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The Case of the Disappearing Whistleblower: an analysis of ~~NHS~~ National Health Service Inquiries

Abstract

Many serious failings in National Health Service (NHS)~~NHS~~ care are brought to light by the action of whistleblowers. However, analysis of the reports of P~~p~~ublic Inquiries reveal how little the Inquiries examined the role of the whistleblower and how rarely they made any recommendations concerning NHS whistleblowing. We examine the case of the d~~D~~isappearing whistleblower, and suggest reasons for the limited focus on them.

Introduction

'Speaking up' or 'whistle-blowing' has come to be seen as making a major contribution to the quality and safety of health services (Francis 2015). This is neatly summarised by the Report of the Shipman Inquiry ~~(below)~~ that the willingness of healthcare professionals to take responsibility for raising concerns 'could make a greater potential contribution to patient safety than any other single factor' (Smith, 2005: 23; see below). Similarly, according to the then CEO of the General Medical Council (GMC), Niall Dickson: 'The eyes and ears of health professionals are often the most valuable means of protecting patients and ensuring high quality care' (in Hooper, 2015: 20). Pointing to 'the vital role of whistleblowing', Public Concern at Work (2013) argued there is now widespread recognition in government and public, private and voluntary organisations of the important role that whistleblowing plays in achieving effective governance and an open culture: they argue that if effective whistleblowing arrangements had been in place both in organisations and in regulatory bodies, many of the disasters and scandals which have caused so much harm and distress could have been avoided.

Dr Steve Bolsin, who was the whistleblower in the Bristol Royal Infirmary case ~~(below)~~ claimed that Inquiries such as Bristol, Shipman, and Mid-Staffordshire ~~(see below)~~ all confirmed that whistleblowers played a crucial and constructive part in the identification of poor patient care prior to deaths and patient harm attributable to that poor care (Bolsin et al 2011; details of Inquiries are given below). Moreover, House of Commons Select committees have expressed concern that the National Health Service (NHS) continues to fail to respond to whistleblowing in an appropriate way. The Health Committee (2009) considered the NHS to be largely unsupportive of whistleblowing, with many staff fearful about the consequences of going outside official channels to bring unsafe care to light. Five years later the Public Accounts Committee (2014) observed that 'the treatment of some whisleblowers has been shocking'. A year after that the Health Committee (2015) described the treatment of whistleblowers as a stain on the reputation of the NHS, which had led to unwarranted and inexcusable pain for a number of individuals whose treatment has not only caused them direct harm but also undermined the willingness of others to come forward, with ongoing implications for patient safety (pp. 3-4). Francis (2015: 4-5) stated that 'I would have liked to report to you that there was in fact no problem with the treatment of 'whistleblowers' and their concerns. Unfortunately this is far from the case. This is a 'serious issue' that requires 'urgent attention'. All this suggests a puzzle – whistleblowers and whistleblowing trigger the chain of events which lead to Inquiries, and often feature in Inquiries, but then are marginalised in Inquiry Recommendations and in Government responses. The whistleblower is thus an absent presence in Inquiry recommendations, the dog that didn't bark.

This paper examines Inquiries into healthcare failings which involve a whistleblower, and their associated Government Responses, in the period since the introduction of the Public Interest Disclosure Act (PIDA) 1998 ~~(PIDA)~~.

Inquiries and Whistleblowing

Public Inquiries (PIs) have a long history in the UK and in the NHS (Walshe 2003; IfG 2017; Powell 2019a). IfG (2017) identified sixty-eight PIs that have been active or established between 1990 and 2017, including 8 underway at time of publication. There have been many inquiries in the NHS. It is difficult to establish a comprehensive or definitive list, but Kewell and Beck (2008) suggested that some 126 took place between 1945 and 2005.

