Witness Name: [Stuart Lythgoe on behalf of HCSA]
Statement No.: [1]
Exhibits: [HCSA1-HCSA16]
Dated: 21/02/2024

THIRLWALL INQUIRY

WITNESS STATEMENT OF [Stuart Lythgoe, HCSA Director of Operations, on behalf of HCSA – the hospital doctors' union]

I, [Stuart Lythgoe, HCSA Director of Operations, on behalf of HCSA – the hospital doctors' union], will say as follows: -

1. Section 1

About HCSA

1.1. HCSA is a nationally recognised professional association and trade union which represents and advises all grades of hospital doctor across the United Kingdom, both in the National Health Service and Private Sectors. HCSA membership consists of hospital doctors at any grade inclusive of consultant, specialty and specialist, and junior doctor grade. HCSA also has a number of Student Associate members.

1.2. A primary function of HCSA is to provide a member casework service, primarily advising and representing members on individual workplace issues such as grievances or disciplinaries. HCSA also represents its members collectively on a national basis and locally where we have representatives on Local Negotiating Committees. A secondary function of HCSA is to campaign in the public domain on issues that affect hospital doctors and the health service. To meet this aim, HCSA carries out research, participates in relevant government consultations and seeks to influence decision-makers and the public. Further details on HCSA's functions can be found in the Governing Document[1].

HCSA governance and management structure

[1] [HCSA/1 – HCSA governing document November 2023] INQ0013291

1.3. HCSA's governance and management structure is also detailed in the Governing Document. HCSA is led by a Council elected by the ordinary membership and compromised of constituency representatives who hold office for four-year terms.

1.4. In practice, the Council delegates the responsibility for day-to-day running of HCSA to the Executive Committee.

1.5. The Annual General Meeting elects the President of HCSA, who chairs the Council and sits on the Executive as an Executive Officer.

1.6. The ordinary membership also elects a General Secretary, and this role covers the trade union functions of HCSA. The General Secretary is a senior figure in HCSA, reporting back to the Executive Committee and sitting on the Executive Committee as a non-voting member.

1.7. The Council also has responsibility for appointing the Director of Operations or to delegate the appointment process to the Executive. The Director of Operations is accountable to the Executive. The Director of Operations leads the staff team, who are responsible for implementing and delivering the business of the organisation.

1.8. This model was implemented in 2019. Prior to this model, the staff team was led by a Chief Executive Officer who also held the role of General Secretary, with this part of their role subject to election by the ordinary membership.

1.9. During the change of structure the Head of Industrial Relations was Acting General Secretary pending the election of the current General Secretary.

HCSA's work with external partners on freedom to speak up and quality of care

1.10. HCSA is affiliated to the Trades Union Congress and regularly communicates with other trade unions on issues affecting NHS and public-sector staff through forums such as annual Congress, the TUC General Council, and other TUC structures such as the Public Services Liaison Group and Covid-19 Inquiry group.

1.11. HCSA is also a member of the NHS Social Partnership Forum and on the staff side of the NHS Staff Council where issues of quality of care and freedom to speak up are also raised.

1.12. At TUC Congress 2019, HCSA was successful in securing support to pass Motion 52[2], titled *"Better and active safeguards for whistleblowers in the NHS and public services"*. It called for the establishment of a "purposely designated agency that is charged with the active protection of all genuine whistleblowers in the NHS and all public services and that has:

i. truly independent leadership and oversight

ii. A remit that allows it to scrutinise all actions taken to address the concern(s) that have been raised and

iii. Powers to review and amend all adverse circumstances that might befall the genuine whistle-blower at any time after concerns have been raised."

1.13. At TUC Congress 2023, HCSA attempted to pass an emergency motion[3] in response to the Letby case that called for the TUC to enact the 2019 policy by campaigning for the independent whistleblower agency. This garnered support from the majority of health trade unions and notably from the Prison Officers' Association and the Society of Radiographers, who had agreed to speak in support, however the motion did not secure a space in the final conference agenda. HCSA also received support from Doctors in Unite, a subsection of the Unite union.

1.14. While the British Medical Association is not TUC-affiliated, HCSA communicates with the BMA in regular health leads meetings mentioned above and through informal channels, primarily in regard to government negotiations on pay where we jointly represent the medical profession. We do not at present have a joint strand of work on whistleblowing with the BMA.

