.** Are you a trained mediator?
6 **A.** Yes.
7 **Q.** And an independent adjudicator in local
8 government disputes?
9 **A.** I was, that has ceased now.
10 **Q.** So far as your private practice as a barrister
11 is concerned, do you have experience of acting both for
12 employers and employees?
13 **A.** Yes.
14 **Q.** You have, I believe, appeared before the
15 House of Lords?
16 **A.** Yes, and the Supreme Court.
17 **Q.** The Supreme Court, the European Court of Human
18 Rights?
19 **A.** Yes.
20 **Q.** The Court of Justice of European Union?
21 **A.** I have.
22 **Q.** You will forgive me if I stop there.
23 **A.** Of course.
24 **Q.** The full details will be in your published CV.
25 Now, before we come to look at the content of your

1 reports, one of the matters that the Inquiry has been
2 making frequent reference to unsurprisingly is the case
3 of Beverley Allitt --
4 **A.** Yes.
5 **Q.** -- and the Clothier Inquiry which followed.
6 I understand that you had some involvement in that case
7 and I just wonder if you could --
8 **A.** I did in the sense that I acted in resisting
9 an injunction application by two of the doctors who had
10 been involved at Grantham Hospital. I wasn't involved
11 in the Clothier Inquiry but I am familiar with its
12 findings.
13 **Q.** Now, turning to the questions that the Inquiry
14 asked of you, we will start with your first report, if
15 we may, and the first question you were asked was to
16 consider a number of the policies that were in place in
17 2015/16, namely the grievance policy, the disciplinary
18 policy, the guidelines for the conduct of formal
19 investigation and the whistleblowing policies and you
20 were asked to consider whether you regarded them as
21 being typical of their time and what conclusion did you
22 reach?
23 **A.** Yes, I think they are quite typical. It's
24 probably not surprising because they derive from
25 guidance in the ACAS Code on Disciplinary and Grievance

1 Procedures.
2 **Q.** Now, as you say, they derive. Put bluntly,
3 are many of the parts of them what could be regarded as
4 a copy and paste from existing other policies?
5 **A.** Yes, I didn't mean that in a detrimental
6 fashion.
7 **Q.** No.
8 **A.** But I think that if you put most NHS policies
9 together, you would find great similarities and indeed
10 in other parts of the public sector. Private sector
11 tends to be a bit different.
12 **Q.** Do you regard that as an acceptable approach;
13 in other words to be derivative as opposed to creating
14 something bespoke?
15 **A.** I think so because the employment issues would
16 be very similar in -- in most NHS Trusts. I mean,
17 obviously it differs in different parts of those Trusts
18 but these policies are at a very high level of
19 generality and I think it, you know, might be surprising
20 if you found that there was a different system at the
21 Countess of Chester Hospital as opposed to a Liverpool
22 hospital, for example.
23 **Q.** Now, the black letter of the policies is one
24 thing, there is a separate question in relation to
25 policies as how they can be used practically, how they

1 can be understood by members of staff.
2 Do you have any view on the way in which such
3 policies can be made more available to people, so not
4 just physically necessarily but conceptually as well?
5 **A.** Well, it's very important that they are clear,
6 it's very important that they are disseminated
7 throughout the Trust and that there's appropriate
8 training on them because like every policy and probably
9 every law, it comes into contact with the culture of the
10 particular employment.
11 So you can have a very open policy about
12 whistleblowing, but the culture may be such as to
13 retaliate or resent the whistleblower and that's what
14 really needs to be addressed. But, yes, I think
15 training and dissemination are probably the key.
16 **Q.** The comment that you make in relation to the
17 whistleblowing policy is that much long along the lines
18 of what you have just said, that the real issue is
19 whether there is a culture in the NHS Trust in which
20 employees truly feel secure and you cite your experience
21 over very many years that the response from management
22 is too often defensiveness towards the concerns and
23 aggression towards the whistleblower?
24 **A.** And that is particularly the case in the NHS
25 I'm afraid, in -- in my experience.

1 **Q.** So far as you can tell from your numerous
2 examples of this, what is the reason for that?
3 **A.** That is very difficult to say. I think
4 there's -- it may be because of the very different
5 professions involved in there that some professions
6 don't relish challenge.
7 I think that's probably all I can say.
8 **Q.** Now, you do comment on the grievance and we
9 will come back to the grievance process in greater
10 detail, as being rather unspecific about the practice of
11 grievance. That is at your point A on page 2.
12 **A.** Yes.
13 **Q.** So on the one hand these are -- have
14 appropriately been derived from other guidance that's
15 been developed and are typical of their time but are
16 rather unspecific. Is that a reflection that back in
17 2015/16 the understanding about how grievances should be
18 run and the guidance given was less well developed than
19 it is now?
20 **A.** Yes, I think so. I mean, it's obviously
21 learning from experience.
22 But I do emphasise throughout the report that there
23 are many different sorts of grievances. I mean,
24 obviously this was a grievance essentially about
25 redeployment. But there can be very minor grievances

1 about who said, who said what and so the grievance
2 policy has to look at all of those. It has to look at
3 grievances that can be dealt with in writing, it has to
4 deal with grievances that do require an oral hearing.
5 **Q.** So that's your, the first question you were
6 asked. You were also asked to look at the current
7 policies and procedures and whether you think that they
8 are fit for purpose. What was your conclusion in
9 relation to the 2024 position?
10 **A.** I think they are fit for purpose, bearing in
11 mind that they need to be general and to deal with all
12 sorts of issues. Within that, though, there needs to be
13 a view, for example, about how those hearing grievances
14 should be selected and what training they should
15 receive, which perhaps should be developed further. But
16 I think at a general level, they are very satisfactory.
17 I -- I think the issue is the culture with which
18 they are imbued and I think actually Robert Francis in
19 his report about whistleblowing in the health service
20 very much said it wasn't a question of further law being
21 developed but changes in culture. I would agree with
22 that.
23 **Q.** You are invited to consider whether the
24 policies currently in place equip managers to take
25 decisions in situations where a nurse or doctor is

