

Learning from Bristol

Whistleblowing in the NHS

Introduction

Public Concern at Work provides confidential advice every week to people in the NHS who are concerned about actual or potential malpractice. We also work with trusts and authorities that are trying to create an open environment in which serious concerns and errors will be safely reported and properly addressed. While Public Concern at Work is a legal advice centre, our focus is on the practical options facing a worker who does not know whether or how to raise a genuine concern, be it about negligence, fraud or a risk to the public. Our purpose is to help individuals and organisations put into practice the principles of accountability and openness. Accordingly we endorse the Kennedy Report's approach that

“Perhaps the most fundamental feature of a culture of safety is the need for the hospital to create an open and non-punitive environment in which it is safe for healthcare professionals to report adverse events, safe to admit error, safe to admit when things have almost gone wrong and safe to explore the reasons why.”¹

Our experience on this matter goes back ten years. We helped to promote the Public Interest Disclosure Act [PIDA] and consulted on its terms on behalf of the Government and its sponsor Richard Shepherd MP. We wrote the compliance toolkit on whistleblowing that the Department supplied across the NHS in 1999. We acted as consultants on whistleblowing procedures to the independent inquiry at Royal Brompton and Harefield NHS Trust.

It was, of course, Dr Bolsin who brought to light the problems at the BRI and his story is well known across the NHS. The Secretary of State said to the House on publication of the Report “Dr Bolsin is owed a debt of gratitude for what he did”². For these reasons the Report's conclusion that a doctor acting today as Dr Bolsin did would not be protected by PIDA is extremely damaging, as it must discourage NHS staff from raising genuine concerns. In our view this conclusion is flawed. We have raised this matter with Professor Kennedy and he says that while he cannot go behind the Report, these comments were based on the legal advice his Team received.

Public Concern at Work asks the Government to make clear whether it supports the Report's legal analysis that there is no protection for NHS staff who act as Dr Bolsin did. If it does, we hope the Government will recommend that PIDA be amended as a matter of urgency. Because of our twin roles of advising NHS staff and providing training and support to NHS trusts on whistleblowing, an early reply on this point is requested.

¹ Learning from Bristol (2001) tSO Cm 5207, page 359, para 17

² Hansard (HC) 18 July 2001, col 290

Public Interest Disclosure Act

The approach in the Public Interest Disclosure Act [PIDA] is a practical one that is already being used in parts of the NHS to put into practice some of the lessons learned from Bristol. By declaring that the law will fully protect those who raise genuine concerns about risks to patients, PIDA has marked a shift in the culture so that raising such concerns is more widely seen as both safe and accepted. By providing strong protection for people in the NHS who raise genuine concerns internally, PIDA helps overcome some of the key reasons why concerns are not raised. By also providing that concerns can be safely raised with the Department, and in any potentially significant case with an independent regulator, PIDA helps ensure that local managers act on the concerns in the first place. This fact alone can encourage staff to raise concerns internally. By providing that wider disclosures can be protected if they are both reasonable and legitimate³, PIDA recognises the principle of accountability and helps ensure that any serious danger or problem is dealt with, rather than wished away.

Outside of the NHS, PIDA has been promoted by both the Audit Commission and the Financial Services Authority and is seen by leading companies as 'a superb management tool'.

Turning from PIDA's framework to its detail, the various disclosures of Dr Bolsin and of the six other whistleblowers to their seniors within the BRI and to the Department would have fallen within sections 43C and 43E PIDA, had it then been in force. These require only that the person [a] reasonably believed that the information tends to show negligence or a danger to the health and safety of any individual, and [b] made the disclosure in good faith. The Report, however, states⁴ that Dr Bolsin would have failed these two key requirements. Yet the Report itself provides no evidence to support either of these conclusions. On the contrary, its findings and conclusions overwhelmingly suggest the opposite.

