DECEMBER 2021

West Suffolk Review

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Table of Contents

Any text in Italics demotes a quotation
Any text in Bold denotes emphasis

1: Introduction

1. This Review was commissioned following widely reported events arising from an anonymous letter that was sent in October 2018 to the relative of a patient who had died at the West Suffolk NHS Foundation Trust (the Trust).

2. The purpose of the Review was twofold:
    a. To consider the appropriateness of the actions taken in response to the issues raised by/ connected with the October letter by the Trust and other relevant bodies and
    b. To produce advisory recommendations and learnings

3. The Review did not consider the cause of death of the patient at the Trust, which was the subject of a coroner's Inquest.

Background

4. Located in Bury St Edmunds, West Suffolk Hospital provides acute hospital services to around 242,000 people living in a predominantly rural geographical area.

5. In January 2018 the hospital was rated 'Outstanding' by the Care Quality Commission (CQC), one of only seven general hospitals in England to achieve this highest possible rating. In the 'Well led' section of its inspection report, the CQC commented on the hospital's stable, experienced and cohesive leadership team and on the *effective governance and performance system which was focussed on the best outcomes for patients*.

6. In summer 2019 members of staff contacted NHS Improvement's (NHSEI) Enquiries, Complaints and Whistleblowing (ECW) team raising concerns about the Trust's response to the October 2018 anonymous letter. ECW were told that the Trust had begun an *investigation into the circumstances around the letter being sent which included requesting fingerprints from a number of staff* who had been told that *refusal to provide consent or refusal to provide an adequate rationale could be considered as evidence that the individual was involved in writing the letter.*

7. The CQC's report published in January 2020, following its inspection in autumn 2019, downgraded its rating for 'well-led' from Outstanding to Requires Improvement. Commenting on the lack of an open culture, it stated that *not all staff felt respected, supported and valued or felt that they could raise concerns without fear.*

8. The Trust's actions came to the attention of the national media in late 2019. The decision to commission an external Rapid Review was announced in January 2020.

Approach and timeline of the Review

9. I was asked to undertake the Rapid Review in February 2020, in addition to my other roles within the NHS. Initially, the view from NHSEI, at that point, was that it should be possible to review the documentation, visit the Trust to interview relevant staff, and write my report by May/June 2020.

10. Following initial discussions with key NHSEI representatives in late February and early March, Janice Barber (an experienced and knowledgeable solicitor specialising in the NHS) agreed to work with me on all aspects of the Review. In addition, Mr David Evans (former Medical Director and Chief Executive at Northumbria NHS Foundation Trust) joined to provide us with his clinical and medical leadership advice. No administrative assistance was made available at that point, so the role of secretariat to the Review was performed entirely by me until Gillian Mackenzie joined us in early 2021.

11. The Trust sent me two bundles of background documentation in mid-March 2020. One week later, however, national lockdown started. I personally contracted Covid-19 and was unwell for some weeks. Given the pressures on the NHS and the inability to travel except for the most essential reasons, it was agreed with the Minister (Health) that the Rapid Review would be temporarily paused and recommenced in August 2020 subject to the national situation making that practical.

12. In the event, during this pause, I was able to make some progress. On the advice of the NHSEI East of England Regional Office a confidential inbox was set up for staff at the Trust and invited anyone with relevant information to contribute to contact the Review team. This proved productive. 32 people wrote to me, of whom 20 were later interviewed, in addition to the further 25 Trust staff and also individuals from other NHS bodies whom I invited to interview. Much of the information that came from those contacting me was valuable to my understanding of the full circumstances under investigation.

13. On review of the initial document bundles, it became clear that whilst these reflected the key issues according to the Trust management's perspective, there were considerable gaps in the chronology. Significant information and documents were missing, including for example key correspondence from the medical staff who had raised concerns; notes of important meetings; interview

statements and other appendices to two external investigation reports commissioned by the Trust; correspondence with union representatives and with Occupational Health.

14. Based partly on references in the material supplied to other events and correspondence, I requested further material which was duly supplied in May. That was not, however, the last of the relevant documents to be given to me. Throughout the entire process of the Review, new documents emerged, either handed to us directly by interviewees, sent to the confidential inbox by members of the Trust's staff, or requested by me later as new facts emerged. The random order in which documents were presented made the eventual process of writing the report significantly more cumbersome.

15. As external reviewer, I was asked to consider six specific issues relating to events connected to the October 2018 anonymous letter. The scope of my work has been confined only to those areas set out in the Terms of Reference, and I was careful not to be drawn into other matters if they were not directly relevant to the issues under consideration.