However, the term PI is a loose one, as they come in various forms and have many purposes, such as establishing the facts; learning from events; catharsis or therapeutic exposure; reassurance; accountability, blame and retribution; and political considerations (eg Walshe 2003; IfG 2017). Governments claim that one of the key reasons for an inquiry is to learn lessons and prevent similar events from reoccurring (Stark 2018; Powell 2019b). According to IfG (2017), there is an expectation that inquiries will answer at least three questions: what happened?; who is responsible?; and what can we learn from this? However, they state that the third question is arguably of the most significant public interest.

There is a broad consensus that Inquiries have led to limited learning in the NHS (but see Stark 2018 for a wider contrary view). For example, Walshe (2003) argued that it is far from clear that the NHS is learning all it can from failures, or making the most of the opportunities

for improvement that they offer. Powell (2019b) pointed to a 'Groundhog Day' of 'lessons will be learned'

As noted above, the focus here is on Inquiries since the introduction of PIDA in 1998. This is to ensure a 'most similar' design in that all of the Inquiries were held under the same broad legal framework (although some of the events in Bristol preceded PIDA). The Employment Rights Act (ERA) 1996 as amended by the PIDA 1998 provides some protection from detriment or dismissal for whistleblowers who raise concerns in the public interest about a danger, risk, malpractice or wrongdoing in the workplace that affects others. For a whistleblower to be protected, the disclosure must be in the public interest, the worker must have a reasonable belief that the information shows the occurrence, or likely occurrence, of one of the categories of wrongdoing listed in the legislation, and the concern must be raised in the correct way.

Ashton (2015) pointed to growing disquiet that, after 15 years in force, the PIDA is not working as it should. With whistleblowing scandals seemingly emerging on a monthly, or even weekly basis, it would perhaps be understandable to conclude that it has effected little, if any, change. She claimed that it is it not difficult to find similarities between pre- and post-PIDA 'disasters' and 'scandals', namely employees fearful of speaking out and detrimental consequences for those who do, and that the PIDA's achievements in effecting a tangible, sustainable cultural shift towards transparency in the UK workplace appear incremental at best. Mannion et al (2018) noted that commentators have been equivocal, with suggestions that it has led to limited change. Moreover, there is a perception that, although ground-breaking in its time, the legislation is dated and has been overtaken in the approach taken in

other jurisdictions. It is impossible to determine whether PIDA catalyzed reference to whistleblowers in PIs from the research design (below) as no 'before PIDA' Inquiries are examined. However, most of the Inquiries do mention the PIDA, with Smith (2005) and Francis (2013) discussing it at length.

WHowever, while there is a standard definition of whistleblowing in the academic literature, there is less consensus in the world of Inquiries and policy. Over 30 years ago, Near and Miceli (1985) defined whistleblowing as 'the disclosure by organization members (former or current) of illegal, immoral, or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect action'. However, Inquiries tend to be based on the legal definition of whistleblower in the ERA Employment Rights Act 1996 (ERA) as amended by PIDA 1998.

Kark and Russell (2018) noted that whistleblowing has a particular legal definition (the individual must make a protected disclosure) and is relatively narrowly defined. They stated that the NHS only received 39 whistleblowing cases about Foundation Trusts in 2013/2014, 28 in 2014/2015 and 60 in 2015/2016. However, in national terms, the numbers of whistleblowing cases received by Employment Tribunals ranges between 1,395 and 2,754 (in the period between 2007/2008 and 2016/2017). They stated that the relatively low levels of whistleblowing cases in the NHS suggests either that there is very good management practice in dealing with whistleblowing issues or that employees are, for some reason, reluctant to raise them. They did not provide a clear answer for this question, but the tenor of the report (and other recent material eg BBC File on Four 2017; Duffy 2019) suggest that it is the latter.