Raising concerns at Bristol – the facts

Reviewing the eight critical occasions when Dr Bolsin raised his concerns, the Report comments that "there was no other obvious route for raising concerns about the quality of care"⁵. The following paragraph summarises the position:

"The path followed by Dr Bolsin in seeking acknowledgement of, and support in raising his concerns was, therefore, understandable.... The difficulties he encountered reveal both the territorial loyalties and boundaries within the culture of medicine and the NHS and also the realities of power and influence. After all, as we have said, his concerns related to one of the most senior and long serving surgeons in the BRI, Mr Wisheart, and had to be addressed by Dr Roylance who was a long-standing colleague of Mr Wisheart. The manner of Dr Bolsin's approach was criticised by his colleagues and he seems to have antagonised both senior management and senior medical figures at an early stage. Thereafter, he felt he had to take a more circuitous route to arouse awareness of what was troubling him. It is also clear that he was not alone in having difficulty in approaching the senior figures, Dr Roylance and Mr Wisheart".

The Report goes on to conclude that

"while Dr Bolsin's actions may not always have been the wisest...he persisted and he was right to do so"⁶.

³ These are the failure of employer or regulator to take appropriate action on the concern, or that the concern was not raised beforehand because of a reasonable fear of victimisation or of a cover-up.

⁴ Page 162, para 20 and in detail in Annex A, page 141 paras 194/5

⁵ Page 161 para 18

⁶ Page 162, para 23.

The nearest things to qualifications of this are the Report's comments are that it was unfortunate Dr Bolsin did not approach Dr Dhasmana and that sometimes he gave mixed signals that all was well.

The Report makes no formal criticism of Dr Bolsin at all. This is abundantly clear from the statement⁷ that "the Inquiry concluded that *in certain respects* adverse comments should be made" of five named individuals at the BRI and three individuals outside. As the Inquiry had no adverse comment to record of Dr Bolsin either generally or in any particular respect, there is no reason whatsoever why it should assert that Dr Bolsin would have failed either the reasonable belief or the good faith test in PIDA. Indeed we have no doubt on the facts found and set out in the Report that Dr Bolsin would have been fully protected by PIDA. As Professor Kennedy has told us that in these conclusions, his team was relying on legal advice about PIDA it is to this legal analysis that we now turn.

Reasonable belief

When reviewing PIDA, the Report states that

"Moreover, the belief must be 'reasonable'. That implies an objective standard in addition to the subjective belief as to the truth of the information. Applying this analysis of the recent developments in the law to the events in Bristol, it is not clear whether any disclosures would have been protected even under the newly enacted law."⁸

The words in the legislation⁹ are that the person should "reasonably believe the information tends to show" some negligence / a safety risk. This is a low threshold akin to a reasonable suspicion.

It is simply incredible that the Report can suggest that on any objective basis Dr Bolsin (or any other clinician) did not believe their concerns were true. Three doctors have been struck off, a two year Public Inquiry has been held and the resulting Report makes over 200 recommendations. Each of these facts demonstrates conclusively that the concerns about poor practice at the BRI were objectively reasonable.

Good faith

The Report also states that

"[It] needs to be emphasised that the provision that the disclosure should be made in good faith means (as the requirement of good faith always does in a statute) 'in the absence of bad faith'. Thus where a worker has mixed motives for making a disclosure (personal pique, pursuance of a political objective or mischief-making) the disclosure may not qualify. Mixed motives may be very easy to attribute to any potential whistleblower and would prevent protection under this section."¹⁰

The only statutory definitions of 'good faith' are that the word means 'honestly'¹¹. We have found no legal authority that supports the view that the term in legislation can mean without mixed motives¹². In a case of protection for a health and safety representative, when

⁷ Page 10, paras 44-47. Neither Dr Bolsin nor any other whistleblower is cited.

⁸ Annex A, page 141, para 195

⁹ PIDA section 43B

¹⁰ Annex A, page 141, para 194

¹¹ Sale of Goods Act 1979 s 61(3) and Bills of Exchange Act 1882 s.90: "A thing is deemed to be done in good faith within the meaning of this Act when it is in fact done honestly, whether it is done negligently or not."

