CHAPTER ELEVEN

Raising Concerns: the Way Forward

Introduction

11.1 In Chapters 8 and 9, I have considered how various people did or did not come to suspect that Shipman might be killing his patients and what, if anything, those with concerns felt able to do about raising them. I have also considered in Chapter 10 the position of two doctors who did not suspect that Shipman was deliberately doing anything wrong but who believed that he had given an inappropriate dose of morphine to a patient, with disastrous results. They did not report their concerns to anyone in authority.

11.2 I have concluded that, before March 1998, when the late Dr Linda Reynolds reported her concerns and those of her partners about the death rate among Shipman's patients, very few people had had any concerns about him. Mr David Bambroffe and Mrs Deborah Bambroffe were concerned and Mrs Bambroffe had mentioned their concerns to Dr Susan Booth. That communication contributed to the raising of anxieties within the Brooke Practice which led, some time later, to Dr Reynolds' report to the Coroner. The only other person who had attempted to raise a concern was Mrs Christine Simpson, who tried to alert her manager, Mrs Janet Schofield. However, her concerns were expressed rather obliquely and Mrs Schofield did not realise what Mrs Simpson was trying to tell her. Mrs Simpson had hesitated before speaking to Mrs Schofield because she feared that people would think she was 'mad' for harbouring suspicions about a respected general practitioner (GP). When her first attempt met with no response, she did not broach the subject directly again but did make comments linking Shipman's name with deaths at Ogden Court. The two home helps, Mrs Dorothy Foley and Mrs Elizabeth Shawcross, were concerned about Shipman but did not feel able to say anything. They did not know to whom to turn and were concerned that, if they did speak out, they would not be taken seriously. Mr John Shaw, a taxi driver who had become suspicious about the deaths of several of his customers, did not mention his concerns to anyone because he did not know where to raise them. Also, he was afraid of the possible legal consequences if it should turn out that he was wrong.

11.3 The apprehension and anxiety felt by these individuals typify the reaction of others who have found themselves in the position of wishing to report a concern. In this Chapter, I shall examine the steps that have been taken over the last decade or so to improve the position of people who have a concern and wish to raise it but who hesitate to do so for some reason. I shall also consider what further steps, if any, should be taken.

Terminology

11.4 In this Chapter, I have tried to avoid using the term 'whistleblowing'. Typically, a person is said to have 'blown the whistle' if s/he has brought to the attention of the authorities or of the public some form of illicit behaviour which has been perpetrated by or within the organisation in which s/he is employed or with which s/he is in some other way connected. Frequently, the 'whistleblower' will make his/her disclosure to a journalist and it will be reported in the media. There may be a number of reasons why the 'whistleblower' has

made his/her disclosure outside – rather than within – the organisation. He or she may have reported the behaviour within the organisation previously, but with no result. He or she may fear (perhaps because the illicit behaviour was being perpetrated by senior members of the organisation) that there would be no point in making a report inside the organisation; s/he may even be fearful of the consequences of making such a report. The essential feature of 'whistleblowing', however, is that the person making the report has chosen for some reason to take that report outside the organisation to which one would have expected the report to have been directed. Usually, there is little doubt in the mind of the 'whistleblower' that the information s/he has is true; his/her energies are directed at ensuring that the information is made known to those who are in a position to right the wrong of which s/he complains.

11.5 The term 'whistleblower' is, therefore, a convenient shorthand way of describing the person who brings information about some form of misbehaviour to the attention of those outside his/her organisation. None of the people to whom I have referred at paragraph 11.2 could properly have been termed 'whistleblowers' had they taken their concerns to the police, the primary care organisation or (in the case of Mrs Foley and Mrs Simpson) to their employers. Mrs Bambroffe was not 'blowing the whistle' when she voiced her concerns to Dr Booth; nor was Dr Reynolds when she made her report to the Coroner. Mrs Simpson was not 'whistleblowing' when she spoke to her line manager of her concerns. None of those persons worked within the same organisation as Shipman; they were merely voicing their concerns to those who they felt were the appropriate authorities.

11.6 Another feature which set those people apart from the typical 'whistleblower' was the fact that most of them were far from confident that their concerns were justified. They were not seeking to make a complaint or to air a grievance about something that they knew to be wrong. Indeed, one of the factors that inhibited them from speaking out was their concern that they might be proved to be wrong and their fear of the consequences of such an error.

11.7 The public generally becomes aware of an incident of 'whistleblowing' when things have gone wrong – usually when the 'whistleblower' has been dismissed from his/her employment for breach of his/her duty of confidentiality or has suffered some other detriment. In some cases involving national security, 'whistleblowers' have even been prosecuted. When it appears that the 'whistleblower' has been motivated by genuine and well-founded concerns, public opinion tends to support the 'whistleblower' and the feeling is that s/he has done his/her public duty. Nevertheless, the message that emerges from media reports of 'whistleblowing' cases is in essence a negative one; namely that those who put their heads above the parapet and dare to speak out are liable to be penalised in some way. I do not think it is helpful to confuse that negative message with a discussion of how people with genuine and legitimate concerns affecting the public interest can be helped to bring forward those concerns in a responsible and effective manner.

11.8 I recognise that the meaning of the term 'whistleblower' has recently been extended somewhat. It is now sometimes used to describe a person who reports his/her concerns within the organisation to which those concerns refer, or even to describe a member of the public who raises concerns about a person or organisation with which s/he has no personal connection at all. It is used also to describe the raising of concerns which are

less serious in nature than those that have formed the basis of the most celebrated 'whistleblowing' cases. Many of the witnesses to the Inquiry used the term 'whistleblowing' virtually synonymously with 'the raising of concerns'.

11.9 I propose to avoid using the expression 'whistleblowing' wherever possible. However, the term has come into such general use that many organisations now have what they call 'whistleblowing' policies, which are really policies to assist employees to 'raise concerns' in an appropriate way, giving them an assurance that they will be taken seriously and will not be victimised as a result of their action. Because the term 'whistleblowing' is used in this way by some, I will occasionally have to use it myself in this Chapter, as I did in Chapter 9. Otherwise, I shall not.

Serving the Public Interest

11.10 The raising of genuinely held concerns about issues of public importance is to be encouraged. The public interest may be served in many different ways, such as by the prevention or detection of crime, by the prevention of accidents or by the protection of the public purse. I have already mentioned some natural barriers to the raising of concerns encountered by those who harboured concerns about Shipman. Others include the fear of being seen as a troublemaker or 'maverick', the fear of recriminations and a feeling of impotence grounded in the belief that, even if the report is made, nothing will be done about it. There may be a concern that making a report might lead to proceedings for defamation. There may be anxiety that the report of a concern will be interpreted as an attack on an individual or body whereas no such attack may be intended. There may be a fear that the group or team of which the person to be criticised is a member will rally round him/her and will ostracise the person who has raised the concern.

11.11 Such fears may be well founded. As I will explain later in this Chapter, the experience of Dr Stephen Bolsin, the consultant anaesthetist who tried unsuccessfully to report his concerns about the high mortality rate among paediatric cardiac patients at the Bristol Royal Infirmary (BRI) in the late 1980s and early 1990s, demonstrates how serious the consequences of raising concerns can be. His decision to cease practice in the UK and to set up practice in Australia resulted, at least in part, from the response to his attempts to raise his concerns. In my view, individuals must be encouraged to raise their honest concerns; they need to know how to do it and they need to have the confidence that, if they do, those concerns will be taken seriously and that they will not be victimised in any way.

11.12 It is now generally recognised that the raising of a concern within the organisation in which it arises is usually preferable to more public disclosure. There are several reasons for this. There is a proper public interest in ensuring that genuinely confidential information is kept confidential. There is also a real public interest in promoting the internal accountability of organisations. Of course, some mistakes and misdeeds are so important that it is only right that the general public should be made fully aware of them; there are, however, many occasions when it would be preferable, in the public interest, that the organisation responsible for an error should be able to correct it and learn from it without any outside involvement. Disclosure to the press can attract a disproportionate degree of publicity with adverse consequences for all. The organisation is 'put on the back foot' by the

unexpected disclosure and can become defensive and secretive. There is a tendency for attention to be focussed on the messenger rather than on the message and the 'whistleblower' may suffer reprisals. In brief, no one benefits.

11.13 The task of devising a system is relatively easy. The real challenge is in developing a culture where every member of a group, team, department or profession feels a sense of responsibility for the actions of the others. Where what is in issue is a question of poor clinical performance, that sense of responsibility may lead, first, to an attempt to assist the person who is performing badly to improve, but should extend, if necessary, to making an official report to an appropriate person. There is also a need to develop a culture in which, when a concern is raised about the conduct or practice of one member of a group, the rest of the group does not 'close ranks' and ostracise the person who has spoken out. In the last few years, real attempts have been made to improve the position of people who raise concerns.

The Evidence

11.14 The Inquiry received a large number of statements, articles and other documentary material from many sources on the topic of raising concerns. A questionnaire was sent to a number of local authorities and other organisations requesting details of their policies and practices. Many responses annexed copies of the relevant body's whistleblowing policy. Several witnesses and participants in seminars held by the Inquiry described the procedures for raising concerns within their organisations. Some explained their own experience of raising a concern. An important contribution was made by Mr Guy Dehn, Director of Public Concern at Work (PCaW), an organisation which, as I shall explain below, has done a great deal of work to promote a legal and cultural climate in which people feel confident to raise their concerns. He gave oral evidence to the Inquiry, and the Deputy Director of PCaW, Ms Anna Myers, attended the Inquiry seminars in January 2004.

Public Concern at Work

The Organisation

11.15 PCaW, which was established in 1993, is a small limited company with charitable status. It offers help and encouragement to organisations (in particular the NHS) that wish to create and foster a culture in which staff feel safe to raise concerns. It gives advice on the relevant law. It provides materials (such as draft policies) and consultancy and training services relating to the raising of concerns and to accountability within organisations. It seeks to influence public policy by the conduct of research and by the publication of articles. It has also set up and administers a telephone helpline that provides free, confidential legal advice and practical assistance to individuals who are unsure how to raise concerns about malpractice, particularly malpractice in the workplace. The service is available to all employees, although a number of leading employers, including the NHS, have begun to take out subscriptions to the service. This subscription scheme was introduced by PCaW to help employers to demonstrate their commitment to the active promotion of whistleblowing policies. PCaW does not play any part in investigating or pursuing those concerns, although it will, if requested, pass on concerns to the

appropriate recipient and assist callers in drafting and communicating concerns, if requested to do so.

