

Testimony of Guy Dehn to the Shipman Inquiry

Monday, 29th September 2003 (10.00 am)

MISS SWIFT: Madam Chairman, the scale of Shipman's criminal activities and the long period over which they were perpetrated made it seem at first sight inevitable that his behaviour must have raised concerns and suspicions among those who worked closely with him. Surely, people such as medical colleagues, other health professionals and members of his practice staff or those lay people (friends, families and neighbours who had been involved in the aftermath of the deaths) must have realised that there was something wrong and reported it.

Other Inquiries which have investigated criminal or other wrongful conduct by an individual or organisation have often heard evidence about complaints made over the years which went unheeded, as a result of which the conduct was permitted to continue without check. Surprisingly, however, the Inquiry's investigations revealed no such history of complaints in Shipman's case. That there was not such a history is an indication both of the high regard in which he was generally held and of his extraordinary ability to lie his way convincingly out of the most compromising situation.

The Inquiry has, of course, heard that a medical colleague, Dr Linda Reynolds, became suspicious about the number of deaths among Shipman's patients and report further suspicions to the Coroner. Her report initiated the abortive police investigation of March 1998. Others too had their suspicions, among them Mrs Debbie Bambroffe of Masseys Funeral Directors. She voiced her concerns to Dr Susan Booth, one of Dr Reynolds' colleagues at the Brooke Practice. Mrs Bambroffe's husband, Mr David Bambroffe, shared his wife's suspicions. Meanwhile, Mr John Shaw, a taxi driver who regularly drove many of Shipman's victims, and two home helps, Mrs Elizabeth Shawcross and Mrs Dorothy Foley, had also come to believe that there was something more than coincidence behind the fact that so many of Shipman's patients appeared to die soon after he had visited them. None of those three people felt able to report their suspicions for reasons which will appear from their evidence.

The Inquiry will also hear about the growing concerns of Mrs Christine Simpson, the resident manager of sheltered accommodation at Ogden Court where nine of the residents died at Shipman's hands. Mrs Shawcross and Mrs Foley acquired the knowledge which led them to suspect Shipman in the course of their work as home helps, whilst Mrs Simpson did so in her role as the resident manager of sheltered accommodation. People employed in such positions may sometimes be, as they were in Shipman's case, uniquely well placed to observe criminal or wrongful conduct by a range of persons, including health professionals.

During the forthcoming hearings, the Inquiry will look at existing systems for the reporting of concerns by such employees and, in particular, we shall consider what more could be done to encourage employees to make known any genuine concerns which they may have.

As an independent taxi driver, Mr Shaw had no employment structure through which he could voice his suspicions. His predicament as an ordinary member of the public who suspected that a highly regarded local professional was committing murder caused him very considerable anguish, yet for reasons which he will explain when he gives evidence tomorrow, he felt unable to voice his fears. The Inquiry will be examining ways in which members of the public like Mr Shaw might be assisted in bringing serious and genuine concerns forward for investigation by the proper authorities. Most of the bereaved relatives and friends of Shipman's victims had no suspicions whatever about their deaths. They were frequently surprised at suddenness with which the death had occurred but, in general, they accepted Shipman's explanations without question. There were, however, those who were unhappy. Their misgivings rarely related to the possibility of criminal behaviour, more usually they were concerned that Shipman might have given substandard care, perhaps by failing to attempt resuscitation, to summon an ambulance or by leaving a dying patient alone. Sometimes their concerns amounted only to a general unease that there was something not quite right about the death. A few such individuals sought an interview with Shipman to discuss their worries but until Shipman was under investigation for Mrs Kathleen Grundy's death, none of the bereaved relatives or friends reported their concerns to the authorities. Some were intimidated at the prospect of questioning the actions of a doctor; others were persuaded by members of their families that their worries were unfounded. Several have told the Inquiry that they did not know to whom they should take their concerns.

Suggestions have been made as to how it could be made easier for patients and relatives to voice their concerns and complaints and, in particular, a number of witnesses have referred to the need for an organisation completely independent of the NHS to which a lay person could report suspicions or concerns, secure in the knowledge that those concerns would be properly and independently investigated. The Inquiry will be considering that and other suggestions for change in the course of the forthcoming hearings.

So far, I have referred mainly to lay people who had concerns about Shipman. What of the position of medical colleagues, other health professionals who worked with him, and of his practice staff? As to medical colleagues, Madam Chairman, in July you heard evidence from members of the Donneybrook Practice of which Shipman was a member from 1977 until 1992. They have told the Inquiry that they had no suspicions whatever about Shipman and no knowledge of the number or circumstances of his patient deaths. The way in which the practice was arranged, with each doctor having his own list, makes their ignorance of what was going on entirely understandable. You also heard evidence last year from some of the doctors who signed cremation Forms C for Shipman's patients. Dr Reynolds and her colleagues became suspicious about the number and pattern of Shipman's patient deaths and, as I have said, Dr Reynolds reported those suspicions to the Coroner. However, none of the other doctors used by Shipman to sign his Forms C noticed anything amiss. Similarly, the district nurses who worked alongside Shipman and who gave evidence in the course of Stage 3 had no suspicions about the deaths of any of the patients with whose care they were involved.

The Inquiry has obtained witness statements from a midwife, a health visitor and a councillor, all of whom were for some time based at Shipman's Market Street Surgery. They had varying degrees of professional contact with Shipman but little knowledge about the deaths of his patients. Other members of the practice staff at Shipman's 6 Market Street Surgery will be giving oral evidence next month. All say that they had no reason to suspect that anything was wrong. Most of the staff employed in general practices (for example, receptionists, practice managers and practice nurses) are employed direct by the practice concerned and not by the local Primary Care Trust. This can make it particularly difficult for them to voice any concerns which they may have about the care being given to patients or the conduct of a doctor within the practice. Yet practice staff may be in an excellent position to observe problems which are liable to put the safety of patients at risk.

The Inquiry will be exploring ways in which practice staff might be given greater encouragement to report issues affecting patient safety. Whistle-blowing is a colloquial term usually applied to the raising of concerns by one member of an organisation about the conduct or competence of another member of the same organisation or about the activities of the organisation itself. In the context of the Inquiry, we are referring in particular to concerns affecting patient safety. The potential whistle-blower might, therefore, be a practice nurse or receptionist raising concerns about the professional conduct or competence of the general practitioner for whom he or she works or the whistle might be blown by a district nurse a fellow GP or a hospital consultant who has become concerned as a result of professional contact with the doctor. It will be clear from what I have already said that during these hearings the Inquiry will be going rather further than looking just at whistle-blowing. Instead, we shall be considering how we can ensure that all those who have genuine concerns about the activities of a member of the medical profession feel confident and able to bring those concerns to the attention of the appropriate authority.

Of course, persuading people to voice their concerns is only part of the challenge. Once voiced, it is essential that the concerns are subjected to prompt and proper investigation. That is a matter about which the Inquiry has already heard some evidence and more will follow in the hearings on the regulation and disciplining of doctors. In the past, those who drew attention, particularly public attention, to misconduct or neglect which was occurring within their organisation tended to be regarded in a wholly negative light and were often penalised by the approbrium of their colleagues and even by the loss of their jobs. However, in the 1980s and 1990s attitudes began to change as it was realised that a number of tragic disasters could have been averted had staff within the relevant organisations felt able to raise their concerns inside or outside the work place. The desirability of encouraging a culture whereby concerns could be raised by an employee without fear of reprisal began to be recognised.

In 1993, the charity Public Concern at Work was set up and over the past decade it has worked with the Government, the public sector, large employers, trades unions and others to bring about change. In July 1999 the Public Interest Disclosure Act came into force. Its effect was to give workers the right not to be subjected to detriment as a consequence of

having disclosed information reasonably and responsibly in the public interest. Since the Act was passed, there have been a number of successful claims for compensation by persons who have suffered victimisation or dismissal as a result of clement whistle-policies; that is procedures for the internal and external reporting of concerns by their employees. Shortly, I shall be calling Mr Guy Dehn, Director of Public Concern at Work, to give evidence about the progress which has been made over the last ten years and the changes which his charity would like to see happen in the future. I shall also be asking him for his views on the particular problems associated with the reporting of concerns about health professionals.

Finally, the Inquiry will be considering the issue of whistle-blowing in the context of the case of Mrs Renate Overton, which you have considered and reported upon in your first and third reports. Mrs Overton was admitted unconscious to the Tameside General Hospital on 18th February 1994. She had been given a lethal overdose of diamorphine administered by Shipman who had attended her home following report that she was suffering a severe asthma attack. She never regained consciousness and died on 21st April 1995. Despite the fact that the doctors and staff at the hospital believed that Mrs Overton's collapse had been provoked by a dangerous overdose of morphine given inappropriately to an asthmatic, no report was made of Shipman's conduct and no investigation was therefore initiated. The Inquiry will consider the climate, the culture and the context in which these events occurred. Why did the consultants in charge (Drs Husaini and Brown) fail formally to report or record their concerns when both recognised that the treatment given was highly unusual and even dangerous? What guidance was available to doctors from the General Medical Council and other bodies as to what they should do when such concerns arose about a fellow doctor? How would colleagues in a similar position at that time have acted? If a substantial body of colleagues might have acted in a similar way to Drs Husaini and Brown, how could that be? What is it about the culture of the medical profession that might allow such concerns to go unreported? How, if at all, has that culture changed? Madam Chairman, all these issues will be examined by the Inquiry during evidence in hearings which will continue until Thursday, 30th October.

DAME JANET: Thank you.

MISS SWIFT: Madam Chairman, I do not know whether there is anything anyone else, any other representative, wants to say in opening?

DAME JANET: Mr Spink?

MR SPINK: No thank you.

MISS SWIFT: In that event, Madam Chairman, I will go on to call Mr Guy Dehn.

GUY JULIAN DEHN, sworn

Examined by MISS SWIFT

Q. Could you give your full name, please?

A. My name is Guy Julian Dehn.

Q. Mr Dehn, if you could just look at the screen of your right, we will put up your witness statement which is in the form of a letter at _WD1900001^.

A. Yes.

Q. If we can go to page _WD1900004^ and scroll down, very faintly there I hope we can see your signature.

A. Yes, that is correct.

Q. Have you had an opportunity, Mr Dehn, of reading this statement recently?

A. Yes, I read it yesterday.

Q. Are its contents true and accurate?

A. Yes, to the best of my knowledge and belief.

Q. Mr Dehn, I wonder if you could just tell us first of all what position you occupy in the charity Public Concern at Work?

A. I am the Director of Public Concern at Work. It is a small charity. We have a total of six staff. I am also a practising barrister because when -- well, now it's called an employed barrister but when we started it was quite important that the charity could provide, in a sense, a safe haven for people who did have concerns about wrongdoing, that by seeking advice from us that they were not jeopardising their position simply for seeking the advice. So the part of the charity -- well, the charity would not have been able to do the work it did if it had not been recognised as a legal advice centre.

Q. I was going to ask about your own qualifications and experience. You have indicated that you are a qualified and practising barrister. What is your experience?

A. Well, I practice at the bar -- I was called to the bar in 1982 and I practised until 1986 when I then became the Legal Officer to the National Consumer Council. Then I worked there for six years but was also asked to be responsible for their parliamentary affairs and then I left to set up Public Concern at Work.

Q. Was that charity established in 1993?

A. We launched in 1993 but essentially when I left the National Consumer Council it was to try to set up the charity.

Q. What was the purpose of the charity in the first instance?

A. In the UK there has always been a tension between self-regulation and regulation and there had been a recognition since the late 1980s partly or at least endorsed by Sir John Banham who was then the Director General of the CBI about self-regulation would not carry public confidence if organisations were unable to obtain the information from the people who worked in the organisation to avoid something going wrong before the damage was actually done. So there had been -- that principle had been recognised, not very fully developed, and from my own point of view at the National Consumer Council, because I had this role doing legal and Parliamentary work, that there had been a number of major disasters like the Herald of Free Enterprise, Clapham rail, Piper Alpha, BCCI, Barlow Cloos, and when some of those disasters -- when you get a big disaster as we have seen with this Inquiry, the response is to try and establish what all the facts are, to learn from the facts what can be done to reduce risk of it happening again. So obviously it being different from a regular court case which is about apportioning blame.

One of the things that struck me while I was at the National Consumer Council, because I was asked to look at what was happening with these different inquiries each of which would look at the issue in a sense in a vertical way, was that in each of the inquiries it would be apparent that staff had been aware of what the danger was and either had been too scared to raise it, which is what happened at Clapham rail, or as at Herald of Free Enterprise that they had raised it but with the wrong people in the wrong way so nothing was done with it. So there was that underlying problem and then you got quite often after the inquiries -- this is back in the 1980s -- that particularly where they related to things like Clapham rail or Piper Alpha that there would be recommendations from the Inquiry, quite often structural or regulatory regulations which correctly and properly would then be discussed by within Government and by Government with outside interests, and then usually about a couple of years later you would get the regulations that would come through from the end of that

In the position I was in the National Consumer Council, I dealt with opposite numbers from people within the professions and business and on certainly several of those cases the view was at the end of the process that what regulations were being implemented, say, after the Maxwell pension thing, whatever, that my opposite numbers would say they did not really think what had come out at the end of it would actually have caught the person and that perhaps it would not make that much difference. So there were a number of reasons, all of those -- I am sorry if this is a long answer -- so there were a number of factors that we wanted to go back to from the experience of the Inquiries in recognising that there was of those Inquiries that there was, in a sense, a breakdown in communication, that that was a practical and a human problem which was not necessarily best or exclusively addressed through legislation and that was the reason we wanted to set up Public Concern at Work.

Q. So the charity was set up and I think shortly after it was set up there was interest from other quarters in the whole issue of whistle-blowing, notably from the Audit Commission and also the Nolan Committee.

A. Yes. If I may, because we are just ten years old in October so I have just been revisiting this stuff. When we tried to set up and the idea came along and we had very fortunately secured the interest of someone called Lord Oliver of Aylmerton who had been a law lord and Gordon Borrie who had been the Director General of Fair Trading, so from our point of view, we actually had people who were bringing expertise and experience from different fields and sort of leading practitioners within them. We thought we were -- I mean, it was very important to us in terms of the contribution we were hoping to make and we had been given -- offered a grant from the Joseph Rowntree Charitable Trust to start.

DAME JANET: From whom?

A. The Joseph Rowntree Charitable Trust. It was called a challenge grant but this was in early 1992 and it took 18 months to launch during which it looked like it was possible the charity would never begin and we were initially turned down for charitable status by the Charity Commission on the grounds that it just was not in the public interest or was not of public benefit to offer advice on whistle-blowing issues. So it was back in the early 1990s there was a very widely held and in some areas deeply held perception that whistle-blowers were in a sense "bad people" or certainly deeply suspect people and that whistle-blowing was not a desirable activity. So I mean, it was a difficult, I suppose you could say, conception or birth but as you rightly say, very shortly after we launched we were very fortunate that the Audit Commission picked up our message and then John Major set up the Committee on Standards in Public Life and that again picked up our message very quickly.

Q. MISS SWIFT: That is referred to as part of the history which is set out in one of the annexes to your statement which is the charity's report to the Royal Brompton Hospital Inquiry. If we just go to _WD1900063^. In fact, if we go to the next page _WD1900064^ that puts it in context. Was this a report which the charity was asked to prepare for the independent inquiry to deal solely with the policy which the trust had in relation to speaking up?

A. Yes. Yes, that is correct. There were essentially two inquiries, the first one which I think was called the Hunter Inquiry -- the Stuart Hunter Inquiry -- which was into the specific allegations that were made and then Ruth Evans was then asked to chair an Inquiry into what the culture at the hospital had been and how the concerns of patients and the confidence of patient could be maintained and then her Inquiry commissioned us to do this review. I mean, these were particularly unpleasant allegations made anonymously and publicly, suggesting that children suffering or Down's Syndrome children were being, in sense, willfully discriminated against by one of the leading paediatric units in the country. When the allegations were published, I believe they went simultaneously to a medical journalist at Private Eye magazine, to the counsel for the Bristol Royal Infirmary Inquiry and I believe the Royal College. So it was a triplicate letter. When that was drawn to the attention of the then Health Secretary, Frank Dobson, the nature of the allegations and particularly on the back of the Bristol Inquiry was to call for an immediate and very thorough Inquiry.

Q. You were involved in that on the whistle-blowing aspect of it. The relevance of the report from our point of view is that it does contain from page_WD1900070^ onwards a very helpful summary of the history of the NHS, the development of whistle-blowing policies within the NHS.

I want to leave that aspect just for a moment but I would like to just refer to page _WD1900071^ which is the -- you refer there to the second Nolan report which did deal in some detail with the issue of whistle-blowing and made a number of points which you set out there which were the features of an effective whistle-blowing system. We can see at the bullet points the four elements which the Nolan Committee thought were essential for an effective whistle-blowing system. Just in the general history, there was obviously the impetus provided by the Nolan Committee and did that impetus eventually lead in the late 1990s to the Public Interest Disclosure Act?

A. Yes, it was certainly very influential in it, yes.

Q. If we could just have a look at the Act, it is SP9801001, we can see set out in italics the purpose of the Act which is said to be to: ".protect individuals who make certain disclosures of information in the public interest; to allow such individuals to bring action in respect of victimisation; and for connected purposes." Can we go to page SP9801007. This is section 2 of this Act which adds section 47A to the Employment Rights Act 1996. Is the effect of this section to confer a right on a worker not to be subjected to detriment?

A. Yes, this is for victimisation short of dismissal.

Q. The effect being that if an employee does suffer any detriment or, indeed, dismissal he or she can go to an Employment Tribunal and obtain compensation.

A. Yes, if they are in breach of the Act, yes.

Q. Compensation I think in those circumstances is not capped so can be in some cases very substantial?

A. Yes.

Q. If we go to page SP9801005, the new section 43J, we see that the Act provides that: "Any provision in an agreement to which this section applies is void insofar as it purports to preclude the worker from making a protected disclosure." We will go into what a protected disclosure is in a moment. Can you just explain the background to this section and the effect of it?

A. There were two main reasons. One was in the early 1990s there was a wide perception not only that there were the implied legal obligations of confidentiality in an employment contract, but also that many employers imposed far and wide-reaching what we pejoratively call "gagging-clauses" in employment contracts, essentially saying that if you disclosed any confidential information it could leave you open to dismissal. From the

point of view of a non-lawyer, it would beg the question if someone read the employment contract as (a) what was confidential information and (b) what was disclosing in terms of did it even have an impact on people to raise concerns in their organisations. So we wanted to make it clear that any such clause would be subject to this legislation.

Secondly, quite often there would be cases where someone had raised concerns or there had been some malpractice, whether they had raised some concern or not, it had led to a dispute between the employee and the employer and then when the dispute had eventually been settled, there would be, as part of the settlement agreement, a confidentiality clause preventing any of the underlying information being disclosed. This was an issue which did have a particular sort of pertinence in the National Health Service in the mid-1990s and there were certainly some Inquiries or reports from the Public Accounts Committee and the Health Select Committee criticising the use of these gagging clauses within the Health Service. I should say that the impression I had was that sometimes the gagging clauses were there as much at the insistence or request of the employee as they were at the employer; so it was not just an entirely one-sided thing of the employer trying.

DAME JANET: Presumably because the employee felt the danger of further forms of discrimination whether in that employment or elsewhere?

A. I think it was partly that, Madam Chairman, but it was also in some -- I am not going to get -- there was a case to do with, I believe it was a consultant somewhere in the South-West who had a dispute with her colleagues or her Trust and had been put on gardening leave for something like two and a half years. That was the concern of the Public Accounts Committee or if it was the certainly on health, the amount of public money that was spent in those circumstances. I think if my recollection is correct that she came to a compromise agreement with her Trust which imposed a confidentiality clause (a) on the amount of compensation and (b) on the underlying facts. My understanding was that that had been put forward by her own lawyers, the confidentiality clause, both as to the money and as to what the underlying facts were because in that particular case there was black and white on both sides. I think very often in this area what has always struck me is there has been a perception in the media that, you know, it was always like the big, bad employer who was sort of -

DAME JANET: Yes, imposing.

A. Behind all the nefarious things. That was the case on some occasions but on other occasions, it was not. So sorry, the purpose was twofold: to try and put a check or a marker down on the use of confidentiality clauses in employment contracts, and, secondly, on how effective they could be in a severance agreement but there is also, if you want to come to it, it does impact back into the disclosure regime within the legislation. This provision does have a bearing on the disclosure regime.

MISS SWIFT: We will come to the disclosure regime now and then you can perhaps explain the connection between the two.

If we can go to page SP9801001, we have seen that the right relates to what is described as a protected disclosure. If we scroll down, we can see that 43A says that a protected disclosure means a qualifying disclosure which is made by a worker in certain circumstances which we will look at in a moment, set out in 43C to 43H. If we can deal first of all by what is meant by a qualifying disclosure and that is defined in 43B to mean:..".any disclosure of information which in the reasonable belief of the worker to making disclosure, tends to show one or more of the following (a) that a criminal offence has been committed, is being committed or is likely to be committed. (b) That a concern has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject (c) that a miscarriage of justice had occurred is occurring or likely to occur." Then over the page SP9801002: "That the health or safety of any individual has been, is being, or is likely to be endangered; "(e) that the environment has been, is being or is likely to be damaged or; "(f) that information tending to show any matter falling within any one of the preceding paragraphs has been or is likely to be deliberately concealed."

So a number of different types of disclosure covered there presumably designed to try and cover any relevant type of disclosure. How successful, in the charity's experience, has this definition been in covering all the various types of disclosure which need to be protected?