¹² See Stroud's Judicial Dictionary (2000), Words and Phrases (1988), Halsbury's Laws. As to the term in equity in Central Estates v Woolgar (1971) 3 All ER 647 the Court of Appeal held that 'good faith' in the Leasehold Reform Act 1967 meant 'honestly'. In his judgement Lord Denning MR said 'To my mind under this Act a claim is made in good faith when it is made honestly and without ulterior motive', while Megaw LJ said the term means just 'honestly' and Phillimore LJ said the test was not met where there 'was plainly a dishonest manoeuvre'. See also Medforth v Blake (2000) Ch 86 at 103 - a Court of Appeal decision on the duty of receivers – where Sir

upholding a decision that the representative had acted in bad faith, the EAT said “this as not a case of mixed motives but of an intention solely to embarrass the company and not to perform...his health and safety function”¹³. In a Court of Appeal decision¹⁴ on asserting a statutory right – where the mixed motives of the employee were not in dispute – no suggestion was made that the employee did not act in good faith and so lost protection.

There have been several decisions under PIDA. Although in many of them the employer suggests the whistleblower has mixed motives, we are aware of none in which the employer has argued that mixed motives defeats the claim. In the only case where the issue of good faith was in issue, the test the Tribunal used was “Did he have an honest and reasonable suspicion that the matters complained of were true, in other words, did he act in good faith?”¹⁵. When the employer unsuccessfully challenged the decision in the EAT¹⁶, it did not suggest that this test of good faith was wrong.

If there is any doubt, the meaning of ‘in good faith’ in PIDA can only be correctly assessed by its context. In our view “a disclosure is made in good faith if it is made honestly, even though made negligently or without due care. Where the disclosure is demonstrably made for an ulterior and undesirable motive, e.g. something approaching blackmail, it is submitted that it would not be made in good faith”¹⁷. Insofar as a whistleblower has an ulterior or improper motive, our view of the correct construction of PIDA is that it can only prevent protection if that motive is found to be the dominant or primary motive for the disclosure.

The assertion that “mixed motives may be very easy to attribute to any potential whistleblower” is true. Wherever a genuine concern has been raised and ignored in the workplace, the whistleblower will feel suspicious, agitated, aggrieved or at risk and his motives may be said to be mixed. If the good faith test has the meaning the Report ascribes to it, protection is lost wherever there are mixed motives with the result that PIDA offers nobody any effective protection. Even if there were legal authority to support this assertion, the result would, as we say above, be contrary to the whole purpose and content of the Act. Finally were there any ambiguity as to the meaning of the term (contrary to what we say) the courts would refer under Pepper v Hart to Hansard and would see that Parliament intended the term to mean ‘honestly’¹⁸.

As to the application of the Act in the NHS, it is also necessary to look to the Departmental Circular¹⁹ on whistleblowing and PIDA, which NHS employers are obliged to implement. This sets out the Department’s view that PIDA protects internal and DoH whistleblowing in the NHS where there is an honest and reasonable suspicion of malpractice. It makes no suggestion that a nurse or doctor who is acting with mixed motives will forfeit protection.

There is nothing – other than the legal analysis - in the findings of the Inquiry to suggest that Dr Bolsin (or any of the other concerned clinicians) was not acting in good faith. Accordingly there is nothing to sustain the Report’s conclusion that Dr Bolsin would not have been PIDA protected when he raised his concerns internally and with the Department.

Richard Scott VC said “In my judgement the breach of a duty of good faith should in this area as in all others, require some dishonesty or improper motive, some element of bad faith, to be established”.

¹³ Shillito v Van Leer (1997) IRLR 495 at 407

¹⁴ See Mennell v Newell (1997) ICR 1039

¹⁵ Bladon v ALM (ET) 2405845/99, page 3

¹⁶ Bladon v ALM (EAT) 709/00

¹⁷ Current Law Statutes (1998, cap 23-9)

¹⁸ Proceedings generally and in particular Hansard HL 11 May 1998, col 890

¹⁹ HCS 198/1999 – see comments on following page

External disclosure

The Report is also in error when it considered whether the wider disclosures to Dr Phil Hammond would have been PIDA protected. This focused²⁰ on whether Dr Bolsin had a reasonable fear of victimisation [the first trigger in 43G(2)]. This was not relevant as Dr Bolsin had already raised the concern internally [satisfying the alternate third trigger²¹]. As such the disclosure to Dr Hammond would have been protected provided only that it was reasonable in the circumstances. We have found nothing in the Report to explain why the Inquiry Team thought that this disclosure was not reasonable.