11.16 Mr Dehn has been personally responsible for much of the progress that has been achieved by PCaW in improving the position of those who wish to raise concerns. He is a barrister and assisted in the drafting of the Public Interest Disclosure Act 1998 (PIDA), which provides a measure of protection from victimisation by employers of those who have raised a concern.

11.17 As its name implies, PCaW focusses its attention on the raising of concerns about activity in the workplace. In fact, much of the evidence heard by the Inquiry about the raising of concerns related to problems that had arisen in the workplace. This is not surprising. First, the great majority of incidents that might give rise to concern about public safety are in some way connected to the workplace. Second, it is employees who are most likely to become aware of such incidents and it is they who have the most to lose if the concern that they raise is not favourably received.

Factors Influencing the Raising of Concerns

11.18 Mr Dehn confirmed to the Inquiry the causes for anxiety that are widespread among people who are thinking of reporting a concern. Among these are included the factors that I have already mentioned, namely, uncertainty as to how to go about making a report, as well as a fear that the report will not be taken seriously and that nothing will be done about it. Also, he spoke of the worry that there will be some sort of reprisal or detriment at work, either from management or from colleagues.

The Genesis of the Public Interest Disclosure Act 1998

11.19 In the late 1980s and early 1990s, when Mr Dehn was working as the Legal Officer to the National Consumer Council, he had to consider the reports of a number of public or judicial Inquiries into major disasters. He saw that, in almost all cases, those Inquiries had found that employees had been aware of the danger that was looming but either had been too frightened to raise their concerns or had raised their concerns in the wrong way or with the wrong person. They had lacked the necessary confidence and/or knowledge to voice their concerns effectively. Examples included the Clapham rail crash (where the Hidden Inquiry heard that an inspector had not raised his concern because he did not want to 'rock the boat'), the Piper Alpha disaster (where the Cullen Inquiry concluded that employees did not want to put their continued employment in jeopardy through raising a safety issue which might embarrass management) and the Zeebrugge ferry sinking (where the Sheen Inquiry found that staff had raised concerns but had done so 'with the wrong people in the wrong way so that nothing was done about it'). Similar conclusions had been drawn from reports on financial scandals. In all these cases, there had been a failure of effective communication between staff and management. Mr Dehn formed the view that communication breakdown was likely to have been a relevant factor in many other accidents which had caused death or serious injury, and in many frauds which had resulted in financial loss but which had not, because of their more modest scale, justified a public or judicial inquiry. It was these thoughts that led to the formation of PCaW in 1993.

11.20 Soon afterwards, as Mr Dehn told the Inquiry, the Nolan Committee on Standards in Public Life (the Nolan Committee) and the Audit Commission also became interested in the issue. The Nolan Committee's Second Report said:

> **'All organisations face the risks of things going wrong or of unknowingly harbouring malpractice. Part of the duty of identifying such a situation and taking remedial action may lie with the regulatory or funding body. But the regulator is usually in the role of detective, determining responsibility after the crime has been discovered. Encouraging a culture of openness within an organisation will help: prevention is better than cure. Yet it is striking that in the few cases where things have gone badly wrong in local public spending bodies, it has frequently been the tip-off to the press or the local Member of Parliament – sometimes anonymous, sometimes not – which has prompted the regulators into action. Placing staff in a position where they feel driven to approach the media to ventilate concerns is unsatisfactory both for the staff member and the organisation.'**

11.21 These views – which I share – summarise the purpose of the legislation that was to follow. That purpose was not to encourage employees with concerns to broadcast them. It was to ensure, through legislation, that employees would feel sufficiently confident to raise their concerns internally. The object was to encourage external disclosure only where internal disclosure was inappropriate.

11.22 The idea of a legislative framework to encourage employees to raise public interest concerns, and to protect those who did so from adverse consequences, was first raised in Parliament in 1995 in a 'ten minute rule' Bill, drafted by PCaW and the Campaign for Freedom of Information (CFOI). The Bill received broad support but got no further. In 1996, a Private Member's Bill with the same object was unsuccessful, although it had been strongly supported inside and outside Parliament. The Rt Hon Tony Blair MP, then Leader of the Opposition and now Prime Minister, pledged that a future Labour Government would introduce legislation with these objectives. Within a few weeks of the election of the Labour Government in 1997, PCaW and the CFOI were asked by Ministers to promote the Bill again, this time through the Private Members' ballot. A Conservative MP, Mr Richard Shepherd, a supporter of the earlier Bills, was successful in the ballot and introduced the Bill which was later to become the PIDA.

The Public Interest Disclosure Act 1998

The Objectives of the Act

11.23 The PIDA came into force on 2nd July 1999. The preamble describes it as:

> **'An Act 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'**.

11.24 The PIDA offers protection from dismissal and victimisation to workers who raise genuine concerns about 'malpractice' in the workplace. This protection forms part of employment

legislation but the PIDA had a far broader underlying purpose than the extension of employees' rights to protection from victimisation. It was seen as a valuable tool to promote openness and good governance. It was intended to help to ensure that organisations responded to disclosures by addressing the concern raised (the 'message'), rather than by focussing attention on the person who had raised that concern (the 'messenger'). It was envisaged that the PIDA would make it more likely that organisations would resist the temptation to cover up serious malpractice. According to PCaW, these wider implications for governance and their relevance across all sectors of the workplace meant that the legislation received broad support from the Confederation of British Industry, the Institute of Directors and other key professional groups.

11.25 The PIDA (like the best whistleblowing policies) is designed to reassure employees that it is safe and acceptable for them to raise their concerns within their organisation. If this is achieved and the raising of concerns internally becomes the norm, management will often receive early warning of malpractice and will have the opportunity to investigate and put matters right. Even where early warning is not given, a later report may lead to the detection of those responsible and the knowledge that malpractice is likely to be reported will, in any event, act as a deterrent to wrongdoing. The accountability of those responsible for the organisation will be improved. Furthermore, if management fails to act on receipt of a concern that is later seen to be well founded, management can be held to account. If the raising of concerns becomes the norm, there is less likelihood of a breakdown in the relationship between employer and employee when a report is made, even if the report turns out to be ill-founded. This point was made by Mrs Pauline Webdale, Fellow and previous national Chairman, Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR), as I explained in Chapter 9. Thus, the policy of the PIDA is to encourage internal reporting but, where there is good reason to doubt that internal reporting will suffice and the employee makes his/her report to a regulator or even more publicly, the protection afforded by the PIDA will not necessarily be lost.

The Tiered Regime of the Act

11.26 The provisions of the PIDA are incorporated into the Employment Rights Act 1996 (ERA), by amendment to a number of sections of the ERA, mainly sections 43 and 47. The PIDA creates a three tiered disclosure regime under which employees dismissed for having reported a concern are entitled to have their dismissal automatically treated as unfair if the report meets certain criteria laid down in the PIDA. Those criteria become progressively harder to satisfy according to the remoteness of the person to whom the concern is reported from the organisation about which the concern is raised.

The Classes of Person Protected

11.27 The PIDA affords protection to all **'workers'** within the definition set out in section 230(3) of the ERA. It also extends that definition (in circumstances where their terms or place of work are not under their own control) to agency workers and independent contractors and to GPs contracted under General Medical Services Contracts. It has, therefore, very broad application.

The Nature of the Protection

11.28 The PIDA confers on workers the right not to be subjected by their employers to any **'detriment'** on the ground of their having made a disclosure that is protected by the provisions of the PIDA (a **'protected disclosure'**). Where a worker suffers such detriment, and/or is dismissed for having made a protected disclosure, s/he has certain enhanced rights in bringing a claim before an employment tribunal. A worker is automatically to be regarded as having been unfairly dismissed if the sole or principal reason for dismissal is that s/he made a protected disclosure. Awards of compensation are based on the losses suffered and there is no upper limit. Aggravated damages can also be awarded. The employee may also, within seven days of dismissal, seek interim relief so that his/her employment continues or is deemed to continue until the full hearing of the claim by an employment tribunal. No qualifying periods or age limits restrict the application of the protection. The protection is available whether or not the information disclosed is confidential and whatever the geographical location of the reported malpractice.

Qualifying Disclosures

11.29 Under the PIDA, only what is termed a **'qualifying disclosure'** has the potential to be a protected disclosure. In order for a disclosure to be a qualifying disclosure, it is first necessary for the worker making it to have a **'reasonable belief'** (reasonable suspicion will not suffice) that his/her disclosure **'tends to show'** (and not merely to suggest) that one or more of the following types of malpractice has taken place, is taking place or is likely to take place. The types of malpractice, which may overlap, are:

(a) an actual or apprehended breach of the criminal law or of **'any legal obligation to which a person is subject'**

(b) a miscarriage of justice

(c) a danger to health and safety

(d) damage to the environment

(e) the deliberate concealment of any such malpractice.

Protected Disclosures

Disclosures to Employers and Related Disclosures

11.30 The first 'tier' of disclosure at which the PIDA affords protection covers those disclosures made to the worker's employer, those made to a person authorised by the employer's whistleblowing policy to receive them directly and those made to the person with **'legal responsibility'** for the malpractice in question. The meaning of the phrase **'legal responsibility'** is uncertain, as I shall explain below.

11.31 Because the object of the PIDA is to offer the maximum encouragement to the raising of concerns within the organisation responsible, the evidential burden on the employee seeking to make a first tier disclosure is set at a fairly low level and the disclosure quite readily becomes protected. The same ready protection extends to disclosures made to a

Minister of the Crown, where the worker's employer is either an individual appointed under any enactment by a Minister, or a body, any of whose members are so appointed. This would apply to the case where a worker employed by a public body subject to Ministerial appointment (e.g. the NHS or a primary care trust (PCT)) 'blows the whistle' directly to the Secretary of State (SoS) for Health (or, more likely in practice, to a senior official at the Department of Health (DoH)).

11.32 Such qualifying disclosures become protected disclosures provided that they are made **'in good faith'**. The question whether or not a protected disclosure is made **'in good faith'** is a question of fact for the employment tribunal to decide. There is no statutory definition of the phrase, although the Court of Appeal has recently held (in the case of Street v Derbyshire Unemployed Workers' Centre[1]) that **'in good faith'** requires that the predominant motivation for the making of the report was the public interest. A person whose predominant motive is, for example, personal dislike would not be entitled to the protection of the PIDA, even though the information disclosed was truthful and accurate and was about the commission of a serious crime. If, therefore, a member of the practice staff employed by Shipman had reported concerns about his conduct, she would not have enjoyed the protection of the PIDA if her main reason for making the report had been personal dislike of Shipman. This is despite the overwhelming public interest in the disclosure that he might be murdering patients. I shall discuss this problem further below.