1.15. HCSA has had several meetings with Protect, the whistleblowing charity, and backed their campaign 'Let's Fix UK Whistleblowing Law'.[4] Protect have provided staff training and sent a speaker to HCSA Annual General Meeting in 2022 to draw attention to the issue of making protected disclosures.

HCSA whistleblowing research

1.16. HCSA regularly polls hospital doctors to inform our policy and campaigns. HCSA carried out a survey entitled "Hospital doctors - share your experiences of whistleblowing" from

[2] HCSA/2 TUC 2019 Motion 52 **INQ0013292**
[3] HCSA/3 Proposed TUC 2023 motion **INQ0013293**
[4] HCSA/4 Protect – Let's Fix UK Whistleblowing Law **INQ0013294**

October 20th to November 2nd 2023 with participation from 526 hospital doctors from across the UK.[5] Respondents were comprised of 393 Consultants, 101 doctors in training, 13 SAS and 20 Trust grade doctors. Of these, 490 respondents confirmed they worked in an NHS hospital setting, 24 did not specify and a further 12 were retired or in private practice. Those retired or in private practice are discounted from the study. In total 390 respondents were based in England and Wales, 33 in Northern Ireland, 27 in Scotland and 76 did not specify. The survey was emailed out to HCSA members and was also shared with non-members through social media. It is therefore not possible to give a response rate as the survey was not strictly limited to members.

1.17. Notable outcomes were as follows:

- Over 70% of hospital doctors believe it is NOT possible to raise patient safety concerns to their employer without career detriment
- 4 in 5 hospital doctors say the Freedom to Speak Up Guardians initiative has NOT given them confidence to speak up in their Trust.
- 96% of hospital doctors feel that short staffing and treatment delays have reduced the patient safety standards you would expect in the NHS
- 95% of hospital doctors feel managers are NOT presently held accountable for harm caused to patients due to delays and understaffing, and 91% feel managers should be held accountable
- Three-quarters of doctors have 'spoken up' at work, and the most common issues they spoke up about are (in order) short staffing, delayed treatment and concerns regarding a colleague
- 93% of hospital doctors who have spoken up were NOT satisfied with the response from management
- Two-thirds of those who have spoken up have experienced impacts to their personal lives, and two-thirds have experienced detriment in the workplace. Commonly cited impacts and detriment are on mental health, being overlooked for promotion, targeted by management via employment processes or their fitness to practice and issues with relationships in workplace or at home.

HCSA also gathered significant anecdotal testimony through the survey.

1.18. This is the only survey HCSA has conducted since 2015 specifically focused on experiences of whistleblowing. However, this issue has featured in some of our other studies. In recent years, we have run an annual survey intended to gain an overview of

[5] HCSA/5 Summary of results of whistleblowing survey 2023 **INQ0013295**

issues affecting hospital doctors at work. This generally run between November and February. We asked the same question two years running in 2021 and 2022, as follows: "What steps do you think would assist in the recruitment and retention of Hospital Doctors?". The question provided a series of possible responses with participants allowed to select a maximum of three. In 2021, 7.5 percent of respondents, 65 in total, selected 'A more effective response to addressing freedom to speak up concerns' as a response. In 2022, this had grown to 13.01 percent or 137 respondents.

1.19. In the 2021 survey, we featured a subsection of the annual survey for junior doctors to complete. Three of the questions related to 'exception reporting', a practice introduced in the 2016 Junior Doctors contract in England to enable and require junior doctors to report circumstances that cause variances in rotas. This is one means for junior doctors to 'speak up' about issues such as short staffing, workloads and patient safety issues. Of 228 respondents, only 22 percent (50 respondents) rated their employer as 'good' or 'very good' in terms of encouraging, facilitating and responding to exception reports. Meanwhile 34.65 percent (79 respondents) rated their employer as 'poor' or 'very poor'. Half of junior doctors (114 respondents) told us they never exception report, while 70.17 percent (160 respondents) told us they would exception report daily or weekly if they were to follow the process strictly. This demonstrates a mismatch in best practice and reality.