A. I think fairly successful. I am not aware of any example of wrong doing that does not come within this definition, but it is primarily because of the (b) which is the failing to comply with any legal obligation which, to some extent, you can say makes some of the other ones less significant, although they are obviously clearer in terms of their language.

DAME JANET: Can we just go back to the previous page SP9801001 so that I can look at (b) again.

A. So it is essentially any breach of any legal obligation that any person is subject. So from a negligence, nuisance, breach of administrative law or whatever. It is not as good in terms of communicating the message to a lay reader --

DAME JANET: It is, in fact, very wide.

A. Yes. Almost everything that comes within the other categories, one could argue comes within (b) and particularly because what the trigger to get into (b) is that it is the belief of the worker that the information tends to show that it is happening. It is not even that the "tends", in our view, makes it a low evidential test. I think there is a sort of slightly unintended or an unforeseen issue and that is that the draft as drafted, is that there is not any specific reference to a public interest dimension to the concern and the earlier draft that we did entirely ourselves, which was in 1996 which was based much more on the law of confidence and public interest disclosures, did make that reference. The Government were reluctant to have a public interest qualification here partly because of the lack of certainty that it would give to a lay person, to an employee. It has this wider group at the moment and there was one case in which someone was, so to speak, blowing the whistle on a breach of their own employment contract and that created a flurry of

interest in the employment law field. Although it was not the intention of the legislation, I think the fact is that there it has not caused any major difficulties either for employers or employees.

MISS SWIFT: If we can go to the next page SP9801002 and just have a look at 43C which deals with disclosures to whom a qualifying disclosure must be made and: "A qualifying disclosure is made in accordance with this section if the worker makes the disclosure in good faith" either to his employer or: "Where the worker reasonably believes that the relevant failure relates solely or mainly to the conduct of a person other than his employer or any other matter for which a person other than his employer has legal responsibility to that other person." Any particular observation you want to make on that section?

A. I think two things -- and this was an issue that came up slightly with the discussion after the Bristol Inquiry reported -- is that the good faith test or the reference to good faith was very much certainly in my understanding -- subject to what you and the Chairman would say -- is in the narrow legal meaning of good faith, as in honesty or an absence of predominant or improper motive rather than in this sort of slightly more common meaning of good faith meaning sort of virtuous. So we generally say that the phrase "good faith" if we are speaking to a public audience is we equate that with honesty. In other words, it is a disclosure that is made honestly. The point that I think may be relevant to you is in (b).

One of our concerns from our casework, particularly in the health and care field, was that you had a lot of people who were agency workers who were technically employed by the agency and were then placed in a care home or placed also with Local Authorities. Very often Home Helps would be supplied by employment agencies and we dealt with a number of different cases in this area.

As I said, when we tried to do the legislation the first time and we based it on the common law approach of the law of confidence, the legislation was not just restricted to the work place, it essentially was going to introduce a tort that if one made a disclosure which the courts would have felt was in the public interest, then it would be wrong for someone to victimise you for having made that disclosure. When the Conservative administration and then following after the election the Labour administration moved quite rapidly on this, for administrative reasons it was agreed it would stay part of employment law. So there was, and it was accepted there was, a significant problem here that if the care worker worked, say, for just hypothetically Reed Social Care but was concerned about abuse happening in the home at which they were working, there was the issue, first of all, as to who one would want them to be making that disclosure to and, secondly, if they were victimised for making that disclosure who their rights of redress would be against. So the one B was trying to make clear was that the worker in the care home could make that report to the care home even though they were not technically their employer.

Q. If we go over the page SP9801003, disclosure to various other people are covered here first of all to a legal adviser if it is in the course of obtaining legal advice, and then to a Minister of the Crown in certain circumstances of the worker's employment. That is if the worker's employer is an individual appointed under any enactment by a Minister of the Crown, or a body any of whose members are so appointed and if the disclosure is made in good faith to a Minister of the Crown. What is the importance of that section and has it been used to a great extent?

A. I think it is important. I think it was a very important marker that was put down on the principle of ministerial accountability and very much towards sort of 1996/1997, there was a lot of discussion and debate about the extent to which ministers were able to demonstrate accountability for the public services that they oversaw. This actually goes slightly beyond what the Nolan Committee had recommended, but it was something which the Ministers who were involved (it was then Ian McCartney of the DTI) was happy to endorse. The implications are very far-reaching if you think of the Health Service, because it as, say, a million employees and what essentially the message it is giving is that you can raise the concern directly with the Department of Health or a Minister at the Department of Health and be protected in the same way as if you raised it with your employer. So it is a strong statement of ministerial accountability over a public service. To be perfectly frank, it has not been, sort of, shouted from the rooftops and for good reason which I am happy to explain later if you want, but it is there as a sort of failsafe in the public service. To the best of my knowledge, there is only one case under the legislation dealing with this which was heard in Scotland and the provision was unfortunately misread and misapplied.

Q. You said that it has not been given great publicity and you explained why. Just before you do, the Act provides effectively a safety net. Ideally if a worker has concerns, who would your charity want to see them notify and in what way?

A. The first step for us is to try and make people -- if you have a genuine concern, you should raise it in the workplace unless there is a good reason you should not. We think that is best for you as the worker; we think it is best for your employer; we think it is best for the public interest. You know, in a range of examples, if you move outside of the health field, say if someone came to us with a pressing safety concern about a fairground or about an oil rig or something and you went to the Health & Safety Executive, the inevitable practical consequences, the Health and Safety Executive would contact the employer, but the employer would, in a sense, then have its back slightly up in saying why has this message come from the Health & Safety Executive? If it is urgent, the people who are able to deal with it more swiftly are actually the people in the work place. Also if you are able to get a proper response internally, it minimises the risk that you will be cold-shouldered or possibly isolated or worse for having made a disclosure outside.

DAME JANET: So it must be faster?

A. It is definitely faster and I think that -- it is definitely faster and I think that a natural response is, if you are a regulator or you are in an oversight position but you have

established a relationship with the people you are overseeing and you get an enquiry and someone says, "I am not happy about X" or "I am not sure Y is doing something right", that one's almost instinctive response is to go back to X or Y and say, "I have had this. What do you think about it?" It makes the communication slightly more round about but I mean, there are cases where we have and do recommend people to make outside disclosures because they are not either -- on the face of it, it would not be effective or safe for them to make the disclosure internally. But generally speaking, it is better if they raise it internally.

I think one of the other factors in this which you can see in the scheme of the legislation is that the sort of cultural shift that we are looking -- you know, we hope to see, is one where people will raise the concern when it is a concern. In other words, if someone in the workplace feels there is a danger or risk and they might when they go home mention to their husband or wife or mention it to their friends down the pub or something like that, that at that point if it is of sufficient interest to them to communicate in that sort of a confidential relationship that they should be encouraged to raise that within their workplace. One of the important things is if you can get people to raise the concern at an early stage, you have to accept and you the employer and you the employee have to accept that the employee may, as likely as not, be mistaken because the employee is never going to have all the information. What you want them to do is raise it when it is a suspicion so that either the employer can review it and say it is mistaken, do not worry about it, or realise there is something in it and investigate it further. Essentially, it is the employee passing the responsibility for the conduct of the business or the organisation to those people in charge of the organisation, saying, "This is something you should be alert to".

Q. In order for that to happen successfully, is it the case that the employee has to have some confidence that there will be a proper investigation of the concern that has been expressed?

A. I think -- well, yes, but I will qualify that. I would rather use a phrase a sort of proper inquiry for which someone will be accountable, in other words as to whether it was an appropriate inquiry. Sometimes the perception about what is an investigation is some people may view it as more sort of draconian or independent. On some facts, an employee can raise something which is a genuine thing to raise and actually the concern can be allayed relatively quickly. On others, it can be a very serious issue which warrants an investigation which could take, you know, two months if you are looking at the sort of long scale finances of a large organisation. The point you make is a very important one, that the evidence -- the sort of empirical evidence from the United States is that the main reason there people in the public service say that they do not raise concerns is that they do not believe anything will be done about it, so that it is an essential part of if you call it a whistle-blowing or a more open culture, that where a concern is raised, it is addressed. I think I would rather use the word "addressed" than "properly investigated" simply because, from our experience, some of the ones are things that if you committed an organisation to investigate each and every one, it would probably be a sort of disproportionate -- I think there is a filter process before you go into a full investigation.

Q. If we can just come back to section 43E and if you could just explain why this has not been promulgated too enthusiastically.

A. Can I say to begin with that the legislation is slightly anomalous because it was always a Private Members' Bill and it went very rapidly. When we were first asked to come up with the idea, which was in the summer of 1995 I do not think we had any idea that within three years a substantial tranche of that would actually be on the statute book. So it was a very quick turnaround. It was a turnaround which, because it was a Private Members' Bill, meant that -- well, it did not really emanate from the machinery of Government in the sort of traditional way and partly because it is a Private Members' Bill the constitutional rules are that Private Members' Bills cannot impose any expenditure on the exchequer without a specific vote of Parliament. So there has been no real Government publicity of this legislation at all. The main exception has been the National Health Service.

The National Health Service has done more to promote this legislation in its area than certainly any other part of the Government. In the city, the Financial Services Authority has promoted it. So that is a sort of general starting point. The impression that I was given shortly after it was enacted was that some people within the senior Civil Service were taken aback in a sense that legislation as far-reaching as this from their point of view in a horizontal effect had been enacted without a greater input from them and there were a couple of areas within the legislation where the feedback that we got was that it had sort of ruffled some feathers within the machinery of Government in terms of the way that the reporting within Whitehall, the fact that civil servants might be protected from making disclosures.

I think also that it is important to remember that for administrative reasons it went through as a piece of employment law. I am not sure if one asked the permanent secretaries or the ministries of a number of Government departments if they are aware of the implications of this, I am not sure they would be aware of it. But the Department of Health did recognise it and this does feature in the policy that, the model policy we developed for them which they distributed to NHS Trusts.

Q. If we can move on to section 43F, "Disclosure to Prescribed Person", and this permits the Secretary of State to prescribe persons to whom disclosures, qualifying disclosures, may be made provided that they are made in good faith. Have persons and bodies been prescribed for these purposes?

A. Yes.

Q. Can you just give us an example?

A. Financial Services Authority, Inland Revenue, Health & Safety Executive, Customs and Excise, Environment Agency, Criminal Cases Review Commission, perhaps of relevance to the Inquiry is that the Government have just amended or retabled the Order

to bring it up-to-date, partly because of structural changes within the Financial Services Authority but for the first time including regulators in the care field. So the General Social Care Council, the National Care Standards, have been brought into this prescribed area for the first time. I think the regulations have been tabled and are probably due to come into force very shortly. I can check that out. So it has widened slightly. The main thing here is that there is a slight perversion of the English language because the 43C or what you call the internal disclosure really is not a disclosure. That is a communication within a confidential relationship.

The 43F is the disclosure to prescribed persons is the first sort of proper disclosure and this was drawing quite a bit on -- this was a judgment of Sir Richard Scott, as he then was, in a case on a disclosure to one of the financial regulators called FIMBRA where he had set out very clearly the circumstances in which -- well, that a disclosure could lawfully be made to a regulatory authority, essentially, is what he was saying even if it was with very little evidence to support it, even if the motivation of the person making it was suspect. This was consistent or anyway his -

DAME JANET: Was this pre the Act or -

A. This was pre the Act. This was pretty consistent with what the existing common law was and then there is this decision of Scott's which went in a sense slightly further. So in this area 43F is more like pre Sir Richard or that judgement. So that does require the disclosure still to be made in good faith. If you imagine a sort of stepped process that if to begin with to raise a concern within the organisation your virtues are automatically protected because it is a very low threshold provided you honestly and reasonably suspect the wrongdoing.

DAME JANET: You mean under the ordinary principles of employment law you would have some protection or do you mean under the Act?

A. Under the Act. So the first one on 43C would be internal disclosure and then the second tier was to say where you could go outside to a statutory authority where the main difference is that you need to demonstrate a higher degree of evidence or to show that your reasonable belief had substance. There were several purposes behind this. The first one was to make it sure that even though one was trying to encourage people to go to their employer, you were making it clear that they did not have to. So there is no requirement under 43F that you have gone to your employer before. It was recognising, in a sense, what the proper role of a regulatory authority was, to be able to investigate serious things, but that rather than to -- to recognise that their role was in a sense to oversee the accountability or regulation by the organisation itself. So that is why it was a stepped regime. There is a difference here. This, in a sense, tiered disclosure regime is perceived overseas as the UK model.

The American model (which they have recently introduced following the collapse of Enron and WorldCom) is not a tiered disclosure regime. It essentially says if you work in

the New York Stock Exchange or a company regulated by them and you think there is financial malpractice you can go to your employer to the Securities Exchange Commission to the regulatory authority or to Congress all equally so that there is no -- the choice is entirely the employee's and there is no, I suppose, guidance given as to which one might generally be more appropriate, what we were trying to do in this legislation.

MISS SWIFT: There are two matters I would just to ask you about relating to this section. You mentioned the recent additions that there had been to the prescribed persons in the care field. We know that the Rodney Ledwood Inquiry recommended that the General Medical Council and what is now the Nursing and Midwifery Council should also be made prescribed bodies. Has that been done, so far as you are aware, in the updated regulations?

A. I do not think it has. I think, if I may -- and I am probably ... we were certainly asked about this a while ago in discussion I think perhaps with some of the disciplinary bodies and/or with Government departments and part of I think it is, as best as I can recollect, it is all right to say, that where the body is primarily a disciplinary body (in other words an employee or a professional) will report another professional for serious misconduct or whatever, that we viewed that slightly differently from the statutory authorities who have function in a sense to protect the public from a danger or a risk. One was trying to be primarily preventative and the other one was in a sense apportioning or imposing some penalty after the event. On the whole, we saw it was more relevant that, for instance, with the GMC if a doctor thought a colleague was presenting a danger to patients, the priority should be to raise the concern either within their Trust or with the Department who would then be able to quickly assess whether there was sufficient substance to the concern to take some action to remove that doctor from presenting the risk to the public.

So in other words, it should be swift, with the main concern being is there a risk and how do you reduce or remove the risk; whereas the professional bodies, like the UKCC and the GMC, is it is more that that needs -- there is a higher level of proof to begin with and the sanction is the disciplinary sanction, which could be removing someone from a Register or something similar to that, and the process is a long process. So I am not actually saying that -- they would not be my first choice of authorities to go in. I am not saying there is not a reason to be in there but I think if the main aim of this sort of legislation is if there is a genuine concern that it is raised early, if there is substance to it it is dealt with swiftly, then other regulatory authorities are probably better suited to achieve that end than professional disciplinary bodies.

Q. As far as the private sector, private medical sector, is concerned, obviously the ideal would be to raise the matter with the particular hospital management, if it was in a hospital setting. In private general practice, it may be that the GMC is the only port of call.

A. I think that is a very good point. A disclosure to the GMC would almost certainly be protected anyway under 43G but we can come to that. The main thing here was an individual worker is not going to study the structure of the Act or whatever as to what

disclosure they make. They might approach us for advice in which case we would give them advice, but the main thing is to try and identify bodies which it is reasonable for them to go to, even if they are wrong, and part of the structure of the Act was to, I suppose, a bit like a, sort of, carrot and stick but to say to employers that, "If you do not make it safe for your employees to tell you, they will be protected and they will more likely go to the Regulator", which most employers, whether it is a public or private body, does not actually want. Then the next bit was to say, "If you deter your employees from going to the regulator" -- and this was the link-up with the point you were making earlier with 43J -- "that that would trigger or make it more likely that the employee would be protected if they made a wider disclosure." So part of the thing was to have a series of -- well, in a sense put pressure on employers to recognise (a) their own accountability to regulators or beyond and to demonstrate that to their workforce by saying, it is safe for you to come to us and, if you are unhappy with that, you can go to the next step."

Q. That deals I think with prescribed persons and if we can just go down to 43G, which sets out the circumstances in which a qualifying disclosure must be made that is in good faith and you have dealt with that: "A reasonable belief that the information disclosed in and any allegation contained in it are substantially true and that the person making the disclosure does not make the disclosure for purposes of personal gain" -- go over the page SP9801004 -- "... or if any of the conditions in subsection (2) is met [and we will go to that in a moment] and in all the circumstances of the case, it is reasonable for him to make the disclosure." Is there anything you want to say about that or shall we go on to subsection (2) so we see the whole picture?

A. That is fine.

Q. We can see here that the conditions that have already been referred to are that at the time the worker makes the disclosure he reasonably believes that he will be subjected to a detriment by his employer if he makes a disclosure to his employer or in accordance with section 43F. So does this section provide for the situation where the worker fears some form of detriment if he goes through internal channels and, therefore, is casting around for an alternative?

A. Yes, but, going slightly beyond, because it is saying it is either, "If you are worried about going to your employer or you think your employer will penalise you for going to the regulator". So that was the thing that was trying to get a message to employers that in their employment contracts and in any whistle-blowing policies, they should not leave it exclusively as a hermetically sealed entity and say, "You can raise it; whatever it is it has to be dealt with by us and determined by us". The purpose of this was really to try and reassure people, not just of the asserting its own accountability to the regulator or to shareholders or whatever but you would also have a situation whereby communicating that option to your workforce, they will believe, they will have greater belief in it; in other words, it is a genuine thing. If you see a policy which says, "If you are worried about X, tell us", quite often in the UK, certainly what used to be the UK Labour relations, the view was, "Why are they asking us to do that", on a sort of sceptical or suspicious motive? If a whistle-blowing policy -- if the policy also says, "if you do not

believe us, we'd rather you went to the Health & Safety Executive, went to the Department of Health, whatever it is, than stayed silent", that is a very strong counter message to any residual suspicion that an employee or worker might have.

Q. So the first circumstance in which a worker might go completely outside employer or regulator is if he reasonably believes he would be subject to detriment by his employer and then, secondly, if there is not a regulator prescribed or a suitable body -- person -- prescribed under section 43 and if the worker reasonably believes that it is likely that evidence relating to the relevant failure will be concealed or destroyed if he makes a disclosure to his employer. So if there is nobody else named that he can go to but he is worried that the evidence will

A. Yes.

Q. Then, thirdly, that the worker has previously made a disclosure of substantially -- the information either to his employer or to the prescribed person. So he has tried in the past, failed and needs to try again some other route. If an employee wants to avail himself or worker wants to avail himself of this section, I think subsection 22 (3) sets out facts to which regard will be had when deciding whether or not it is reasonable for him to have done that. The facts to be taken into the consideration are: the identity of the person to whom the disclosure is made; the seriousness of the relevant failure; whether the failure is continuing or likely to occur in the future; whether disclosure is made in breach of a duty of confidentiality owed by an employer to any other person; any action which was taken or might reasonably have been expected to take if there had been a previous disclosure; and also whether, if there had been a previous disclosure, the worker had complied with the proper procedures. So all those matters will be thrown into the decision as to whether or not this was a reasonable disclosure?

A. Yes. When one -- I have two main comments on this. Under s.43 that, in fact, most cases will meet one or other of those triggers.

Q. Can we just scroll back to s.43 G(2) so we can see what we are talking about here.

A. Either the concern was not raised because the person thought they were going to be victimised, the concern was not raised because they believed their employer would destroy or conceal the evidence, or the concern had been raised. That is essentially -- one or other of those triggers would apply theoretically or could apply in most circumstances. So the key really in this section to my mind is 43G(3) which is just taking the principles developed by jurisprudence over the last 120 years as to what are the criteria where -- the criteria that the courts consider in deciding whether a disclosure of confidential information is justified in the public interest. I do not believe we were doing more than that -- the legislation follows the common law jurisprudence pretty closely, in my view. There is not much which is new knobs or wings put on it. It follows that principle and was developed on cases -- on real cases and it seemed very practical and, so far at least, the legislation seems to be working all right.

Q. Finally, if we scroll down to section 43H and go over the page SP9801005, this provides for as described by (1)(d) where the relevant failure is of an exceptionally serious nature. What is the regime in that event?

A. It is not really that much different from the one in 43G I think it is unlikely that anyone would succeed under 43H and not also succeed under 43G. So with hindsight it is not so important a section for that reason.

What it was meant to be aimed at was a situation where perhaps there was a concern of sex abuse within a people's home or a concern about an imminent and serious danger to food safety or perhaps in a power station or something, but essentially you should have a less potential obstacle or issues that they needed to overcome if they could show the concern was exceptionally serious. When you are doing these things you have to both look at it from the point of view of the worker as to try and makes it relevant and simple to them, but also the position of a reasonable employer and their interests and then also the fact that if it does all end in tears and there is a dispute how those issues can be weighed and assessed against one another in a tribunal or court. This was really just removing the trigger so it meant that if someone worked in, as I say, food safety or a sex home they should not have to feel encouraged to raise the concern internally first.

Q. You mentioned the attempt to make this, the whole piece of legislation, relatively easy to understand both for employee and employer. To what extent do you think that attempt has been successful? (Pause)

DAME JANET: For example, has there been much Judicial Review of had decisions or appeals from Employment Tribunal decisions?