Disclosures to External Regulators

11.33 The second 'tier' of disclosure covers the protection to be afforded to qualifying disclosures made to certain external regulators and similar bodies or, using the words of section 43F of the ERA, to persons **'prescribed by an order made by the Secretary of State** (*for Trade and Industry*) **for the purposes of this section'** (**'prescribed persons'**). The object of the PIDA is to offer only slightly less encouragement to concerns raised in this way than to concerns raised within the organisation responsible. These **'prescribed persons'** – all external regulators – include bodies such as the Financial Services Authority, the Health and Safety Executive, the General Social Care Council and the Environment Agency. They do not include the General Medical Council (GMC) or the Commission for Healthcare Audit and Inspection (known as the Healthcare Commission).

11.34 Before a disclosure made to an external regulator can be protected under the PIDA, the worker making the disclosure is required not only to have acted **'in good faith'**; s/he must also have had a **'reasonable belief'**, first, that the information disclosed or allegations made were **'substantially true'** and, second, that the disclosure fell within the description of the kinds of disclosure that the **'prescribed person'** was authorised to receive. I have already mentioned that, before a disclosure can gain even the status of a qualifying disclosure, it is necessary for the worker to have a **'reasonable belief'** that his/her disclosure **'tends to show'** one or more of the various types of malpractice. Under the second tier, the reasonable belief must be that the information is **'substantially true'**, a higher threshold than for the first tier, where the additional requirement before a qualifying

[1] [2004] EWCA Civ 964.

disclosure becomes a protected disclosure is, as I have said, only that the disclosure should have been made in good faith. I shall return to this issue below.

Wider Disclosures

11.35 The third 'tier' of disclosures covers those qualifying disclosures that do not fall into either of the above categories. I shall refer to them as 'wider disclosures'. They may include disclosures to the media or to regulators that are not **'prescribed persons'**, such as the GMC at the present time. For such disclosures to attract the protection of the PIDA, the worker must satisfy quite onerous requirements, additional to those required in the case of disclosures to **'prescribed persons'**. The first additional requirement (which can be fulfilled in any one or more of three alternative ways) is satisfied where:

(a) the worker reasonably believes that s/he will be subjected to a detriment at the hands of his/her employer if s/he makes the disclosure either to that employer, to a person authorised by that employer to receive it, to the person responsible for the malpractice or to a **'prescribed person'**

(b) where there is no **'prescribed person'** to whom the disclosure could be made (e.g. because no person is prescribed to receive disclosures of that description), or the worker reasonably believes that relevant evidence will be concealed or destroyed if s/he makes the disclosure to his/her employer

(c) where the worker has previously disclosed substantially the same information to any of the persons listed at (a).

11.36 Broadly speaking, therefore, this first additional requirement depends on the worker either having the reasonable belief that his/her employer will 'respond badly' to the disclosure or having already unsuccessfully raised his/her concern (provided it has been made through the proper channels or there are no proper channels through which to take it).

11.37 The second additional requirement for a wider disclosure is that the person making the disclosure does not do so for personal gain. Thus a disclosure made to the press for financial reward would not be protected.

11.38 The third and final additional requirement for a wider disclosure is that it must be reasonable, in all the circumstances, for the worker to have made the disclosure. In determining this question of reasonableness, regard has to be had to:

(a) the identity of the person to whom the disclosure is made

(b) the seriousness of the matter at issue

(c) whether the malpractice is at an end or is likely to recur

(d) whether the disclosure puts the employer in breach of a duty of confidentiality owed to another person and (in a case where the person concerned has previously disclosed substantially the same information to any of the persons listed at (a) in paragraph 11.35 above) whether s/he did so in compliance with a procedure authorised by his/her employer.

11.39 Where wider disclosures are of what are described as **'exceptionally serious failures'**, the requirements at (a) to (c) in paragraph 11.35 do not have to be satisfied. The other requirements do, however, have to be satisfied and, when determining the question of reasonableness, particular regard is to be paid to the identity of the person to whom the disclosure is made. By way of illustration, a report to the GMC of concern about a serious continuing risk to patient safety where the worker has previously raised the concern internally would be more likely to be protected than a first-time disclosure to the press of a minor concern not involving public safety.

Contractual Duties of Confidentiality

11.40 Many contracts of employment contain express confidentiality clauses; in many others a duty is implied. When parties to an employment contract fall into dispute and reach agreement over the terms for the dissolution of their relationship, there is often a clause in the agreement (a 'severance agreement') to keep its terms confidential. Such confidentiality clauses are usually perfectly proper. However, the PIDA provides that a provision in any agreement between a worker and an employer shall be void insofar as it purports to preclude the worker from making a protected disclosure. The PIDA therefore covers all agreements between employers and workers and is not limited to contracts of employment. It also covers severance agreements.

Disclosure to Legal Advisers

11.41 These are fully protected. However, I think it unlikely that many cases will arise out of disclosure to a legal adviser because, in the nature of things, such disclosures are confidential and are therefore unlikely to result in dismissal or other detriment.

The Impact of the Act

11.42 Mr Dehn told the Inquiry that the PIDA is working well and that it has had a significant beneficial effect. Since its enactment, many employers have become more aware of the need to develop and put in place good, robust whistleblowing policies that embody the features I shall shortly describe. Employers are now more aware that it is legitimate for their employees to raise concerns, that they need to be circumspect about how they handle concerns when raised and that 'if it goes wrong they may have to pay'. In this way, the balance of power has been somewhat redressed.

11.43 Mr Dehn was keen to emphasise the deterrent effect of a good, robust written policy setting out the procedure to be followed when raising and dealing with a concern. He spoke of 'early evidence' that such policies are having that effect. He told the Inquiry that a wrongdoer is more likely to commit malpractice if s/he suspects that his/her peers and colleagues will not know what to do, or will be too afraid to act, if and when they become aware that malpractice is being committed.

Employment Tribunals

11.44 According to information collated by PCaW in 2003, the public register of employment tribunal applications suggested that some 1200 claims under the provisions of the PIDA

were registered in the first three years after the PIDA came into force. These claims had led to one Court of Appeal decision, one Scottish Court of Session decision, six decisions of the Employment Appeal Tribunal and about 100 full decisions of employment tribunals. I have mentioned already the later Court of Appeal case of Street v Derbyshire Unemployed Workers' Centre. These are substantial numbers. They confirm the need for employees to be protected in this way. The concerns raised by those who brought claims ranged from quite trivial matters to serious crimes and grave dangers. The reprisals suffered also covered a wide spectrum. While the majority of the cases involved the raising of concerns internally, employment tribunals readily regarded disclosures to regulators as protected. Five public disclosures – including two to the media – were also held to merit protection. Aggravated damages have been awarded in several cases and, in one case, compensation of £50,000 was given for injury to feelings. While the largest tribunal award by 2003 was £805,000, PCaW suggested that several cases had been settled for more than £1m.

11.45 Mr Dehn was at pains to emphasise, however, that neither the number of employment tribunal decisions nor the sums awarded are the correct measures of the success of the PIDA, the primary purpose of which was to create a culture where employees would feel able to raise genuine concerns in a constructive way and where employers would address properly any real danger or risk.

Changing Attitudes and the Development of Whistleblowing Policies

11.46 Mr Dehn told the Inquiry that the PIDA has provided a major stimulus for organisations to introduce their own whistleblowing policies. Such policies can be a very useful and positive tool for 'corporate governance' and 'risk management' and they are viewed favourably by employers' and employees' organisations. The key elements of such policies, as described by PCaW and as endorsed by the Nolan Committee, are:

(a) a clear statement that malpractice is taken seriously in the organisation

(b) an indication of the kinds of matter regarded as malpractice

(c) respect for the confidentiality of staff raising concerns, if they want it

(d) affording the opportunity to raise concerns outside the line management structure

(e) indicating the way in which concerns may, if necessary, properly be raised outside the organisation

(f) affording access to confidential advice from an independent charity

(g) giving staff of contracting firms access to the organisation's whistleblowing policy

(h) imposing penalties for malicious false allegations

(i) effective promotion of the policy.

11.47 According to PCaW, there have been some good recent local government initiatives and larger private organisations are becoming more interested and involved. There is, however, still a lack of awareness of the legislation in small and medium-sized institutions.

Of the large Governmental organisations, the NHS apparently has the greatest awareness; at paragraphs 11.66–11.73, I will deal specifically with the raising of concerns in the NHS. The position is probably very much the same in large commercial and industrial organisations. Awareness is variable in Government Departments other than the DoH but is quite high in local government.

11.48 Although progress is being made, Mr Dehn told the Inquiry that he believes that it will take a generation or more to achieve a real change in attitude. Clearly, PCaW has an important long-term role to play.

11.49 Several contributors to the Inquiry seminars confirmed that, although attitudes towards people who raise concerns are improving, there is still a long way to go. Mrs Webdale said that one of the main comments from her membership was that there was a lot of work still to be done to make people brave enough to 'put their head above the parapet'.

Raising Concerns in the Health Sector

The History

11.50 To modern eyes, it seems obvious that a culture in all healthcare organisations that encourages the reporting of concerns would carry with it great benefits. The readiness of staff to draw attention to errors or 'near misses' by doctors and nurses, and the facility for them to do so, could have a major impact upon patient safety and upon the quality of care provided. However, those benefits have not always been generally appreciated. In Chapter 10, I described how, in 1994, the culture within the medical profession was not conducive to the raising of concerns by one doctor about another. The Inquiry also heard evidence about the way in which nurses or more junior staff might be ignored or even victimised if they reported malpractice or poor performance by a colleague or doctor. In the early 1990s, the GMC had made plain to doctors where their duty lay; it was to make a report in any case where poor practice or performance might affect patient safety. Yet, as I was to hear from numerous witnesses, the GMC message was not really heeded. Thus, although things may have improved in the aftermath of Shipman's convictions and of the Public Inquiry into children's heart surgery at the BRI (the Bristol Inquiry), there is still room for improvement. As I explained in Chapter 10, Dr Gerard Panting, Communications and Policy Director at the Medical Protection Society, lectures to groups of doctors on ethical issues and is often surprised by the degree of ignorance displayed in relation to such issues.