1 suspected of harming patients. That's at your page 4,
2 the third question. And what conclusion did you reach
3 on that?
4 **A.** Well, I think generally, they do. But I would
5 say two things: firstly, there's a tendency to consider
6 employment issues separate to the issues of patient
7 safety so that we look as employment lawyers, for
8 example, at whether the employee might have a potential
9 claim for constructive dismissal or have a valid
10 grievance and perhaps put issues of patient safety into
11 another box and maybe that can be dealt with by having
12 within the employment sphere an overriding objective of
13 some sort to take into account patient safety in all the
14 employment decisions.
15 The other area which of course -- and of course
16 I don't know the facts, I haven't studied the facts, but
17 that does seem to arise here, is about the use of
18 redeployment which is a constant issue that it is used
19 sometimes to avoid a disciplinary process, but as
20 an easy option and that isn't provided for specifically.
21 The reason why people do that is that disciplinary
22 proceedings can take a very, take up a lot of time. It
23 can be costly and by cost I don't just mean financial
24 cost, but the cost to the morale of the institution and
25 also pit professions against each other, for example

1 nurses and doctors. But it -- it can be other
2 professions as well.
3 **Q.** On that point of redeployment or suspension,
4 as it may be, within safeguarding when a risk is
5 identified it is expected that immediate action is taken
6 to address that risk. If the risk is from a person or
7 may be from that person, then from a safeguarding
8 perspective the correct response is to remove the person
9 from that situation so that they no longer pose a risk.
10 From an employment and discretionary perspective,
11 suspension or redeployment may be the outcome of
12 a legitimately run process?
13 **A.** (Nods)
14 **Q.** But if you are simply following that process,
15 there is a risk that the individual may still be able to
16 cause harm when thinking about it from a safeguarding
17 perspective?
18 **A.** Yes.
19 **Q.** Does there need to be greater strength given
20 to the safeguarding side of things, in other words that
21 it is not viewed as an employment issue, that it is
22 an entirely neutral act, which is a phrase that is often
23 used, but not how it's experienced by the individual,
24 does something like that need to be built in?
25 **A.** Yes, I mean, I think this is a real problem.

1 I should say that I am by no means an expert on
2 safeguarding. But I think that the -- you can see these
3 two issues going on separate tracks and from an
4 employment point of view, there's usually not a right to
5 suspend. So suspension would be a potential breach of
6 contract, could lead to a constructive dismissal.
7 There may or may not be a right to redeploy
8 depending on the contractual circumstances. But from an
9 employment point of view, people will be concerned about
10 either suspending or redeploying.
11 So maybe it should be looked at in a more holistic
12 way.
13 I mean, it is often said in letters of suspension
14 or redeployment that this is a neutral act. But of
15 course as far as the employee is concerned, indeed as
16 far as the people around that employee are concerned, it
17 will not be seen as a neutral act at all. And of course
18 some suspensions do go on for months, indeed years.
19 **Q.** But you can recognise I think that there is
20 a potential there --
21 **A.** Yes.
22 **Q.** -- and that if you favour the rights of the
23 employee in that situation, that that is capable at
24 being at the cost of the safety of patients?
25 **A.** Absolutely. And I think the danger is that

1 you look at it in separate -- in separate spheres.
2 **Q.** Now, we will come back to the detail of some
3 of the policies. But taking matters in the order that
4 you have dealt with them in your first report, the next
5 question you were asked was about the legal framework
6 that exists. This is at page 5 of your report.
7 Question 4, it is about the law and whether it is
8 currently sufficient to protect whistleblowers and staff
9 working in the NHS.
10 In summary, what's your conclusion about the
11 current legal position?
12 **A.** Well, I think generally, it is satisfactory,
13 it's the way that it's operated that is problematic and
14 the lack of knowledge of the law. I think Protect --
15 and I think you have just heard from a representative of
16 Protect -- found that only four in ten of employees knew
17 who the regulator was to whom they could complain, which
18 is a real indictment of the situation.
19 I think the two areas that I would comment on is
20 the decision of the Court of Appeal in the King v Gulf
21 case which draws the distinction between dismissal for
22 whistleblowing and dismissal for the way in which
23 whistleblowing is presented and I think that can be
24 difficult because it's too easy for the employer to say
25 it wasn't the -- what you said, it was the way that you

1 said it.
2 Now, I can well understand why the Court of Appeal
3 decided that case in the particular way but I think it
4 does have potential dangers further down the line.
5 I think the other thing is that it would be very
6 useful to have a duty on the employer to consider the
7 disclosures because at the moment, there's no obligation
8 to do that. There's protection for the whistleblower in
9 whistleblowing, but there's nothing of a duty on the
10 employer to follow up on the disclosed and I think that
11 is an important thing; that actually would give succour
12 to or support to whistleblowers who often feel extremely
13 beleaguered that they have gone out of their way,
14 sometimes lost their careers, to make information
15 available and then nothing is done with it.
16 **Q.** Dealing with the first of the two areas, the
17 Kong case. I just wonder if you could just illustrate
18 a little bit more detail about the distinction that was
19 being drawn there between dismissal for whistleblowing,
20 which is unlawful, and dismissal for the way in which
21 the whistle is blown?
22 **A.** Well, there the concern of the whistleblower
23 was a legitimate concern about the way in which the
24 employer was conducting the business but the dismissal
25 was found to be on the basis that the claimant had

1 questioned, and I am quoting from the judgment here:
2 "... the managers' professional awareness and
3 integrity, both orally and in a meeting, and in
4 a subsequent email."
5 So it was found that the dismissal was not an
6 unlawful, unfair dismissal but was on the grounds of
7 misconduct. And it's that sort of elision which I think
8 can cause could cause problems in other cases.
9 I think obviously if an employee seriously
10 misconducts themselves in the way that they go about
11 presenting the whistleblowing concern, I mean, for
12 example there was one case where it involved hacking
13 into an employer's computer. I mean, clearly if there's
14 serious misconduct as well, then that should be taken
15 into account.
16 But the manner in which a whistleblowing concern is
17 presented I think is -- is a difficult distinction being
18 drawn there.
19 **Q.** Is one of the challenges facing whistleblowers
20 in terms of how they communicate their concerns --
21 **A.** Yes.
22 **Q.** -- and in your experience the fact that they
23 often feel very emotionally --
24 **A.** Yes.
25 **Q.** -- invested?