1.20. In the 2022 annual survey, we asked a subsection of our members identifying as belonging to an ethnic minority group specifically about the ethnicity pay gap. In response to the question "What do you believe are the top three main factors driving the ethnicity pay gap?", 28.75 percent (92 respondents) identified "Fear of speaking out" as a main factor, and notably, this was the third most popular response behind "Cultural bias favouring white employees" and "Bias in recruitment processes".

1.21. HCSA also conducted "Sexual Harassment at Work", a survey of 319 hospital doctors from May-July 2023. This survey found that of those who had experienced sexual harassment, only 1 in 10 had reported it to their employer. Nine in 10 had not reported it to their employer. Reasons for not reporting include not being sure if it was sexual harassment and concerns over impact on career. Further, of those who reported sexual harassment, 75 percent felt their employer could have done more in response.

1.22. While neither of these last examples is explicitly linked to patient safety, it does however reflect a trend and reasons why doctors with protected characteristics may find it

particularly difficult to 'speak up' more broadly, and the wider sense of apprehension and inadequacy when it comes to the expected employer response.

HCSA experience with assisting doctors to speak up

1.23. HCSA National Officers work with members who have spoken up. There appears to be a common pattern of victimisation of doctors who speak up in some trusts. Often, doctors are reported to the GMC and taken through a local disciplinary process, 'Maintaining High Professional Standards'.[6] National Officers also often hear from members who would like to speak up but are unsure or fearful to do so. HCSA have supported members to make protected disclosures while still protecting their careers.

1.24. HCSA has contact with the GMC where Fitness to Practice[7] issues arise affecting our membership. In cases which involve an instance of whistleblowing, the likely scenarios where the HCSA National Officer may have contact with the GMC are as follows: where there's been a complaint to the GMC by our member about a colleague; where our member has been reported to the GMC by the trust; or where there has been a threat made to report our member to the GMC by the trust.

1.25. HCSA has repeatedly expressed concerns regarding a 'blame culture'[8] perpetuated by the adversarial approach from the GMC regulator and note they have been found to have acted in a discriminatory fashion on several occasions. We believe this inhibits doctors from speaking up.

1.26. It has not been possible for HCSA to provide statistical data on member cases, or requests for support, regarding whistleblowing, working environments and NHS culture. Prior to 2023, HCSA did not collect data centrally via a case management system. Instead, National Officers dealt with enquiries individually. HCSA therefore cannot quantify the data on case type to reach any conclusions on trends.

1.27. Since 2023, HCSA has been migrating to a shared online case management system. National Officers have only recently begun tagging their cases. Currently, one in 25 (4 percent) of active cases on this system are categorised as 'whistleblowing'. This figure is likely to be artificially low, given the process underway of embedding use of the system. The complexity of members' circumstances also leads to ineffectual

[6] HCSA/6 MHPS Framework INQ0013296
[7] HCSA/7 GMC Fitness to Practice Procedures INQ0013297
[8] HCSA/8 HCSA statement on Bawa-Garba case INQ0013298

categorisation, as it is often the case that a grievance or disciplinary also has aspects of speaking out.

2. Section 2 Countess of Chester Hospital ("CoCH")

2.1. Despite searches enlisting the support of the HCSA officer responsible for information technology it has been confirmed that the HCSA records regarding the support given to Dr B regarding his concerns about Nurse Letby are no longer available. It appears that this is the result of the records being saved to either a redundant and destroyed laptop or a redundant and deleted file system.

2.2. The HCSA Director of Operations spoke with a former employee who was the HCSA National Officer that advised Dr B regarding his belief that Nurse Letby was responsible for the deaths of infant children at the CoCH. The former National Officer is Ms Jennie Bremner. The following summary of HCSA involvement in support of Dr B is based solely upon the unaided recollection of Ms Bremner. No contact has been made with Dr B and the following summary has not been disclosed to him.

2.3. Ms Bremner first learnt about the problems at CoCH when Dr B rang her and said that he needed to meet with her for advice but that he was not willing to commit what he had to say to writing.