11.51 Within the NHS also, there has been a move in the direction of greater openness, although it seems originally to have come about, not as the result of concerns about patient safety, but because doctors felt that they were being inhibited from speaking publicly about their concerns over the running of the NHS. In 1993, the NHS Management Executive published guidance entitled 'Guidance for Staff on Relations with the Public and the Media'. This guidance was intended to address the concerns of hospital doctors who felt that their complaints about political interference in health matters were being stifled by confidentiality clauses in their employment contracts. The guidance represented the first formal attempt by the DoH to give guidance to NHS employers and staff about how staff

should go about raising matters of concern, but it was less than ideal. Mr Dehn explained that the procedures to be adopted under the guidance were long and exhausting. The guidance did not make clear what employees should do when they wanted to make a disclosure; nor did it offer them any degree of comfort about what might happen to them if they did so. It did not make clear that the options were to say nothing, to make an internal disclosure or to make an external disclosure.

11.52 Moreover, the procedure for raising concerns described in the guidance was akin to a grievance procedure. The procedure had an adversarial feel to it, which was the opposite of what was wanted. The person raising the concern was the 'owner' of it and was identified with it. In other words, the issue for the employer was 'Is this grievance made out?' rather than, as it should have been, 'What do we need to know about this concern? How do we remedy it? What can we learn from it?' The PCaW view is that employers have to encourage their employees to communicate their concerns to someone within the organisation who is able to assess those concerns and act if appropriate. The employee should not normally have to do any more than raise the concern. It must be emphasised that it is 'concerns' and not 'complaints' or 'grievances' that are being raised.

11.53 Mr Dehn said that this period (by which I understood him to mean the early 1990s) was a time of great activity in the NHS. There were probably several reasons for it but, in brief, the initiative taken by the DoH in 1993 was not followed up. The then Chief Executive of the NHS said in a letter introducing the 1993 guidance that **'a sustained effort is required to ensure that these guidelines** (*i.e. those that made up the guidance*) **are carried through, both in spirit and in detail at local level'**. In May 1995, the Nolan Committee's First Report recorded that the Audit Commission had found that none of the 17 NHS bodies they had visited was promoting a whistleblowing scheme, as the 1993 guidance had recommended. The Audit Commission had also found that one third of NHS staff interviewed said that they would not raise a serious concern if they had one, for fear of losing their jobs.

11.54 The Nolan Committee's First Report recommended that every NHS body that had not already done so should allocate to an official or to a board member the duty of investigating staff concerns about propriety which had been raised in confidence. It recommended that staff should be able, where necessary, to make complaints outside the normal line management chain and, when doing so, should be guaranteed confidentiality. If they were dissatisfied with the response they received, they should also have a clear route for raising concerns about propriety with the sponsor department, i.e. the DoH.

11.55 According to PCaW, the Nolan Committee's Second Report, published in May 1996, reminded NHS bodies of this advice and provided a checklist for use by NHS trust boards to assess how far they were complying with their obligations.

11.56 Fresh DoH guidance was issued on 27th August 1999, following the coming into force of the PIDA. Health Service Circular 1999/198 recommended revision of existing whistleblowing policies in accordance with the PIDA and stated in terms what was expected by Ministers. The Circular read:

> **'Ministers expect a climate of openness and dialogue in the NHS, a culture and environment everywhere in the NHS which encourages staff**

to feel able to raise concerns about healthcare matters sensibly and responsibly without fear of victimisation. The Public Interest Disclosure Act provides fresh impetus for further action.'

11.57 The Circular required positive action by NHS trusts and health authorities. In line with what had been said in the Nolan Committee's First Report, senior managers or non-executive directors were to be given specific responsibility for addressing concerns that were raised in confidence and had – because of their sensitive nature – to be dealt with outside the usual line management chain. Guidance had to be made available to staff to enable them to raise any concerns they might have had about health care, reasonably and responsibly and with the right people. A clear commitment had to be given that concerns would be taken seriously and would be properly investigated. There should also be an unequivocal guarantee that staff raising concerns reasonably and responsibly would be protected from victimisation. Enclosed with the Circular was a resource pack produced by PCaW. This included a copy of the PIDA and a toolkit, comprising an introductory explanatory booklet and a number of case studies, an implementation guide, a computer disk containing educational and promotional materials and other material including checklists. The initiative was in the spirit of the legislation and was welcomed by PCaW.

The Bristol Inquiry Report

11.58 Further impetus towards a culture of open reporting within the NHS came from the Report of the Bristol Inquiry. The Bristol Inquiry began in October 1998 and its Report was published in July 2001. It was set up to inquire into the management of the care of children receiving complex cardiac surgical services at the BRI between 1984 and 1995 and relevant related issues. It was to establish what action had been taken to deal with concerns that had been raised about the services and to identify any failure to take appropriate action.

11.59 The Bristol Inquiry Report concluded that standards in the relevant areas of clinical practice at the BRI had fallen below what was acceptable. Over a period of about four years, from 1991 to 1995, about one third of all the children who underwent open-heart surgery had received less than adequate care. The shortcomings had been recognised by some, in particular Dr Bolsin, a consultant anaesthetist at the Hospital. His attempts to raise his concerns about the standards in the Hospital's paediatric cardiac unit and the poor outcomes had fallen on deaf ears. He first wrote to the Chief Executive of the Hospital Trust, Dr John Roylance, in 1990. This initial, **'rather oblique'** (as the Bristol Inquiry Report described it) approach to Dr Roylance was rebuffed. Thereafter, Dr Bolsin spoke to others including Mr James Wisheart, the relevant consultant in charge, and colleagues within Dr Bolsin's specialty. Later, Dr Bolsin spoke or wrote to anaesthetic colleagues outside the Hospital, to his Hospital peer group among the newly appointed consultants in a number of specialties including surgery, and finally to the management of the Hospital Trust and of the DoH. According to the Bristol Inquiry Report, the difficulties he encountered revealed **'both the territorial loyalties and boundaries within the culture of medicine and of the NHS, and also the realities of power and influence'**. The manner of Dr Bolsin's approach was criticised by his colleagues, and, according to the Bristol Inquiry Report, he seems to have antagonised both senior management and senior medical

figures at an early stage. Thereafter, he felt that he had to take a more circuitous route to make his concerns known. He was not alone in having difficulty in getting a response from Dr Roylance and Mr Wisheart. The Bristol Inquiry Report concluded that **'while Dr Bolsin's actions may not always have been the wisest, and sometimes he gave mixed signals he persisted and he was right to do so'**.

11.60 The Bristol Inquiry Report noted that the systems and hierarchical **'club culture'** in place at the time (and still said to be **'too prevalent'** at the time of publication of the Bristol Inquiry Report) were such as to make open discussion and review of outcome data difficult. Staff were not encouraged to share their concerns or to speak openly. Nursing staff were let down by this culture, which excluded them. Those who tried to raise concerns found it hard to have their voices heard. I note that, in a different context, similar findings were made by the Inquiry into the case of the gynaecologist Rodney Ledward.

11.61 The Bristol Inquiry Report concluded that there was a need in any organisation to have in place systems that allow it to learn and develop; a key feature of such systems should be that all involved must feel able to be open about their work and about the work of colleagues. The Bristol Inquiry Report and the related proceedings before the GMC have, I believe, had an important effect upon attitudes within the NHS. The culture is changing but it is a slow process.

The UNISON and Public Concern at Work Survey

11.62 In May 2003, the public services trade union UNISON published the results of a survey of its members, reporting their experience and levels of awareness of whistleblowing procedures in the NHS. PCaW helped to design the survey, the responses to which were analysed by an academic statistician.

11.63 About 50% of UNISON members did not even know whether their hospital or NHS trust had a whistleblowing policy and about 30% said that their trust would not want to be told if there was a major problem. Unfortunately, of those who had raised concerns, one third had suffered some personal **'comeback'** (not elaborated upon), although one half felt their concerns had been dealt with reasonably. At first sight, these results can only be described as disappointing.

11.64 Mr Dehn's attitude was, however, optimistic, and he was encouraged by the significant improvement in awareness and positive experiences of whistleblowing, as compared with the position when he had first become involved. Most encouraging was the fact that 90% of UNISON members who had had a concern over the previous three years had felt able to raise that concern. This was particularly encouraging because the membership of UNISON is populated by a large number of junior staff. One quarter said that the culture had improved over the previous three years.

11.65 I suspect that these results are significantly better than would generally be expected of results in the workplace outside the NHS. This strongly suggests to me that, when such policies are vigorously and enthusiastically promoted, the benefits can swiftly become apparent. As Mr Dehn said, the message is that, where time is invested in the setting up and administration of a well-designed whistleblowing procedure, that investment is repaid

by an improvement in the culture of the organisation. According to PCaW, the media emphasised the negative but not the positive elements of the survey results.

Public Concern at Work and the NHS: the Current Position

11.66 Mr Dehn told the Inquiry that, since PCaW had been established, 515 of the 3846 expressions of concern received had been from the healthcare and care sectors. In the years 2000, 2001 and 2002, PCaW had received, respectively, 78, 87 and 73 concerns from persons employed in those sectors. There had been a marked increase after 1999, which Mr Dehn ascribed to the Bristol Inquiry and Shipman's arrest in 1998 and conviction in 2000.

11.67 According to Mr Dehn, many NHS organisations now encourage their staff to raise concerns and offer them access to independent advice. Staff are also told that, if, for any reason, they are unwilling to report a concern within the organisation where it has arisen, they may raise it externally.

11.68 In July 2003, the DoH sent a circular letter to the directors of human resources of all NHS trusts, PCTs, strategic health authorities (SHAs) and special health authorities, reminding them of the guidance in Health Service Circular 1999/198. The letter drew attention to the UNISON and PCaW survey and reminded the organisations of the need to introduce and promote a whistleblowing policy for staff. It enclosed a policy pack (in electronic form), produced in partnership with PCaW, which was designed to help NHS bodies to draft a suitable policy. It said that the Government expected organisations to foster a climate of openness.