1 **A.** Yes.
2 **Q.** So the way in which they speak up may be in
3 intemperate language?
4 **A.** Yes.
5 **Q.** It may be demonstrating less rationality and
6 more passion perhaps --
7 **A.** Yes.
8 **Q.** -- than would otherwise be the case. In those
9 circumstances, do people in such positions need to be
10 protected from any allegation that they have gone about
11 it in the wrong way?
12 **A.** Yes, I mean, as I say, there will be cases of
13 serious misconduct in the manner in which a complaint is
14 made. But I think one should be careful not to make
15 that sort of distinction.
16 **Q.** So it is potentially a way in which the
17 potential chilling effect of the Kong case, as you see
18 it --
19 **A.** Yes.
20 **Q.** -- presumably addressed that there is a very
21 clear and high threshold set --
22 **A.** Yes.
23 **Q.** -- before an individual can be penalised for
24 the way in which they raised it?
25 **A.** Yes.

1 **Q.** Now you also comment at F under this section,
2 which is towards the bottom of 6, about your
3 understanding of concerns about the Speak Up Guardian
4 system, the Freedom to Speak Up system and I just wanted
5 to draw upon your experience, if I may, in terms of what
6 you understand the challenges have been to the practical
7 implementation of that.
8 **A.** I mean, this really comes from speaking to
9 people who have -- are more familiar on a day-to-day
10 basis with the system and also to the people in Protect
11 and also WhistleblowersUK.
12 I think there is a feeling that some Trusts have
13 excellent Speak Up Guardians who are dedicated to the
14 role and are sympathetic and have sufficient time to
15 devote to it. But in some it's really just another role
16 on top of busy, busy roles that they are conducting
17 anyway and there's no, as I understand it, job
18 description or standardisation of what they should do.
19 So I think the answer is that in some Trusts it
20 works well, with some dedicated people. In others, it
21 works less well and of course there is a different model
22 in Scotland. I think it's called the Independent
23 National Whistleblowers Office, which has an
24 investigatory role, although I know that there are
25 different views about how well it's been operating. Yes

1 Independent National Whistleblower Officer, that is it.
2 **Q.** The next question you were invited to consider
3 was the interplay between Freedom to Speak Up and the
4 bullying and harassment policies.
5 I wonder if you could just speak to what your view
6 about that is and, in particular, whether there is any
7 risk for confusion or inaction or some other sub optimal
8 outcome where you have to make a choice between two
9 policies?
10 **A.** Yes. Well, inevitably there -- there will be
11 and one of the issues would be: could you put all
12 bullying and harassment policies under a Freedom to
13 Speak Up. But I don't think that would be possible
14 because bullying and harassment policies cover things
15 beyond whistleblowing about it. So you have just got to
16 look at each -- each case as to which it most naturally
17 comes under.
18 **Q.** So in a sense there is a need to recognise
19 that there is an overlap between the two --
20 **A.** Yes.
21 **Q.** -- and it is a matter of training and
22 ultimately judgment by the person on the ground --
23 **A.** Yes.
24 **Q.** -- who's receiving the information as to how
25 they manage it?

1 **A.** Hopefully it's that decision can be taken by
2 HR professionals who are experienced in dealing with
3 both.
4 **Q.** Now, before we turn to some more specifics,
5 I just want to ask you about something that isn't in
6 your report but which the Inquiry has heard quite a lot
7 about and that is the potential between the need to
8 ensure the privacy of the individual employee on the one
9 hand, and the other being able to have a frank and open
10 conversation in an appropriate forum about whether
11 a person may pose a risk and we have heard, for example,
12 that various committees have been said by witnesses not
13 to be the appropriate place to talk about that issue.
14 It's just whether you have a view upon that
15 apparent tension and how it might be resolved?
16 **A.** Yes. Obviously I don't know the underlying
17 circumstances that you are addressing but I think we
18 have got to be very careful not to allow the privacy of
19 the employee to interfere with safeguarding concerns
20 because I mean the rights, rights under Article 8 in any
21 event are balanced rights. So if it can be defeasible,
22 if it's a matter of public interest.
23 But I would have thought one should be very careful
24 not to allow -- I mean, obviously unless it's necessary,
25 it shouldn't be, but if it's necessary in order to

1 protect patients I would have thought that should
2 overcome privacy concerns.
3 **Q.** So does that perhaps go back to the same topic
4 that we touched on earlier which was about the primacy
5 effectively of safeguarding?
6 **A.** Yes.
7 **Q.** Or the overriding objective, in your words?
8 **A.** Yes.
9 **Q.** Or patient safety, however you are
10 characterising it, when looking at an employment
11 problem?
12 **A.** Yes, it is very much the same thing, although
13 of course this is influenced also by European Convention
14 on Human Rights issues because the right of privacy
15 derives as you know from Article 8. So that may have
16 some different considerations.
17 Yes, but conceptually I think it is. And, you
18 know, I think there is a real point here that as
19 employment lawyers we think very much about the rights
20 of the employees and as far as the employer is concerned
21 they are looking at the risks that there may be
22 a constructive dismissal case, potential costing tens of
23 thousands of pounds, ten days in an Employment Tribunal.
24 So they are looking at those risks rather than
25 perhaps the wider risks to patient safety. So they can