2.4. When the Ms Bremner met Dr B he explained his concerns regarding Nurse Letby. He said that he and another doctor had raised the issue with management on two or three occasions using the internal Trust policy. Their concerns were the result of analysis (in the form of a spreadsheet) which apparently showed both a clear correlation between babies collapsing in the CoCH Special Care Baby Unit when Nurse Letby was on duty and also at far greater rate than previously (namely an increase from 2.34 collapses to 13 year). Despite this evidence, the Trust was unwilling to investigate the doctors' concerns. As a result of raising the concerns, Nurse Letby had submitted an internal grievance (alleging bullying and harassment by B and his colleague) which concluded with the two doctors being directed to write letters of apology to Nurse Letby.

2.5. Dr B also said that he had been threatened by his Medical Director who had pointed out to him that Dr B had been working on the ward at the same time as Nurse Letby and, as such, he (Dr B) could be responsible for the deaths. Despite this, the Medical Director still did not initiate an investigation into the situation.

2.6. It was at this point that Dr B approached Ms Bremner in desperation as he and his colleague (represented by another union) felt helpless.

2.7. There were no direct interactions by HCSA with CoCH as, due to the constraints of the Public Interest Disclosure Act 1998, an employee risks losing protection for disclosures made to their trade union and Dr B was in an extremely vulnerable position at the time he approached HCSA. The risk of Dr B losing his protection was a pressing concern for Ms Bremner. She approached the local representative of the union that the other doctor belonged to and that union representative felt similarly constrained as Ms Bremner.

2.8. Ms Bremner recommended that Dr B approach the police but he said that he was too concerned of the possible adverse consequences to him (in view of what the Medical Director had said) to do so. Ms Bremner also suggested that Dr B contact his local Member of Parliament but, possibly for similar reasons to those for his reluctance to contact the police, he was unwilling to do that. Ms Bremner also recommended that Dr B suggest to one of the parent that they raise the issue with their local Member of Parliament.

2.9. Soon after, the police did initiate and investigation but Ms Bremner does not know who raised the issue with the police.

2.10. HCSA issued a single press statement in relation to the conviction of Lucy Letby, released on Monday 21st August 2023. A copy of the press statement is provided in accompanying documents.[9]

3. Section 3 – Effectivenesss of NHS management and governance structures, external scrutiny and professional regulation, including consideration of NHS culture

3.1. On behalf of HCSA I have deep concerns over the current culture and barriers which prevent hospital doctors from speaking up or, when they do, from being heard and their warnings acted upon. Undoubtedly it inhibits staff from doing so.

3.2. The approach by too many managers and leaders in trusts is to treat concerns raised as an issue to clamp down upon and silence, for reputational reasons, rather than be taken seriously and addressed. Speaking up is often seen as an unwelcome complication that reflect badly on leaders and could prompt a CQC investigation, which trusts are keen to avoid. This creates a defensive culture within trusts, where concerns

[9] HCSA/9 Press statement on conviction of Nurse Lucy Letby INQ0013299

around behaviour or medical practice are minimised or marginalised. It can mean the individual concerned facing pressure to amend or withdraw their allegations, or facing threats of disciplinary action or other negative outcomes should they continue.

3.3. From discussions with doctors who have raised concerns and then faced disciplinary processes themselves, something which does not happen in every case but does act as a disincentive to others where it does, it seems increasingly clear that there is a fairly standard methodology applied.

3.4. This can involve the individual coming under increased scrutiny or being the subject of a vexatious evidence-gathering process – for instance, facing their electronic record notes and letters being reviewed in the search for potentially incriminating information. Given the complex nature of and risks involved in practising medicine, many doctors may have something in their history which could be used to try to justify a formal disciplinary procedure, but which in normal times might be deemed an unfortunate feature of medicine and no disciplinary action would follow.

3.5. Individuals in this situation are likely to find themselves put through a formal investigation as part of the Maintaining High Professional Standards in the NHS (MHPS) process. It is HCSA's view that this framework requires urgent reform to prevent its abuse or use to make vexatious complaints. Regulator the General Medical Council can play a key role here in making clear that tabling such complaints plays a destructive role in terms of an open, safe culture and where levelled by doctors could lead the complainant to fall foul of the Fitness to Practice standards which govern doctors' practice and behaviours. Our view is that a similar regulator should be in place for non-medical managers which again should take a firm position against the abuse of disciplinary procedures.