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~~For a whistleblower to be protected, the disclosure must be in the public interest, the worker must have a reasonable belief that the information shows the occurrence, or likely occurrence, of one of the categories of wrongdoing listed in the legislation, and the concern must be raised in the correct way. This is now enshrined in the NHS Constitution.~~

The Shipman Report (Smith 2005) tried to avoid using the expression 'whistleblowing' whenever possible, and Francis (2015) considered replacing the term. The Shipman Report (Smith 2005) considered that none of these persons who raised concerns were 'whistleblowers' per se, as they did not work in the same organisation as Shipman. The Bristol inquiry (Kennedy 2001) did not appear to recognise Dr Steve Bolsin as a whistleblower, as it is stated that had PIDA ~~(below)~~ been in force it would not have applied to Dr Bolsin because he did not make a 'qualifying statement' So, there appear to be three dimensions to whistleblowing contained in formal inquiry reports: (1) whether or not the person works for the organisation; (2) whether they raise concerns internally or externally (or escalate from internal to external, if the internal route produces no results); and (3) whether or not they are a whistleblower in the strict legal sense of the term and are making a 'qualifying statement'.

Method

This paper draws on interpretive content analyses that includes attention to both manifest and latent content, and centres on descriptive narratives, or themes, summarizing the collected and coded data (Drisko and Maschi, 2016). The coding was a mixture of a priori or deductively generated coding and inductive or "emergent" coding. The documents (Inquiries

and Government Responses) were searched for terms such as 'whistle*', 'concern*' and 'speak*', with the surrounding text explored for connotative codes, which are based not on explicit words but on the overall or symbolic meaning of phrases or passages. The documents are the 'primary' evidence from Inquiry Reports, starting with the Bristol Inquiry (Kennedy 2001) on the grounds that Bristol was the first major inquiry since PIDA, that it featured a clearly identified 'whistleblower' and that it discussed issues that foreshadow those in subsequent inquiries, such as the importance of 'culture' and the duty of candour. Government responses to Inquiry Reports were also explored, but we do not consider the Francis 'Freedom to Speak Up' (FSU) Report (aka 'Francis III', Francis 2015), which was specifically set up to consider whistleblowing or 'speaking up' and the subsequent government response (Secretary of State for Health 2015b).

Inquiries

The Bristol Royal Infirmary Inquiry (Kennedy 2001) was set up in 1998 to inquire into the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995.

The Ayling Inquiry (Pauffley 2004) related to the GP and hospital doctor Clifford Ayling, who in 2000 was convicted on 12 counts of indecent assault, relating to 10 female patients, and sentenced to four years' imprisonment, and had his name placed indefinitely on the sex offender's register. In 2001 the General Medical Council (GMC) removed him from the Medical Register (Pauffley 2004)

The Kerr/Haslam Inquiry (Pleming 2005) was concerned with the sexual abuse of patients in psychiatric hospitals. The first complaint against William Kerr was made in 1965, and 38 former patients claimed they made disclosures to NHS staff of sexualised behaviour by Kerr

before his retirement, but none of these led to any investigation (p. 6). The first complaint was made about Michael Haslam in 1974, and at least eight patients had raised concerns about his alleged sexual advances towards them. (p. 8. 294). In 2000 Kerr was convicted (in his absence, on a Trial of the Facts) of one count of indecent assault, and in 2003 Haslam was convicted of four counts of indecent assault (a conviction of rape was quashed on appeal) (p. 4).

The Shipman Inquiry (Smith, Six Volumes, 2002-2005) was concerned with GP Harold Shipman, who was convicted in 2000 of murdering 15 patients, and of forging a will. However, the Report identified 215 victims, but 'the true number is far greater and cannot be counted' (Vol 1, p. 202). The Shipman Inquiry consists of six reports, with the main material about whistleblowing in Volume Five.

The Mid Staffordshire Inquiry was set up by the, Labour Secretary of State for Health, Andy Burnham, in July 2009 (Francis 1, 2010) in response to concerns about mortality and the standard of care provided at the Mid Staffordshire NHS Foundation Trust, which had at that point already resulted in an investigation by the Healthcare Commission (HCC) which published a highly critical report in March 2009, which were followed by two reviews commissioned by the Department of Health. It focused on the period 2005-2009.