1 be occluded from those wider risks.
2 **Q.** Within the regulatory sphere, so within GMC or
3 Bar Standards Board or other regulators, it is
4 a recognised cost of being a member of that profession
5 that if there is -- if you are alleged to have done
6 something which poses a risk, that you may be the
7 subject of suspension. That's priced in, in a way, to
8 the privilege of being a member of such professions.
9 Do you see any merit in transferring that sort of
10 thinking to the context of the NHS? I mean, in a way
11 it's imported for doctors and nurses by their regulator
12 but I am talking here at an employment level?
13 **A.** But do you mean to professions other than
14 doctors and nurses?
15 **Q.** No, but to be administered by the employer
16 rather than at the regulatory level?
17 **A.** I mean, the employer can suspend. But there's
18 a lot of defensiveness because that could lead to
19 a constructive dismissal. I mean, I don't know in this
20 case whether that was one of the considerations of the
21 employers or not but it may well have been --
22 **Q.** But that is --
23 **A.** -- particularly with the redeployment as well.
24 **Q.** But, I mean, speaking generally, that is
25 commonly a mindset that you have come across, is it?

1 **A.** Yes, yes.
2 **Q.** Okay. So just returning to the questions that
3 you were asked to deal with. You were asked at
4 question 6 to consider guidance in relation to when the
5 police should be contacted and the Inquiry has received
6 evidence that there was such guidance which was marked
7 as having been developed in conjunction with ACPO, as
8 they were.
9 But that, it would appear, was archived shortly
10 before the time period that we are looking at. Do you
11 see an advantage about having a clear memorandum of
12 understanding about how where suspicion arises, who you
13 should contact and what the expected response will be?
14 **A.** Well, I don't know about the expected response
15 because of course that will very much depend on the
16 fence that's been suggested. But yes, absolutely,
17 I think that everybody would be -- would benefit from
18 a protocol of those things that you would look for in
19 deciding whether to refer to the police.
20 I mean, the only thing that I could find was in the
21 guidelines for conduct of formal investigations, it
22 talks about the deliberate harm test, flowcharts says in
23 this case consider referral to police and disciplinary
24 regulatory body.
25 I think it -- it could be much clearer, not -- not

1 buried away in an Incident Decision Tree.
2 I mean, I know that there is a great reluctance to
3 refer to the police a) because of the reputational
4 damage perceived to the employer; and b) because it's
5 likely to take a very long time for the police to deal
6 with something, which means that discipline procedures
7 would often be put on hold while the police investigate.
8 But yes, I do think a protocol is important. I'm
9 not sure whether Clothier looked at this in the Clothier
10 Report because this came up in the Beverley Allitt case
11 as well.
12 **Q.** Certainly there was guidance post Clothier?
13 **A.** Right.
14 **Q.** It just appears that it was sent to the
15 National Archive around 2014?
16 **A.** I see.
17 **Q.** But we understand that further guidance is
18 under development at the moment.
19 The phrase "Reputational harm" has been given
20 a number of definitions in the course of this?
21 **A.** Yes.
22 **Q.** What did you mean by "reputational damage" or
23 harm when you said your perception is that that is
24 a concern?
25 **A.** I -- I meant really that that's how it would

1 be viewed by the senior management, that it would become
2 known that there were issues.
3 **Q.** Now, your second report was focused upon
4 consideration of the grievance process and you were
5 asked a number of questions about it, some of which you
6 touched upon in your first report?
7 **A.** Yes.
8 **Q.** But if I could invite you to turn up that
9 second report --
10 **A.** Sure.
11 **Q.** -- before turning to those questions, you made
12 a number of general remarks and I just wonder if you
13 could introduce this topic in terms of how you see
14 grievance procedures, how you think they should be
15 structured or run before we come to look at the
16 particular questions?
17 **A.** Well, I think the key thing is that they
18 should be kept as informal and non-legalistic as
19 possible because they are intended to be dealt with
20 relatively speedily. There's actually very little law
21 on grievances because you can't appeal to the
22 Employment Tribunal or court from a grievance unless
23 it's a very special statutory form of grievance but it--
24 they do come up in constructive dismissal claims.
25 I think the key points are to consider whether the

1 grievance is sufficiently clear enough to be dealt with,
2 what sort of documentation should be taken into account,
3 that people should not be criticised in a grievance
4 without having the opportunity to put their case. That
5 can be sometimes difficult. And that the people hearing
6 the grievances should be as independent as possible from
7 the people bringing the grievance or against whom the
8 grievance is brought.
9 Now, of course that's quite difficult in a small
10 organisation and there is some tension between perhaps
11 wanting people to hear the grievance who may come from
12 a particular speciality, yet also be independent. So it
13 is a question of balance.
14 So I have put rather a lot of different things
15 together but it was a very open question you asked.
16 **Q.** Deliberately so. One of the things that you
17 mentioned there was the importance that a grievance
18 process doesn't make a criticism of a named individual
19 without that individual having had an opportunity to
20 effectively have that put to them and to respond to it.
21 So although on the one hand your view is that they
22 should avoid being too legalistic --
23 **A.** Yes.
24 **Q.** -- on the other you nevertheless think that
25 there is an importance of the rules of natural justice

1 and that people should have a fair opportunity to defend
2 themselves if what the grievance really is an allegation
3 that they have in some way behaved as they shouldn't
4 have?
5 **A.** Yes, I mean, it can of course be an indirect
6 allegation. It may come up in the course of
7 an allegation which is against something different. But
8 the outcome of a grievance can have consequences for
9 people beyond the person grieving and the person grieved
10 against.
11 **Q.** Is the requirement for an apology or a request
12 for an apology a standard and recognised outcome of
13 a grievance process?
14 **A.** Yes. But it's got to be, I think, very
15 carefully thought through as to any particular
16 circumstances. Yes, it is very commonly one of the
17 things that's requested in a grievance.
18 **Q.** Is your experience that it is subsequently
19 mandated, ie they must apologise, or that it's, "This
20 would be nice"?
21 **A.** It, it very much depends on the nature of the
22 grievance. But, yes, I have seen it often as a result
23 of the grievance or indeed a mediation.
24 **Q.** That was going to be my next question. Is
25 mediation a recognised outcome of grievance?