11.69 Clearly, the DoH and PCaW have been working closely together on the introduction of whistleblowing policies within the NHS. At present, the development of whistleblowing policies is still primarily regarded as a human resources function. I can understand how that comes about; the human resources department will be responsible for drafting the policy and incorporating it into employment contracts. Also, the policy will be intended to cover many different types of concern besides those relating to clinical treatment. However, the purposes of the policy include ensuring that staff feel able to report concerns about clinical treatment, that any such concerns are properly investigated and that lessons are learned. Preparing the policy is a human resources function but making it work should be, as Mr Dehn suggested, an aspect of clinical governance. PCaW welcomed the fact that the reporting of concerns about clinical matters was increasingly being used as a clinical governance tool. PCaW would also like the DoH to give directions rather than exhortations to NHS bodies about the introduction of whistleblowing policies. It would, I think, be sensible if circulars or directions about raising concerns were sent to clinical governance leads and medical directors, as well as to the human resources directors of NHS bodies. These suggestions would help foster the culture of openness about clinical errors and shortcomings that the DoH is seeking to promote.

Primary Care

11.70 Primary medical care is provided by GPs and also by a range of other healthcare professionals such as midwives, health visitors, counsellors and district nurses. These

other healthcare professionals are usually employed by the local PCT or community health trust. Practice nurses are usually employed by the GP practice itself. In addition, there will be practice managers and administrative/clerical staff, whose task it is to organise and manage the smooth running of the practice. In general, they are employed directly by the practice. In Chapter 9, I described some of the difficulties that such staff face if they wish to raise a concern about something that is happening within the practice.

11.71 Historically, PCaW was involved only rarely with the primary care sector. Mrs Webdale had, until recently, not heard of the organisation despite her involvement in AMSPAR and the fact that she is very much in the vanguard of GP practice management. In 2003, the PCaW advice line received about 15 calls in relation to primary care, of which at least three concerned single-handed practice.

11.72 However, at the time of the Inquiry's seminars, the DoH and PCaW were working together on the preparation of guidance for GPs on how to develop and implement a whistleblowing policy for healthcare professionals and other staff in their practice. The Inquiry has now seen a draft of that guidance and of the whistleblowing policy contained in it. The draft policy embodies most of the key elements identified in paragraph 11.46 above. I have described it in more detail in Chapter 9. Staff are advised that, if they are unable to raise the concern internally, or if it has not been dealt with properly, they should approach a named contact at the PCT. The draft policy is clear and reassuring in tone. It contains contact details for PCaW and also mentions that free independent advice may be available from the trade union or professional organisation to which the member of staff belongs.

11.73 It will in my view undoubtedly be beneficial for the raising of concerns to be publicised and promoted in primary care, as it has been in secondary care. It seems to me that the same broad principles should apply in primary care as apply in secondary care. Practice staff at all levels should feel confident that their employment structure allows them to raise concerns without fear of detriment. However, the complex and differing employment/partnership relationships that exist in primary care are not conducive to clarity or certainty about lines of disclosure. As I have already suggested, the option of disclosure to the PCT (or to the GMC) could be written into the whistleblowing policy of a GP practice (the effect of which would be to afford maximum protection to disclosures to those bodies).

Private Healthcare Organisations

11.74 Ms Beverley Cole, transitional project manager of the National Care Standards Commission (NCSC), said that staff working in private care homes, hospitals and clinics often experience even greater difficulty in voicing concerns because they have no PCT to go to. It was a big leap for them to go directly to the NCSC, whose responsibilities included the regulation and inspection of private healthcare organisations, a role now undertaken by the Healthcare Commission.

11.75 Fewer than 5% of referrals to PCaW emanate from private healthcare organisations. When someone from the private sector contacts PCaW with a concern, it is sometimes difficult for PCaW to advise. Very few private hospitals have a whistleblowing policy and this means that it can be difficult for PCaW to give clear advice.

11.76 In my view, staff working in the private sector should have the same opportunity to raise concerns without fear of retribution as staff within the NHS. Also, the same culture of openness should be fostered in non-NHS healthcare organisations as within the NHS. The Healthcare Commission could require all private healthcare organisations to have a clear written policy for the raising of concerns as a condition of registration. The position of staff working in the private sector could be improved if the Healthcare Commission were to be included as a **'prescribed person'** for the purpose of receiving expressions of concern about the private healthcare sector, as well as under the NHS.

The Professional Obligation of Doctors

11.77 The case of Mrs Renate Overton brought to light important questions concerning the duty of a doctor who has concerns about the professional conduct or performance of a colleague, where patient safety may be at risk. My First Report contains my decision about Shipman's involvement in Mrs Overton's death. My Third Report contains an examination of the roles played by the various agencies and individuals who became involved in the case from the time Shipman administered the lethal dose of diamorphine in February 1994. Chapter 10 of this Report deals with the question of whether two consultants at Tameside General Hospital should have reported their concerns about Shipman's treatment of Mrs Overton.

11.78 As I explained in paragraph 11.50, in the early 1990s, the GMC made plain the duty of a doctor to report to an appropriate person or body any concern about the conduct or performance of a colleague that might have an impact on patient safety. The current guidance to doctors appears in the latest (May 2001) edition of 'Good Medical Practice', which is provided to all doctors by the GMC. It says:

> **'Conduct or performance of colleagues**
>
> **26. You must protect patients from risk of harm posed by another doctor's, or other healthcare professional's, conduct, performance or health, including problems arising from alcohol or other substance abuse. The safety of patients must come first at all times. Where there are serious concerns about a colleague's performance, health or conduct, it is essential that steps are taken without delay to investigate the concerns, to establish whether they are well-founded, and to protect patients.**
>
> **27. If you have grounds to believe that a doctor or other healthcare professional may be putting patients at risk, you must give an honest explanation of your concerns to an appropriate person from the employing authority, such as the medical director, nursing director or chief executive, or the director of public health, or an officer of your local medical committee, following any procedures set by the employer. If there are no appropriate local systems, or local systems cannot resolve the problem, and you remain concerned about the safety of patients, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defence body, a professional organisation or the GMC for advice.**

28. If you have management responsibilities you should ensure that mechanisms are in place through which colleagues can raise concerns about risks to patients.'

11.79 The guidance is clear in that it leaves doctors in no doubt about their obligation to report concerns about another health professional. It could usefully be updated to mention that other recipients for the expressions of concerns could include the clinical governance lead and/or other officers of a PCT. It seems to me that the important thing now is to ensure that doctors accept where their duty lies and act accordingly. In Chapter 10, I explored in some detail the reasons why doctors have been reluctant to report concerns about colleagues, even in the face of clear advice that they should. Historically, the culture has been that it is 'not done'. The Inquiry was told that there has been a significant change of culture and attitude since 1994 and that doctors are now far more likely to comply with their duty to report. I have not received evidence directly on that issue but such evidence as has touched upon it suggests that the old culture lingers on. As I have mentioned, the change of attitude was ascribed to, among other things, learning from the events revealed to the Bristol Inquiry. However, the Bristol Inquiry Report itself suggested that the **'club culture'** still prevailed to some extent in 2001. There is other evidence that confirms that this is so. Reports prepared for the GMC by a firm of management consultants (described further in Chapter 26) suggest that, within the GMC, there is still scepticism about the level of reporting of concerns about doctors. Evidence submitted to the Inquiry by the British Medical Association Junior Doctors Committee suggested that junior doctors are unwilling to raise concerns about a consultant because of the fear that consultants might block their juniors' career progression. It is inevitable that deeply engrained attitudes take a long time to change. In my view, it is important that young doctors are imbued with the new culture from the start. But it is also vital that the leaders of the profession consistently put the message across to the present generation of doctors.

The Position of Nurses

11.80 Evidence given to the Inquiry suggests that nurses have faced particular difficulty in reporting concerns about doctors, although they have found it rather easier to report concerns about members of their own profession. Both the Bristol Inquiry Report and the Ledward Inquiry Report said that the culture in medicine inhibited the proper reporting of concerns by nurses about doctors. Most of the nurses who gave evidence about Mrs Overton's case said that, in the past, they would have found it very difficult to raise a concern about the conduct or performance of a doctor. The position was now easier, they said, and either they would report a concern to their line manager, or they would seek guidance from the Nursing and Midwifery Council as to what they should do.

11.81 Mr Ian Hargreaves, retired Regional Director of the Royal College of Nursing (RCN), giving evidence in October 2003, said that he still remained concerned about the continuing existence of a culture in hospitals that discouraged the raising of concerns, although he had noticed improvement over the year or so prior to his retirement in the spring of 2003. He had noticed that NHS trusts and the managers within them showed a greater acceptance of the raising of concerns openly. Although his impression was that change

was happening at the top of organisations, he was unsure 'how embedded it is ... at the front line ... and that is where some of the problems arise'. There are at least two reasons that might explain why the message is not getting through despite the efforts to bring about change. First, it may well be that the perception 'at the front line' is that policies and procedures are regarded as 'fine words', which do not reflect the approach that will be taken in practice. The fear of retribution may still be real. Second, it may be that some people remain to be convinced of the benefits of the new openness in terms of improving patient care.

11.82 The RCN has set up a 24 hour helpline in order to advise nurses who wish to know how to raise concerns. This is regarded as an important element of the support it provides for its members. The College also publishes guidance on raising concerns and offers professional counselling, where needed. From that perspective, therefore, nurses are well supported.

11.83 Mr Hargreaves said that the experience of the RCN is that the raising of concerns can be followed by disadvantage in at least two forms. Usually, such disadvantage comes from the doctor who has been complained about, who may refuse to work with the nurse and/or demand the nurse's transfer. Sometimes, nurses who have raised concerns become the subject of investigation themselves because they may have delayed before reporting and/or because they may be said to have participated in the conduct which was the subject of concern. In such situations, it has been suggested, there is the possibility that, if healthcare professionals witness dangerous practice once and do nothing about it, 'they too have an interest in any subsequent cover-up'. Thus, it may not be surprising if there is a reluctance to raise concerns.

11.84 Mr Hargreaves said that, despite the assistance that the RCN is able to give, the anecdotal evidence received is that it is still very difficult for a nurse to challenge poor practice by a doctor. He said that he still knew of consultants who could put 'fear and trepidation' into nurses and who sometimes used that power to impose their will on the rest of the team, though not necessarily to hide poor clinical practice. He told the Inquiry that nurses who complain about hospital doctors are often moved on to another position, away from the doctors about whom they have raised a concern. This, he said, is counter-productive. It does not resolve the concern about the doctor and it also acts as a disincentive to other nurses who might find themselves in a similar position. First, the nurse's concern is not addressed and, second s/he loses her position. Plainly this kind of situation ought not to arise, although I can see that, sometimes, working relationships within a clinical team may become very difficult following the raising of a concern about poor practice. It seems to me that, where a concern has been raised honestly, every effort should be made to encourage the parties to 'mend their fences'. If that cannot be done, someone will have to move but there should not be a presumption that it is always the nurse. Even less should there be a presumption that it should be the one who raised the concern rather than the one whose conduct gave rise to it. In any event, there must be seen to be a proper, fair and thorough investigation of the concerns.