The second Mid Staffordshire Inquiry (Francis II, 2013) was set up by the Conservative Secretary of State for Health in the 2010-2015 Coalition government, Andrew Lansley, who decided this should be a public inquiry, and include investigation of the wider health care system.

Table 1 provides details on the identified whistleblower, their methods, and the main conclusions on whistleblowing for all Inquiries, with the detailed recommendations and the responses by government given below (Table 2).

Table 1 about here.

Government Responses to Inquiries

Most of the Inquiry Reports led to a government response, although one Response covered the Shipman Inquiry's Fifth report, Ayling, and Kerr/Haslam. On the other hand, while the first Francis Report of 2010 produced no response document (but see the statement by Health Secretary, Andy Burnham: Hansard 24 February 2010, col 309), the second Francis Report of 2013 produced three response documents (in addition to setting up the 'FSU' Review, see above). The text below discusses the broad response, while specific responses are provided in Table 2.

Bristol Royal Infirmary Response (Secretary of State for Health 2002)

According to Secretary of State, Alan Milburn, the Kennedy Report provided a powerful analysis of the flaws and failures of the organisation and culture, not only at the Bristol Royal Infirmary (BRI) in the years in question, but of the wider NHS at that time. The Government accepted most of the recommendations.

Shipman Response (Home Secretary and Secretary of State for Health 2007)

The Government agreed with most of the 190 Recommendations of the Shipman Inquiry. The response stated that the crucial first step in any system for managing professional performance is the initial identification of cause for concern. In the case of Shipman, a

number of potential clues were missed, and similar lessons emerge from the Ayling and Kerr/Haslam inquiries of failure to recognise the significance of concerns expressed.

Shipman Inquiry's Fifth report and Ayling, Neale and Kerr/Haslam Inquiries Response (Secretary of State for Health 2007)

This response stated that while the nature of the abuse differs between the four reports, the underlying question is the same in each case: why did the NHS at the time fail to identify the risk and take the appropriate action to protect patients? (p. 5). The Government agreed that complaints (from patients or their representatives) and concerns (from fellow professionals) can provide vital information in identifying potential risks to patient safety (p. 9).

The government stated that the Ayling, Neale, Kerr and Haslam cases showed that there were enough clues potentially available to indicate serious problems at a much earlier stage. Yet the information was not "joined up" and no effective action was taken. The document continued that this partly reflected the then prevailing culture, in which it was almost unthinkable that health professionals would deliberately set out to harm their patients. But even more, it reflected the fact that NHS organisations did not have the systems and processes to ensure that the relevant information was brought together and critically scrutinised.

Initial Response to Francis II (Secretary of State for Health (2013)

The theme of 'openness, transparency and candour' included actions such as strengthening the protection and support available to whistleblowers. It is stated that the Government has already taken a series of steps to enhance the protections available to whistleblowers –

including a right to raise concerns within staff contracts; amending the NHS Constitution to include explicit rights and pledges on whistleblowing; issuing new guidance to employers; and extending the national helpline to include staff in social care settings for the first time. Earlier in the year the Secretary of State for Health wrote to all Trusts reminding them again of their obligations to have (PIDA compliant) whistleblowing policies and asking that they 'check that the confidentiality clauses in your contracts (and compromise agreements with departing employees) do indeed embrace the spirit of [this] guidance (p. 47). The Department of Health established an independent review to consider the handling of concerns and complaints (Clwyd and Hart 2013), which includes the handling of concerns raised by staff, including the support of whistleblowers (p. 52).

Second Response to Francis II (Secretary of State for Health (2014) (Two Volumes)

The first volume repeated the earlier responses on whistleblowing: on gagging clauses, and strengthening the position of whistle blowers under the Enterprise and Regulatory Reform Act 2013. Since September 2013 the CQC's new inspection system included discussions with hospitals about how they deal with whistleblowers, and that the Care Bill stated that as a registration requirement with the CQC, providers must be open with patients about care failings. It argued that many of the measures set out are designed to ensure that the NHS is a genuinely open and transparent culture, a culture that will make whistleblowing far less necessary than at present. There would always, however, be a need to ensure that staff who have concerns are able to raise them.