A. There have been -- until last July we did an assessment of the claims. There have been 1,200 claims registered, which is about 1 per cent of all Employment Tribunal claims, and about 70 per cent of claims were settled. It has been in the Court of Appeal I think once, including Court of Sessions twice, and it had been in the EAT eight or nine times. That was in the period of three years. The way that the tribunals and courts were applying it, in as much as our opinion is worth anything, is what we understood Parliament to be trying to legislate and that is working well. What is happening outside of the tribunal is exactly the same in the cases which are settled or we do not know. The feedback we get is: employers are more aware that it is legitimate for people to raise concerns; that if they do, they need to certainly be circumspect about the way they handle the matter, and that, if it goes wrong, it may result in adverse publicity and/or a substantial award of compensation. So it has altered, you can say, like the bargaining position once a concern is raised or the way that people would address a concern and I think that has happened. My own view is that the disclosure regime is relatively simple to communicate and understand but, equally, I have heard people describe it as incredibly complicated. So --

Q. Your charity has the experience of actually speaking to workers who are in the position of wanting to make a disclosure to somebody and having to explain the regime to them.

A. It is very easy for us.

Q. Do you find that it is readily understood by people?

A. Certainly our advice is readily understood but, I mean very often -- I mean, the point is when anybody ever wins under the Act, it is actually a failure. It is not a success for us at all. If someone has raised a concern, legitimately in the public interest and they have lost their job over it, that is nothing to be content or happy about. A lot of the advice that we are giving is to get people to identify what it is -- you know, what their expectations are, the best way to raise the concern so that it is more likely the employer will address the issue rather than deal with them or view them as a problem. To the best of my knowledge, when people ask us for advice on how to raise a concern, the concern tends to be -- I do not think it ends up in tribunal because what we are trying to do is avoid that happening; we are trying to get the problem dealt with properly. So the advice that we give is not heavily laden with what the law is. If they ask us about the protection, we explain that to them but it is much more about how they can practically communicate it, be aware of what it is they are trying to achieve, be aware of what the risks and opportunities are and the advice that my colleagues give is very well received.

Q. You have mentioned the effect on employers. Has one important effect of the Act been to make employers more aware of the need to develop and put in place good robust whistle-blowing policies?

A. Yes, I think very much so. As I say, the Health Service has done a lot in this. I think in local authorities there have been some good moves. In the City the Financial Services Authority has as well. We do train with employers, you know, from big blue chip companies down to small charities and when they understand what the approach of the legislation is, they feel sort of very positive about it.

The issue then is really the communication of the policy and to what extent that impacts on the behaviour in the workplace. I think above all in the workplace probably the most important thing is the culture and the culture is actually set by the leader of the organisation or the leadership of the organisation. One of the reasons that we did not sort of include a schedule to the Act which had a whistle-blowing policy in it was because we were very confident that a lot of organisations would then, sort of, so to speak, photocopy the schedule to the Act, write their name on it and say "Smith's whistle-blowing policy" and then circulate that and nobody would bother to think about the issue at all. What we wanted to do was get a situation where organisations and people within organisations would try and address the issue as to what they wanted and thought someone within their workplace should do if they thought something was going wrong and they felt uncomfortable or unable to either raise it with their line manager or within the organisation.

A lot of organisations have started to do this. In the City, the British Banking Association which obviously represents the bankers, the Financial Services Authority, whatever, they have all said that they think that this is a very useful and positive tool for corporate

governance and risk management and that is obviously important to us. We are pleased, arrogantly pleased, that this is one of the very few pieces of employment law that has been passed in the last ten years which was and retains the support of the Institute of Directors and the CBI and the TUC. It is not viewed as a regulatory burden. It is not a sort of criticism from their sectors and that is quite important to us.

MISS SWIFT: Madam Chairman, I wonder if that --

DAME JANET: Yes, that is a convenient moment to break. 11.55. (11.41 am)

(Short Adjournment) (11.55 am)

MISS SWIFT: Mr Dehn, I wonder if we could now look at the various types of work which your charity undertakes. If we go to _WD1900001^ and look at the four bullet points at the bottom, we can see what are described as the four key ways of dealing with public interest whistle-blowing, the first of which is the offering of: " confidential, practical and legal advice to individuals concerned about wrongdoing in the workplace." These will presumably mainly be workers who want to know how to proceed and how to go about raising their particular concern.

A. Mmm.

Q. It is the second function which you fulfil, the provision of: " training, guidance and consultancy to employers and other organisations on risk management, governance tools and whistle-blowing." Can you just tell us a little bit more about the work that you do in that sphere?

A. We are -- I mean, it is a very small field, the whistle-blowing field, and we are approached by departments, Government departments or private sector employers or charities or whatever who are addressing the issue of whistle-blowing. Sometimes they want advice either on a policy or they might buy our compliance toolkit or they may want training either on how to communicate the policy to staff, how those people who are what we call designated officers (so they would be senior people within the company who would receive whistle-blowing concerns which were not being raised at line management level and how those people would be trained on how to handle a concern or how to handle a whistle-blower) and also some general consultancy. So we have expanded very slightly beyond the pure whistle-blowing.

Recently, in the last 12 months we have done training for the Ministry of Defence; we have done some training in legislative policy guidance for foreign countries; we were asked by BP to advise on their global employee concerns policy; we work with Abbey National on their policy and communicating that; and also with Argos. It is quite varied. It is predominantly about winning.

There is a company called Nirex which deals with long-term disposal of nuclear waste where they use us more generally for governance and accountability advice as well on

openness of information and so on. I think that from the help-line work we do, we have a relatively unique position on understanding the dilemma that people have on how to raise a concern and therefore how you can overcome that. I suppose that that is what you can describe as our unique selling-point which is added value in terms of the second activity. We do not receive any public funds so that the income that we earn in the legal consultancy role, which now brings in over 50 per cent of the charity's costs, so that subsidises our other activities.

Q. Sometimes looking at whistle-blowing policies one can see that the organisation is actually named in the policy as a repository of advice to which the employee can go if needs be. Is that a facility that you charge for or how does that work?

A. No. We do not charge for that. I think what happened was that after the Nolan Committee endorsed the issue and then in I think their third report they added two additional recommendations. One was -- and obviously the Nolan stuff is directed at the public sector -- that they should provide an access to an independent charity for independent advice and they should promote the policy. That was the key thing: to promote the policy effectively.

We never had a problem about our name being put in these policies. What we discovered after a period of time was that either from a sort of template model policy that someone else had produced or just by accident a range of employers had put us in the policy but in a way we felt was rather inappropriate. Essentially, what we say is we are most use in a policy if it says, "If you are unsure whether or how to raise a concern or whether or how to use this policy, you can get confidential advice from Public Concern at Work". So in other words, making it clear that the offer of guidance is there at a very early stage. What happened was a lot of the policies that we started to see were ones which would say, "If it has all gone wrong and you have lost your job you can go to Public Concern at Work". That is not actually what we do. We will obviously try and help people at that stage but it is not really the contribution we feel we are best able to add in this process. There is a split in the way that employers address the issue at the moment. One of the ways is to internalise or make whistle-blowing part of the internal risk management or in the NHS -- you call it clinical governance -- where the ownership of it is very much within the organisation and that that will be communicated through the management line. In our view, if you can do it effectively, it will actually reassert the management line rather than undermine it.

Another way which has had more popularity in America (and there are occasions where there are companies who try to do it over here) is to outsource the reporting line. So you would give employees a card with a number to call, a free phone number, and then this would be picked up by staff not giving advice in the way that we do, but who would take details of the concern or the information and then relay that back into the company at a higher level.

Q. Are there private companies who offer that facility?

A. There are, yes. After the Act came in, there were three. I think two of them have since closed down but two more, new small ones, have come up. It is more used in the States. It also has particular relevance for multinationals where you are dealing with different time zones. That can be an appropriate response for certain sorts of organisations.

Our own view, which is partly our experience because we were asked to audit some of the organisations which had done this, was that that can quite undermine the management line because the approach very often of these companies is that the employee is not encouraged to raise the matter, in a sense, through the management line at all but is encouraged to raise everything outside through this hotline number. When Lambeth Local Authority did this and when we were subsequently asked to audit this we found it demoralised the management line very substantially because they found staff were raising, in a sense, all range of things which normally you would expect people to raise with their manager, but they were just using this free phone number because it was convenient.

This is a very long way -- and I apologise, getting back to your answer -- we do not charge for the advice on the help-line. What happened was about 18 months ago we were approached by a number of companies who we had given advice to who wanted to promote the help-line to their staff, wanted to make a payment for it but also wanted some practical help from us on how best to promote, as in advertise, the help-line. So within the last year, we developed what we call a help-line subscription service which provides promotional tools, posters, cards and so on, where the employer, if they choose to do it then we ask them to make a subscription of 10p per employee per year, which they all think is very modest partly because the commercial operators charge about, I think, £2 or £3 per employee a year. It does not alter -- what we did not want it to do was to alter the relationship we have which is of a lawyer giving advice to the employee. So we did not want to, in a sense, have to trump that obligation with an obligation to the employer. We wanted to be able to give the best advice we could to the employee in that situation and that was the way we structured it.

Q. So that has, I think, dealt with the second of the bullet points. The third is: ".informing public policy on the responsibility of individuals and the accountability of organisations ." You have indicated the contribution which the charity made to the legislation and do you continue to do your best to inform public policy on these matters?

A. Yes, but, I mean, it is a bit of firefighting. We are very small and I suppose if you had to prioritise these, the help-line is obviously reactive and that is very often heavy demand on the staff. The work with the organisations is very important to us because it is probably the most effective way to embed the culture change, if you can get the organisation to buy into it and communicate it. As I said, public policy is a bit of firefighting. In the last 18 months, the legislation was extended to police officers or it was agreed it would be. There are new rules on employment disputes and we had a bit of a barney with the DTI but they agreed to amend that legislation to make it clear that the new rules on grievances did not undermine the whistle-blowing law.

We contribute to things like the Higgs Review, the Financial Service Authority policy. We have had in the context of the whistle-blowing Act probably -- I mean, we have had a serious dispute with the DTI over some regulations about open justice. When the Act was being -- its details were being considered with the DTI, partly because of the provision you referred to in 43J, we wanted to know whether, if there is a Tribunal claim or a Tribunal decision where it became apparent to the Tribunal that there was a risk either that there was a risk or that there had been a risk and it had not been properly addressed in the dispute between the employee and the employer, whether the Tribunal was either at liberty or should be encouraged or required to notify the appropriate regulator. At that time, the view of the DTI, not unreasonably, was that tribunals were under enough pressure as it was but we were given an assurance that this information was on the public record and it would be able to be dealt with in that way.

After the Act came into force, we sought copies of the claims and decisions that had been brought and made under the Act, perhaps six months after it began, and we were told that we were not entitled to these, that these were not public documents. We took legal advice and under the then rules, we were advised that we were, in fact, entitled to the claim forms. The reason we wanted them was to assess what the nature of the concern was, what the disclosure had been, and what the alleged reprisal was. Our own view was what we wanted was both the claim and the reply to that to be able to assess on a monitoring and empirical basis how the Act was being used. After we had been denied the information, we took advice, we took a Judicial Review and we won that where in the High Court they made very strong -- or from our point of view they made welcome and strong statements about the need for open justice in the public interest.

Regrettably but as yet for reasons we have not understood, over a period of three or four months after that decision was reached when we had been given the clear understanding that the matter was going to be appealed to the Court of Appeal, we were called in to see a minister the day before Parliament went into recess and were --

DAME JANET: Is this year?

A. No, the matter is ongoing but what happened was that the Department introduced regulations to reverse the decision of the High Court. They did not consult on the regulations, they did not publicly announce the regulations, the regulations were introduced during the Parliamentary recess and we felt we had been misled. Then they agreed it was all very difficult and said they would consult further on the issue and then they failed to consult on the issue again and again we felt misled. In the end -

MISS SWIFT: Mr Dehn, I do not want to stop you

A. No, no, you are quite right.

Q. in the middle of this but I am not sure that

A. The direct relevance of this. It was relevant to the point on open justice that with the PIDA claims, with say out of the 1,200 that had been brought in the first three years, 70 per cent of them have settled. I am not saying -- some of those could be about a practitioner or about an -- all that one knows is the name of the applicant and the name of the respondent. If the claim was settled, then the public interest purpose of the legislation is not pursued, and all of that information is then kept off the public record. That is -- I apologise, I took too long on that.

Q. It is a helpful example of your working on the public policy side. Can we just go on to the fourth of the bullet points which is really the educational aspect within the community. You have mentioned here and one sees in other documents that you do a certain amount of work in schools and groups and obviously with the media

Q. What does the charity perceive as the importance of that work?

A. I think though the whistle-blowing dilemma is at its most acute and the risks of it going wrong are perhaps most serious in the workplace. The actual human dilemma of where you have conflicts of loyalty between yourself and different people around you and you are not sure how to work your way through them is more widespread.

It is not restricted to the workplace. What we would like is to get to a situation where it is more widely accepted that it is safe and accepted to question suspect conduct but, equally, you have both sides of the table, that people need to recognise that it is safe and accepted for someone to conduct (sic) your suspect conduct. In other words, I think that is an important shift, that people -- and that is an educational thing. I think that comes about ... the best opportunity we have to influence it at the moment is through the workplace where I think obviously people who are at work are very often receptive to more informational values than probably from anywhere else, on the basis when they go home they are tired, they go to sleep and then go back to work and that is an influence on how human beings -- or they might relate to other people in their immediate community and those around them. I think schools are terribly important and if we had the human resources, the financial resources or the opportunity to do it that would be a very important thing that we would want to do.

Q. Obviously, the prime interest of the Inquiry is in the National Health Service or certainly health-related issues. If we go to the next page [_WD1900002^](#), you address the issue of whistle-blowing in the NHS and, if we can just scroll down, you indicate that you have dealt with I think the figure is over 500 concerns from the Health Service.

We can see a graph depicting that at page [_WD1900062^](#) if we can just have a quick look at that. These are help-line clients from the health sector for the last decade, obviously this year being only part of a year. You set out there the raw numbers and the percentage overall of the calls which you have had which emanate from the health sector. Is it right that this is not only the National Health Service, some of these are in relation to private health as well?

A. Yes, a handful.

Q. Could you just explain the "Excluding Unknowns" table?

A. Sorry, I cannot. What happens is sometimes we have unknowns. I can check with my colleague who did it. As the figures are exactly the same I cannot believe -

Q. There are just not any unknowns?

A. The headline excludes the unknowns I am fairly certain.

Q. So it does vary from time to time but usually something over 10 per cent, the highest 16 per cent, going down 5 per cent of the calls being in connection with the health sector. You observe elsewhere that the most concerns with which your help-line is concerned come from the care sector.

A. Yes.

Q. Is that mainly residential care homes, that sort of sector?

A. Yes, it would be.

Q. Or are you looking at other parts of what might be described as the care sector there?

A. No, that would be where there were professional carers. I think it is important in the context of these too, that the issue of whistle-blowing has probably been more heavily promoted in health and care over the last decade than in other sectors.

DAME JANET: In particular, I notice since 1998 you have a distinct increase. Whether that is a change of Government or whether it is the effect of at least two major health scandals, one of which is Shipman --

A. I definitely think they had -- with Shipman and Bristol, the Government put out in 1998/99 quite strong messages to health trusts to address whistle-blowing and sent them this compliance toolkit we produced. And that obviously raised the profile of the issue, it also raised awareness of our existence. There are a number of qualifications on this. It is indicative of people who know of our existence. You cannot assume that every one of those is actually a well-founded case of malpractice but it is an indicative that the -- well that in response to promoting whistle-blowing mechanisms it is inevitable that you will get more people raising concerns or asking about raising concerns and I think the important thing there from our point of view is the deterrent effect. The real benefit is not so much that people blow the whistle and are victimised and compensated or, indeed, blow the whistle and are not victimised, I think the benefit that -- there is some early evidence that if you promote whistle-blowing effectively what you actually do is deter wrongdoing, that the person who is in an opportunity where they feel they are presented with it, quite often their view may be that they might be able to get away from it because

no-one would see or if anyone did see they wouldn't do anything about it. The idea that, in fact, it is safe and accepted for someone to raise a concern about that thing is a check on someone in that position.

MISS SWIFT: I have already referred to the Royal Brompton report where there is a helpful summary of developments in the NHS.

If we can just go to page _WD1900064^ within this file and then scroll through the pages until _WD1900070^. If we can just see there, there is reference to first of all to the 1993 NHS guidance which it is said was published in June of 1993 and sent to a range of people, in particular Trust Chief Executives. You say that this was the first concerted attempt by a UK employer to address the issue of whistle-blowing. So only a decade but the first real attempt. If we go to that document, it is at page _WD1900174^ of the guidance itself. The title of the guidance is, "on relations with public and the media". Is that a slightly odd title for something about whistle-blowing?

A. Yes, but you are absolutely right. I think what happened in the very late 1980s and the early 1990s was that the initial view on whistle-blowing was what we would call more about protest whistle-blowing; so in other words, it was that there was a piece of publicly-known policy, for instance, the then Conservative Government's proposals on the internal market or something which people were unhappy about, and there were examples where someone had spoken out.

There was a consultant called XXXX -- I have forgotten what the consultancy was -- who spoke at a public meeting expressing concerns about the proposals on the internal market. Perhaps the consultant used injudicious words -- I cannot remember. But as a result of that the consultant was dismissed and then appealed. I believe it was then Virginia Bottomley who was the Health Secretary and she allowed the appeal so the consultant was able to return to the job. But there was a whole lot of political -- there was a big political battle then about the National Health Service and what the then Conservative Government's reforms were and it either fostered or created an impression of a culture of fear because some people who speak out were victimised. Our own view is that some of those were more what one might call protest whistle-blowers rather than the whistle-blowing referred to under the legislation.

Q. So it was against that backdrop that the title was formulated and this guidance came into effect. If we can just look at it briefly, if we can go down to paragraph 3, that sets out the purpose which was, first of all, to make plain that: "Individual members of staff had a right and a duty to raise with their employer any matters of concern and the types of concern are set out." Furthermore that: "Every NHS manager has a duty to ensure that staff re easily able to express their concerns through all levels of management", and that, "NHS employers should ensure local policies and procedures are introduced", so the encouragement of whistle-blowing procedures. Also within the same paragraph that: "Individual members of staff have an obligation to safeguard all confidential information to which they have access: particularly.." obviously patient or client information. Was there a problem within the guidance with the juxtaposition to that reference of

confidentiality with the other stated purposes of the guidance?

A. Yes, I mean, there was. It was the first attempt to address the issue, as I say, in the UK and there were definitely confusing signals within it as they were trying to balance competing interests. We felt it did not give a clear message to staff as to what they should do. We felt it focused too heavily on the management line. Very often it actually meant that a Trust could comply with this guidance and do nothing at all. In a sense, one of the routes through which the guidance could be complied with was literally just to say, "If you have an issue you raise it with your manager, if he did not do it you went to your manager's manager and then your manager's manager ..." and treating it like a traditional complaint or grievance procedure. But it was the first effort and it was then a very sort of heated atmosphere in the Health Service.

Q. You have mentioned it was now the distinction between the whistle-blowing, the raising of concerns and grievance procedures.

A. Yes.

Q. Do you regard that as an important distinction?

A. Yes. It was very important when we began because the initial view at that time was when we would speak to employers or something was, "Well, we have a grievance procedure" and we felt that a grievance procedure was really, in a sense, singularly inappropriate for whistle-blowing because normally with a grievance procedure it is adversarial and you legitimately expect the employee to prove his or her case, and if they do then there will be some outcome or redress or some benefit for the employee at the end of that process.

When you look back at the sort of examples that, in a sense, have prompted us to address whistle-blowing, if you say like the Herald of Free Enterprise when, you know, on five occasions people had said it was sailing with the bow doors open; that is not something one would logically expect an employee to bring a grievance about. What you want them to do is communicate the perceived risk to someone in a position of authority who is then able to assess the risk and take action, if it is well-founded, to remove it. You know, the idea that an employee has to go back and file a formal grievance and say, "The boat is sailing with the bow doors open", and they say, "Okay, even if it was, is it a danger?" And then the employer says, "Well, it did not sink the previous three times", it is just not a practical solution. So this is one of the reasons we use the word "concern" as opposed to a complaint or grievance. Complaint and grievance to us is much more associated with an adversarial procedure, properly so, and where the individual who you want to get on that bicycle and pedal that procedure is, in a sense, there is an outcome which he or she is seeking to achieve for him or herself.

Q. If we just go back to the guidance and go over the page [_WD1900175^](#), we then see set out the key principles, the first of which is that patients' interests must be paramount and that is then expanded upon. Then at paragraph 5, there is the aspiration that the

normal working culture of the NHS should foster openness and that the views of staff should be welcomed and they should feel that it is welcomed and appreciated and acted on positively as appropriate. Then -- and this is given bold type -- there is also the principle that: "Under no circumstances are employees who express their views about Health Service issues in accordance with this guidance to be penalised in any way for doing so." That is really the same principle that is enshrined now in the Public Interest Disclosure Act.

DAME JANET: Can you remind me of the date of this?

MISS SWIFT: 1993.

A. I agree with that but with a qualification: certainly the criticism that was made by a number of unions and patient groups legitimately was that, in a sense, the process set out in the guidance was actually relatively limited in terms of being able to raise a concern and pursue them. So it wasn't from their point of view addressing the bald point.

Q. The limitation being that it provided for internal raising of concerns and not external?

A. Primarily internal, also exhausting; in other words, not simply a process but a long process. Then, as you have rightly identified, there is a sort of inherent conflict or contradiction within the competing obligations of the duty to raise, not revealing patient information or whatever.