3.6. Available data shows that those from minority ethnic backgrounds are more likely to face a GMC referral[10] and, as noted above, HCSA's own research suggests that 'fear of speaking out' is contributing to an ethnicity pay gap. It is reasonable therefore to extrapolate that a similar fear of speaking out extends more broadly to safety or other whistleblowing-type concerns.

3.7. There are also systemic barriers which come into play – there are multiple touchpoints where concerns could be raised by a staff member, creating an incoherent framework which means they are not properly progressed or collated. For instance, in appraisals, via incident reporting, through Freedom to Speak Up Guardians (FSUGs), or direct line

[10] HCSA/10 GMC update on progress of equalities agenda INQ0013300

management. Sometimes those receiving reports of a concern are unclear about how they should respond, facing a maze of policies which are often lengthy and not easy to follow.

3.8. Even where clear policies are in place it is by no means the case that trusts follow them correctly. Given the concerns noted above, there is an overriding sense that whistleblowing policies merely allow trusts to highlight staff who may then be labelled troublemakers. There is a significant difference between policy on paper and policy in practice.

3.9. The net effect in terms of the behaviour of staff is a general sense that speaking up will often lead to no outcome and at worst could lead to the complainant themselves being left exposed and targeted with unreasonable behaviour. Doctors effectively must decide whether to speak up and potentially damage their career prospects or even lose their job – impacting on reputation, the chance of re-employment, mental health, self-esteem and personal lives[11] – or turn a blind eye. Many choose to turn a blind eye. This culture inevitably has a detrimental impact on patient safety.

3.10. The implementation of FSUGs often feels more like a tokenistic measure rather than representing a serious attempt to shift culture to a more open, blame-free environment where issues are raised, acknowledged and addressed. It certainly does little to address the fear of recrimination among hospital doctors who do wish to speak up.

3.11. In any case most individuals carrying out the FSUG role hold insufficient status within an organisation to challenge defensive or more aggressive leadership cultures, and themselves can face pressure to prevent escalation of issues raised. They are often under-resourced, unpaid for the role, and are not given sufficient time to carry it out.

3.12. I doubt very much that cultural barriers to speaking up can be addressed without applying greater external pressure upon, and consequences and accountability regarding the actions of, managers and boards. Too often they are part of the cultural problem, so it would be inappropriate and unrealistic to expect them to lead the change which is required. Even with reforms to the FSUG role which sought to address the issues highlighted above, without wider changes they would likely remain in an isolated position within trusts with limited political currency.

3.13. It is HCSA's view that the current system is not fit for purpose and has been proven wholly inadequate to address the personal risk which speaking up entails. Without

[11] HCSA/11 Post-survival strategies - Transforming whistleblower experience **INQ0013301**

significant measures to strengthen the position of those speaking up and to protect them against unfair recrimination, I fear it is inevitable that we shall see a further safety or similar scandal in future which could have been prevented. It is a case of when, not if.

3.14. In order to address these barriers to speaking up, we need to see wider changes to the legislative framework to bring in greater penalties for managers and leaders who seek to silence or penalise those who do so. It is essential that hospital doctors, and all NHS staff, see that participating in an open culture leads to positive change and their concerns being seriously addressed, and that they are shielded from recriminations. This is the only way we will move from a culture of fear and resignation to one where honesty and respect is celebrated in the interests of staff and patients.

3.15. We note that Scotland has led the way with the introduction of an NHS-specific Independent National Whistleblowing Officer (INWO)[12], and we are monitoring its implementation. The INWO was an element of new Once for Scotland National Whistleblowing Standards introduced on April 1st 2021[13]. It provides information and guidance for NHS Scotland staff. The standards set out high-level principles and provide a detailed procedure for investigating concerns with the aim of promoting a culture of speaking up in the NHS. The INWO aims to ensure that everyone delivering NHS services in Scotland is able to speak up to raise concerns when they see harm or wrongdoing putting patient safety at risk, confident that they can do so in a protected way. The HCSA National Officer for Scotland has reported that the introduction of these standards has had a beneficial impact for members working in Scotland. For these reasons, HCSA is strongly of the view that some form of independent office should be established in England given the shortcomings of the current Public Interest Disclosure Act 1998 (PIDA)[14], which covers protected disclosures.