11.85 Although much of Mr Hargreaves' experience was with nurses employed in a hospital setting, he also knew of instances where practice nurses had raised concerns about their

GP employer. In a single-handed practice, that might mean that they could no longer work with their employer. He said that there was evidence, even in a group practice, that if a nurse raises concerns about one partner, the reaction of the other partners is to 'wrap themselves round that partner' with the aim of preserving the partnership.

A Study of Community Nurses

11.86 A paper published in the Medical Law Review in the summer of 2001[2] revealed the results of a study undertaken in March 2000 of the level of awareness among 70 community nurses in Sheffield of the legal protection afforded to whistleblowers. The community nurses in Sheffield are not in a direct line-management relationship with GPs and it was thought that this might have encouraged openness in the reporting of concerns.

11.87 Nearly one third of the nurses questioned said that at some stage during their career they had had concerns about a GP's performance to the extent they felt patients were at risk, yet over half of them had not reported those concerns. Of the 41% who had reported the concern, no action was taken in more than half of the cases. Only 61% of nurses said that they would report a concern about 'risky' GP performance. Even among those who said that they would report a concern, there was little clarity about the correct reporting procedures. I share the author's concern that this has worrying implications for patient safety.

The Position of Local Authorities

11.88 In the last few years, according to PCaW, local authorities have shown considerable interest in the development of whistleblowing policies. The Inquiry sought and obtained a large number of such policies; two, in particular, from local bodies which provide home support services (Tameside Metropolitan Borough Council Home and Support Service) and warden-controlled accommodation (the New Charter Housing Trust). Each policy meets the criteria I have outlined. Each also offers reassurance that the employer is genuinely interested in receiving reports of concern and states that the worker will be kept informed of progress of any inquiry into the concern and action taken. The Tameside policy states:

> **'As a Home & Community Support Worker you have a duty to report any concerns you may have in the provision of the service to our service users. These could be provided by colleagues, private/voluntary workers, others.**
>
> **We cannot ignore any form of abuse that would affect the well-being of our service users.**
>
> **If you have any concerns:-**
>
> **Procedure**
>
> **1) Ring the office and inform a Manager.**

[2] Julia Burrows. 'Telling Tales and Saving Lives: Whistleblowing – The Role of Professional Colleagues in Protecting Patients from Dangerous Doctors', Medical Law Review, 9, Summer 2001, pp. 110-129.

2) Write a short summary of events in your diary – day, date and the incident. Write the name of the Manager you have spoken to.

(This information will assist you at a later date if you need to make a statement).

This will then be actioned, you will be kept informed of the situation and the outcome.'

11.89 Without hearing extensive and detailed evidence from employees of these and other organisations, it is impossible to assess how well understood and how well implemented these policies are. However, some evidence received from witnesses with responsibility for the operation of these policies indicates that there has been a significant change in attitudes towards the raising of concerns within the last few years.

Improving the Position for the Future

11.90 It appears to me that the position of any person seeking to raise a concern is now very much better than it was even six years ago, when the PIDA was passed. I think that the PIDA has been of great value, both in the relief it has provided for individuals and also in changing general attitudes. However, I am sure that more remains to be done. Mr Dehn told the Inquiry that the operation of the PIDA had been found to be less than perfect in some respects and it was intended that its operation should be reviewed with a view to introducing amendments. That being so, I propose to make some suggestions as to how the PIDA should be amended.

Possible Changes to the Public Interest Disclosure Act 1998

11.91 It is perhaps worth saying again that the object of any legislation of this kind must be to encourage persons to bring forward genuinely held concerns where the bringing forward of those concerns, whether subsequently found to be right or wrong, is in the public interest.

Use of the Word 'Disclosure'

11.92 As I have said, the PIDA refers generally to the making of **'disclosures'**. To my mind, the use of that word conveys the presumption that the 'disclosed' facts are true. What is in fact happening is that concerns or information (that may be true or false) are being 'reported'. I would suggest that thought be given to the possible substitution of the word 'report' for the words **'disclose'** and **'disclosure'**.

Extension of the Categories of Persons Prescribed under Section 43F

11.93 In the context of raising a concern about a doctor or nurse or other healthcare worker, it is not satisfactory that a **'disclosure'** or report made to the GMC or to the Healthcare Commission does not attract second tier protection. If and when the legislation is amended, I suggest that the Healthcare Commission, all the healthcare regulators and possibly even the Council for the Regulation of Healthcare Professionals (now known as

the Council for Healthcare Regulatory Excellence) should be included in the list under section 43F of the Act. I note that the Ledward Inquiry Report recommended that second tier protection should be given to workers reporting a doctor to the GMC.

Good Faith

11.94 As I have explained above, no disclosure (except a disclosure made to a legal adviser in the course of obtaining legal advice) can be a qualifying disclosure unless it is made **'in good faith'**. When Mr Dehn gave evidence, in September 2003, he was asked about his understanding of that phrase. His response suggested that PCaW generally advised that **'good faith'** equated to honesty. He said:

> **'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.'**

11.95 The first point to make is that the proper question for the employment tribunal to ask will always have to be framed in the words of the statute. At present, the question will be 'Was the complainant acting in good faith?' and not 'Did the complainant act honestly?' or 'Did the complainant have mixed motives?'

11.96 The question of the meaning of **'in good faith'** in the context of the PIDA arose in the recent case of Street v Derbyshire Unemployed Workers' Centre to which I referred earlier. The facts were as follows. In January 2001, the Derbyshire Unemployed Workers' Centre dismissed the appellant, Mrs Frances Muriel Street, from her employment as an administrator. She had made an allegation that the manager of the Centre had committed a fraud on the Centre by spending time on other projects when he should have been working in the interests of the Centre and that he had spent money on other projects which should have been applied for the benefit of the Centre. Following a disciplinary interview, Mrs Street was dismissed for **'gross misconduct'** and **'breach of trust'** on the basis of her **'unfounded and libellous'** allegations against the manager and because she had refused to co-operate with an investigation into her allegations. Mrs Street's internal appeal against dismissal was unsuccessful. She applied to an employment tribunal (ET) alleging that she had been unfairly dismissed. She claimed that, because they fell within the protection of the PIDA, the circumstances of her dismissal entitled her to claim that it had been 'automatically' unfair. One of the disclosures had been made internally and for that Mrs Street claimed first tier protection. Another was made to the treasurer of the local Borough Council; that person was not a **'prescribed person'** and so, in order to gain the protection of the PIDA, Mrs Street had to satisfy the third tier requirements.

11.97 The ET dismissed Mrs Street's claim for interim relief and 'automatic protection', although her 'ordinary' unfair dismissal claim (i.e. that not attracting automatic protection) was allowed to continue. None of her disclosures was, it was found, protected by the PIDA. The ET held, in relation to the external disclosures, that Mrs Street had reasonably believed that:

(a) her disclosures tended to show that the manager had failed to comply with his legal obligations

(b) they were substantially true

(c) they were not made for personal gain

(d) she would be subject to a detriment if she reported the matter to her employer.

11.98 The ET also held that it had been reasonable in all the circumstances for her to make the disclosures. Nonetheless, her claim failed because the ET found that Mrs Street had not made her disclosures in **'good faith'**. It found that Mrs Street had been motivated by her personal antagonism towards the manager of the Centre. There was evidence that, in one of her disclosures, Mrs Street had made a passing reference to something about the manager which she knew to be untrue. So she had successfully overcome all the hurdles, save for the one relating to **'good faith'**, which applied to both the first tier and third tier disclosures. Mrs Street's appeals to the Employment Appeal Tribunal (EAT) and to the Court of Appeal were dismissed.

11.99 Mrs Street's argument before the Court of Appeal was that the phrase **'in good faith'** meant no more than 'honestly'. As she had proved that she had had a reasonable belief in the substantial truth of her allegations, the requirement of **'good faith'** was satisfied. It would, it was argued, subvert the purpose of the PIDA to hold otherwise. The employers, seeking to uphold the decision of the ET and the EAT, argued that the requirement for **'good faith'** was an additional requirement over and above the need to show a reasonable belief that the allegations were substantially true. The phrase **'in good faith'** must be taken to impose an additional requirement, otherwise it would not have been included in the statute.

11.100 PCaW was allowed, as an interested party, to make written submissions. The main thrust of those submissions, which supported Mrs Street's argument, was that it would seriously damage the working of the PIDA if ulterior motivation – in particular the promotion of a grudge – were to prevent a finding of **'good faith'** and result in the loss of statutory protection. PCaW argued that motives other than the 'pure' desire to promote the public interest are often present when disclosures or allegations are made. The Court should not concern itself with the motive of the messenger but should concentrate on the message and whether there was a reasonable belief in its truth. The purpose of the legislation was to encourage people to bring forward their allegations in the public interest; the fact that they might have mixed or ulterior motives should not matter. PCaW submitted, in the alternative, that an ulterior motive should operate to vitiate **'good faith'** only where it was the predominant motive and/or was 'wicked' or 'malicious'.

11.101 Counsel for Mrs Street adopted these submissions as an alternative to his main submission, arguing that the presence of an ulterior motive should indicate lack of **'good faith'** only if it were the predominant motive.

11.102 The Court of Appeal accepted the employer's submission and held that the words **'good faith'** must require something more than a reasonable belief in the substantial truth of the allegation and something more than 'honesty'. The purpose of the PIDA, it emphasised, was the protection of those who make certain disclosures and were motivated by 'the public interest'. The preamble to the PIDA was cited. That says that the PIDA exists to protect those who make certain disclosures of information in the public interest. The phrasing suggests that the PIDA exists to protect 'individuals' who act in the public interest. I observe that it does not say that the PIDA is to protect individuals who disclose information, the disclosure of which is in the public interest. If it had done so, Mrs Street might have been on stronger ground before the Court of Appeal.