If you are a 25-year old nurse what you have done is learnt nursing. If you look at a guidance like that and you are looking at it, they are actually quite -- I mean, you know, the words are quite worrying words. If you are concerned that the matron on your ward is doing something wrong with a particular patient, I do not think it is fanciful to say the warning or restriction on revealing patient confidential information -- you may be thinking if you went to a regulatory authority or went to a non-executive director of the Trust it would be legitimate to ask yourself is that when you said Mrs Jones -- the fact you told someone who was not in your team it was Mrs Jones. So all of those things which I think make it quite difficult for the individual, it is whether the policy is something which is capable of giving confidence to an individual in that situation.

Q. If we just scroll down, there is the final principle identified is that it should be for local management in consultation with all staff and staff representatives to implement it in a way appropriate local circumstances. So it was to be interpreted as appropriate for the local conditions. Then there is a section on confidentiality to patients and employers and the duty of confidentiality which has already been alluded to is expanded upon: first of all, the duty of confidentiality to patients and then also the implied duty of confidentiality and loyalty to the employer. So, again, you have already referred to mixed messages -- you have not used those terms -- but was this another section that gave rise in the view of your organisation to mixed messages?

A. Yes, certainly. There was a draft form that did take on board one or two of our concerns in the draft but, yes, these were all problems on -- these were all going to be real problems but, having said that, you have reminded me, which I think is important, is that it did emphasise the need for local consultation.

Q. Then if we go to the next page [_WD1900176^](#), we can see that there is some guidance about circumstances in which confidentiality to an employer could be broken and the public interest is referred to with a caveat that: "A belief that it was a justification that it was in the public interest should be soundly based." There is the suggestion that an employee should seek specialist advice before taking action and certain organisations were cited from whom advice could be obtained.

A. Can I say, even though -- I mean, okay, it is a slightly overly-weighted thing. The problem from our point of view is that, if an employee reads that and you are worried -- I mean, you will know far better than I some of the people who may have had or did have concerns about Shipman, if one had then given them this policy and had asked them at the end of it, "Do you now know what to do? Do you feel confident about doing it?", the impression we had at the time was that it did not pass that test, that it left people feeling -- when you are communicating with employees, in a sense the thing -- and particularly an employee who is concerned, say, about a public interest matter, that overemphasising the fact that it might all go wrong and you will end up in court is a massive turn-off. What you are actually -- the person is already in enough of a dilemma as to what their loyalties to different people are, but then to the prospect put at the end of it of a sort of complicated court case looming ahead if you are misguided it says things like, "Even if you raise it in your best intentions ..." is a very serious dampener.

Q. Then there is a section on establishing local procedures. This is obviously guidance to NHS employers as to the establishment of local procedures and how that should be done. Then informal procedures are covered, it being acknowledged that the aim should always be for staff concerns about Health Service issues to be resolved informally wherever possible. Then there are some instructions to managers. Then how to deal with staff who are not in formal line management relationships, such as consultants, and then at paragraph the need for action and prompt action where appropriate and the need, if it is not considered appropriate or practicable to act, to give a proper, prompt and thorough explanation of why no action is to be taken and also of what further action they can take. So useful guidance to be implemented there.

If we go over the page [_WD1900177^](#), it then goes on to deal with formal procedures and how those should be tackled and the sort of information that should be contained in local procedures, such as representation at any meetings.

"The formal procedures should always provide for the employee to raise his or her concern, where necessary, with the highest level of local management", and that they should then provide if all else fails for the individual member of staff to go to the Chairman of the Authority or trust. Then there is some advice about how the Chairman might deal with that. Then there is the provision for where one has a very long

management chain and it may be a very long time before any concern got to the top and so it is suggested that as an alternative there could be a senior officer designated so there could be a leapfrog, as it were, from an immediate line manager to a designated officer to avoid all the intermediate steps. Again, if that fails, the concern could go to the Chairman of the Authority or Trust for action. Can we see the suggestions of who those other bodies should be. We see representative and regulatory organisations, Mental Health Act Commission and the ombudsman, with appropriate comments. Then there are references to Members of Parliament and the media. It is contemplated that an employee who has exhausted all the local procedures might wish to consult his or her MP in confidence or might contemplate, as a last resort, disclosure to the media. There is then a mention that: "Such action, if entered into unjustifiably, could result in disciplinary action and might unreasonably undermine public confidence in the Service." So there is advice to seek further specialist guidance before doing that and to discuss matters further with colleagues and line and professional managers. Did that particular portion of the guidance cause some concern when the guidance was promulgated?

A. Yes. The particular problem was the reference to or the perceived restriction on approach to MPs and that led to a correction, I think after the Select Committee on Health or possibly the Public Accounts Committee had considered that, the then Chief Executive of the NHS (I think it was Duncan Nichols) wrote a clarifying letter a couple of months later saying they wanted to make it clear that nothing in the guidance sought to restrict the constitutional right of an individual to see their MP about any concern at.

Q. Yes, if we can just see that letter at page _WD1900212^. So this was sent in the September. If we scroll down, it was the Select Committee on public expenditure that raised the matter and, as you say, there is clarification there. Indeed, it suggested that the disciplinary action refers, in fact, only to the media not to communication with Members of Parliament. Can we just go back to _WD1900178^ and go over the page _WD1900179^ because I am not sure if we have finished this document. Yes, we have finished that document.

A. Can I just make a couple of observations?

Q. Yes. Can we go back to the previous page _WD1900178^.

A. I think one of the things -- and after, whatever it is, almost a decade of experience that we have had, it is easier to articulate now, but on the whistle-blowing dilemma -- and I think this is probably where the guidance, in a sense sort of saw more of the problems because that was what one saw then than the potential solutions, but the dilemma really is if an employee is worried about wrongdoing, there are three options. The easiest option for them is: it is only a suspicion, they do not want to cause trouble, why should they stick their head above the parapet, other people know about it -- all that. The second one: encourage and enable them to raise the concern within the organisation so the organisation, if it is a proper organisation, has an opportunity to address it and deal with it. The third one is to go outside. At that moment when that individual sees something or is driving along or is on their way home and they think, "I wonder why or I wonder if ...",

that is actually the options for them. It is: silence; raising it within, in a sense, the workplace relationship that they are in; or going outside.

I think one of the things is that someone reading that guidance could end up not seeing those as distinct opportunities which can be dealt with in different ways. I think the fact was there was this confusion, as you picked out on the title of the document, of disclosures to the media.

Our experience is that hardly anybody who contacts us -- well, hardly anybody who contacts us with a genuine concern really feels the first port of call should be the media. They don't feel that for the concern itself and they certainly do not feel that for themselves in terms of they just think they will end up being, sort of, personally identified or exposed in the piece.

The second thing going back to 1993, and this is more comment on what my observations were at the time and other people who I would relay it to, sort of, would nod wisely, is that the early 1990s there was an enormous amount of initiatives coming out of the Department of Health for Trusts. The actual structure of the Health Service, when it was moving from this, sort of, what had previously been a pure, monolithic, central thing into Trust, it is the creation of the internal market and all of those things, it meant that the impression -- I remember saying sometimes when we did training in Trusts was I had this impression that each week a little sort of Ford van would drive up to each Trust and the doors would open and there would be five or six cardboard boxes full of new circulars which they had to comply with and I think there were a great number of initiatives all about well intentioned or whatever but coming from the centre which were sort of paper-based initiatives, all being asserted as being of great importance or whatever and I do not think there was the follow-through. I think there was a bit of the suspicion outside was that the initiative was a, sort of, tick box saying, "We have done it and if there is a criticism about it, it should not rest on our door". I will be interested to find out in due course whether the health authorities that are relevant in this area had actually introduced a policy after this and if so at what time.

I am not saying it is necessarily a great criticism of them whether they did or not, I am not aware -- I suspect a large number of trusts or authorities did not follow this up and, indeed, I mean -- sorry, Duncan Nichols did say in 1995 when he gave evidence to the Nolan Committee that it was a real problem and a sustained effort is required to ensure that these guidelines are properly carried through both in spirit and detail at local level. I do not think there was a follow-up to it. Sorry about that.

Q. You have referred there I think to a WD1900070[^] of this file, we have dealt I think with the guidance and, indeed, with the Chief Executive's letter. Can we just scroll down. There is then some comment from Public Concern at Work which I think you have really dealt with. Then there is the reference to the Nolan Committee, the first report and also reference to the Audit Committee which had found in 1994 that none of 17 NHS bodies they visited had implemented a whistle-blowing scheme and a third of NHS staff they interviewed would not raise a serious concern because of fear of losing their jobs. So that

is some indication perhaps of the state of affairs at that time. Then there is the quotation which you have already referred to from Mr Duncan Nichols which is quoted in that Nolan report. "The [Nolan] Committee recommended that each NHS body 'that had not already done so [this was in 1995] should nominate an official or board member with the duty of investigating staff concerns about [_WD1900071^] propriety raised confidentially. Staff should be able to make complaints without going through the normal management structure and should be guaranteed anonymity.'" Just on that particular word, was that at a time when there was a confusion but confidentiality and anonymity?

A. Yes, and we were responsible for that or I was responsible for that. When we began, the idea was that it had not recognised there were, sort of, three things. One doing it entirely openly, "Hello, my name is Guy Dehn. I think this is going wrong". The other one was, "Hello my name is Guy Dehn. I think this is going wrong. Can you look into it and please don't disclose my identity. Don't say it is me without checking with me first", which we call confidentially, and then the third one is purely anonymously which is where I write a note saying, "X is going wrong. It is terrible", without my name on it and put it in a brown envelope under your door. Through our work we realise that is a very important distinction. Something like most of the people who seek advice from us, I think probably 80 per cent of them, are happy to raise concerns openly and this is increased after the legislation because obviously you can only invoke it if you can show you were victimised because your employer knew you raised a concern. I think it is something like 2 per cent do so anonymously which is a good thing from our point of view.

Q. So the effect of the legislation is to encourage people and to enable you to encourage people wherever possible to disclose their names; is that the position?

A. Well to raise the concern openly. One of the underlying things is that part of the purpose of the legislation is trying to enable and encourage organisations to behave openly. In our view, you are not really going to do that if the method by which you do it is you say that the employee is in a sense themselves excused from any comparable openness at all; in other words if it is driven anonymously. There is a lot of historical evidence about anonymity and informing in totalitarian states and how that is very disruptive.

Q. Then this history goes on to deal with later Nolan recommendations. We have already referred to the four bullet points here. Madam Chairman, I should say that the various extracts from the Nolan Committee reports have not yet been scanned in. They are in fact about to be scanned. We have had great difficulty in getting a full set of the reports but we have done so, we have identified the extracts and they should be on the system very shortly.

DAME JANET: Thank you.

MISS SWIFT: The report that is referred to there I think actually included a whistle-blowing policy checklist which was endorsed by the Nolan Committee and the Audit Commission.

A. Yes

Q. So did that add an extra impetus to the production of whistle-blowing policies?

A. I think so. Not greatly. The Audit Commission had commissioned it from us as a checklist. There was a bit of follow-up that we certainly heard from it. There are a number of initiatives going on in terms of trying to open up the NHS. There was a lot of reform going on at the time. I think, when you look at someone like the Chief Executive of the NHS in his position overseeing it and saying the problem is with the follow-through, certainly I know of nothing to qualify that. I think -- I mean, the checklist that the Audit Commission recommended, it was in a good report exposing the risk of fraud and financial irregularities in different parts of the Health Service, primary pharmacies, opticians and trusts and I am not -- I am fairly certain the report would have been sent, for instance, to the Finance Director to each NHS Trust but with the initiatives coming from the Department of Health which were "must do" -- I think one of the things is that in this area there were a lot of "must do" initiatives, there were a lot of "should do" and there were a lot of, sort of, "good idea to, we expect you to". These would be arriving when many of these people were probably working hard trying to deliver a service at the same time. So I think quite a lot of things fell through the cracks on the floor in terms of turning them into reality.

Q. The history then goes on, just to add for completeness if we just scroll down, that subsequent Nolan Committee reports added to their recommendations about whistle-blowing and there is a quotation from one of the reports (I think the fourth report) stressing the importance of all departments, Executive NDPBs and NHS bodies instituted codes of practice on whistle-blowing appropriate to their circumstances to enable concerns to be raised confidentially inside and if necessary outside organisations. You then go on to refer or the report goes on to refer then to Government initiatives coming right forward to December 1997. There are various Government initiatives mentioned there and then, of course, the important landmark of the Public Interest Disclosure Act. You have already mentioned, I think, that once the Act was implemented your organisation assisted with supplying written material for NHS organisations about policies to be formulated following the introduction of the Act.

A. Yes.

Q. Did those go to all NHS organisations?

A. What happened, when the Act went through, we then drew on the experience (a) from our help-line and (b) from working with organisations on trying to provide a practical tool; so not just explaining how the Act worked but some promotional materials and case studies and Power Point presentations and what have you for them to communicate the issue. Initially that was designed for NHS Trusts and could we, sort of, revise modestly the pack for the NHS", and they let us do that. I think we retained all sort of editorial control over it and they did that and then they purchased I think probably about 450, which I think is probably the number of Trusts that there were. All of the stuff in the

NHS at this time that we were dealing with certainly on Central Government level was on secondary health care. We did have dealings with some individual health authorities overseeing primary care providers but most of the impetus and I would say the concern was to do with secondary care, hospitals particularly.

Q. In addition to the information which you were able to provide, I think that the Department of Health also sent out at that time fresh guidance. If we look at [_WD1900109^](#), this is a circular which was issued in August 1999, the Act having come into force at the beginning of July 1999. You can see the circulation and the fact it is for action by the various Authorities and Trusts. If we scroll down and go over the page [WD1900110^](#), we can see reference to the Act and a summary of what the Act provides. Then in the third paragraph it is observed that: "The Act does not require organisations to set up a whistle-blowing policy, but provides strong reasons why they should." It is said that trusts and health authorities should have policies already in place but those policies will need to be reviewed and updated. There is then some background about whistle-blowing and about, in the second paragraph under that heading, there is reference to the disasters and scandals of late and the fact that previously there had been a consequence of poor practice over a long period of time which was often known about by employers. Then there is a recognition that the NHS had its share of such incidents and have damaged public confidence, a reference to a letter which had been sent in September 1997 by Mr Milburn and also an assertion that ministers expect a climate of openness and dialogue in the NHS.

Then if we go over the page [_WD1900111^](#), it identifies the action which is required, which is to have in place local policies and procedures which comply with the provisions of the Act and then the minimum requirements are set out. So there is to be a senior manager or similar designated with specific responsibility for addressing concerns raised in confidence where appropriate; there is to be guidance and a clear commitment that staff concerns will be taken seriously and investigated and unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected against victimisation.

Also there is a prohibition of confidentiality clauses in employment contracts and compromise agreements. Also there are actions required to ensure awareness of staff of local policies and procedures and the staff's own responsibilities. Then there is reference to your resource pack and the reference to the various components of the toolkit which was included. If we go over the page [_WD1900112^](#), there is reference also to associated documentation on the topic. So this is the new guidance that goes out. How helpful did your organisation consider this guidance to be?

A. I mean, we thought -- well we welcomed it. We welcomed the initiative. We thought - for our own private reasons we were very pleased that the NHS was happy to, in a sense, endorse the approach we were taking to it and to just leave that to Trusts. We thought that was good for the NHS and good for us as well. I mean, this sort of material went out in a big bold box and it was very well received certainly on the back of that, we had a lot of enquiries from Trusts on sort of the finer points of the policy or wanting us to

review the policy which we did at the time. The NHS bought packs and did that as a natural follow on from that -- but that was quite well received. The interesting thing is they have just recently relaunched the pack, as we had updated it anyway on a CD ROM and used the new technology, and the thing that they picked up on which when you asked me about this subscription service which these other employers had asked about was to provide material which would help promote the policy in the work place, so posters and cards and so on. That is really the main change that has happened. So there is more, I suppose, bolder promotional material in the later version. I did say that the emphasis was on secondary care.

DAME JANET: You did.

A. Knowing the relevance of primary care to your authority, certainly there are initiatives to deal with initiatives in primary care but it was not overlooked when we and people in the Department of Health were looking at the legislation because one of the issues that concerned us was that in, for instance, a GP surgery or any primary care practice where the GP -- or you might have two GPs -- would actually be self-employed with no employers, how you dealt with their , position when this was a piece of employment law. The Department of Health picked up on this very quickly and it was agreed and, you know, very exceptionally for employment law, that even someone who is self-employed if they were self-employed but working within and predominantly for the NHS they would be treated for the purposes of the 1998 Act as an employee. So you know a GP would be employed by the Health Board or Health Authority even though technically that

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DAME JANET: They would be treated as such.

A. Yes.

DAME JANET: Is that a convenient moment?

MISS SWIFT: It is, Madam Chairman, yes.

DAME JANET: We will start again at 2.00. Will that be sufficient for your purposes do you think?

MISS SWIFT: Yes, I think so. (1.05 pm) (Luncheon Adjournment) (2.00 pm)

MISS SWIFT: Mr Dehn, bringing matters up-to-date, I think that recently a survey was carried out by Public Concern at Work and UNISON jointly into awareness of whistle-blowing policies and indeed the existence of such policies within the NHS. If we go to [_WD1900097^](#), we can see the first page of that document entitled: "Is whistle-blowing working in the NHS?" Then if we go to page [_WD1900099^](#), we can see the executive summary and recommendation. The key findings, if we scroll down, of this survey which was reported in May of this year was that 90 per cent of people had blown the whistle when they had a concern about patient safety. Just pausing there for a moment and just

considering that statistic, are these people who in answer to an appropriate question said to you, "Yes, whenever I have had a concern I have blown the whistle?"

A. This was a survey conducted of UNISON members which we helped design the survey. It was analysed not by us but by an academic statistician. I am fairly certain the question was: in the last three years have you had a concern about patient safety and, if so, have you raised it?

Q. These people would inevitably be self-reporting as to whether or not they had blown the whistle. Does that factor lead you to treat 90 per cent with some caution or do you think that that is a truly representative proportion?

A. I think probably -- I think it is accurate but bearing in mind that the meaning of the words "whistle-blowing" has revolved really quite a lot so what that is when they have had a concern about patient safety they have raised it, which could perhaps more often than not would be within the regular line management process. I think the distinctive thing about that figure to me is that going back a decade ago to the sort of early 1990s, I think it is almost inconceivable to imagine that you would have had a response at that sort of level. These are UNISON members, so they are not necessarily going to be the more senior medically qualified staff, it will include some nurses, some of the ancillary staff and so on.

Q. The next statistic is that 50 per cent did not even know that their Trust had a whistle-blowing policy. Is that a matter of some concern if that is a true percentage?
That is a matter of great concern to us. Obviously, what we do not know -- there has not been any empirical survey across the NHS to determine whether in fact the Trusts do have whistle-blowing policies. I suspect that most of them do but they have not been effectively communicated. It certainly is possible that one or two Trusts may not yet have actually addressed the matter.

DAME JANET: Those two statistics taken together must indicate that some of the 90 per cent -- at least 40 per cent of them did not perceive what they had done as blowing the whistle.

A. Absolutely and I think it is a very important point. On the whole, if someone phones us up and says, "I am a whistle-blower" we tend to treat them with a degree of scepticism. The ones --

DAME JANET: Who say "What shall I do"?

A. The ones who are most important, they do not want to think of themselves as a whistle-blower. Their view is literally there is something wrong and they want to know how to raise it or they think someone should look into it. The word still has pejorative meanings.

MISS SWIFT: Just looking at those two percentages, I suppose that 100 per cent of respondents would not necessarily have had any concern.

A. That is correct.

Q. So the 90 per cent may be the smaller figure?

A. It is 90 per cent of a smaller number and I am sorry because I had anticipated that the full statistical data would be here. I can certainly make sure you are sent that. I am fairly confident that it was over two-thirds said they had had cause to have a concern and of those two-thirds, 90 per cent had raised the concern but I am happy to supply you with that.

Q. That would be helpful. There is a bit of explanation which we see on the pages afterwards but it does not go into full details. Then we have 33 per cent say their Trust would want them to blow the whistle even if it resulted in bad publicity, contrasted with 30 per cent who said that their Trust would not want to be told there was a major problem. Those are not quite two sides of the same coin.

A. Looking below the headline into the colour of it, it certainly is possible you could have the same Trust with a different employee describing or viewing the culture differently, but I do think it is to the credit of the NHS that one-third of staff are saying that they think their employer would want them to blow the whistle even if it resulted in bad publicity. I think if you asked that same question of the workforce generally, I would imagine the figures would be dramatically smaller than 33 per cent.

Q. Perhaps also significantly 25 per cent said that the culture was improving.

A. Yes. That was over a period of the last three years, yes.

Q. Then specifically in relation to those who had blown the whistle on a patient safety concern, we have a third saying that they suffered some personal comeback, half that the concern was dealt with reasonably, and also interestingly where a whistle-blowing policy was used, no staff reported reprisals and two in three said the concern reasonably dealt with. Do you find that an encouraging statistic?

A. Yes. All three of them. I mean, obviously it is certainly regrettable, if not more, that a third said they felt some personal comeback but it was not clear from the survey -- I mean, if one had known the results before, one probably would have asked additional questions as to where they felt they had suffered some personal comeback, whether it was enough for them to make a formal complaint or to do something about it or whether it was literally that the colleagues whose conduct was in question cold-shouldered them or the message was not welcome.