1 **A.** It -- it is and indeed it's built into the
2 grievance policy and it's become part and parcel of
3 grievance procedures more and more.
4 However, there are cases in which mediation is not
5 an ideal solution. You know, I think mediation is very
6 useful if it is a pure breakdown of relationships and
7 perhaps there have been misunderstandings. But when
8 it's an allegation as serious as in this case, I would
9 be a bit dubious as to mediation being an appropriate
10 course.
11 **Q.** Whose responsibility is it to recognise that
12 or make a judgment about whether the facts justify it?
13 Does it sit with the decision maker in the grievance?
14 Does it sit with the employer?
15 **A.** Well, it can be put forward as a way of
16 avoiding a grievance hearing, so to come before that or
17 it could be the outcome of the grievance itself.
18 I think it very much depends on the particular
19 case.
20 But you know I think, I think we have got to be
21 careful not to see mediation as a magic solution in all
22 cases, particularly serious cases and particularly where
23 effectively some form of adjudication -- and I don't
24 mean that in the strict legal sense, but some sort of
25 finding should be made.

1 So I mean in serious sexual harassment cases
2 I would think it's unlikely to be an appropriate course
3 and if something involves allegations -- I know this
4 wasn't directly the nature of the grievance -- but if in
5 the background you are talking about allegations that
6 someone may be harming babies, I would have thought that
7 is not an area that you would want to mediate on.
8 **Q.** In terms of when mediation or an apology are
9 thought to be appropriate, is it appropriate to go to
10 the next step and say to the person who is being
11 expected to engage in that behaviour, "If you do not do
12 this it is going to be a disciplinary matter for you"?
13 **A.** Well, that's putting pressure on someone to
14 mediate, isn't it, and it's unlikely to lead to
15 a successful outcome and I think I am just going to say
16 it depends on the circumstances.
17 **Q.** So if we turn now to the questions that you
18 were asked and we start with the investigating officer
19 who you have touched upon.
20 Here we are conceiving of a structure where you
21 have somebody who investigates and somebody who then
22 makes a decision, so --
23 **A.** Yes.
24 **Q.** -- we are in that structure. I suppose the
25 prior question is, do you always need to structure

1 a grievance in that way?
2 **A.** No. And as I said you have sort of very
3 straightforward grievances and much more complex
4 grievances. Some grievances can be dealt with just on
5 paper, some you need a hearing for.
6 In the health service it's very common to have an
7 investigating officer and then a hearing, although as
8 I understand it, as I say I am not familiar with all the
9 facts here, the hearing officer didn't actually hear
10 from the individual. So it was effectively a review of
11 what the investigating officer had come up with --
12 **Q.** And --
13 **A.** Is that right?
14 **Q.** That is correct.
15 **A.** Yes.
16 **Q.** Is that how you would expect it to be
17 organised?
18 **A.** As I say, there's a whole range and there may
19 be cultures developed within the institutions.
20 But normally, no, I would expect the hearing
21 officer who is chosen to be independent here, I think
22 from a different Trust, should hear directly from at
23 least the important people.
24 **Q.** I just want to give you something --
25 **A.** Sorry, when I say "important people" I meant

1 in the sense of important to the hearing of the
2 grievance. I didn't --
3 **Q.** To the issues?
4 **A.** Yes, to the issues, sorry.
5 **LADY JUSTICE THIRLWALL:** Understood.
6 **MR DE LA POER:** So I just want to bring you
7 a little closer to our facts, but not I don't think in
8 any way that is controversial.
9 Where the investigating officer makes findings of
10 fact about a person's credibility or comments adversely
11 about their behaviour to the investigator, would you
12 expect the decision maker to simply accept and adopt
13 that or would you expect there to be an opportunity for
14 the individuals who are the subject of that sort of
15 criticism to present their position to the decision
16 maker?
17 **A.** Well, it depends how important that issue of
18 credibility is. If it is central to the determination
19 of the grievance, yes, I -- I would expect, I would
20 expect that.
21 **Q.** So going back to the selection of the
22 investigating officer and here we are envisioning
23 a situation where they aren't the ultimate decision
24 maker. Is it normal for such a person to be selected
25 from within the organisation that the grievance has

1 arisen in?
2 **A.** Yes, it would be. I mean, there are
3 circumstances in which institutions are increasingly
4 going out to either lawyers or non-lawyers as
5 investigators. But, yes, normally it would be within
6 the organisation.
7 **Q.** What degree of importance should be given when
8 selecting that person that they are independent?
9 **A.** Well, I think it's clearly very important
10 because particularly within institutions where people
11 have worked together, which will often be the case in
12 a hospital, for, for decades. Animosities or
13 friendships can grow up and you would want to not have
14 that influence, either adversely or favourably, when it
15 comes to a grievance.
16 **Q.** Does that need to be spelt out in the
17 policies?
18 **A.** Well, I would hope it was pretty obvious. But
19 yes, I suppose it should be, yes.
20 **Q.** So far as any training that such a person may
21 or ought to have had, would you expect them to have
22 received training in how to conduct an investigation?
23 **A.** Yes, yes.
24 **Q.** Who would you expect to provide that training?
25 Is that internal or is it external or might it be both?