16. We have interviewed many of those who were directly involved in or witnessed events directly relevant to the Terms of Reference and reviewed considerable quantities of written material in the form of reports, correspondence, and other documentation. Almost from the outset it was clear that there were often very different - and contested - perspectives and interpretations of what happened and why. As a result, it became clear that the events being reviewed were more complex, contentious, and disputed than had perhaps initially been thought.

17. The very differing - and sometimes surprising - perspectives of those we met during the Review reinforced the need for me to approach each contested matter with scrupulous fairness. We began our process of interviewing at the Trust in July 2020 with an open mind and have been conscientious in examining all the different viewpoints and balancing all the evidence presented to us, before reaching conclusions. Those who have engaged with us have been given every opportunity to provide information and evidence. I ensured that, both during the evidence gathering phase and more recently, prior to publication of our report, I put potential criticisms to those we interviewed in order that they could respond. All of the conclusions in this report are supported by the evidence we received.

18. The Review has taken considerably longer than initially envisaged, and I do not refer to it in this report as 'Rapid'. The reasons for this include:
    - The national Covid-19 lockdown which delayed the start of the Review.
    - The number of staff who wished to come forward with evidence.

- The sometimes haphazard way in which documents were received at different points (as referred to above).
- The disputed nature of many of the events and issues under consideration.
- The consequent need to carefully balance these different perspectives and to seek the appropriate evidence in order to come to a fair conclusion.
- The small size of the Review team.

19. It is extremely important to note that this report describes a series of events that took place two or more years ago. During the time that has elapsed since the Review was first announced in early 2020, the Trust has undertaken considerable work to improve the confidence of its staff in its Speak Up culture. I commend them for these efforts and wish them well for the future.

How this report is structured

20. The six issues set out in the Review Terms of Reference are to a degree overlapping. The series of events preceding and following on from the sending of the anonymous letter are best understood in chronological order: therefore chapters 5 to 11 of this report tell the story of those events, which took place between November 2017 and January 2020 (when the Review was announced). This narrative account is punctuated by discussion of the various reports, perspectives and arguments put to us by interviewees, and by the findings and conclusions that I have reached as a result.

21. The findings detailed throughout the chronological narrative have been brought together and listed at chapter 4.

22. The executive summary (chapter 2) gives a concise account of the events under review, referring to the chronological chapters so that the reader can both access the more detailed account where desired, and understand in greater depth the issues that I weighed up in order to reach my conclusions. It is followed by a short section (chapter 3) with my overall reflections on the wider issues raised by this Review and areas of learning.

23. A separate section of this report (chapter 13) gives a summary response to each of the six issues set out in the Terms of Reference for the Review.

Thanks and acknowledgments

24. I wish to place on record my thanks to all those who have assisted me in undertaking the work required to carry out a thorough and fair investigation, and to publish my report.

25. I am extremely grateful to all those members of the Trust's staff who contacted me via the confidential review inbox and provided invaluable written information in addition to offering their perspectives at interview. They did not have to get in touch at all, but all wanted to contribute and ensure that we had the fullest picture from which to draw the right conclusions. A number of these individuals supplied us with information that they feared would damage their careers. They did the right thing, and I would like to thank them for trusting us to protect their confidentiality.

26. Jeremy Over, now Director of Workforce at the Trust – who was not part of the organisation for the majority of the period in which these events took place - provided considerable help in meeting our requests for documents and further information, and also in the practical arrangements for our visits to the Trust in the summer of 2020.

27. I would like to thank everyone we met at the Trust for their courteous assistance.

28. Finally, I would like to thank my colleagues on the Review team. David Evans has provided expert advice throughout based on his considerable experience as a medical director, clinical leader and Trust chief executive. Jen Coyne, an employment barrister from 11 Kings Bench Walk, provided invaluable support and insightful advice in my initial drafting. Since joining us in January 2021, Gillian Mackenzie has provided efficient and effective support, and patiently and diligently managed the editing process. Pearse Butler, an experienced NHS leader, provided a 'critical friend' review of an early draft of my report which was most helpful. Finally, I am indebted to Janice Barber for her expertise, unfailing attention to detail, sheer hard work, and personal support throughout the entire Review.

29. I am grateful for all the assistance I have received, but stress that I take full responsibility for the conclusions reached and views expressed in this report, which are entirely my own.

2: Executive Summary

Introduction: The Anonymous Letter

1. On 15 October 2018 an anonymous letter was sent to the widower of a patient who had died in the Trust's Intensive Care Unit (ICU) on 30 August 2018, following her admission to the hospital for emergency surgery on 27 July 2018. Post-operatively, an arterial line had been inserted in theatre, but instead of the intended normal saline the patient was given dextrose solution. The error was not spotted and corrected until 8pm on 28 July 2018.