I should add that where whistle-blowing was used my recollection is that the actual statistics there, the numbers used were very small but nonetheless the message from here and from our help-line and the work we have done with Trusts is that where a Trust has a policy and someone has in a sense invested some time into what it means and why it is important for the Trust and where it fits into the clinical governance, they are very

conscious and keen to administer the policy in as generous a way as possible on the whistle-blowing issues because they are wary that if someone uses the policy and then says, "It is no bloody use" or says they have suffered reprisal, that it is not sort of Chinese whispers, but in the workplace the message will go round it is not worth using the policy. So we find once there is an investment into promoting the policy and making people aware of it, they tend to be operated with considerable diligence.

Q. If we just scroll down, the observation is made that although: ". substantial improvement is still needed, NHS staff are increasingly willing to speak up for patient safety, even at some personal risk." Although there is a caveat that it is said that it seems that this welcome change is across much of the NHS, "... in spite of, not because of, management action or encouragement. Overall, do you regard the findings of this survey as encouraging?

A. Yes, very much so.

Q. If we go over the page ([_WD1900100^](#)), there is a reference to the importance of whistle-blowing being underlined by Government policy over the past decade, but it is noted that somewhere along the line the information is not getting through. Is the problem sometimes putting over the policy and implementing it in the lower levels of management right down to the shop floor, as it were?

A. Yes. I think one of the things that happened to begin with if you go back to about that 1993 guidance and perhaps the first time our policy pack was put out in the Health Service, I think there was a tendency to view it as an issue for human resources and it is obviously better it is dealt in human resources than nowhere but we have always been lightly sceptical about the merits of that because the essence of the human resources function is to look at the individual, the messenger, rather than the message. What the purpose of a whistle-blowing policy is to try and make clear that if someone is worried about a clinical governance issue or is worried about financial malpractice that is not probably an issue for human resources to deal with. The substantive message is for some other part of the organisation. What human resources should be trying to do is ensure there is a culture in which people feel it is safe and accepted to raise such concerns. I think what has happened in the last few years on the back of CHI particularly and I suspect also what NPSA is doing is whistle-blowing is being seen as an integral part of clinical governance and I think that that is a very welcome development from our point of view.

Q. The executive summary concludes with a recommendation that the Government should remind all NHS healthcare providers, both public and private, of the need to introduce and promote a whistle-blowing policy. Was it as a result of that that the new toolkit was circulated or is that entirely coincidental?

A. The decision -- I think not the decision to, because that had been taken before and the toolkit had been designed and whatever. I think that what happened was that this survey I am fairly certain it was related to me by someone in the Department of Health was that it

meant there was a window because the material in the policy pack had to be signed off by a minister and when the officials put the policy pack to the minister to be signed off, either they must have briefed him or he had recollected that there had been this UNISON survey. I should say one of the things is that even though, as I have said, this is all positive news from our point of view for the NHS that I mean, that was not the way it was reported in the media. The media emphasised on the fact that in a sense what was the still worrying levels not really emphasising or recognising that there had been or there is ongoing a welcome change in the culture.

Q. You have mentioned a moment ago the activities of CHI. I think as part of their clinical governance reviews they look at whistle-blowing policies, test staff awareness of whistle-blowing policies and indeed we heard about the results and the trends emerging from those reviews last Thursday. Are the activities of CHI helpful, do you think, in reinforcing the message locally?

A. I would certainly imagine so. I mean, from our -- I think from the point of view of when you are looking at the Trust that actually in probably every Trust every day there is some incident happens on which someone would have a legitimate cause to raise a concern. I think a lot of those concerns are raised in a routine way. I think there is more of a sense of teamwork developing within medical groups and so on and I do not think that is necessarily -- as Madam Chairman said, it is not necessarily seen as whistle-blowing at the time that happens. I am ever so sorry, I have forgotten what your initial question was so I cannot answer it. I apologise.

Q. I think you said the activities of CHI must be helpful?

A. No, I have no doubt they are helpful. Certainly we have dealt with a couple of Trusts who have received adverse comments in CHI reports, some of which were dealing with whistle-blowing and we have dealt with them and there is no question that they felt stunned but in a benign sense, stunned to address the issue, and I got the impression that CHI was held in considerable regard across the Health Service when we have done training.

Q. We have talked about the pack which has gone out and also if we can just go to [_WB4900002^](#), this is in a statement by Simon Bennett of the Department of Health who I think you are acquainted with and have worked with on occasions and if we just scroll down, we can see at the bottom of that page, paragraph 7, the statement that: "The Department of Health will be working with [your charity], the health trade unions and practice staff during 2003/2004 to review the need to issue tailored guidance on whistle-blowing for general practice." That is an initiative of which I think you are aware.

A. I had not actually seen that it had gone into the letter, but I am delighted to see that.

Q. How far advanced is this?

A. It is not really advanced at all other than the intention to do that. I believe some of that

is prompted twofold by the shift towards Primary Care Trusts but also your work here, the Inquiry, and the need for there to be a different in a sense both a simpler and a different support for primary care providers to address whistle-blowing. The policy pack as devised is really for an organisation of what -- I will put it bigger than an SME so larger than 250, perhaps 1,000 or several thousand staff. I would not think it was realistic to say that a GP's practice of two or three practitioners and 10 support staff should put aside half a day to develop a whistle-blowing policy. I would not think that would be an appropriate use of their time.

Q. You were asked when you prepared your statement to give particular thought to the issue of whistle-blowing in certain different settings. If we can go to _WD1900003^, at the top of the page you make some general comments. First of all, you say that in your view the way to overcome barriers to speaking up in any setting is to embed a culture where it is safe and acceptable to raise a concern and question suspect conduct. I think you have already indicated that and your belief that the earlier it is taught and the culture is inculcated, the better. Secondly, you make the point that in workplaces in general and the NHS in particular, the culture is best embedded where those who oversee the organisations, large or small, recognise their own accountability and view whistle-blowing as the key to patient safety and good clinical governance. So in other words, looking at the whole picture, embracing the concept of clinical governance and accountability and viewing whistle-blowing or the voicing of concerns as part of that.

A. Can I just clarify one small bit, which may not be necessary, and that is when we use the term "accountability", we use it in the sense that someone in a position of authority can reasonably be expected to give an explanation for their conduct where they receive, in a sense, a warning or a concern that something may be going wrong. We separate that accountability from actually a legal responsibility which may or may not flow from their response to the question.

Q. Can we just deal with the first of the scenarios that you were asked to look at in particular. Let us take the situation of an employee being concerned about another professional employed in another organisation. What we had in mind here was, for example, the district nurse who may be concerned about the conduct of a doctor or the health visitor; the district nurse and the health visitor being employed by the PCT or Community Trust and the GP obviously not being so employed, and there being fragmentation and a degree of isolation of the unit from the unit at which the concerned professional works or is attached. What are the particular problems associated with that situation?

A. I do think there is a sort of added human disincentive to blow the whistle where you are in a fragmented or geographically isolated area. I think when we dealt with cases on the help-line from the north-east or from Wales or from Scotland, the opportunities that the person feels to have a proper or independent oversight or look at the conduct are reduced, particularly if the individual or an individual that they are concerned about is in a senior position.

Secondly, this close-knit nature of the community creates the perception that if they do raise a concern, whether it proves to be well or ill-founded, that it may make their position -- their continuing position within the community untenable or uncomfortable. So it has greater ramifications than, say, if there was someone in Manchester or in London or what ever - so that is the bit of the geographical isolation. I think that where -- what I would hope is if you were a health visitor or a district nurse that there would be within the Authority, your employing Authority, a whistle-blowing policy and the way the policy would have been communicated would have meant that you would know it was proper and reasonable for you to flag that concern with someone. Part of the approach of whistle-blowing is not just to say that the individual ought to have that (inaudible) in terms of silence but by communicating it to someone in an appropriate position is actually the best way for it to be reviewed and to see whether it is well-founded or not or whether action ought to be taken. It is not just relieving them of the weight on their shoulder but it is actually the proper way of dealing with the issue within the structures that exist.

Q. So for a health visitor or a district nurse employed by some other authority, you would expect that that Trust, their employer, would have their own systems which were clearly understood which they could follow?

A. In theory, that employee -- certainly desirably the district nurse should be working for an organisation which does have a whistle-blowing policy. The whistle-blowing policy should not have been communicated in a defensive way but saying if you were concerned about an aspect of patient care, we hope you can raise it with your line manager. If for whatever reason you do not feel able to or you do not think it has been resolved satisfactorily there is someone you can go to, if you wish to, in confidence or if not openly and ask them to review it. So it is expressing things in an informal and quite friendly way.

We do also, as in the extract on the screen at the moment -- it certainly is desirable where possible that someone raises the concern with the person. We do not rule that out. Again, that person may indeed have their own employer. I would have thought with the district nurse/health visitor example you were giving, that I would hope that -- I would hope that there would be some existing reporting line anyway in which it would be normal for them to flag that concern and it would be accepted for them to do it. If, for whatever reason, they felt unable to use that or that had not been addressed or recognised as a proper issue, and they felt it should go further, then under that organisation's -- the Trust's or PCT's -- whistle-blowing policy, they would be able to do that.

Q. You raised a moment ago the point that once the concern is raised that there obviously has to be an examination of it to see whether there is anything in it or not. A number of people who have concerns may be afraid to voice them because they think, "Well, I might be wrong and then I am going to get into trouble or I am going to look a fool or I am going to have made trouble for myself unnecessarily." What about the sort of reassurance that can be given in relation to that and the question of support generally for the person expressing concerns?

A. Those are all bull's eye points. The first one is that the policy or culture needs to provide that reassurance that it is safe. Secondly, it needs to make it plain: if in doubt, please raise it. That is the sort of strapline of it. Certainly raise it while it is a suspicion it is not the job of the employee to collect all the evidence, but one of the benefits if you can get -- or certainly where we have seen, if an organisation does have a whistle-blowing policy, part of it, as I think I indicated this morning, is to assert the management line so when, say, that district nurse goes back and reports to her -- I do not know what it would be called, but anyway the senior district nurse, perhaps the senior district nurse may know of the doctor socially or may feel that it is not a serious concern or not want to deal with it for a number of different reasons. If the organisation has a whistle-blowing policy, then that person in the management position cannot assume that their decision is the end of the matter. So in a sense it is creating a culture where the people in the management line are aware that if they do not deal with the issue responsibly or effectively, that the system is one where the employee can safely and properly go higher up the line. So in a sense it is the idea that someone may be looking over your shoulder. I think that part of the -- if you can call it the deterrent effect of whistle-blowing is probably its greatest benefit. The evidence that we understand at NPSA has come up with shows that by providing safe routes to report things that actually it has a beneficial effect on reducing the number of things to report. Similarly, within local Government for a period of about -- the Audit Commission monitored the levels of fraud and corruption that are detected and there was a period after about five years where whistle-blowing was being promoted in local Government, which one would normally think would mean that you would find more fraud and corruption if you make it easier to report it, but actually they discovered that the levels of fraud and corruption that were being reported were going down. I am not saying that is caused by whistle-blowing, but it is certainly plausible that it was a cause in that. So the key thing in the example

DAME JANET: Are they saying also that there is less fraud and corruption? The two things are different, are they not? There may be less being reported but does that mean that there is also less taking place?

A. I think -

DAME JANET: Because if not, then the whistle-blowing policy has actually been counterproductive.

A. Absolutely, but their report was not of the perception but what fraud and corruption they had found. As the district auditors, there is an obligation to report incidents which meet a certain level to the district audit. Then that gets relayed to the Audit Commission. It is certainly possible but I think the conclusion that certainly I understood they reached was that it indicated the levels of fraud and corruption in local Government had gone down. It is only me who is saying that a plausible cause of that, bearing in mind the period during which they found that decline, as that was

(DAME JANET: The reporting --)

As that period coincided with heavy promotion of whistle-blowing policies which logically one would have thought would have meant more cases would be reported rather than less, that it indicated that the levels of fraud and corruption probably had gone down. I think if you go back to the position of the -- I mean, where having looked at policy and legislation and the communication of it, if you can have a reminder in the workplace, a ready reminder, that it is safe and accepted, (like a poster or something), that it means if you think of the scenario of the district nurse who comes back and sees her manager that it reassures her that she is right to be raising it is if the manager in a sense does not want to do it because for whatever reason, the manager is also aware that it is very easy for that district nurse to go higher up the organisation, therefore that is an incentive for the manager to deal with the matter properly in the first place.

MISS SWIFT: If we can just have a look at _WH3500003^, this is part of a statement by Mr Ian Hargreaves on behalf of the Royal College of Nursing. If we can scroll down to the bottom, he talks about evidence at paragraph that bullying takes place by doctors against nurses where nurses speak out against poor medical practice. He gives some examples of that and says that in most of the cases, the action taken by the employing authority is to move the nurse from her post to another post where she is less likely to have contact with the particular doctor, which it points out is counterproductive. Then he puts it into the context of general practice where the nurse may be faced with a prospect of having to resign her post in order to escape reprisals for reporting poor clinical practice. Then he goes on to say that whilst there is protection afforded by the 1998 Act, lawyers working with the RCN believe that to date the Act has not yet proved to be a satisfactory safeguard for workers who were sacked or victimised after blowing the whistle on colleagues. He refers to a particular conference. Just on the position of nurses, it may be that you have no special knowledge or information about the position of nurses but what are your observations on the points made there?

A. Yes, the professional bodies have a much better and deeper view of the use of the legislation after the event than we do, because primarily what we are trying to do is to avoid the thing going wrong. Certainly, if you are a nurse and you are sacked, you would go to the RCN or UNISON or, if a doctor, the BMA.

I am slightly surprised about the statement that it has not proved a satisfactory safeguard because I am not aware what it is based on. What we have analysed is all the reported decisions of tribunals in the EAT and the Court of Appeal and we are not aware of a decision where a nurse has been -- we are not aware of a decision involving a nurse who has lost a PIDA case having blown the whistle. It may be that the RCN lawyers have decided to settle the claim on some ground or other.

Q. I suppose it may be even the compensation may not be considered to be satisfactory to make up for losing a job.

A. Sure. That is a very important point. But in the end, the limits of the law are to when

the law talks about protecting someone, it means not that it will not happen, it means that if it does happen you will in as far as the law is able to put you back in the position you would have been if it had not happened. But in the context of an employment relationship, I just do not believe it would be desirable.

I am not saying this is what the RCN is asking for, but if you have a situation where you have a small GP's practice and where you have a negligent GP or not, a GP perhaps who is not doing his financial affairs as properly as he should, and if you had a nurse or an administrative worker who did blow the whistle on that, my view is that the relationship is over.

DAME JANET: You are saying you would not want to see enforcement of the employment contract. And it is not the usual thing in any event.

A. No, not at all. My view is that an employment relationship probably has more in common with a marriage than many other relationships. Once one -

DAME JANET: If it has broken down -

A. -- party has gone to law, the prospects of the relationship continuing in any sense with any mutual respect or --

DAME JANET: That is so particularly with small employers, not so much with very large employers.

MISS SWIFT: If we can just look at a slightly different position, if we go back to your statement at page _WD1900003^ we then come to what might be described as the imbalance of power perhaps.

A. Yes.

Q. What I have in mind here to take an example from Shipman is the home help who has reason to be concerned about the doctor and who may look at the respective positions of both and say, "Well, who is going to believe a home help as against a respected professional?" One can think of other examples and also, of course, the concern that that person may have that her worries are entirely unfounded. Is there any way in which a person who feels that sort of imbalance of position can be given the confidence to voice concerns in those cases, do you think?

A. I think it is very difficult because I think the precise example you are giving, I think actually if you say the home help is, say, of my age or above that the sort of deference in which doctors or the establishment professionals were held in was quite sort of ingrained and deep-seated. So I think it perhaps was not just a thing about the power structure, it was something to do with the respect for someone who was through their position more influential, more important, more valued in the community than you. I think that -- and it is the two-edged sword -- but I think that the default of the sort of respect that people

would have for a professional doctor I think that is not as great as it was perhaps a couple of decades ago. I think people probably encourage more if they do not understand what a doctor says or they feel that something is wrong. There are certainly more mechanisms available to them to complain. It does not necessarily mean they will avail themselves of them but I think that that has been a shift in the last 20/30 years in the last generation. The business of overcoming the home help's anxiety that she is just a home help and, you know, this other person -- and she does not know and she is not meant to know is very -- is going to be difficult.

Again I think it comes back to the fact that if you have -- I suppose one of the points with a home help is they will be going from a Local Authority out into a series of different homes. If there is a mechanism in the Local Authority which is reminding them that if they think something is wrong they should not keep it to themselves but they should communicate it to someone perfectly safely in a more senior position, I think that would be a good thing.

I suspect that some of the points that you and Madam Chairman will be addressing will be similar to the issues which I think came up during the Climbe Inquiry and the recommendations about having someone with a sort of clearer line of accountability or someone who if someone thinks something is going wrong, can at least communicate that information to that person and it is assumed that person will deal with it.

Q. So is it really a matter in the home help example where there is an employment infrastructure of the employers to work towards giving the necessary confidence and providing the structures to raise concerns?

A. I certainly think that is something which is practical and relatively easy for employers to do. From the work that -- from the help-line work, one of the things that interests me is where you have, say, in a care home and you may have care assistants who feel something is going wrong, either a resident is not being properly treated or perhaps may be being assaulted, when they talk to us, it is not naturally -- the role of the GP is not something which they have themselves recognised as a helpful or useful way to raise or review the situation or remedy the situation. Certainly our understanding is that if you have a care home, you will have GPs who will come in and visit and if someone is ill, prescribe medicine or whatever. Almost invariably when we are approached from a care home, even if it is a case where someone is alleging that a resident may have been hit or could be badly bruised or something, it is not within the -- the role of the GP in that which, say, in my position would be quite a natural one that you would say, "Have you thought of telling the GP?" or, "If the person is badly bruised was the GP called", it is not actually seen instinctively on the part of the care assistant that that is -- I suppose you know a relevant part of the jigsaw almost near the centre of the jigsaw. They are looking at it much more like it is a position between them and their employer or the manager of the home or something.

Q. If we just scroll down, we can see that you express the view in your statement that the extent to which a more junior person would feel able to raise a concern would largely

depend on the number of factors: fear of reprisals, whether they feel their opinions carry any weight. Is that an important issue? Whether they are made to feel that their opinions will carry any weight?

A. This is speculation, in the example you are giving of a home help worried about what a GP is doing, they would probably want to be really feeling very sure. In other words, there would probably be a weight of evidence before they thought it was proper to challenge the conduct of a GP. I could well imagine that. Outside of that, even within a hospital setting with a junior doctor and a more senior doctor, that is an important factor. The first one is: do you think you can be worried that you might be victimised but even if there is a sort of neutral on that or you say, well, you think you probably will not be, the next question is, "What is the reason you are raising the concern?" If the reason you are raising the concern is you think somebody is doing something wrong or is a risk to patients and something should be done about it but actually the way you evaluate the situation is that people will not do anything about it because the other person is so senior or because your opinion does not count for anything, but then you have removed pretty much a major incentive for someone to raise the concern to begin with.

Q. Then you identify uncertainty about the route which obviously can be clarified in a policy and confusion about where to go to get the issue properly looked into and finally -- and you have already mentioned this - suspicion that nothing will be done anyway, which is bound to be a discouragement. Can I just put another particular problem which we have already touched on which is that of the small organisation. The example for us is general practice but one could think of many other small organisations where it may be that the line manager is the person being complained about or at least a very close colleague and a general practice would be a good example of that. You have issues of loyalty and issues of dependence upon the job and perhaps the individual for one's livelihood and for a job. An example would be a receptionist complaining about a GP. In a GP practice, that receptionist is going to be somewhat remote from, for example, the PCT.

A. Yes.

Q. An employee may or may not have any sort of relationship with the PCT. What is the way forward there to make it easier, do you think?

A. I can offer my view. It is very likely that when you and Madam Chairman have this session in January, we are not -- we can contribute to that but I think you raise a very important point and that is that even if you provide a mechanism within the practice and it was well promoted and it said if you cannot raise it with the practice manager, you can go to the PCT, procedurally that all looks very good but as you have said for the receptionist in there the PCT is an anonymous distant organisation that he or she perhaps has had no dealings with at all.

DAME JANET: In any case, even if the concern were raised in confidence as to its source, there is only a limited number of people that it could be and there is a fear that even then you will be identified as the source.

A. That is a very important point and as you have seen with the Hutton Inquiry and some of the issues they are addressing but -- I think that where someone -- I mean, our advice is that if you have a concern which you think you ought to raise, you should raise it openly. Even though there is the option of going to someone confidentially, it is actually much better for you if you can raise it openly. So in the example that you have given, it would be best if it can be raised openly in a sense and then the GP is on notice that someone is worried about it and if the GP's response to it is not reasonable, then the GP knows that the person can readily go to the PCT. But in terms of the identification of the individual, I think it is much better if it is done openly for that reason. But it does not quite -

DAME JANET: It must depend also, must it not, on the seriousness of the allegation? It is one thing to express a concern that a doctor perhaps ought to have visited a patient on a particular day or occasion, quite another to suggest that you are worried because he might be murdering his patients.

A. Absolutely. I mean, the nearest I can say is we have dealt not anywhere as near as grave as this, but we have certainly dealt with in what was a small care home where the Deputy Manager who was a qualified nurse was concerned that the owner of the home was sexually abusing some elderly ladies there who suffered from Alzheimers and were blind. That was obviously a situation where there was no possibility of raising the concern effectively with the owner of the home and it was necessary to go out. That was in fact a very difficult case to deal with because there was not much oversight from the District Health Authority and the position there -- I mean the dilemma that we had was that we checked as to who to try and identify who was the appropriate outside body to look into these sorts of matters and it was not even clear within the police what, and this was in XXX, what part of the police it was.