The second volume provided a detailed response to each of the 290 recommendations made by the Inquiry across every level of the system. It made clear which recommendations were accepted, by whom and what progress is being made towards their implementation. However,

it did not accept Recommendation 183 of a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation to make untruthful statements, although it agreed 'with the intention behind this recommendation'

Third Response to Francis II (Secretary of State for Health 2015a)

This document once again stressed that since 2010 the Government has put in place a range of new measures to strengthen the voice of people who speak up for patients, known as 'whistleblowers', but there was still a strong sense that the NHS has yet to turn the cultural corner and face up consistently and with humility to the hard truths spoken by its staff. (p. 16). It stated that one of the key lessons of the Public Inquiry was the importance of listening to staff (p. 30).

Table 2 about here

The Case of the Disappearing Whistleblower: the dog that did not bark?

A number of issues arise from these analyses of the Inquiries and responses.

Lack of specific focus on whistleblowing

Given the importance of whistleblowers in responding to concerns over quality and safety, it is surprising that there is virtually no discussion of, of, or Recommendations concerning, whistleblowing across these Inquiries. The Inquiries highlight the role of (patient complaints rather than employees raising concerns (see below) despite both Hooper (2015: 2) and Francis (2015) noting that the Shipman Inquiry (above) highlighted the fact that the willingness of health professionals to air concerns could make a greater potential contribution to patient safety than any other single factor' (Smith, 2005: 23). It is striking that of about 800 recommendations across all of the Inquiries reviewed in Table 2, only two (Ayling R2,

Kerr/ Haslam R37) adopt the term 'whistle', while Shipman R37 refers to PIDA, and a further 16, while not directly using the term, have some broader relevance such as 'raising concerns'.

System heal~~th~~ thyself

Most Inquiries identified the 'system' as culprit rather than those working within it. Structural and collective, causes and solutions to failings in quality rather than individual agency and mistakes were highlighted. However, Pleming (2005) contrasted the action of the first 'whistleblower' in the case of Kerr of Dr Mathewson, a GP practising in Northern Ireland, who gave evidence at a disciplinary tribunal in 1964, with the result that Kerr's career in Northern Ireland came to an end, with the inaction of GPs in England: 'it is a sad fact … that once in England there was not a single GP who displayed the fortitude of Dr Mathewson in pursuing any one of the many complaints against William Kerr to the logical conclusion of any form of disciplinary' (p. 446). As the Counsel for the patients put it to the Inquiry: 'for the main part, we do not say they are system failures, they are personality failures, where patients were so short-changed by individuals, not by the system: the system worked in 1966 [a reference to Northern Ireland], the system could have worked if individual doctors, GPs, had taken extra steps.' (Vol 2: 801-2).

Cultural rather than legal remedies

The most consistent remedy drawn out from Inquiry recommendations has been cultural rather than legal reform. Inquiries since Kennedy (2001) have consistently argued in favour of the need for cultural transformation and renewal. For example, while Francis (2010: 409) noted a 'very real reluctance' by health care professionals to raise concerns, and a 'widespread belief that the protections offered are theoretical rather than real', he considered that 'the most important factor in changing this will not be a new system or policy of protection for whistle-blowers, but the fostering of a culture of openness, self-criticism and teamwork.' Francis (2013) suggested that whistleblowing was only necessary because of the absence of systems and a culture accepted by all staff which is receptive to internal reporting of concerns. 'Therefore the solution lies in creating the right culture, not in focusing on improvements to whistleblowing legislation, important though such protection is' (p. 242).

Similarly, whether expressed in terms of 'a system devoted to continual learning' (Berwick 2013) or 'a culture which is comfortable with challenge' (HCHC 2013), it has been claimed that 'culture change' would make the role of the whistleblower redundant. As Berwick (2013:

11) put it, ‘In the end, culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime’.