11.103 In the Court of Appeal, Lord Justice Auld observed that the draftsman had plainly contemplated that, although a disclosure might have been made with a reasonable belief that it was true, it would not qualify for protection if it had not been made **'in good faith'**. He said that, **'shorn of context'**, the words **'in good faith'** do have a **'core meaning of honesty'**. However, **'in good faith'** had to be construed in the context of the PIDA. Having considered and drawn comparison with the law of defamation, where the defence of qualified privilege can be defeated by the presence of malice, Auld LJ concluded that the words **'in good faith'** required that the dominant or predominant purpose of the worker had to be that for which the statute was passed, namely, the disclosure of information in the public interest. If another purpose was dominant, good faith would be absent.

11.104 In a concurring judgement, Lord Justice Wall stated that **'good faith'** is a question of motivation and observed that, **'as a matter of general human experience, a person may well honestly believe something to be true, but, as in the instant case, be motivated by personal antagonism when disclosing it to someone else'**. He went on to define the extent to which mixed motivation should undermine the protection afforded by the PIDA, at the same time acknowledging that the question for the ET will always be 'Was the complainant acting in good faith?' and not 'Did the complainant have mixed motives?' He said that the primary purpose for the disclosure of the relevant information should be to remedy the wrong that is occurring or has occurred (or, presumably, to prevent that which may be about to occur). Alternatively, the primary purpose must, at the very least, be to bring the information to the attention of a third party in an attempt to ensure that steps are taken to remedy the wrong. In answering the question whether **'good faith'** was present, Wall LJ said that ETs must be free to conclude that a worker had mixed motives and was not, therefore, acting **'in good faith'**. It would be open to them to conclude – though they would not be bound to do so – that a worker was not acting **'in good faith'** if his/her predominant motivation was not the remedial or preventive purpose described above.

11.105 The Court of Appeal quoted with approval the following words from the EAT decision:

> **'It is not, in our view, the purpose of the Public Interest Disclosure Act to allow grudges to be promoted and disclosures to be made in order to advance personal antagonism. It is ... to be used in order to promote the**

public interest. The advancement of a grudge is inimical to that purpose.'

The Court of Appeal dismissed the appeal. It seems to me the decision was plainly right as a matter of law. As I have explained, the preamble to the PIDA shows that it was intended to protect those who act (by disclosing information) in the public interest; it is not designed to protect those who disclose information, the disclosure of which is in the public interest. The Act plainly intends that protection will be provided only if the person making the disclosure is motivated by a desire to promote the public interest or, as the Court of Appeal has now held, if the person has that as a predominant motive. The position of PCaW, based on its extensive experience of advising people who are considering whether to make a disclosure, is that such people often have mixed motives but should be encouraged to make their disclosure, if it is in the public interest that it be made. In other words, if disclosure is in the public interest, it should not matter whether the person making the disclosure has mixed (or, possibly, even malicious) motives.

11.106 I can see the force of PCaW's argument. If employers are able to explore and impugn the motives of the 'messenger', when trying to justify having taken action against him/her, many 'messages' will not come to light because organisations like PCaW will have to advise those who come to them for advice that, if their motives can be impugned, they may not be protected by the PIDA. The Court of Appeal emphasised that someone in Mrs Street's situation was not totally without remedy; she lost the 'automatic protection' of the PIDA but retained the right to argue that, in all the circumstances, her dismissal had been unfair. That is undoubtedly so, but anyone advising her before she made her disclosure would have had to give very cautious advice. The effect of receiving that cautious advice might well have meant that she would have kept quiet. This would be unfortunate if the information affected, for example, patient safety in a healthcare setting. It is clear that, prior to the decision in Street at least, PCaW did not advise those who sought its advice that the presence of mixed motives would defeat a claim to automatic protection under the legislation.

11.107 It also appears that some organisations operate a policy which guarantees their employees greater protection than is, in fact, provided by the PIDA. Mr Alan Turner, consultant urologist and, since 1993, Medical Director of Peterborough Hospitals NHS Trust, provided the Inquiry with a copy of the whistleblowing policy operated by his Trust. Its language does not have the clarity that would be desirable in an Act of Parliament but its message is tolerably clear. It says:

'No disciplinary action will be taken against someone who makes a disclosure in good faith regardless of whether or not it is substantiated. (Of course, we do not extend this assurance to someone who maliciously raises a matter they know to be untrue).'

The phrase **'in good faith'** in that context, juxtaposed with the state of mind of a person who **'maliciously raises a matter'** s/he knows to be untrue, would not appear to require the absence of mixed motives that the PIDA has been held to require. The policy of the New Charter Housing Trust contains the following paragraph, which again goes further than the PIDA:

> **'If it is discovered you have abused this confidential reporting process and have maliciously or in bad faith or without reasonable belief raised unfounded allegations, we will treat this as a very serious disciplinary matter. No-one who comes forward in good faith and/or with a reasonable belief has anything to fear even if it turns out that their concerns were unfounded.'**

Although the words **'in good faith'** appear in that policy, it would seem that a person with 'mixed motives' would not have **'anything to fear'** so long as s/he had **'a reasonable belief'**, even if his/her concerns were unfounded.

11.108 It seems to me that the assurances given in these two policies are pitched to give the level of protection that the PIDA ought to give – and that PCaW would like it to give – but does not. I think that there should be public discussion about whether the words **'in good faith'** ought to appear in the PIDA. In my view, they could properly be omitted. The three tiered regime of the PIDA, with its incrementally exacting requirements, should afford sufficient discouragement to those minded maliciously to raise baseless concerns. I think that it would be appropriate also if the preamble to the PIDA made it plain that the purpose of the PIDA is to protect persons disclosing information, the disclosure of which is in the public interest. That would serve to focus attention on the message rather than the messenger. The public interest would be served, even in cases where the motives of the messenger might not have been entirely altruistic.

Reasonable Suspicion and Reasonable Belief

11.109 I have already explained that, before any disclosure can become a qualifying disclosure, it is necessary for the worker making disclosure to have a **'reasonable belief'** that the information tends to show that an act falling into one or more of the listed categories of malpractice has been, is being or is likely to be committed. Reasonable suspicion of that is not enough.

11.110 It seems to me that this requirement also may operate against the public interest, especially in cases where the worker has access to incomplete or secondhand information. I am concerned that, in order to make a disclosure even to his/her employer, a worker has to be in the position where s/he could say, for example, 'I believe that this disclosure tends to show that a crime has been committed and my belief is reasonable.' As can be seen in Chapters 8 and 9, if this threshold were applied to workers having the state of mind of Mr Shaw, Mr and Mrs Bambroffe, Mrs Foley, Mrs Shawcross and Mrs Simpson, I doubt that they would confidently have been able to cross that threshold. Moreover, I do not think that anyone answering a call on the PCaW helpline could confidently have assured any of those persons (had they been **'workers'**) that their state of mind was such that they were guaranteed protection.

11.111 The onus should not, in my view, be on an individual to establish **'reasonable belief'** in the case of internal disclosures and disclosures to external regulators. The public interest would, in my view, be best served by substituting 'suspicion' for 'belief'. The Tameside Families Support Group suggested this and I agree with its suggestion.

11.112 I am also of the view that to apply the **'reasonable belief'** test to reports of concern to **'prescribed persons'** sets the threshold for protection too high. In determining whether disclosures to **'prescribed persons'** attract protection, this test requires a **'reasonable belief'** that the information disclosed and any allegation contained in it is **'substantially true'**. This may be desirable and appropriate when the information is a matter of firsthand observation but the position is different when the information is secondhand, perhaps a strong rumour or suspicion. The individual concerned might well not be in a position to say that s/he reasonably believes **'that the information disclosed, and any allegation contained in it'** is **'substantially true'**, although s/he might strongly suspect that to be the case and that suspicion might well warrant investigation. In an area where the natural tendency will be for people to 'sit tight' or 'keep quiet' I take the view that to apply as a threshold 'reasonable belief in substantial truth' will result in the regulators remaining unaware of cases of which they should be aware.

11.113 The third **'reasonable belief'** test, applicable, for example, to disclosures to the media, depends on the worker having the **'reasonable belief'** that his employer will 'respond badly' to the allegation, before an external disclosure (other than to a regulator) becomes protected. I do not regard this as being so onerous. It is far less exacting to expect a worker to be able to explain the basis for a belief about the likely response of his/her employer than it is to require justification of a belief about a state of affairs of which s/he may have only partial knowledge or understanding.

Internal Disclosures

11.114 As I have explained, the PIDA affords protection most readily to disclosures made to the worker's employer, to a person authorised by the employer's whistleblowing policy to receive them directly or to the person with **'legal responsibility'** for the malpractice in question. In my view, these provisions leave some employees in a difficult position. In particular, I have in mind employees in very small organisations. There may be no whistleblowing policy or it may be impossible in practice for an employee to raise a concern directly with the employer. There may be no person or organisation that appears to have any legal responsibility for the malpractice in question. Take, for example, the position of a nurse who is directly employed by a GP practice and who becomes suspicious that one of the GPs in the practice is guilty of irresponsible prescribing of controlled drugs to patients. The practice nurse may well not want to raise his/her concerns directly with the practice but deserves, it seems to me, a high level of protection if s/he wishes to report those concerns to the PCT. It is arguable – but far from certain – that such protection exists under the PIDA. It could be said that the PCT has **'legal responsibility'** for the GP's acts because it has a duty of quality imposed by the Health Act 1999 in respect of the services provided by the GP. However, the argument might well fail. Protection under the PIDA would be very unlikely to be available where the concern was that the GP was prescribing controlled drugs irresponsibly for him/herself.

11.115 The problem could be resolved in the particular example I have given by imposing a requirement that each GP practice have a policy authorising disclosures to be made directly to the PCT. That is desirable and, indeed, it is contemplated by the draft policy to which I refer in paragraph 11.72. However, there may be other situations in which the

problem cannot be resolved so easily. I have in mind, for example, the position of an employee in a small firm or business who begins to suspect that his/her employer may be defrauding clients. He or she is likely to feel unable to raise the matter within the firm, yet may not feel sufficiently certain to make a report to the police. A report made to a trade or professional organisation would attract protection under the PIDA only at the third tier, with all the additional hurdles that must be overcome before protection is secured. A possible but unwieldy option would be for the range of **'protected persons'** to be extended. The preferable solution – and I suggest this for consideration only – may be to consider requiring all employers to specify a third party recipient for expressions of concern. Provision could be made to allow third tier disclosures by employees of employers who did not take this step to be treated as second tier disclosures. I recognise that this suggestion is outside my Terms of Reference but, if the PIDA is to be reviewed, it occurs to me that it might help for such a provision to be included.