In the end we went to them and outlined the situation, they said that if the nurse did go to the police and even if -- and the complaint, in a sense -- what the police would have to do was immediately put the allegation to the owner of the home. If it turned out that she was unable to substantiate it, obviously her position became untenable as the nurse in the home. He was the owner of the home, she was the Deputy Manager and she would have reported him to the police and the police would have decided there was not enough evidence to prosecute. In the end in what were very unpleasant circumstances, we felt the best thing was to advise our client -- and she said her colleagues were also concerned -- to be vigilant and that if they thought such an incident had happened again, they should this time not destroy the evidence which is actually what had happened the first time she phoned.

When she had gone in she had been so disgusted that she had cleaned the elderly ladies up and anyway on this occasion she did retain the evidence, but because of the way the system then operated was that when we told the police, we went to the Department of Health and they did not want to know about it. We actually said, "What shall we do now? She has some hard evidence", they did not know what to do. We went to the police and the police said they would not be able to submit the evidence to forensics without her

making a complaint and so even if the forensic evidence came back and said it was not semen, that because it was a complaint they would have to put it to the owner of the home so her job would be lost anyway. So in the end we sent it to forensic and it turned out it was semen and the man was arrested and then sent to prison for five or six years. This was an individual who had won a gold medal for services to the elderly and it turning out he had been abusing these residents for something like 10 or 12 years.

MISS SWIFT: So obviously that employee as you have indicated sought help from you which prompts the question that if one has somebody, for example, in a GP practice who does not know what to do, has not actually got so far as telling anybody about the concern, just wants to know what the options are and what the pitfalls are, would it be helpful in your view for people within a small organisation such as a general practice to at least know of an organisation such as yourself with whom there can be a preliminary chat about what could be done without making the complaint?

A. Yes, very much so. I mean, I think that it is that having a safe haven of someone where you can talk to or you are not initially making the external report that are you able to go through what is the concern, what the basis of it is, so you can make an informed choice about the risks and opportunities. That is essentially what we try and do and I think that that is a very valuable thing if people do know about it.

DAME JANET: If somebody telephones you for advice and they are not at all an employee, simply a member of the public, do you treat them in exactly the same way or do you confine yourselves to giving advice in the context of an employment relationship?

A. No, we do give advice. We are not frequently approached but certainly I do not know perhaps less than 5 per cent of people who approach us will not be employees and in that situation it is directing them to an appropriate place to raise the concern. Sometimes they can be worried about what possible repercussions there are for them individually but obviously they are of a very different nature from in a sense the economic dependency.

DAME JANET: Within a community they could be very serious indeed although they do not involve the loss of a job. We have in the Inquiry certainly two examples of people who were not in a employment relationship to Shipman who would have liked to blow a whistle but did not and we have evidence about why they did not. But you would listen to and give advice to such people?

A. Yes, and it is trying to identify what is an appropriate person or body to go to and what information they should put to them. Very often on the business about whistle-blowing, there is this confusion of the message and messenger. Quite often, it is as much to do with the way the messenger expresses the message, the individual when they start off what can be the salient points that they actually do want to communicate can get lost or slightly lost within other things around. So what we try and get them to do is identify what is the key point that they actually think; so the sort of phrase we use quite often is that you do not help anyone by going with a shopping list, it is a lot easier if you can identify -

DAME JANET: Your main concern?

A. Yes, what your main concerns are, what they are based on and so there is something which the recipient of the information is able to investigate.

DAME JANET: Yes.

MISS SWIFT: Just going back to the plight of a ordinary member of the public who has a serious concern -- and we will be hearing from one such tomorrow -- no idea who to go to and even if he or she was aware of your organisation, the title actually would suggest that it is really for work-related problems as primarily obviously you are. Is there a case for some sort of independent help-line available to the public to express and discuss concerns and to serve perhaps a dual purpose: explanation of the various possibilities available, but in the last resort the repository of the actual complaint which it then parcels up and takes elsewhere?

A. Certainly there is, you know, there is no question there is merit in exploring it. I think one of the difficulties which or something which can be become a difficulty when one goes down that route is that if it is a sort of statutory body, there is an assumption perfectly properly that the statutory body should not just be giving advice, it ought -- in other words, if someone phones up a statutory body and says: I am a taxi driver and I am worried that seven of the elderly ladies in the area where I live have died this year and I think it is a local GP" there would be a view certainly the view would be expressed and it may well be accept or felt by ministers -- and, I am sorry, I am speculating because obviously I am not a minister but if that information was somehow or other received by a State entity, then that would trigger an obligation on the State in a sense there and then to deal with it. One of the advantages that we offer is because we are not part of the State and it is purely legal advice, it is in a sense a safe haven in which you can discuss how best to do the thing.

DAME JANET: And decide to do nothing -- well they could.

A. Well they obviously could and that was one of the concerns we had when we started. In fact, we had legal advice on what our opportunities were and whether we might be, in very serious circumstances, able to go to court and seek release from obligations of client confidentiality to pass on information. That has never really happened. I mean once someone has taken the decision that they wish to discuss it with someone outside they are, particularly if it is meritorious, they are not somebody trying to find a defence to them, to their own predicament, they will pursue it. If I can give an example, it is in the employment field but it might help, is that in the City with the Financial Services Authority, obviously financial malpractice can have very serious implications and people can be worried what to do and the consequences can be serious.

The message that we gave -- even though the FSA has set up a very good policy -- is that sometimes when people phone they are heavily lent on, not just -- if somebody says, "This is the dilemma", the person on the end of the phone says, "You have to tell us the

name of the company now". Obviously it is quite difficult to deliver all that to someone who is just down a telephone line, but it can put in that case the individual employee (a) off communicating the information and (b) in a sense make them feel more intimidated. So I think that if Madam Chairman was thinking of developing a recommendation in this line that there should be somewhere, I think there would be some merit if the overriding obligation of that entity was to provide the legal advice or confidential advice to that person and it was not moving onto a -

DAME JANET: Body with a statutory duty in itself?

A. Absolutely.

MISS SWIFT: So presumably you would make the same point even if the help-line was not just a general ringing up of any concern that the public had but specifically health-related, the same reservations which you have would apply.

A. Yes. I think you could do something which was a sort of souped-up version of us, say, where or -- sorry, along our lines where the body would be able to in a sense pass the information to another appropriate authority which could then act on it, but I still feel that the sort of entry point for the -- it is better if it is the provision of confidential advice rather than straight reporting. For instance, if it is a health and safety matter, there is already the Health & Safety Executive so there is a question if someone just literally wants to phone someone to report something so it can be investigated, the avenue exists, whether the avenue -- and the avenue is, in that case, quite well promoted, I mean, most work places will have a notice in saying that. I do feel that the practical difference we made was because it was in a legal advice relationship and people knew, and very often people would say, "You know, is it safe that I can talk to you, you will not do anything about it without telling ... I can talk to someone in confidence about that", and certainly that is very important to a good number of our callers

Q. Can we just perhaps look at the position a little bit more generally now. What more in your view can be done first of all to encourage the sort of general culture of openness which you have spoken of?

A. At the moment, the legislation seems to be working well. Certainly, as I said, it works well in tribunals. Employers who deal with the issue seem to think it is in their self-interest to deal with it so that is an important way. If employers communicate the message within their workplace effectively then obviously that is spreading the message to their workforce and conceivably beyond their workforce. Quite often an increasing number of people who ring us find out about us in a sense from workplace policies and from friends of theirs or whatever.

Having said that, this sort of wider and bigger issue about the culture which I think in a way through much of the 20th century the default was if you thought something was wrong, whether it was a Shipman or something else, the default was to keep quiet, really and there were a lot of different reasons for that. That is a very ingrained culture. It will

take a generation or more to change. We are probably making more progress than we had imagined but I mean obviously the ability of a very small charity to influence a change in culture is limited. There has not really been any active promotion of this form of whistle-blowing I think. As I say, outside of the NHS there has been no active Government promotion of the whistle-blowing legislation. Odd regulators have done it, the National Health Service have done it so that is an opportunity we think is slightly missed. We think -- well, not slightly missed, we think is missed and will need to be picked up at some point. If it was possible to get the issue considered in schools I think that is probably quite an important way to do it in terms of that is the workplace of the future, to get people to think through what the consequences of silence in extreme cases can be and what dilemmas there are of raising a concern and, you know, weighing your own self-interest against the interests of your colleagues, the other people, and in a sense the innocent people who may be at risk.

Q. Can we just have a look at local Government. You did mention that there had been some initiatives in local Government and, although I do not propose to go to it, we do know that the local Government management board, the predecessor of the employers' organisation, produced a whistle-blowing policy in 1997/1998 [_WS420003^.] They have also given us information about a survey carried out last year. If we go to _WS4200014^, this was a survey of confidential reporting whistle-blowing procedures in English and Welsh Local Authorities. If we go to page _WS4200015^, can we just enlarge the top half of that, and we see that after the preamble it is expected that there is to be a Code of Conduct for local Government staff under the ethical framework. Then whistle-blowing is brought in the second paragraph tabled to raise concerns. Then there is a reference to the confidential reporting code and model policy in 1998 that is linked with the Act and then there is an explanation that the study has been carried out. If we can just scroll down, we see that the researchers make a number of recommendations for the improvement of confidential reporting procedures and some are aimed at the employers' organisation. Then there is an expression of guidance to incorporated updated advice on the issue of confidential reporting. So without looking at the detail of this survey, are there movements within local Government organisations also?

A. Yes. I mean, I think that is both from LGA (Local Government Association) -- there is a professional body called -- well, its acronym is CIP for the Chartered Institute of Public Finance Administration and they run a better governance forum and they have certainly done quite a lot of whistle-blowing. The new Standards Board also has a whistle-blowing role. So it certainly is on the agenda at local Government in the vertical sense of local Government and then obviously within the sort of childcare section, there will be particular initiatives as well, yes.

Q. You mentioned some of the larger employers with which your charity has been concerned in giving advice. Is there still a problem and a lack of awareness in small and medium-sized organisations even?

A. Yes. I mean, I think very much. We have not had the resources to do it but I suspect that the level of awareness of the legislation is probably very high if you looked at the

top, the FTSE 250 companies. Government departments varied, in Local Authorities, it will be quite high and in the Health Service I think it would probably be higher than anyone else. But I would not be remotely surprised if we went out and stopped 100 people outside the Town Hall and asked them three questions about whistle-blowing, one of which is, "was there any legislation?" it would not surprise me if an overwhelming majority did not know there was whistle-blowing protection legislation at all. There has been no promotion of it other than by us and employers in the workplace.

On the private sector -- it is relevant of where the debate is moving in terms of the accountability and governance generally -- the new Combined Code on Corporate Governance, which is a compliance with -- which is a listing, essentially a requirement for listed companies, that has just been revised over the summer and that for the first time we have the requirement on Audit Committees to oversee and review whistle-blowing policies and to ensure, there is -- I think the words are independent and proportionate investigation of concerns. So that will give a good fillip to the message in the private sector.

DAME JANET: Requiring independent investigation or appropriate?

A. If I may, Madam Chairman, can I send you exactly the text so I am not going to mislead you.

DAME JANET: Is this a successor of the Cadbury -

A. This is the great-grandchildren: so you went Cadbury, Hempal, Greenbury.

DAME JANET: It started with the Cadbury Principles on Good Governance. What happened was you may remember there was a fuss over the summer recently about the Higgs report on non-executive directors and what happened was the Financial Reporting Council amalgamated and changed the recommendations of the Higgs Report and the recommendations of what is called the Smith Report on Audit Committees and they revised those. So it is called the Combined Code on Corporate Governance. The previous one was someone called Turnbull it was known as.

MISS SWIFT: Can I just ask you briefly about one or two ideas which have been canvassed for making it easy or more attractive to whistle-blow or indeed for making it obligatory to whistle-blow and if I might start with the idea that, in the Health Service at least, there should be a duty of candour, that is a statutory duty to report concerns about patient safety, for example. What is the view of Public Concern at Work about the imposition of such a duty?

A. In the context of whistle-blowing, we are not in favour of a duty and there are probably a number of reasons for this. If what one is trying to do is create a shift in so to speak a shift in the culture, a shift in the value as to whether if you see someone else's interests being prejudiced or threatened, whether you under some moral obligation or whatever to raise that matter, it is better -- it is more likely we believe that you will

achieve a benign or a beneficial shift if you make individuals think about it, empowering them and protecting them while they exercise, that power is a means to do that because you are recognising it is their choice and it is something that you are trying to get them to think through. I think that -- for that reason I think a duty is blunt and probably is unlikely to secure the sort of cultural change that certainly we would like to see.

I think another problem with a duty is that for people who are sceptical about the way organisations are run and, in our society, many people are sceptical about many things, the introduction of a duty would probably make it more likely that when something went wrong commentators or sceptics would be saying there was a search for a scapegoat. Whenever something does go wrong, it will always be easy to show a number of people who could have done something and did not. Just from my limited understanding of what you and Madam Chairman have said today, if you looked at the context of Shipman and you said that there was someone in the District Health Authority, a health visitor who had been anxious about raising a concern but had not or a health visitor or something, then I am not sure that by putting a duty on them -- it is almost inevitable you are saying the failure to fulfil the duty means that they must be sanctioned or it is open to them to be lawfully sanctioned for not having performed that task.

Q. Are you suggesting that the effect of that, quite apart from the effect on them, might be to shift the focus when something goes wrong from the ill itself?

A. I think if I was a senior manager of a not very well-run company and something went wrong whereas I would hope in the mechanism that we have that the accountability of people would be looking at why at a senior level the thing fell down, was the information received, was it acted on, if it was not received, why was it? Was it because we turned a blind eye or a deaf ear to it and so on? I think that if you get a difficult situation where perhaps there has been loss of life or a large loss of money and there is a lot of media scrutiny for it, that the sort of society we live in now is someone in that position, if they were offered the opportunity of saying, "It was the fault of some junior member of staff who did not comply with their duty and we are now taking action against Smith" or whatever their name is, I think there would be a risk of that.

Also the issue about the duty to report, that is a general cultural thing. The issue about a duty to report is that it does slightly beg the question of a duty to report to whom, because the Public Interest Disclosure Act, because it is not a duty but a power, it recognises the different levels of accountability both of the nature of the problem and for the type and, you know, within the communities so the role of government regulators, the organisation itself and the wider community. I imagine it would be quite difficult to conceive of a duty that necessarily ran through those sort of tiers of accountability. You might have the duty which, in a sense, ran to raise it with the employer and stop there but then again that is not always going to be the most effective way of protecting the public interest if the issue is not dealt with there.

I do remember, looking at the LGA thing, there was a recommendation from the LGA that there was going to be a duty on councillors, because councillors not being employees

were not protected under the Whistle-Blowing Act -- or sorry, I think my memory is right. It was actually then suggested a duty on employees in local Government to blow the whistle, someone had proposed that and we were asked to go and see some of the officials and talk them through this. When we went through it -- I am happy to look for the paper I did for them -- they realised that a duty would probably be counterproductive.

One of the problems in the whistle-blowing area is also that as there has been a shift in the culture so that whistle-blowing is not always pejorative, some people who may not have genuine public concerns or whistle-blowing concerns will wish to portray themselves as a whistle-blower when -- I mean we do not badge it as such, we have no ownership over the term. I can imagine that if you have a difficult employee who does not get on with colleagues and perhaps does not get on with his organisation very well is that if there is a duty to report and he says there is a duty, he could make quite a lot of hay out of that by continually reporting things.

So, I mean our feeling overall is that the power -- it is still early days, but the whistle-blowing legislation seems to be working well. I have to accept that if it was fully publicised and everybody knew about it then maybe we would find out flaws in it earlier but, so far at least, it is working well and the approach is one which I think is important. It has had a buy-in by organisations, regulators and unions so there is -- and they are obviously important players in making it work and making people believe it can work.

Q. This is a slightly different point which may not be completely whistle-blowing, but I would just like to ask you for your organisation's views about it -- that there is a suggestion which has come in a paper by the Chief Medical Officer that that there should be immunity for a person reporting an adverse event and this is as part of the open culture and enabling events to be looked at and learned from. Does your organisation have any views about the offering of an immunity?

A. Yes. I mean, we did mention this. We sent it to you on our response on the Bristol Inquiry. Our view is that if someone is disclosing information (on the Bristol Report) in a sense in a way that Parliament has said is acceptable and proper and that the law recognises, then they should not be penalised because they have disclosed the information. We think there is a lot of moral hazard in going a step further and saying that not only will you be protected against reprisals for disclosing the information, if you are self-reporting your own misconduct, you will be excused any sanction for that. I think the debate has moved on. I am sure the debate will have moved on. We have not been active players in it, but certainly when we felt that that recommendation about the immunity would prove counterproductive if it was implemented -- I mean, what the public want to know is if there is a surgeon or a doctor who is presenting a risk to the public that that surgeon is in a sense removed from public operation until such time as his employers at the Trust were satisfied that he is not a risk. If I am that incompetent surgeon (perhaps I am going through a difficult divorce, perhaps I am drinking a bit much, whatever it is, maybe my Trust is merging with another Trust, I am not sure I am going to keep my post and I botch up one operation, I do not have a problem and it should be encouraged that I should self-report. That should be encouraged; that should be

a good professional practice. But if in the space of a month I seriously botch up three or four operations but by my reporting myself it means that my employer the Trust can take no action against me at all, I do not see what the public interest is there at all.

Q. Another issue that I would like to ask you about -- and you may like to just refer to the position abroad on this -- is the issue of rewards for whistle-blowers because I think it is right to say that in some jurisdictions, whistle-blowers are rewarded in monetary terms for coming forward. What is your organisation's view about that?

A. The examples where you have reward systems or legislative or sanctioned reward systems are in America and just recently Korea has followed that approach. It is primarily for cases of financial malpractice and financial malpractice where the victim of the financial malpractice is the taxpayer or the Government/taxpayer. The mechanism in the States have proved from the point of view of fiscal, good fiscal controls very effective since not just on the federal level but on the State level in America I think now 44 States now have this what is called a false claims. It is where a contractor or someone dealing with the Government submits a false claim and the whistle-blower is then able to bring a qui tam suit, so in a sense to act on behalf of to initiate a claim against their employer or ex-employer, the claim can then be taken up by the Justice Department and the whistle-blower is entitled to between 15 and 30 per cent of the sum that is recovered by the Government. So these can be enormous sums. A recent one which was very large was of I believe it was a British and German drug manufacturers had been overcharging for drugs supplied and that led to a recovery by the Federal Budget of \$400 million.

Q. One can see how in a financial setting it would be easy to ascertain what the harm has been and one can offer a proportion. Do difficulties arise where information is not of such a concrete financial nature?

A. Yes, I would imagine. So I am not aware of comparable examples where the award system is there. What you can have is systems where there is an award for the whistle-blower; in other words a sort of public honouring of what they have done and certainly -- I mean, the client who referred to in the care home sex abuse case who probably would not ever wish to be thought of as a whistle-blower at all and was a very shy and diligent person, we nominated her for an honour but I mean, that was not successful. I do think it would be desirable, where there are cases where someone has raised a concern, there is some recognition of that from a recognition from society of the value of what they have done. I think that would be helpful. I think one of the problems about rewards is it can give a mixed message. If you want a system similar to that that we developed which was to try to promote the internal accountability at the low level, it is quite difficult to see where you would be saying who would be giving the reward? The employer is free to say, "Well done, we will promote you, you know, you can have an extra week's holiday and so on", and that sort of initiative. We do encourage the employers to think about and promote to their workforce. But if you go to a reward from the public funds, I would imagine that would primarily or perhaps exclusively be given where the report was made to an authority. It would be quite difficult if it was done say to the employer because the employer, even though they would remedy the problem, the natural human instinct of the

employer would be to say, "We are glad it was raised; we sorted it out; we probably would have sorted it out anyway whistleblowing is a safety net, it is not a substitute for all the other mechanisms, and very often where the whistle-blowing is successful you do not really know whether the bad thing would have happened anyway.

Q. Can you just comment on the system that has developed in this country over the last decade when compared with other jurisdictions? Are we ahead or behind in your view in general? Do you have any comment?

A. The perception in most of the other countries who look at whistle-blowing prefer the UK approach. South Africa has legislated on this basis; Netherlands have, Japan is now legislating on the basis of the UK legislation and bear in mind that is a very different culture there so that is indicative of the legislation's attempt to address a universal human dilemma.

The American approach, in a sense, works in America, like many things work in America but are not so well exported. As you and Madam Chairman will know punitive damages, jury trials, contingency fees, when they are all put together as part of an American solution it works in a way for America but if you pick out one bit of it does not fit very easily, say, in the more balanced approach that the UK adopts to the issue. One of the differences: the American approach is much more closely based or rooted in the concept of freedom of speech, whereas when we developed the UK approach we were much more interested in looking at the institutional accountability. So it was looking at the problem in a slightly different way. I think it is true to say our American cousins think we have had much better buy-in from other stakeholders into the UK approach than they have had.

Q. I would like finally just to come on to the context of a particular case about which I know you have been told, the case of Mrs Renate Overton. If we can go to [_WD1900004^](#), you have raised a number of questions there. I think we can probably simplify the facts into we are only concerned with the activities of two consultants who were aware of the circumstances and concerned about the circumstances and not about other staff. Can I just ask you this first of all: one would imagine that when a doctor has anxieties about whether or not to voice a concern, the natural place that he or she would go for advice would be his or her medical defence organisation. Do you have telephone calls and requests for advice from doctors in that position?