The government similarly advocated the need for cultural reform : while progress on Francis’ 290 recommendations were important, ‘perhaps the most important point is that the ongoing need to change the culture in the NHS to one of patient-centred, continual improvement in care and safety’ (Secretary of State for Health 2015a: 17). As then Health Secretary for Health, Jeremy Hunt, put it there should ultimately be no need for whistleblowers, because ‘we should have a culture where people want to find out that things have gone wrong and why they have gone wrong, and to learn from them. You only have whistleblowers when you have a system which is not doing that’ (HCPASC 2015: 37). Nevertheless,, according to Dalton and Williams (2014: 14-15), even in a culture of greater candour, effective whistleblowing and complaints systems would continue to be vital parts of an open and transparent culture committed to improvements in safety and quality. Moreover, the Department of Health has sought to move the NHS away from a “blame culture” since 2000 (HCHC 2009: 17). In terms of whistleblowing and speaking up, the NHS appears to have much to learn in becoming a learning organisation. At times the NHS appears to be an organisation without much of a memory: ‘sorry’ may be the hardest word but learning and implementation seem to be the hardest activities (Powell and Mannion, 2015). In short, ‘culture change’ in an organisation as large and complex as the NHS may be a much more difficult enterprise that such optimistic accounts assume (Davies and Mannion, 2013).

Reinventing the wheel

Evident from these Inquiries is a high degree reinvention and re-treads with some return to similar solutions over time – a situation that has been described as “Groundhog Day” as recommendations from previous Inquiries become recycled and presented anew (Powell and Mannion, 2015). The clearest example of this is the repeated identification of culture as both culprit and solution to periodic failings in health care (above). A further example is the term ‘duty of candour’, which appeared in Kennedy (2001) through Pleming (2005), to Francis (2013), and Dalton and Williams (2014). However, this term appears to be rather widely and ambigiously defined and it is not clear what sanctions may be applied to those who fail to honour their statutory duty of candour.

Similarly, there has been a repeated stress on re-issuing policies and guidelines despite scant evidence that these have led to any discernible improvement in quality and performance.(Smith 2005; Pleming 2005; Secretary of State for Health 2007; HCHC 2009). This is reminiscent of Einstein's definition of madness: doing the same thing over again, and expecting different results. Indeed, as Francis (2013: 280) noted, although the Mid Staffordshire Trust had, had a policy on whistleblowing since 2001 the tragic events at the organisation exposed the 'hollowness' of that policy.

Misplaced optimism over improvements

Many of the inquiry reports display an attitude that 'things are getting better', that institutions, policies and procedures are in place that will prevent earlier problems from recurring in the future (e.g. Pauffley 2004; Smith 2005). Governments tend to have argued that 'much has changed' since the incidents took place and that effective remedial policies have been put into place that will prevent a recurrence of failings in care (e.g. Home Secretary and Secretary of State for Health 2007; Secretary of State 2002, 2015a). However, while there have undoubtedly been some positive reforms (cf. Ashton 2015) there is remains a concern that healthcare will follow that of child abuse inquiries: that we have learned lessons and this will never occur again – until the next time.

According to Francis (2013), Professor Sir Brian Jarman highlighted that at the Bristol Inquiry, there were 120 mentions of the word "hindsight" in the evidence. (p. 29). Francis pointed out that unhappily, the word "hindsight" occurs at least 123 times in the transcript of the oral hearings of this Inquiry, and "benefit of hindsight" 378 times. (p. 30)

Moreover, it is assumed that existing policies are working. For example, according to DH (2000: 63-64), PIDA represents an important step forward in encouraging and protecting appropriate reporting of incidents or concerns. It was claimed that the ~~The~~ Act gives significant statutory protection to employees who disclose information reasonably and responsibly in the public interest and are victimised as a result, and has prompted renewed

interest in supporting the creation of open reporting in the NHS. The Health Committee (2009) quoted Health Secretary, Alan Johnson, on "the mystery of Stafford being the absence of any whistleblower" as he considered adequate legal protection for whistleblowers existed" (HC Deb, 12 May 2009, col 672). This assumption by Johnson was proved to be incorrect; staff had expressed serious concerns repeatedly and had been ignored (Francis 2010, 2013).