1 **A.** It could be from HR. I mean, most HR officers
2 would have this as part of their own training as CIPD or
3 it could be external, yes. There's quite a lot of
4 courses on this sort of thing.
5 **Q.** In terms of the input of HR, what is their
6 role, would you believe, in relation to supporting,
7 assisting, co-investigating a grievance? Where do they
8 sit on that spectrum?
9 **A.** Well, I think it's administrative. So setting
10 up the process, note-taking, if necessary advising on
11 the HR aspects, advising on getting documents and
12 witnesses; not, not beyond that though, really.
13 Oh -- yes.
14 **Q.** In terms of who decides what questions the
15 investigating officer asks, are they expected simply to
16 look at the terms of the grievance and determine the
17 scope of their own investigation, who they are going to
18 speak to, what they are going to ask those individuals
19 or should there be input from anywhere else?
20 **A.** Well, I think HR can advise on that and of
21 course sometimes there might be legal issues for which
22 you would need legal advice, I mean issues of
23 confidentiality often come up in these matters.
24 But yes, it would normally be HR and, you know, HR
25 will often be experienced in dealing with these issues.

1 **Q.** One matter you comment upon in your
2 first report is that applying your experience to no
3 doubt many transcripts of grievance proceedings and
4 interviews, that something struck you about the
5 questioning by Dr Green of Dr Brearey.
6 Now, obviously you are simply reading these as you
7 will have read many. But, what struck you about that
8 based upon your experience about how you would expect
9 a grievance interview to be conducted?
10 **A.** I mean, the -- the notes are quite sterile, so
11 you don't know the atmosphere there.
12 But I was struck. I thought it was quite a hostile
13 questioning of -- is it Dr Brearey?
14 **Q.** Dr Brearey. Yes.
15 **A.** Of Dr Brearey, just by the nature of the -- of
16 the questioning as reflected in, in the notes.
17 **Q.** What sort of tone do you think a grievance
18 interview should be conducted in?
19 **A.** Well, it should be fair and independent and
20 not by the nature of the questioning seek to be less
21 than partial. It should be fairly monotone.
22 I mean obviously there are cases in which you do
23 need to press if you think that someone is keeping
24 things from you -- and it may be, I don't know, that
25 that's what Dr Green thought in this case -- but it

1 didn't look the normal sort of independent questioning.
2 **Q.** Now, we have talked about the investigating
3 officer. We will turn now to what I've termed "the
4 decision maker"?
5 **A.** Yes.
6 **Q.** So in other words the person who determines
7 the outcome of the grievance. Similar questions.
8 How important is it that they are both independent
9 and seen to be independent?
10 **A.** Well, in a way it's even more important that
11 they are because they are making the ultimate decision
12 on which, you know, people's careers can be advanced or
13 the opposite. So, yes, it is important.
14 But, you know, I do stress that we are talking --
15 we are talking in the Countess of Chester Hospital about
16 reasonable-sized employers but grievance procedures also
17 apply to the one-person shop, you know, very small
18 operations as well. So you have got to be a bit careful
19 not to sort of produce a system that just isn't capable
20 of being implemented.
21 **Q.** Again, in terms of the input from human
22 resourcing specialists, to what degree should they be
23 involved with the decision-making process?
24 **A.** Well, I think at that level perhaps not so
25 much, unless you have got someone perhaps hearing

1 a grievance for the first time.
2 But, again, setting up the processes, advising on
3 the HR policies, possibly reviewing the report to ensure
4 that there's no obvious blatant factual errors. But,
5 but not, I would have, thought be involved in the
6 decision-making itself.
7 **Q.** So far as the relevance of any standard of
8 proof is concerned, whether for the investigating
9 officer or for the grievance, would you expect either to
10 be -- receive training that they should apply a standard
11 of proof or whether that is making these sort of
12 processes too legalistic?
13 **A.** Yes, I think a general assessment of the
14 standard of proof not being needed to be the criminal
15 standard of proof would be part of the training.
16 But as I said in the report, I can't think myself
17 of a case that's turned on the standard of proof, but,
18 you know, there may well be some. Often it is
19 a question of judgment as opposed to setting out the
20 facts.
21 **Q.** When it comes to how the grievance hearing
22 should be run, if it's decided that it can't be resolved
23 on paper and that a hearing needs to be convened, whose
24 decision should that be? Should that rest entirely with
25 the independent decision maker or should the

1 investigator have a say in that? Should the hospital be
2 determining what that structure should look like and who
3 should come? Where should that rest?
4 **A.** I mean, I think normally it would be fairly
5 obvious in a particular case as to whether a hearing
6 should take place. But, yes, it would be for the chair
7 or the hearing officer to -- to decide.
8 **Q.** So would that necessitate them getting the
9 papers in good time before that hearing so that they can
10 make an assessment about whether or not they want
11 particular individuals who may have other commitments to
12 be present to be heard from?
13 **A.** Well, in theory absolutely, yes. But of
14 course people are doing this, particularly in
15 a hospital, as part of very busy life and often the
16 papers do arrive late. But obviously the hearing
17 officer could determine to adjourn it so that they have
18 more time to consider matters.
19 **Q.** Do you think that there are any ways in which
20 policies could be strengthened to ensure a greater
21 degree of fairness? I mean, we have touched on the idea
22 that perhaps policies need to make clear that the
23 investigator is independent, some sort of checklist for
24 that perhaps or for the chair. Do you think -- or is
25 that going to overburden what should be an extremely

1 flexible process as you have described it?
2 **A.** Yes. I think in the -- in the health service
3 where you are generally dealing with reasonable-sized
4 employers, then yes you could have a checklist of how
5 the -- how independence could be derived. You could
6 have a clearer delineation between the investigating
7 officer and the hearing panel. I'm not sure beyond
8 that.
9 **Q.** At page 8 of your second report you were
10 invited to make some general observations on grievance
11 processes. We have touched on this a little already,
12 but let's just deal with it head on.
13 What is your experience about the use of
14 a grievance as a response to criticism?
15 **A.** It's happening more and more that you get
16 a discipline and then you get a grievance and it may be
17 a whole series of grievances about the way the
18 discipline is happening. Here, I believe there was no
19 discipline, but it was moving in perhaps in that
20 direction in the sense of the redeployment.
21 It is often used as a defensive manoeuvre and often
22 you get a grievance against one person and then that
23 person brings a grievance against the original griever
24 and you have a whole series of grievances and, now, it
25 shouldn't delay discipline procedures but it's very