Recommendation to amend PIDA

The Report's recommends²² that PIDA be amended so that disclosures to the National Patient Safety Agency are protected. This recommendation is difficult to square with the legal analysis that PIDA offers no effective protection. Either the Inquiry Team was not heeding its advice on PIDA or its recommendation will provide no reassurance to any doctor or nurse who may have reason to contact the Agency. If the latter, this will seriously jeopardise the work of the Agency.

For this reason, we believe that the Government should clarify the position in its formal response and to Parliament. It should state either

- that the Government agrees with the Report's analysis and will seek to amend PIDA as a matter of urgency to replace the term 'in good faith' with 'honestly', or
- that, contrary to what the Report says, the Government's view is that 'in good faith' means 'honestly' and this is how the Act applies and is intended to apply in the NHS.

HSC 1999/198 – whistleblowing in the NHS

We agree with the Report's description that

"If the culture of openness between the NHS and the public has to change, so too does the internal culture within the NHS, so as to allow for greater openness with and between staff. Currently, there continues to be a sense among the workforce that they cannot discuss openly matters of concern relating to the care of patients and the conduct of fellow workers. There is a real fear among junior staff (particularly amongst junior doctors and nurses) that to comment on colleagues, particularly consultants, is to endanger their future work prospects. The junior needs a reference and a recommendation; nurses want to keep their jobs. This is a powerful motive for keeping quiet.

The workforce must feel that they will be safe if they wish to raise and have discussed matters of concern. Managers must put in place mechanisms to facilitate this process. We were much impressed during our Seminars by the way the airline industry has approached the issue by providing a neutral reporting system to which staff can report errors, near misses or concerns about safety. There is much here for the NHS to learn."²³

When the Government addresses this issue, we hope it will take into account

- the Department's Circular HSC 1999/198 which addresses whistleblowing in the NHS and
- the experience of those trusts who have put in place the open culture that the Government then called for.

²⁰ Annex A, page 140, para 192

²¹ PIDA section 43G(2)(c)

²² Page 362 and note 24

²³ Page 273, paras 28-29

In our view the Circular is an example that the NHS has already moved on from the situation the Report describes where

“A serious failure of some sort occurs somewhere within the NHS. An Inquiry is set up. Months or years later a report is published. Almost always, the report singles out an individual or group who are held responsible. The individual is condemned. The NHS proceeds on its way, assuming that the matter is resolved: until the next failure”²⁴

It is surprising that the Circular is not mentioned in the Report when, acting on it, NHS employers are recognising and addressing many of the issues the Inquiry is concerned with: club culture; whether and how to raise concerns; the need to address concerns rather than assume someone else will; the monitoring roles of NEDs, the DoH and regulators; clarification of who is in charge for what; leadership, lines of accountability and the attitudes those in the NHS bring to their work.

HSC 1999/198 requires trusts and authorities to have in place local policies that at the minimum include

- Designation of a senior manager or non-executive director with specific responsibility for addressing concerns raised in confidence which need to be handled outside the usual management chain
- Guidance to help staff who have concerns about malpractice to do so reasonably and responsibly with the right people
- A clear commitment that staff concerns will be taken seriously and investigated
- An unequivocal guarantee that staff who raise concerns responsibly and reasonably will be protected from victimisation
- The prohibition of gagging clauses in contracts and confidentiality agreements

And take action to

- Ensure that all their staff are aware of local policies and procedures and their own responsibilities for raising genuine concerns in a reasonable and responsible way.

Our one concern with the Circular has been that there has been insufficient follow up to reinforce its message and to ensure that its practical steps are complied with across trusts. Both employers and staff within the NHS have expressed this view to us. Their view is consistent with the reports that the Commission for Health Improvement says that the response of trusts to the Circular has ‘varied enormously’ and, from Unison, that some trusts ‘are only just developing the policy’²⁵. The fact that the response has been patchy does not mean that there are no examples of good practice (indeed at one point the Report²⁶ appears to recognise that at some NHS employers the situation may already be changing for the better). Rather it is our view that the examples of good practice at the local level offer much that the NHS can learn from.