Reporting Concerns in Relation to Linked Organisations

11.116 It will sometimes happen that an employee in one healthcare organisation develops concerns about the conduct or performance of a healthcare professional in another organisation. The most common situation will probably be where a concern arises in a hospital about the care provided by a GP or *vice versa*. The case of Mrs Overton is an example. A hospital employee who is concerned about the treatment provided to a patient by a GP will or should know of the policy for raising concerns operating within the hospital but may not know of the policy operating within the PCT or GP practice by which the patient has been treated. In cases such as this, there will not usually be any anxiety about loss of employment or fear of any other kind of retribution; the only problem may be one of ignorance or confusion as to what to do.

11.117 I suggest that policies for raising concerns, certainly in the healthcare sector, should in future be capable of being used for the raising of concerns by and about persons who do not share common employment. One example has been the recent development in Hyde, whereby, following the publication of the Inquiry's Third Report, which dealt with Shipman's unlawful killing of Mrs Overton, the local PCT and the local Hospital Trust have joined forces to devise a very useful policy. In essence, the policy provides that a concern should be raised initially within the organisation of the employee who has the concern. The concern is then assessed by a member of senior management within that organisation. If the concern is considered well founded, it will be passed on to the organisation employing the person about whom concern has been expressed. That organisation will investigate the concerns but the directors of both organisations should agree the action to be taken, including disciplinary action. I suggest that other NHS trusts and PCTs should develop such policies. On a wider footing, it would be sensible for employees in general to be told that, if they have concerns about persons employed by another organisation and do not know what to do, they should seek advice from their own employers. Not everyone can have reciprocal arrangements.

Self-Reporting and the No-Blame Culture

11.118 There has in recent years been a move within the NHS to encourage doctors and nurses to report any incident in which they have made an error resulting in harm or giving rise to

a **'near miss'**. The idea is to promote an atmosphere of openness in which, instead of seeking to blame someone who has made a mistake, the organisation will seek to learn from its mistakes. In many ways, this is the ideal situation and, if it were to come to pass, there would be very little need for the reporting of concerns. However, the evidence I have heard suggests that we are a long way from that ideal at present. In this context, I should say that I have already explained the proposed **'duty of candour'** in Chapter 7. I have not analysed the topic in detail but I share the concerns of the GMC and of the RCN.

Concerns Felt by Others

11.119 So far I have dealt mainly with the position of employees. Nevertheless, as I explained at the beginning of this Chapter, some of the constraints on disclosure by employees apply also to others whose concerns do not arise in the employment context. For example, although the concerns of Mr Shaw and Mr and Mrs Bambroffe arose in the course of their work, they had no employer to whom they could take them. Mr and Mrs Bambroffe had a professional association but they cannot have thought it appropriate to discuss their anxieties with its officers.

11.120 The fear of litigation operated on the minds of at least two of the people who had concerns about Shipman. Mr Shaw and Dr Reynolds both feared the prospect of potentially ruinous defamation proceedings if they were to 'speak out'. At the time when they became concerned, of course, the very idea that Shipman might have been killing his patients would have been considered unthinkable by most members of the public. Also, much of the evidence that has since been uncovered was not available to either of them. They had no way, therefore, of taking further steps to refute or confirm their suspicions. Nor was it their responsibility to do so. All they wished to do – and all they could reasonably be expected to do – was to bring their suspicions to the attention of the proper authorities and to leave it to them to investigate.

11.121 In fact, neither Mr Shaw nor Dr Reynolds need have feared an action for defamation. However, they would not have known that without legal advice. They need have had no fear for two reasons. First, if they had confined themselves to saying that which was in fact true, they would have had no need to worry, because statements that are true cannot be defamatory. If Dr Reynolds had provided the statistics of the number of cremation certificates that she and her partners had been asked to sign for Shipman, who had a patient list of 3000 patients, and those that she and her partners asked other doctors to sign, in respect of their list of 8000 patients, she would not have needed to make any allegation of wrongdoing against Shipman, even though the implication behind her report would have been clear. The facts alleged would have been plainly true. Mr Shaw's information was less demonstrably true because what he was concerned about was not the number of patients who were dying but the fact that they did not appear to have been ill beforehand. The truth of those facts would have been more difficult to demonstrate although, in the event, we now know that he was right.

11.122 Second, even if Dr Reynolds and Mr Shaw had not been at all sure of the truth of the facts, they could have successfully defended an action for defamation, provided that they had raised their concerns in an appropriate quarter and had not been actuated by malice.

They could have relied upon the defence of qualified privilege. The defence of qualified privilege applies when the person making the communication does so because s/he has some legal, social or moral interest or duty to make it and where the person to whom it is made has some corresponding interest or duty to receive it. The defence classically avails those who report concerns to the police or to other investigatory or regulatory bodies. The defence is available even where it turns out that the information communicated is untrue. In order to strike a balance between encouraging the fulfilment of the duty and discouraging the malicious making of unfounded complaints, the defence is not available where the making of the communication is actuated by malice or improper motive.

11.123 Had Mr Shaw reported his concerns to an appropriate body, he would have done so out of a sense of moral obligation. Dr Reynolds considered herself to be under a professional duty to make the report that she did and, in view of the nature of the information to be communicated in each case, no one would seriously doubt the existence of the duty. Mr Shaw might have needed advice about the suitable recipients of the information, i.e. those organisations with a duty to receive it. The GMC, the West Pennine Health Authority, the Coroner and the police all come to mind. In Dr Reynolds' case, another appropriate recipient might have been the medical referee of the crematorium at which the bodies of many of Shipman's former patients had been cremated. Dr Reynolds consulted her defence organisation. Neither Mr Shaw nor Dr Reynolds need have feared the suggestion that they were actuated by malice or improper motive and nor would others in this situation. Moreover, the House of Lords has stated that judges and juries should **'be very slow to draw the inference that a defendant was so far actuated by improper motives as to deprive him of the protection of the privilege unless they are satisfied that he did not believe that what he said or wrote was true or that he was indifferent to its truth or falsity'** (in the case of Horrocks v Lowe[3]). In short, a person who feels under a duty to raise a concern and does so as a result of honestly held suspicions need not fear an action in defamation, provided that care is taken in making the report to the right quarter. For that, some people, such as Mr Shaw, may need advice. Such advice should be made readily available.

11.124 I mention in passing that the protection that the common law gives against proceedings in defamation is rather wider than that given under the PIDA to workers who have suffered a detriment on account of making a disclosure. The effect of the decision in Horrocks to which I have referred, is that, at common law, if it appears that the person making the allegation had mixed motives, judges and juries should not closely scrutinise those motives to ascertain which was predominant. Instead, they should concentrate on whether the person believed in the truth of what s/he said. If the words **'in good faith'** were removed from the PIDA, the test under the PIDA would be brought more closely into line with the test for 'malice' in defamation proceedings. It would seem to me to be desirable that the tests should be as close as possible so that a person thinking of making a report can be safely advised about his/her position in respect of both types of proceedings. It would also bring the test to be applied under the PIDA closer to the terms of many whistleblowing policies currently in force.

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[3] [1975] AC 135, 150.

The Availability of Advice

11.125 I have said that people who are contemplating making a report or disclosure need advice on how to go about it for reassurance and so as to avoid, so far as possible, any adverse consequences. If there is a policy governing the raising of concerns in operation at the place of work, that should provide all that is needed. If there is not, there may be other sources of help and advice connected with the workplace, such as a trade union or professional association. However, there is a *residuum* of cases in which there is no or no appropriate source of advice. The problem is exemplified by Mr Shaw, who had no employer and no professional association to advise him. Another type of case arises where the information to be divulged is so sensitive in the locality in which it arises that the person concerned is unwilling to speak to anyone in that area. A number of witnesses told the Inquiry that, if they had had concerns about Shipman, they would not have felt able to talk to anyone in Tameside because Shipman was so well known and respected. These witnesses told the Inquiry that what they needed was an organisation upon whose confidentiality they could rely utterly, which was in a position to give them sound advice and which was completely unconnected with the subject of their concerns or the area in which they arose. Those requirements seem to me to be entirely reasonable.

11.126 How and by whom should such advice be given? PCaW provides this kind of advice and is prepared to give advice to callers about all manner of problems related to the raising of concerns. A caller will not be turned away because s/he is not an employee raising concerns about events occurring in the workplace. However, at present, PCaW is not very well known and money would have to be spent on publicising its services if it were to be able to fulfil the need I have identified. I confess that I had not heard of the organisation before this Inquiry began. Another factor is that it is a charity and I am not sure that it would be fair to impose upon it a duty to advise any member of the public about the raising of any concern outside the field of interest that it has taken upon itself. It could certainly not be expected to fund the necessary publicity. However, I do not doubt its ability to give sound advice, in confidence and in a helpful and supportive way.

11.127 If financial support can be provided and if PCaW is willing, then it could undertake this function. If not, the need will have to be met in some other way by some other organisation. In a different context, the Inquiry has considered the idea that there should be a 'single portal' for the signposting of all complaints about the healthcare system. In the event that a 'single portal' is set up for that purpose, I envisage that it would direct persons seeking advice to PCaW or whichever organisation is to undertake the function I have described.

Conclusions

11.128 The value of the honest raising of concerns within the healthcare services should not, in my view, be underestimated. Together with patient complaints, of which I shall say more later in this Report, it provides an important source of information about clinical performance and has a vital role to play in clinical governance. The culture that for many years effectively prevented the raising of such concerns is changing but the old attitudes have not yet by any means died out. It is important, in my view, that those in positions of leadership, whether in managerial positions or at the head of the professions, should be

committed to openness of reporting, not only by endorsing policies and the like but by practising what they preach.

11.129 I have already suggested a number of ways in which the momentum for change can be kept up. I have suggested amendments to the PIDA which would, if implemented, strengthen the position of those who raise concerns. I shall not repeat those suggestions here. I have also suggested that policies for the raising of concerns across different sections of the healthcare services should be promulgated. I have called for the provision of an advice service available to any person, whether or not a healthcare professional, so as to provide the advice, encouragement and reassurance necessary for them to bring forward concerns which it is in the public interest to report.