1 tempting for an employer to say, "Well, we will hear the
2 grievance first and then move on to the discipline."
3 And within the health service, I don't know what it
4 is about the health service -- well, I think it's partly
5 because of the traditional protection for the medical
6 profession and indeed for the nursing profession --
7 these procedures take a very, very long time anyway and
8 if you have grievances in the mix and also potentially
9 a police investigation they can take years and years and
10 years.
11 **Q.** What is attractive to an employer about
12 prioritising resolving the grievance ahead of
13 a disciplinary?
14 **A.** Well, because if the grievance is upheld then
15 perhaps you either don't go ahead with the discipline or
16 you do it in a different way. That, that would be the
17 potential for doing, for doing that.
18 **Q.** And is there a solution to this?
19 **A.** Well, I think it's really that one would hope
20 that those hearing the grievances would perhaps put less
21 weight on the validity if it is clearly a
22 counter-manoeuvre to a disciplinary process.
23 But, you know, it all depends on the facts really.
24 **Q.** And obviously in the midst of all this, as we
25 have touched on already, the matter of central

1 importance is the patient?
2 **A.** Yes.
3 **Q.** So, again, are we circling back to the point
4 you have already made twice now, which is that perhaps
5 some kind of overriding --
6 **A.** Yes.
7 **Q.** -- objective needs to be imposed when such
8 matters come up so that that is the first thought and
9 that everything else is secondary.
10 **A.** Well, I -- I think there is a lot to be said
11 for that. But of course it does need to then become
12 part of the culture because, as we have said before, you
13 can have lots of fine statements but if it doesn't get
14 actually into the day-to-day culture it really doesn't,
15 you know, it doesn't have great effect.
16 **Q.** The last question you were asked was -- and
17 this is in your second report, number 17 -- whether you
18 had experience of a doctor or a nurse being effectively
19 threatened with referral to their professional
20 regulator. I mean, that is to state it at its highest
21 but, perhaps more neutrally put, that the fact that they
22 had breached their professional code. Is that something
23 that you see?
24 **A.** Well, I haven't myself come across this.
25 But I mean threats of referral to professional

1 regulators are becoming more frequent and some of them
2 may be malicious. But I have not come across it myself
3 in the course of a grievance process, but I mean that's
4 not to say that it doesn't happen.
5 I mean, just to -- if I may just go back to the
6 point about the length of time for disciplinary
7 processes to happen.
8 I dealt, admittedly about 25 years ago, with a case
9 where a doctor had been suspended within the health
10 service for 10 years. I mean, that was a real scandal
11 which finished up actually in the -- with a hearing
12 before the Public Accounts Committee. But long periods
13 for discipline to take their course; 10 years is
14 obviously exceptional, but two or three years is not so
15 exceptional.
16 **Q.** Now, the final matter that I wanted to ask you
17 about, looking to recommendations, and I will give you
18 in a moment an opportunity to add to anything you have
19 said already about potential recommendations, but one
20 that is floating around that I seek your comment upon is
21 we see that in other professions that a statutory duty
22 to report safeguarding matters is thought to be
23 appropriate, potentially backed up by a criminal
24 sanction if there is a failure to do so.
25 Do you -- although that's not strictly an

1 employment issue plainly it has potential
2 consequences --
3 **A.** Yes.
4 **Q.** -- in the employment context.
5 Do you have a view about whether that's a good idea
6 or not?
7 **A.** Yes. I can -- I think it is generally a good
8 idea. I mean, my query would be whether criminal
9 sanction is appropriate or a duty which could be
10 enforced as misconduct because I think many of these
11 criminal sanctions in the employment sphere it's very
12 unusual that this CPS, or whoever's the decision-making
13 body on prosecution, would actually allow a prosecution.
14 But I think some form of duty is, is appropriate.
15 **Q.** Of course if it wasn't criminal, but it was
16 professional regulation --
17 **A.** Yes.
18 **Q.** -- that would mean that any of the individuals
19 upon whom such duty might be expected to fall would
20 themselves need to be regulated?
21 **A.** Yes, yes, that's true. So you could put it in
22 the employment contract as a duty. That would be
23 another mechanism because, as you say, not everybody
24 even within the health service would be under
25 professional duties.

1 **MR DE LA POER:** Yes. Mr Bowers, those are the
2 questions that I have for you.
3 **A.** Thank you.
4 **MR DE LA POER:** I know that there are some further
5 questions, my Lady, and I wonder if you are content that
6 we will continue now with those. I think that we have
7 from one Core Participant as I understand it unless --
8 **LADY JUSTICE THIRLWALL:** Do come forward,
9 Mr Jamieson.
10 **MR DE LA POER:** I think certainly Mr Jamieson.
11 **MR JAMIESON:** What I was going to say, my Lady, is
12 I have 10 minutes. I think if I -- well, we are
13 approaching the lunch hour and I am sure I will be put
14 under very quick pressure if I go any further. So if
15 you are happy that we do that now.
16 **LADY JUSTICE THIRLWALL:** Yes. Does anyone else
17 want to ask questions? There is no difficulty about
18 taking the break now if anyone wants to make their mind
19 up. No. Would you mind then if we just continued?
20 Can I check with the shorthand writer. That's all
21 right. Thank you.
22 Questions by MR JAMIESON
23 **MR JAMIESON:** Am I safe to assume that we're still
24 in the 99% and you would prefer Mr Bowers?
25 **A.** Yes, please.