Neverthless, according to the HCHC (2015: 35), evidence from Public Concern at Work and others argued that PIDA was a deterrent rather than a remedy, and that if an employee has to have recourse to PIDA's provisions then his or her prospects were already substantially impaired. In short, PIDA has not been as effective as anticipated (Bolsin et al 2011; ~~), has not adequately protected whistleblowers, and its achievements in effecting a tangible, sustainable cultural shift towards transparency in the UK workplace appear incremental at best~~ (Ashton 2015; Mannion et al 2018).

Patient Complaints versus Staff concerns

Though patient complaints and staff concerns may be seen as two sides of the same coin, there has previously been more attention on addressing complaints than responding to the concerns employees. Indeed here has been much more attention directed at patient complaints through a series of official Reports (eg Clwyd and Hart 2013; HCPASC 2014; see their references). Moreover, the Health Committee (2015) Report on 'Complaints and Raising Concerns', devotes much more attention to (patient) complaints than to (staff) concerns. However, it may be argued that the staff are the canary in the coalmine. The NAO (2014) cites the British Standards' Whistleblowing Arrangements Code of Practice that: "… the first people to know of any risk will usually be those who work in or for the organisation.

Conclusions

In spite of the thousands of pages and hundreds of recommendations of health care Inquiries, and assurances of learning over a period of nearly 15 years, it seems that the NHS still finds it difficult to encourage its employees to raise concerns and respond appropriately when they do (eg Hilton 2016). Kennedy (2001) stated that 'It would be reassuring to believe that it could not happen again. We cannot give that reassurance. Unless lessons are learned, there is a risk that they could recur again, if not in the area of paediatric cardiac surgery, then in some other area.' Bell and Jarvie (2015) argued that the hundreds of recommendations from recent Inquiries seemingly have had only limited effect. They cite Professor Sir Ian Kennedy's evidence to the Mid Staffordshire Inquiry. Kennedy drew a number of similarities between Bristol and Mid Staffordshire, noting that 'the history of the NHS is littered with the reports of Inquiries and Commissions: most have been consigned to gather dust on shelves'. He considered that, unlike other industries, the NHS does not appear to learn the lessons from previous failings: 'there is something in the NHS that militates against recommendations like this entering the DNA of an organisation' and asked 'what is it about healthcare and the NHS that it does not seem able to learn lessons…to prevent their recurrence?' Similarly, Francis (2013: 24) argued that the experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent. It is respectfully suggested that the subject matter of this Inquiry is too important for it be allowed to suffer a similar fate.

Some reforms, partly based on the recommendations of Francis (2015), have been introduced after the Inquiries considered above. These include the introduction of the national (but part-

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time) 'Guardian', 'Freedom to Speak up guardians' appointed in NHS trusts, and the PIDA was modified by the Enterprise and Regulatory Reform Act 2013 (ERRA) (Ashton 2015; Mannion et al 2018). However, recent evidence suggests that whistleblowing remains a problem in the NHS (eg BBC File on Four 2017; Duffy 2019). Health and Social Care Secretary, Matt Hancock, admitted that whistleblowers are still ignored, bullied, or, worse, forced out. He declared that "Making someone choose between the job they love and speaking the truth to keep patients safe is morally abhorrent and operationally foolish. It's an injustice I am determined to end." (in Dyer 2019). However, previous Health Secretaries have said similar things.

It seems that, despite the burgeoning literature on whistleblowing (eg Brown et al 2014), there is relatively little on developing effective whistleblowing policy. It is therefore ironical that the Inquiries considered here did not appear to blow the whistle loudly enough (ie few recommendations on whistleblowing) and that the government failed to listen and act appropriately when they did.

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