Although further steps are certainly needed to reassert the messages in the Circular across all NHS employers, our experience is that the approach in PIDA appears to be working well in those workplaces, in and out of the NHS, where it has been implemented. We have seen welcome and tangible moves by the Government, the Department and a number of trusts to learn lessons from Bristol and to put these into practice. We hope that in its formal response to the Inquiry the Government will not ignore these efforts but build on them. When

²⁴ Page 259, para 19

²⁵ Nursing Times, 2 Aug 2001, page 7

²⁶ Page 369, para 43 entitled Learning from what is already working in the NHS quotes CHI’s view in 2000 that a fear of raising concerns exists in most NHS organisations

considering the implementation of a number of the Report's recommendations²⁷, we additionally believe the Circular will be of assistance to the Department.

Sentinel events: immunities and duties

The legal advice that the Inquiry received about PIDA may also have influenced its thinking about the reporting of sentinel events²⁸. PIDA protects people from reprisals for disclosing or reporting such incidents - it confers no protection or immunity for the malpractice itself if the whistleblower is culpable. In this respect PIDA's approach differs from that behind the Report's recommendation to provide immunity to someone if they report themselves within 48 hours²⁹ of their misconduct or negligence.

While the detail around this recommendation is still to be settled³⁰, it does appear that this immunity will apply irrespective of how culpable the doctor or nurse has been³¹. We do caution that such a blanket immunity may lead - and be seen to lead - to a culture of no responsibility rather than a no-blame culture. More specifically, we could not support a recommendation which had the effect that a Trust or disciplinary body would be powerless to protect the public from a doctor or nurse whom it considered posed a risk to safety simply because he or she had reported themselves.

If the Government is to accept this in principle, we think that the related recommendation³² (imposing a duty on all within the NHS to report such events) will cause practical problems. The experience of our helpline is that someone in the NHS has reasonable grounds for believing there is a sentinel event in most hospitals most days. If everyone in a team is to be under the threat of disciplinary action for failing formally to report any sentinel event, then there will be a plethora of reports. Trust within teams will be eroded as people will be second-guessing whether colleagues will be reporting themselves or one another.

The reason that PIDA did not require people to make reports or blow the whistle was, we understand, because it was considered that such a duty would do little to instil responsible conduct by individuals or inspire trust among colleagues. Additionally it was thought such a duty would be likely to cause at least as many problems as it would solve, particularly with difficult or aggrieved individuals and those approaching disciplinary action.

For the above reasons we are concerned that imposing a duty on everyone within the NHS to blow the whistle is unlikely to help the creation of the "open and non-punitive environment in which it is safe to report and admit sentinel events"³³ which the Report sees as critical to its recommendations.

²⁷ Such as those on duty of candour (33), open cultures (107), circumspect data analyses (112), local reporting schemes (118) and the incorporation of safety (121)

²⁸ This is defined at page 362, para 20 as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof".

²⁹ Page 368, para 39

³⁰ There may be potential inconsistencies with recommendations 33 & 34 on feedback to patients; 104 on discipline and, as mentioned above, with the principle of the primacy of patient safety (page 257, para 4).

³¹ Page 362 para 20 says there must be guarantees that there will be no disciplinary action; page 368 para 39 excludes criminal acts from the guarantees [NB This can only apply where the employer or authority establishes the crime to what is effectively a criminal standard of proof]; and page 369 para 41 proposes that where a doctor is 'consistently' reporting their own errors the Trust should tell the National Clinical Assessment Authority.

³² Recommendation 117

³³ Page 450, para 107

Summary

- The legal advice the Inquiry team received meant that the Report misunderstood how PIDA operates and how it would have applied to the events at the BRI
- We request early clarification from the Government whether it endorses the Report's legal analysis and view that there is no effective whistleblower protection in the NHS
- If it does, we ask for a commitment that the Government will seek to amend PIDA urgently
- We ask that when responding to the Inquiry, the Government does not ignore the steps that have been taken by various NHS employers to address the cultural and human problems that underlay events at Bristol
- In considering the implementation of the recommendations we ask that the Government builds on and reasserts the practical steps set out in the 1999 Health Service Circular on whistleblowing
- If there is to be some immunity for reporting sentinel events, this should not prohibit a trust or professional body from acting where it reasonably believes an individual poses a risk to patient safety
- We do not believe that placing a duty on all NHS staff to report sentinel events will help create an open and non-punitive environment.

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