1 **Q.** Thank you.
2 **A.** Even for you.
3 **Q.** I am very grateful.
4 Mr Bowers, what I would like to talk to you about
5 please is candour.
6 **A.** Yes.
7 **Q.** So in the healthcare setting, it's easy to
8 anticipate circumstances where whistleblowing and
9 protected disclosures are going to concern issues of
10 direct patient harm?
11 **A.** Yes.
12 **Q.** And indeed the most grave patient harm?
13 **A.** Yes.
14 **Q.** And that context, we know, engages obligations
15 of candour to those patients and to their parents
16 potentially and both the professional and ethical duty
17 that clinicians have but also the legal duty in certain
18 circumstances?
19 **A.** (Nods)
20 **Q.** And whilst that gives us an intersection
21 between those duties, I don't understand from anything
22 I have read that you've written that there is anything
23 in the employment law context, duties to protect the
24 whistleblowers, that removes or mitigates or affects
25 those duties of candour?

1 **A.** No, no, absolutely not.
2 **Q.** These are duties that are in parallel rather
3 than in tension?
4 **A.** Yes.
5 **Q.** Thank you. May I offer an observation for
6 your comment?
7 **A.** (Nods)
8 **Q.** You spoke at the start of your evidence about
9 a common NHS management response to whistleblowing
10 concerns being raised. The adjectives that you used
11 were "defensiveness" and "aggression".
12 The observation is this: might it be much more
13 difficult for those reflexes to operate in
14 a circumstance where there has already been, at an early
15 stage, a candid disclosure to families?
16 **A.** Yes. Yes, that's right.
17 **Q.** Because, as I understand the position, you get
18 those reactions where the overarching intention is to
19 keep the matter quiet --
20 **A.** Yes.
21 **Q.** -- to prevent it from emerging. And so if
22 candour is given prominence actually that might also --
23 it serves the purpose of informing patients and their
24 families, but might it also operate so as to protect
25 whistleblowers?

1 **A.** Yes, I think that's right. I mean, the
2 defensiveness often comes from perhaps a misguided view
3 that our reputation will suffer if the truth comes out.
4 **Q.** Yes.
5 **A.** And that's actually not a good approach for
6 a public body to have. But I mean I think we need to
7 recognise that is what actually happens.
8 **Q.** Well, I wonder if -- the question is from your
9 experience of looking at I'm sure policies on
10 whistleblowing in all sorts of contexts, is it common
11 for those policies in a healthcare context to include
12 clauses that emphasise that need for candour at the
13 beginning of a process?
14 **A.** I mean, the duty of candour is relatively
15 recent and some of the policies have not been updated to
16 take that into account. I think, like a lot of things,
17 each one is sort of treated in its individual box.
18 **Q.** Quite.
19 **A.** So you have got the candour, you have got the
20 safeguarding, you have got the bullying and you have got
21 the whistleblowing and they are treated separately.
22 But I think, I think the word, if I may say so,
23 that you use correctly is intersectionality between
24 them --
25 **Q.** Yes.

1 **A.** -- is often not recognised.
2 **Q.** Because one way of combating, I suppose, that
3 division of the different concepts is if I think what
4 you have told us is the way that these policies tend to
5 proliferate is from a central position and they are then
6 copied outwards --
7 **A.** Yes.
8 **Q.** -- by individual Trusts.
9 If it's recognised that in a healthcare context
10 really candour does need to be there at the start --
11 **A.** Yes.
12 **Q.** -- in a whistleblowing context, that would
13 help to put the two concepts together?
14 **A.** Yes. I mean, I -- there is a national
15 Speak Up Guardian, it was Henrietta Hughes. I'm not
16 sure who fills that position now. But I would have
17 thought that is the sort of body that could help to roll
18 this out.
19 I'm just not familiar with what, if any, guidance
20 they give on that.
21 **Q.** No, and an additional benefit that might come
22 from this is often the process: the whistleblower raises
23 the concern, there may well then be an investigation
24 into the circumstances whether there is an issue or not?
25 **A.** Well, I mean, that's -- that's the problem,

1 that often there isn't an investigation.
2 **Q.** Yes, quite.
3 **A.** And it stops at the concern being raised but
4 yes, you are right, if there is then an investigation --
5 **Q.** Quite, so if we have that candour and if the
6 families are informed --
7 **A.** Yes.
8 **Q.** -- they are likely to be a strong voice that
9 is going to want that investigation?
10 **A.** You mean in this particular situation? Yes,
11 yes.
12 **Q.** So there will be a strong voice who wants the
13 investigation. They may also be an important source of
14 information and evidence for that investigation itself.
15 **A.** Yes, yes, absolutely.
16 **MR JAMIESON:** Mr Bowers, thank you very much.
17 My Lady, 12.59. Thank you.
18 **LADY JUSTICE THIRLWALL:** Well done.
19 Questions by LADY JUSTICE THIRLWALL
20 **LADY JUSTICE THIRLWALL:** May I just ask one brief
21 question --
22 **A.** Certainly.
23 **LADY JUSTICE THIRLWALL:** -- in relation to
24 mediation. So there's been a grievance and the
25 recommendation is for mediation and one of the parties

1 doesn't want to mediate.
2 **A.** Yes.
3 **LADY JUSTICE THIRLWALL:** Is there any obligation on
4 someone to mediate, can they be required to mediate in
5 that circumstance?
6 **A.** Well, I don't think contractually they can be
7 required to mediate. But if it's a recommendation from
8 the grievance, I suppose you feel some pressure and
9 responsibility to do so. But, I mean, it's slightly
10 against the whole concept of mediation to force people
11 into it.
12 **LADY JUSTICE THIRLWALL:** Yes. Thank you.
13 Well, thank you very much indeed, for the reports,
14 both of them, and for coming to give evidence today and
15 you are now free to go.
16 **A.** Thank you very much indeed, my Lady.
17 **LADY JUSTICE THIRLWALL:** So we will rise now until
18 10 o'clock tomorrow morning.
19 **(1.01 pm)**
20 **(The Inquiry adjourned until 10.00 am,**
21 **on Friday, 6 December 2024)**
22
23
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25

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