A. Yes. I would slightly qualify but I think rather than rely on it I think you ought to check it with the MDU and the MPS. I think that a doctor will contact the MDU, MPS or BMA when they felt their own private interest was at risk, so in other words if they had raised a concern and it received an unwelcome response. Certainly the impression that I have had from the doctors who have communicated with us is at that point they do go quickly to the BMA or MDU, MPS, and certainly I am not aware that they view them, at that earlier stage -- that a doctor might phone up and say, "I am worried about this position in my Trust or about another doctor, what shall I do?"

Q. In fact, we do know that some of them do because that is what Dr Reynolds did before

she took her concern to the Coroner, but obviously practices may vary. It is clear from what you said that you do sometimes get overtures for doctors. What I would really like to ask you about is what you know of the culture of doctors reporting doctors back in 1994 and also the extent, if any, to which it has changed since?

A. There really wasn't very much of it that I was aware of in 1993/94. I think within the venerable professions the general view was that it was not a done thing to report another member of the profession and certainly I think if you look at complaints that the professions handled, say, in the 1980s or something, those complaints would, in a sense, be rooted -- if they were complaints between professionals -- they were rooted in personal or personality disputes between the professionals rather than a professional saying, "I am worried that another professional is presenting a danger to the public." So I think that if you went back more than a decade it was not very accepted or common practice for doctors to report even within the profession. I recollect an article I think it was by someone called Thomas Stutterford in the Times around the time the Bristol thing was coming out and talking about the culture that when he had qualified and learnt to practice that -- I mean, it has a sort of pejorative meaning now but what was then a sort of old boy network would identify if someone was not up to scratch and if they were not up to scratch, they would not end up being a surgeon, they might end up as a GP or something, that somehow or other it was in the way that the --

DAME JANET: The profession dealt with its own, in a way?

A. Absolutely.

DAME JANET: With enormous respect to Dr Stutterford, he did qualify quite a long time ago. I think he is probably the best part of 70 now, certainly well into his sixties. The particular period that I am concerned about is 1994 rather than much earlier period.

A. 1994, we definitely dealt with concerns from the Health Service. They were more likely to be concerns from nursing staff about consultants or doctors than the other way round, than doctors into doctor concerns. As you said, it may well be that they were contacting their professional bodies. The big -- as I have described, there was what was perceived in the early 1990s as a sort of culture of fear in the Health Service and I think in that BMJ article they used the phrase "Stalinist" or "Stalinism" or something. I think what happened was in about 1994/95 there were two or three, not on the scale of Shipman but still serious and significant cases. There was one in Birmingham which was the misdiagnosis of bone tumours where my recollection is that there was a consultant who had a failing eyesight and this was known that she had failing eyesight and notwithstanding her failing eyesight her colleagues let her carry on practising. The effect of her failing eyesight was she was misdiagnosing these tumours. When it was eventually found out there was naturally an outcry as to how it could become so bad. The Government and -- I think the Minister at the time was called Gerald Malone -- they produced in 1994, I think it was, or 1995, they wanted to respond to this misdiagnosis of bone tumours.

I think there had been another one about smear tests which had gone wrong and obviously the Bristol thing was just coming to public attention then. There was a review among the medical profession which was run in the Department of Health but with senior doctors on it. It was a report which came out, I think, in the summer of 1994/95 which was called "Maintaining Medical Excellence". This was a Department of Health document and I believe that this included a recommendation that doctors should report other doctors if they believed other doctors were posing a threat to patients. There was quite an outcry at the time and if my recollection is correct that even though there had been a lot of doctors on this committee coming up with the thing, that the particular recommendation which the media had picked up on and which was viewed by the medical profession then as controversial which was that doctors should be under a duty to report one another. Certainly it was alleged that that had never been discussed by the committee at all. So there was a sort of another outcry about not just the subsequent recommendation but whether in fact it had come from or been approved by the doctors who were on that committee.

Shortly after that was published, the GMC produced an attractive booklet which I imagine must have been sent to all doctors which I think was called "The Duties of a Doctor" which had -- it was a sort of folder and it had different leaflets inside, duty of maintaining 5 confidentiality; what to do if you think a doctor is posing risks to people. Certainly the reception that that received confirms or supports my assessment of the scene in 1993, 1994, 1995 that it was uncommon, not accepted and conceivably viewed as not the right thing to do to report another doctor.

Q. Do you detect a change now?

A. Yes, and I think that -- I am very sorry, the best example on all of that is, of course, [the person] who was behind the Bristol incident. He says that there are still many people in the medical profession who believe he was wrong to do what he did. I do think the culture is changing. I think it is changing partly on the back of that, I think it is on the work of this Inquiry, on what the Government have done to try and promote whistleblowing. I think perhaps more importantly there is a different generation coming through from medical school, medical teaching is different. I think that they are probably much more -- perhaps, if I had not gone into the law and become a doctor I would have been around the end of the period when a doctor had sort of semi-divine status by virtue of their profession. I think that if my daughter became a doctor now then it would not cross their mind for a moment that they were going to have a semi-divine status. Part of this consumer society has meant they are probably more open to people questioning them. They are probably a bit more concerned about the sort of bureaucracy of the structures that oversee them, that is the impression I get from people who talk to us.

MISS SWIFT: That is all I propose to ask today but I understand that we need a break for a tape change.

DAME JANET: Yes, we will have a five minute break. (3.44 pm) (Short Adjournment)

Examined by MR SPINK

MR SPINK: Mr Dehn, I ask questions on behalf of some of the families involved in the Inquiry. May I just first of all clarify quickly a point that you dealt with with Miss Swift latterly in relation to immunity for those who report their own misconduct. You suggested in your answer that you dealt with it in the documentation you had supplied. I think it is at _WD1900146^ under the heading "Sentinel Events"; is that right?

A. Yes.

Q. This is part of the exchange of correspondence and other documentation between you and the Inquiry at Bristol regarding the recommendations that they have made and that in those two paragraphs under that heading I think if I understood what you said in your oral evidence, you were there seeing saying what you have written here in these two paragraphs. You have expressed the same concern here, I think, that you were expressing in your oral evidence just now; is that right?

A. Yes.

Q. Just for clarification, you said events have moved on, the debate has moved on, but is your view still the same as that expressed in the document?

A. Yes. We think that a duty to report will in practice prove more problematic.

Q. This does not quite go to that point. This goes to the issue of immunity.

A. Yes.

Q. So although the debate has moved on, you remain of the same view?

A. The most important thing is that if someone is reasonably perceived to present a risk to patients in the context of the Health Service, then I can -- we can see no reason why that person should be able to sort of put up a ring of -- an electro-magnetic ring around them and say, "You cannot touch me because I reported myself". The only relevant criteria should be: is the employer or the Health Service satisfied that the person is not posing an undue risk and if they cannot say tick that box, then they should be asking the person not to practice until such time as they can tick it.

Q. I make it clear I was not challenging the validity of that view; I was checking if it remained the same. May I move on to take up the theme introduced by Miss Swift about the position of the receptionist in a small general practice. In your answers to her questions, you dealt I think mostly with the practicalities, the difficulties of drawing up an in-practice whistle-blowing policy. What I want to ask you about is the other side of it which is the protection that might be afforded to a receptionist under the Act.

I wonder if I might briefly ask you to help me navigate through the Act there and see if it might apply by starting at SP9801002, section 43C. I have jumped straight to there because this is the case not of, for example, the taxi driver who was not anyone's employer for these purposes, but an example of someone who was /is employed by the practice not by the Health Authority.

A. Yes.

Q. Obviously the first tier qualifying disclosure, to use terminology you have used, is the section 43C tier which, if the concern is a serious one of the sort that might have occurred perhaps to a receptionist working for Shipman, is not practicable so we have to move on from there to see where that receptionist might be able to raise his or her concerns and get the protection of the Act. If we move on to 43E, correct me if I am wrong, there the difficulty is that the receptionist is not an employee of the Crown and therefore cannot avail herself or himself of section 43E.

DAME JANET: Can we go to 43EF, please.

MR SPINK: Sorry, it is the next page (SP9801003).

A. Yes, I think that is a very good point. I think that even though the Department of Health have moved and if there is responsibility for it, it probably rests with us rather than them having to try and provide comparable protection across the Health Service for the reasons that you are pointing to, in this situation Shipman is the employer, Shipman is not appointed under an enactment and is definitely not a body so 43E is not. So that option which would reply for, say, someone working in a Trust, which would exist the option of going to the minister is not readily there. So that is a very fair point.

Q. I should emphasise I am not in any way seeking to draw you into giving any definitive opinions into what effectively is a matter of law. This is a conversation to see what arises. It may be on reflection by many of us a different solution might appear, but that at first blush appears to me to be the position. It focuses on the employment status of the worker who is bringing the complaint.

A. Yes.

Q. Similarly, if we move on to the next tier, 43F, the list of prescribed persons may have no relevance to this situation, in particular notwithstanding the reservation you expressed about the desirability of going to the GMC, the fact the GMC is not a prescribed person, therefore section 43F simply does not apply. We are left it seems -

A. Can I interject because I think you are making a very, very good point which I had not been aware of and it clearly does need addressing and that is that because of 43E providing or the ready protection of going to the Department, the view as I understand it in the Department of Health is that that is the means that the minister -- the Secretary of State, so to speak -- says that for the purposes of 43E he is happy to treat a disclosure to

the NPSA or to CHI as a disclosure to him, so in the sense that he might delegate to his officials because they come within the body of the Department of Health. So in fact there is not a health regulator that is actually prescribed. Now, for the reasons that you have identified, it does mean that there is a hole in the situation in primary care because essentially all that the employee is being left with is going to the employer or 43G protection.

Q. To which I shall come in a moment, if I may. Of course, we can draw the distinction at this point between a situation of the receptionist and on the other hand there is the position of the district nurse working within the practice who is employed by the PCT or may be and thus has the protection of section 43E.

A. Yes.

Q. If we then do move to section 43G, you made a comment earlier in your evidence that of course a disclosure to the GMC might well attract protection under section 43G and one can see how that might be but of course the difficulty with the receptionist is that he or she needs to reasonably believe that the allegation is substantially true; whereas under the first tier all that they would need to reasonably believe is that the information tends to show. That is, I would suggest, a difficulty quite apart from the minefield that would be presented to a potential receptionist who wants to bring this information to light of working her way or his way through section 43G even with your help

A. No, I agree entirely and I am very grateful for this because if you take that precise example, probably the first thing you can say is that PIDA is unwieldy in providing its protection. It has a lot of holes there. So that individual they cannot raise it with even if it is not just a sole practitioner. If it is a joint practice the ability perhaps of raising it with a joint practitioner is limited, they are not given the ministerial route. For technical reasons there is not a regulator prescribed although that could perhaps be quite easily remedied, but not really in a Shipman-style case which leaves them with 43G which is in a sense onerous and much more difficult for them to invoke that. So it is a very fair point, thank you.

Q. There is technical difficulty with 43G as well which is perhaps less important is that indeed for it to apply at all one has to go through subsection 2, there must be a reasonable belief that he or she will be subjected to a detriment by the employer. That may or may not apply. The employer, I suppose, might simply be indifferent.

A. Sorry, in the example of the Shipman case presumably that is -- the reason she would not be going to Shipman is because if she went to Shipman and said "I am worried that so many of our patients are dying, are you killing them" -

Q. Plainly in Shipman's case that is so, but there may be examples of concerns that fall well short of that about something that he is doing within the practice that he might not act to the detriment of the receptionist if she brought it to his attention, he might simply ignore her and similarly he might take no steps to destroy or conceal evidence. Then of

course the only way round it would be for her to bring it to his attention once; if nothing happened do it again under (c) and then at least section 43G would appear to be invoked?

A. She only had to do it once under 43C and certainly the decision from the EAT is making this clear. It is not you have to exhaust your employer's whistle-blowing policy or anything like that at all; it is that you have raised it with someone in a position senior to you in your workplace and you are not satisfied by their response and then you chance your luck on -- in a sense (a) on the wider disclosure and then were you to be victimised for the wider disclosure, the issue then is for the Tribunal decide why the disclosure was unreasonable, but you do come within the trigger of C.

Q. But you would have had to have tried to raise it with your own employer, that is the point?

Yes, but I mean -- I think I am very happy to consider this again but if you factor in the 43H exceptionally serious and put that in as a fourth trigger in 43G(ii), I think that is probably the correct test. I mean, it is not going to meet every circumstance and obviously the situation for your clients is particularly grievous. Overall I think that if you have the four in there, if it is exceptionally serious they can go straight outside and makes a wider disclosure. If they are worried they are going to be victimised they can make a wider disclosure. If they are worried there is going to be a cover-up they can make a wider disclosure and if they do not feel the initial response is reasonable, I think those are probably the correct -- I think the problem is if one was to introduce another window or another door in the context of this sort of legislation, what it is trying -- the culture is trying to create, you would in fact undermine the other windows but -

Q. I think I prefaced my question by saying it perhaps was more technical and less important than the first point I was making which I think we are in agreement about?

A. Absolutely, yes.

Q. May I move on from that situation, please --

DAME JANET: I do have some residual concerns and interests as to whether 43E might possibly apply because the PCT -- on the basis of a report to the doctor about -- because the PCT is admitting the doctor for the list. We are talking now about a GMS contract rather than a PMS contract and the position might be different in respect of a PMS contract, but if you had a GMS contract, the PCT might be said to have appointed to the list or admitted to the list, which might equal appointment, under a power given by the Secretary of State.

MR SPINK: And the others that the GP would fall within 43A(i) as an individual appointed under enactment of the Minister of the Crown.

DAME JANET: It is not clear, I agree, but it is just a possibility but I was wondering how the remedy would work because normally if the GP dismissed it, it would be the GP that

had to pay the compensation but if the protection -- well, I do not know. If the protection was within the Act because the report was made to the PCT, that might suffice.

MR SPINK: I think perhaps the fallback position, Madam Chairman, that one might state is the lack of clarity is unfortunate in this particular situation for the purposes of, for example, Mr Dehn's charity giving advice.

DAME JANET: -- to one of the receptionists that may have telephoned.

MR SPINK: The mere fact we have had this debate over five minutes is indicative of that difficulty.

DAME JANET: I agree.

A. If I may, one possibility would be to say to use the fact that the extension to self-employed people in the NHS in 43K and to insert that -

DAME JANET: Can we go down to 43K, please. MR SPINK: It is SP9801005.

A. It says if someone works -- so they are treated as a worker -- if they worked in the NHS in a sense in a self-employed capacity, but from the context of dealing at least in the context of the Health Service by maybe you could have a cross referral to 43K(c) and putting that in 43E, so making it clear that in fact where you worked for someone who was be it a dentist or a doctor that then a disclosure to the Department of Health would come within 43E and that would be one way of doing it. That would catch it.

DAME JANET: That would cover the point, yes.

A. The reason, as you have rightly said, Madam Chairman, it means if I work in a sense for -- If you were the practitioner and I worked for you and I in fact end up making the disclosure to the Department of Health or perhaps to the PCT, that in the end the Act is only triggered where there is a reprisal. So in a sense it is where you dismiss me. What one would hope is that where it was bona fide or proper disclosure and recognised as such, that you would recognise in a sense of yourself that though it was unwelcome and you would rather I had done it in a better way that it was perhaps better than I raised it than not at all, and the other thing is that there would be influence from the point of view of the PCT in their ability to influence -

DAME JANET: The way in which the doctor --

A. -- would respond to it. We have had cases in primary care where this sort of situation has arisen and both in primary care and in care itself and what we have found as a practical thing is that the influence of the PCT or the Social Services Inspectorate or -- sorry, not Social Services, the Local Authority equivalent is quite considerable. Even if the relationship in the example I gave would become unworkable between you and me, that one of the options is that we have found that the regulator who had received the

report will use their good offices to find me work somewhere else in the vicinity and there will be other homes which had been regulated or other -- you know, they can just say this person is okay.

DAME JANET: Other practices into which the practices into which the receptionist might be moved.

A. Yes, there was a misunderstanding there, good, and that is a helpful way.

MR SPINK: Moving briefly to the private sector, if one takes as an example the long-standing receptionist to a private general practitioner in Harley Street who is concerned, to take an example from our last phase at potential misprescribing of controlled drugs on private prescriptions, am I right in understanding that the only real route to obtaining PIDA protection is via the section 43G disclosure?

A. Yes, that would be certainly -- another way of remedying the problem you and Madam Chairman have identified would be to say that the health regulators or a key health regulator should be prescribed under 43F which would then be -- it would apply whether or not it was a National Health Service doctor or not. The relevance there would be or the important point there would be that whatever the regulator was, that the regulator had power over the private sector as well.

Q. Because simple mischief is the hurdle over which they have to get in terms of their level of belief in order to invoke that section and that I would suggest is a potential deterrent.

A. Yes, I am very grateful.

Q. May I move on from that to a few miscellaneous matters, Mr Dehn, please. Your sample policy which is at _WD1900091^ I apologise if I have missed this, but are you able to date this for us?

A. If this is the NHS one, that would have gone in the policy pack that was distributed in I think 5 August/September 1999. So about two months after the Act came into force.

Q. Is that still your current NHS whistle-blowing model?

A. I think it has been amended slightly but it is essentially -- if you got a copy of the CD ROM -- the policy pack on the CD ROM which has recently been distributed, it is likely there are some modest changes.

Q. I receive that this morning so I am still working from this one attached to your documentation.

A. I think the thrust of it -- certainly I welcome any comments you have but -- I mean, there have been changes but I suspect they are modest and more of a drafting than a fundamental revision.

Q. I will not take up time on that now. May I ask you briefly about the help-line results at _WD1900062^ which you dealt with Miss Swift. This is NHS and private, is it?

A. Yes. We get a very small number of private. I would be surprised if it was more than -
- I would be very surprised if it was approaching 5 per cent to be perfectly honest.

Q. Are you able to give us one concrete example of a private -

A. Oh, yes -

Q. -- brought by whom?

A. In fact ... I think this is pertinent to the sample that you are just giving. It was a dispute between -- it was to do with one of those plastic surgery clinics which I am pretty certain was private and if my recollection serves me correctly, there was a sort of a turf war between two clinics and there was certainly someone who worked for one of them who I think was poached to go and work for the other one or something like that. Anyway, someone was seeking advice from a whistle-blowing point of view on that. It certainly was not a straightforward whistle-blowing arrow case, it was somewhat confused but it was a private clinic doing plastic surgery. Also we have had -- certainly from at least one -- a private hospital, someone who had been an NHS nurse who was then were working a private hospital, had a concern in the private hospital and remembered us from when she was in the NHS and wanted to know what options there were in the private hospital she was in.

Q. Very briefly, the nature of the advice you give in a situation like that is to do what?

A. The -

Q. Go through the private hospital whistle-blowing policy?

A. The likelihood is it will not have one. The first thing is to assess from the client what the concern is, what evidence they have to support it, how urgent they think it is, what they think should be done about the concern, what they view as the options as to whether there are any to raise it at a local level because very often they just do not know if there is anyone, and they want confirmation that it is right to raise it or how to raise it. It is not that they have taken the decision that the information is bound to be unwelcome in their workplace before they phone us, and then to identify with them in a sense what they are hoping to achieve if they are on their own whether they have colleagues who might share that concern.

Q. There is no standing answer to the question is: to who do I take this concern in the

private hospital context; it will depend entirely on the circumstances of each individual case?

A. Yes, but that is also the same within an NHS one. I mean, we would indeed end -- I think very often the dilemma someone has is that they have a concern, the concern relates to someone in a sense to whom -- sorry, my English is going to escape me anyway -- whom they work closely with and it is more about the manner. They do not know how to broach that at the local level, very often they are content to raise it within or just around the team but they do not actually know how to do it and they are worried that there may be some reprisal or repercussion.

Q. So the absence of a whistle-blowing policy as such does not necessarily preclude you to helping them find a solution to that problem?

A. No, not at all.

Q. Do you have any idea why 50 per cent of staff do not know that a Trust has a whistle-blowing policy? Have you done any research on it?

A. No, not beyond this UNISON survey. I mean, there are some Trusts who have a sort of bought into the idea and promoted it and trained people and discussed it and said and I believe there's a Trust in Manchester I seem to collect which came up with some very good promotional material themselves. I think there are other Trusts where it is possible they have done nothing at all. I think real issue is about promoting it as to whether people are aware of it. As I said to Madam Chairman or Caroline Swift I suspect it is more likely that most -- I would imagine perhaps 80 as a guess 80 is it -- is it 85 per cent of Trusts will have a whistle-blowing policy but for many it will never have really been promoted to the workforce at all. There will not be -- it will be a policy in a drawer which when something goes wrong, you will pull it out and try and find out what ought to have happened. It is not something which people are reminded of in advance. It is possible that the figures here are slightly skewed because as I was indicating earlier, the recent moves in the NHS have been to emphasis whistle-blowing as part of clinical governance, and it is possible that the UNISON members who on the whole would be blue collar or nursing staff may not be perceived -- I do not know, may not be perceived as having an integral role to play within clinical governance and to that extent, if the survey had been of BMA members, the awareness of a whistle-blowing policy might have been higher.

Q. It would seem there have been over the last ten years a series of initiatives, 1993, 1999 and now again this summer and there was plainly a perceived need this year to reinforce the message to the Trusts.

A. Yes.

Q. Suggesting there had been perhaps a degree of inertia since the Health Service circular of 1999. There was plainly a need to do something about it?