3.16. PIDA merely allows an individual to make a claim via employment tribunal if they have made a protected disclosure and feel they have subsequently suffered detriment. However, in HCSA's experience it is often extremely difficult to prove that detriment which takes place after an individual speaks up is definitively connected to the disclosure. Acts of retribution can take different forms, but can routinely involve those who speak up themselves finding their own records being scrutinised forensically for any evidence which might provide a basis for disciplinary action against the doctor

[12] HCSA/12 INWO What we do INQ0013302
[13] HCSA/13 National Whistleblowing Standards _ INWO INQ0013303
[14] HCSA/14 Public Interest Disclosure Act 1998 INQ0013304

which otherwise would not have been lodged against them. This allows the limited protections granted by the legislation to be easily bypassed and therefore acts as a huge deterrent for other doctors to themselves speak up.

3.17. HCSA's experience of the employment tribunal approach to speaking up also means that in cases where an NHS staff member was to be dismissed prior to bringing a case to an employment tribunal, even if they were able to prove a link to a previous disclosure, protected or otherwise, they are unlikely to ever be reinstated. The damage will have been done.

3.18. For the above reasons, HCSA is developing an enhanced service for those who wish to raise protected disclosures which will involve in members being advised to approach their National Officer before they make a disclosure so that an assessment can be made on the most suitable way to manage the situation before any concern is expressed.

3.19. The Scottish approach, while in its infancy and therefore hard to measure in terms of effectiveness, is a separate process where the office can review any complaints around how concerns are handled by an organisation, decisions taken the treatment of whistleblowers or witnesses etc, and also organisational culture itself. The establishment of the INWO in Scotland reflects the shortcomings of the PIDA protections.

3.20. HCSA would however go further in the interests of bringing about the open culture that is required. Discussions with whistleblowing members of HCSA underlines that many "speaking up" issues are not made in the form of protected disclosures under whistleblowing regulation, and therefore staff have no protection whatsoever. Often an individual may not even realise that the concern they have raised makes them a potential "whistleblower". The crucial point is to have recourse to an independent body outwith their employer to ensure that speaking up concerns are properly handled.

3.21. We therefore believe that it is essential that independent statutory national bodies responsible for speaking-up issues are accessible to all NHS staff across the UK with a role of logging and assessing allegations, tracking the progress of investigations and outcomes, and ensuring they do not result in detriment to the individual. It is essential to create such an independent paper trail and to be able to draw the connection between speaking up and resulting treatment of individuals and to have a body able to intervene to correct potential injustices in a way beyond the narrow scope of employment tribunals. Such a body would also assist in guarding against malicious allegations. It is by neutralising the fear of retribution that we will empower individuals

to feel able to speak up and create the necessary culture of openness. The current National Guardian, whose main remit is to lead, train and support local FSUGs[15], is simply inadequate.

3.22. HCSA also holds the view that there must be an avenue open to refer NHS managers, to their own regulators for behaviour which contributes to cultures of silence. Currently, while doctors are regulated by the GMC, non-medical managers have no similar accountability for their professional conduct.

3.23. We would argue additionally that to send the strongest possible deterrent message it is necessary to introduce a new criminal offence of causing detriment to individuals who have made protected disclosures.

3.24. One of the further issues of concern to HCSA is that the government's "Prescribed persons and bodies list"[16] – those able to receive a formal whistleblowing disclosure – does not include trade unions. Yet trade unions, which are a trusted independent body for individuals who wish to seek advice and assistance, are a natural point of contact when issues arise, and the inability to receive a protected disclosure significantly hampers our ability to support and protect members. We therefore believe it is essential to extend the scope of the list to encompass trade unions.

3.25. It is our feeling that these external steps, while sweeping, are necessary to force a shift within a system which does not pay due focus to the need for a safe, open culture which recognises the positive contribution that speaking up represents. While FSUGs could still have a role in cultural change if their status was enhanced, the existence of independent pathways outside of a given trust should complement their work and get to the root of the fear and retribution which are currently preventing people from speaking out.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

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[15] HCSA/15 About Us - National Guardian's Office INQ0013305

[16] HCSA/16 Whistleblowing_ list of prescribed people and bodies - GOV.UK INQ0013306

Signed: ___ Personal Data

Dated: __21st February 2024