A. Yes, we had made the point that there needed to be a proper follow-up. This is an observation: the impression I get even though there was a binding and sort of genuine commitment at a senior level of the Department of Health, some of the cases posed quite difficult problems for what the structure of the Health Service was. So in other words, although you had a message coming out from Richmond House saying: you must introduce a whistle-blowing policy and not victimise people who raise it -- that obviously there are a million employees, people performing all sorts of different roles and at that stage there were 450 and now with PCTs there are probably 1,200, 1,400 different Trusts with different leaders and different ways of doing things, which in my view is a good thing, not a bad thing with plurality, but it means that where someone was invoking the whistle-blowing thing and would go to -- for instance, might write to Alan Milburn or write to a Government minister or something that actually the ability of the Government ministers to intervene was very greatly circumscribed because the Trust, each Trust was obviously a separate legal entity. The Trust would often say: we have received legal advice that we are right to suspend Consultant X or to take particular action and to in a sense defend their decision. The individual would be arguing that it was all grossly unfair.

The actual structure of the Health Service I think within what the structure is, they have done probably as well as one could have hoped in terms of pushing the message out, I think if they promote. I mean, I would like them to promote (a) the whistle-blowing posters as in the policy pack much more actively. They have only just started. I think it should not be one or two to each Trust. I think there should be 20 or something. I think they ought to make sure people have access to confidential advice whether it be from us or from some other independent body I do not mind, but they ought to make access to that sort of advice readily available and easily accessible at the point that someone has the concern, rather than two months afterwards when it has all gone wrong.

Q. Rather than simply pushing a message out from the centre, time and again, is there nothing more proactive that could be done to require Trusts to take steps to introduce proper whistle-blowing policies on your understanding of the position?

A. Yes, they certainly can require -- I believe there is a thing called a Secretary of State's Direction that can have a greater force than this. Essentially there is a requirement -- the requirement at the moment is "should have" rather than "must have".

Q. Is it the position that we have not reached the stage so far as the Health Service is concerned of having to say "must have"?

A. The impression and you and Madam Chairman and I think everyone here will be much closer to the 6 machinations and ebb and flow -

Q. I am looking at it from your perspective?

A. From my perspective, there is a move away from a central command control. I think that is probably a good thing from the point of view of getting the message across on a

local level. If there is a way that a Trust -- But I definitely I think ... it's not speculation. All the evidence is that the Trusts that do have whistle-blowing policies -- it works well, it is not that they get a whole series of rubbish cases. On this, if I may say so, one of the interesting things is, if you think how high profile whistle-blowing was prior to the implementation of the Act, one would have expected after implementation there to be a good number of high profile and quite serious whistle-blowing issues that might come about through someone having been victimised, for having raised them and becoming a PIDA claim. That is not what the evidence has been. We are now four years after the Act has been enforced.

The most high profile NHS case is the Tribunal is I understand will issue its decision soon but is actually about a finance director who was dismissed, he claims because he passed on the concern of a junior member of staff that waiting lists figures had been manipulated. The junior member of staff is still employed in the Trust. So I mean, that is the most high profile NHS whistle-blowing case legislation in four years not about patient safety and not where the whistle-blower is a junior person, which one might normally expect, but where it is a finance director who says he has been traduced for spurious reasons.

Q. On that topic would you look at WP1800022^ . This is part of an exhibit to a statement from Dr Panton(?) who is the Communications and Policy Director of the NPS, who is going to give evidence later and he is attaching to his statement a publication in which under the heading "Whistle-Blowing Open to Inspection", I should tell you that this is the MPS casebook dated summer 2000 -- so three years ago. You can see there is reference to your organisation, Public Concern at Work, and to the fact as we get to the right-hand side of the page: "Three cases have so far been heard at Tribunals -- none of them involving the NHS, although several such claims are pending. Whistle-blowers have scored 100 per cent success rate in three cases." In the three years since this article was written, have in fact the number of NHS claims gone through the tribunals?

A. Yes and they are attached certainly the one that were reported they are attached I think -

Q. To your statement?

A. I think it is to the UNISON survey actually on the back of them. One of them is a media disclosure which was protected and in that case the Trust held that -- sorry, the Tribunal held that even the Trust had a whistle-blowing policy, the individual employee would have been unaware of it because it had not been promoted and therefore the Tribunal felt there was no -- it but it is not that every whistle-blower is going to be at all meritorious or everything they blow the whistle on will be of -- you know, necessarily in the public interest.

One of the examples was a consultant who blew the whistle on the fact that a psychiatric nurse who was a nun was visiting patients in the community wearing her habit and the consultant was claiming that this was a danger to the patients and then the consultant,

having unsuccessfully persuaded her employers that there was any such danger at all, went to the national newspapers and said that it was a matter of entirely her own public decision as to what was or was not in the public decision(sic). She was dismissed, perhaps not surprisingly in the circumstances, but then brought a claim and lost it -- so, you know, and not surprisingly was not reasonable to have expected the employee to follow it.

Q. There are two parts to which I do not need to take you, but there is part of your documentation and also part of the UNISON documentation that does set out a number of legal decisions. That is correct.

A. You know from the legal decisions, it is important -- I am sure you will not lose sight of it -- either.

Q. We do not need to look at it but for the reference, the transcript is _WD1900117^ where the cases are listed.

A. On the piece you have on the screen here, this was the thing I was referring to Madam Chairman I think it was this morning when Caroline Swift asked us about our policy work. This is an important issue in the context of -- certainly for us in the context of the legislation and trying to prevent the malpractice because when it talks about whistle-blowing open to inspection because in as much as -- the victory was initially short-lived. We are keen and fairly confident that the loss we then suffered reversed but when these regulations were passed, which meant that all Tribunal claims were secret, if you imagine the scenario -- and if I may without any disrespect to your clients, but if the situation were that the legislation had been enforced, that there had been a receptionist of Shipman's who was worried about what Shipman was doing and had asked pertinent questions of him and he had then dismissed her on the basis that, you know, either her work was not very good or whatever, but she felt fairly adamant it was because she had been probing him on the mortality rates or something, if she then went to your lawyer and brought a PIDA claim as she would be able to do, I would imagine that someone like Shipman would rather than fight the case in the Tribunal and run the risk of drawing attention to what he was doing, he would wish to settle the claim with her.

In that scenario, if he did that, obviously purely on financial terms, the effect of these regulations would mean that that information would be kept secret. All people in Hyde or anyone else would know at best is that there is a Register in Bury St Edmunds that would say: Jean Brown v H Shipman, Manchester Tribunal, PIDA and that would be all the public information. The only way that one could then hope that that receptionist might pursue the matter would be to take advantage of the provisions in 43J of the Act which would enable a further disclosure if there was an appropriate regulator or to the media.

A. But the reality of the situation is that if a human being has raised a concern such as that at a local level, has then lost their job over it, has then gone to a Tribunal and all the stress and anxiety of doing that and then perhaps the cost as well and has then settled the case, the likelihood that human being will then find renewed energy to make a further

disclosure outside is very small even though it might be lawful for them to do it.

Q. But that is the current position?

A. It is the current position and as I say we have a complaint to the Ombudsman about it and we hope that there will be a finding that the regulations were borne of maladministration which will then pressure the DTI to re-examine the fundamental issue.

Q. It may be something the Inquiry will give some thought to as well.

DAME JANET: Can you off the top of your head give to me the name of the regulation?

A. It is the Employment Tribunal Register ... I am very happy to supply you the -- exactly what happened and without much difficulty, I can give you the complaint -- the ombudsman which has all the sequential information on.

MR SPINK: My last question is this. We dealt with the position of the receptionist who at least has a way in to the Act. The position of the taxi driver from whom we are going to hear tomorrow is that he does not. As things stand at the moment, is your organisation involved in any form of consultation or consideration about the widening of the scope of the Act to cover non-employees?

A. As I believe I mentioned this morning, originally when we developed it, it was not restricted to employees it was in a sense creating a statutory tort but it was more closely connected to the breach of confidence so that -- it is not necessarily that helpful because obviously the taxi driver would not be under -- I do not believe he would be under an obligation of confidentiality in respect of that so perhaps that is not that helpful.

Q. I mean, there is no ongoing discussion with your organisation at the moment?

A. About a wider -

Q. About a wider act?

A. Ability or ... we had been approached by certainly some -- we are approached and recommendations made. We are likely to review the Act next year when it will have been in force for five years and to consult with all the relevant players on that. I have received or we have received correspondence in fact from doctors suggesting that the Act be extended in the way that you are talking about, not on the basis of the work of this Inquiry, but as briefly as I can in the way that some Trusts and doctors operate is that the doctor can be employed, for instance, by a teaching hospital or by a university, but working in the hospital and -

DAME JANET: So there is a related problem to the one that has been identified today? It is not the same but it is similar.

A. There is a potential -- If I may say, the one that has been identified today I think is more substantial.

MR SPINK: Thank you very much.

Examined by MR ECCLES

MR ECCLES: I appear on behalf of Tameside and Glossop PCT, prior to that the West Pennine Health Authority. Can I take you to page 4 of your statement; that is _WD1900004^, please. At the top of that page you see the heading "The Case of Mrs Renate Overton". You say basically you will be happy to comment on the case and you give various factors and your A, B and C; do you see that?

A. Mmm.

Q. Below that, you say this: "Our comments are for this reason depending on the facts the Inquiry found. As to the general climate at that time in the NHS, it was dominated by a perceived culture of fear." When you gave evidence, and I think this is about page 145/146 of the transcripts, Dame Janet specifically addressed your attention to 1994 because Shipman injured Mrs Overton on 18th February 1994 and she died of those injuries effectively 15 months later. You said at that time your organisation was getting a number of complaints, a number of incidents related by nurses about consultants.

A. Yes.

Q. That rather indicates not actually a climate of fear, but that a lot of nurses were able to contact you and blow the whistle if they felt it appropriate?

A. No and I think if I may say, if you are saying the date is February 1994, we officially launched in October 1993 so there is not a great passage of time in between. Certainly the nurses who and it particularly strikes me of one of the nurses who worked in XXXX at a Trust hospital and indeed I think may have been a XXXX rep, so it was not an ordinary employee not knowing their way around at all who was very concerned about the competence of a surgeon -- not just he himself, but his colleagues as well. They were terribly concerned that if they raised what their concerns were that they would lose their jobs. So the mere fact that someone sought advice from us is not evidence that they felt it was safe and proper to raise concerns within the Health Service. Certainly in that case to the best of my knowledge, it took them the best part of 6 to 12 months before they were formally prepared to raise the matter at a senior level in their Trust because they were so worried and I think they may have asked us to write to the Trust first on their behalf.

Q. Let me take you to the next sentence in this paragraph. You said: "The climate was dominated by a culture of fear. On one occasion, I recall one time I appeared on a news programme and two nurses came on with stockings over their head in the same way as a terrorist might appear. It was said this was necessary because they feared reprisals".

A. Yes.

Q. We asked you through my solicitor for a little information I will read this so you know I am not deceiving you as to what we know. The letter has come back. It is written by Henry Palin, the Solicitor to the Inquiry. It has not been scanned in, Madam Chairman: "We have spoken to Mr Dehn and he has provided us with some further information. The programme was Newsnight, it occurred in 1993/1994 and was filmed in XXXX. Mr Dehn is not certain that the two people in question were actually nurses as opposed to people [persons I should say] in nurse's uniforms. He believes the whole thing was related to an incident that had occurred in the XXXX area around the time involving a Matron that had attracted media attention." Did it actually involve somebody in the NHS or was it, for example, in a nursing home?

A. Sorry, there is one bit where whoever has transcribed that -- I have no reason to doubt that they were nurses and they were -- I am sure you can approach BBC Newsnight and ask them and get a copy of it. What happened was they -- as probably you still see today, they have these sort of discussions on the state of the Health Service or whatever it was and for reasons to do with internal BBC politics, they decided to have this -- they needed something outside of London and they decided to take -- there were 12 of us all sent down from London anyway almost all of us were Londoners anyway for live studio discussion in XXXX. What had happened was a matron at a hospital which I believe was called XXXX Hospital who had been in the way when I was a child what one would call an old fashioned matron, very much in control of the ward, well respected by the patients, well respected by her colleagues, she had had a falling-out with the new management or whatever the management of -- I think it is called XXXX Trust and she had -- I think what happened was it was possible that there had been a change in the rules or the regulations about prescribing drugs or something or other which she had objected to, but somehow or other the Trust had failed to be a better use of nurses' time or the administrators' time -

DAME JANET: Just hold on a minute. Mr Eccles, where is all this taking us?

MR ECCLES: I was concerned as to how accurate the story was. I was not wanting to hear the whole story. Can I ask it this way -

A. They are NHS nurses. They were -- unless the BBC is totally unreliable. There were two women who came in -

Q. Can I ask you my point. The term "matron" is something that went out of use in the Health Service I think probably in the 1970s?

A. I said like a matron.

DAME JANET: Yes.

MR ECCLES: I understand that. But you are saying --

DAME JANET: Senior nursing officer.

A. Can I make the point -- I am not saying because I think you may be reading more into what I am saying than what I meant. There were including XXXX, he was one of the people in the audience. He was meant to be discussing the climate of fear in the health service, which I did not have a problem about discussing in a studio audience with 12 of us sitting on a podium. Completely unaware of this, across the studio, a sort of partition moves and there are two people dressed in nurses' uniforms, stockings over their heads and the BBC starts a thing with them saying how scared they are to say anything at all. I am not saying that that was an accurate portrayal of what the state was, but the way it was --

DAME JANET: That is enough!

MR ECCLES: I understand that point. I am not taking that point any further. To finish what I want to ask you is this: are you saying that the approach of the NHS has changed markedly within the last ten years or so.

A. Yes, it has become much better. The only thing I might add is that that might conceivably have fed in and it was this difference between protest whistle-blowing and watchdog whistle-blowing -- was that 12 years ago or something like that -- I believe it was near XXXX, there was a mixed case of protest and watchdog whistle-blowing of a nurse called XXXX which received a degree of notoriety. It ended up going to an employment tribunal -

Q. That was at least ten years ago somewhere in the XXXX?

A. All I am saying is that people talk about it down in London and they talk about it here. Very often this was about the way things were misperceived.

I do not want to take you to the document because we have seen it a time or two on the screen. It is this. It is a document which says 90 per cent of people with a concern in the NHS have reported it. Only 50 per cent have employed a whistle-blowing policy.

DAME JANET: But the 90 per cent of people with concerns -- it might have only been saying there might only be 20 per cent of people with concerns.

MR ECCLES: Indeed. It rather indicates, does it not, Mr Dehn, that even if people do not know there is a formal policy, the culture has changed in that it looks as if some people are recording incidents without knowing there is a formal mechanism for doing it.

A. It is possible that that was the case and I am not for a moment suggesting that if a Trust does not have a policy it means no-one reports anything even to their line manager, that would be ludicrous. I mean, I think one can go back and look at the figures and ask a statistician to number-crunch them. But I think -- I mean, the really important thing is that on this point of the change in culture, I do not believe that if you had asked the

question if you had a concern about patient safety in the last three years, did you raise it and one had asked that question in 1994, that you would get a response of those who said they had a concern that 90 per cent had raised it.

DAME JANET: Mr Pittaway, I do apologise for not having noticed your presence in the chamber earlier this morning when I was asking if anybody else wanted to speak.

Examined by MR PITTAWAY

MR PITTAWAY: I had nothing to ask, thank you very much.

Mr Dehn, I appear on behalf of Drs Brown and Husaini. I am not going to ask you any questions about Mrs Overton; I only want to take up a point really in the expectation that it might assist the Inquiry as to the Act that Mr Spink was referring you to. It is about the drafting of the Act. This was a Private Members' Bill, was it?

A. Yes.

Q. Were you closely involved in the drafting of the Act?

A. Yes.

Q. Could you then perhaps assist us because Mr Spink has highlighted that in 43B it says "tend to show" and then by my calculations on four other occasions on 43C it refers to "reasonably believes", 43F it refers to "reasonably believes" and 43G it refers to, "reasonably believes" and then in 43H it refers to, "reasonably believes?"

A. Yes.

Q. Did you consider or did the drafters of the Act consider that instead of using the expression of "reasonable belief", the expression should be one of reasonable suspicion?

A. Yes. Can I first of all clarify. The Act was, as all Acts of Parliament -- although we were more closely involved in the sort of scope and content of it than anything else, the drafting of this Act was drafted by Parliamentary Counsel and instructed by the DTI; that was what the arrangement was. We had a great deal of influence over that and I can answer your questions, but I do not want you to think that I am not good enough to draft this sort of thing. On the detail, yes, reasonable suspicion was what we -- I am fairly certain it was what we suggested but within -- there was quite a lot of toing and froing within the DTI at the time. I mean, it is worth -- for sort of historical -- or to understand the toing and froing is that the same DTI officials from the Employment Rights Unit who had been instructed to oppose the earlier version of the Bill which we had drafted were then within a few days of the 1997 election -- were then being told that they had to work with us on the same Bill which for the previous sort of 12/18 months they had been saying was unworkable. So that put them in a difficult position to begin with and I think there were arguments perhaps over things like whether it should be reasonable suspicion

or reasonable belief -

Q. You may or may not be aware that in other areas of the law (for instance, so far as police officers are concerned) with grounds for arrest it is reasonable suspicion -

A. Yes.

Q. -- and not reasonable belief.

A. Well, we have said that -- I think we made the point in our submission to the Bristol Inquiry after Queen's Counsel had responded from that Inquiry -- and this is in the papers as well -- we counter-responded and said that we would rather and we would support any amendment that reasonable belief information tends to show became reason suspicion, but that our view was that -- you know, actually going back to Parliament at this stage and saying they had to amend a piece of legislation on that basis was probably not that wise.

Q. I think the point is made that if reasonable suspicion was the test that was used, then it would at least need some of the objections that Mr Spink has raised so far as the receptionist is concerned?

A. I think the way the tribunals are interpreting 43C, so this test, they are interpreting it, they are equating it with reasonable suspicion. So I think it is more the way that --

DAME JANET: That is the tends to show.

A. The reasonable belief it tends to show. The totality of that, reasonable belief, the information --

DAME JANET: That is the lower one. I think Mr Pittaway is concerned about the higher test.

MR PITTAWAY: What I am concerned about is if you look at the wording of the higher Act you make a very large leap from tending to show to reasonable belief, which is then used throughout the remaining provisions which Miss Swift took us through in your evidence today.

A. I apologise. So on 43C I am saying that there is this equivalence

DAME JANET: So you say that the courts and perhaps the employment tribunals are interpreting 43C as reasonable suspicion --

A. As equivalent to reasonable suspicion to them.

DAME JANET: But of course they cannot do the same for F, G and H.

A. The policy reasons were that because the Act was not requiring people to raise the matter internally, it was whether what you started with was a level and you said whether or not if you have a concern it does not matter whether you raise it with your employer or with an outside regulatory body that they should be treated as an equivalent and the choice is entirely yours. In practical terms that -- from the experience of our helpline that threw up problems because as I indicated this morning, one of the responses from the regulators when they get that information is to tell the employer: we have this information in; what the is your comment on it? So it is an odd way -- say if you are a solicitor, within your solicitor's practice, the way that you would find out that a secretary or junior partner or junior solicitor had a problem was because they had gone to the Law Society, the Law Society sent the letter to you and said what do you think about it? You would think: what a strange way of communicating; it is not the way I want my practice to run. So there is a separate tiered level in a sense -- to encourage people if they could to raise it internally but to make it clear that if they had any evidence to substantiate their concern, then they would protect it if they went to an outside regulator and the interesting thing under the Act so far is that the people who have gone outside to outside regulators have all been very readily protected by the tribunals.

MR PITTAWAY: Final question: do you remain of the opinion that you expressed to the Bristol Inquiry that the Act would be more suitably phrased if where it said "reasonable belief" it said "reasonable suspicion"?

A. I would love to answer it as briefly as you have said but that is with respect to 43C and I do agree with that. If the point you are raising is why is it that there is a higher hurdle for an employee to be protected for going beyond their employer, I think there are -- I am not saying it is perfect -- I think there are legitimate policy reasons for that. I definitely think my recollection is they were important for securing the support or buy-in of employers' groups and other groups who believed that in a sense that the idea of encouraging people to raise concerns would turn into something which they felt very happy with and the structure of the Act was something which allowed them to help them to do that.

Q. So you are for it on 43C and equivocal on the other references?

A. I think the -- I think that if someone has a genuine concern about wrongdoing, the test ought to be as you have said and I have said the practical equivalence for raising it with your employer or under 43E with the minister, I would rather it was expressed as "reasonable suspicion". That is what I think it means. In terms of going to a regulator or wider outside, I think the test isn't -- I think there are valid reasons why there should be a slightly higher threshold to go to a regulator. The words of the legislation I think are perhaps a bit convoluted -- they are not convoluted; they are not as readily understandable to the man in the street. It is reasonable belief in the substantial truth of the information and of any allegation contained in it. That is not normal speak in the workplace. The idea of having a slightly higher hurdle I think is probably correct and I would still support that. As I say, the way that the tribunals in the EAT have applied that test for the wider disclosure has not given us any cause for concern at all.

MR PITTAWAY: Thank you, Mr Dehn.

DAME JANET: Miss Swift, is there anything arising?

MISS SWIFT: No thank you, Madam Chairman.

DAME JANET: Thank you very much, Mr Dehn. It has been a very long day for you. I am very grateful. Tomorrow, Miss Swift?

MISS SWIFT: Tomorrow we have Mr John Shaw and Mrs Shirley Harrison.

DAME JANET: We will start at 10.00 as usual. (Hearing adjourned until 10.00am on Tuesday 30th September 2003)