2. The anonymous letter read, in part: *We think you should know that the consultant anaesthetist who made the mistake with the fluid into the arterial drip in theatre should never have been at work. He had injected himself with drugs before while in charge of a patient and it was all hushed up and he was at work like nothing at all had happened – but we all knew the truth. You need to ask questions about this doctor and what investigations had been had about him before. We think there is a big cover up. Operating Theatre Staff*

3. On receiving the letter, the patient's widower informed the coroner, and reported it to the Suffolk Constabulary three days later. He understood the police would liaise with the Trust. However, they had not done so by the time he was contacted by the Trust's Deputy Chief Nurse (DCN) on 20 December 2018 to ask if he had any questions about the Serious Incident Report that had been undertaken into his wife's care and sent to him earlier that month. He confirmed he had no questions in relation to the report (which fully disclosed the fluid error) but did want to discuss the anonymous letter. The DCN sought his authority to obtain the letter from the Police.

4. The staff we interviewed universally viewed the anonymous letter as reprehensible. A Serious Incident investigation was launched into an Information Governance breach (on the assumption that to send the letter the author must have obtained the patient's address from her hospital records). Thereafter the Trust sought to identify its author.

5. The Trust reasonably deduced that the letter referred to an incident that had occurred on 5 November 2017, when a consultant anaesthetist, Dr A, experiencing back pain, self-administered intravenous magnesium and parecoxib whilst responsible for an anaesthetised patient (referred to throughout this report as the self-medicating incident*).* Dr A was permitted to remain on unrestricted duties after the incident was belatedly reported on 22 March 2018.

6. Dr A had been in theatre with the patient on 27 July 2018 when the wrong arterial line had been put up, although, as was later confirmed at the coroner's inquest in September 2020, he was not personally responsible for that error.

7. The self-medicating event was the seminal event that triggered the chain of events that the Review was asked to consider.

The management response to the self-medicating incident

8. There were key shortcomings in the response to the self-medicating incident. Specifically, the Medical Director (MD) and the Director of Workforce and Communications (DWC), had one meeting with Dr A, and at that meeting decided they neither needed to place him on special leave nor restrict his clinical duties in any way. This decision was made without first:
   8.1. speaking with the direct witnesses to the incident. Had they done so they would have learnt that Dr A had persisted in self-medicating despite being urged not to proceed and being offered practical alternatives.
   8.2. immediately arranging for Dr A to be reviewed by Occupational Health (OH) to assess his current fitness to work.
   8.3. consulting the Clinical Director of Anaesthetics (CDA); or
   8.4. seeking independent expert anaesthetic advice (if they did not wish to seek such advice from within the Trust).

9. The advice of the General Medical Council (GMC) by the MD was sought on the day after the incident came to light and prior to the Directors' meeting with Dr A. However, the GMC's advice was based on an account which lacked key information, including that:
   9.1. there was an anaesthetised patient for whom Dr A was the responsible consultant during the incident.
   9.2. the operating department practitioners who witnessed the incident were highly concerned throughout (the GMC were told the opposite); and
   9.3. Dr A's consultant colleagues had recently raised serious concerns about his working relationships; the MD did not apparently consider those concerns valid as he informed the GMC that the delayed reporting of the incident might have been raised retrospectively in retaliation to a falling out over Dr A's *patient advocacy*. I disagree.

10. The handling of the incident was inadequate because it showed insufficient regard for patient safety, the practitioner's wellbeing, the understandable anxieties of the other staff on duty, and the legitimate concerns of other anaesthetists about Dr A's potentially harmful actions.

11. My full findings in relation to the response to the self-medicating incident are set out in chapter 6.

The investigation into the self-medicating incident and subsequent MHPS process

12. An investigation under the process for managing serious concerns about doctors, Maintaining High Professional Standards in the Modern NHS (MHPS), was later carried out, and reported on 7 June 2018 (see chapter 5 for further details). It found that Dr A's conduct was inappropriate and could have resulted in compromising patient safety and standards of care, as well as putting his own health and safety and that of others at risk; but on this occasion did not. The investigator noted that Dr A had fully accepted his judgement had been flawed.

13. The outcome of the process was agreed without a disciplinary hearing, at Dr A's request. Whilst this represented a saving in terms of Trust resources, I would observe that it is unfortunate that it also meant that there was no opportunity for a panel to hear evidence from the witnesses nor, indeed, to form an independent view as to the seriousness or otherwise of Dr A's conduct. Nor was there any opportunity for scrutiny of the MD's and DWC's decision in immediately clearing Dr A as fit to continue in unrestricted duties.

14. In May 2018, Dr A applied for a post in another NHS Trust, and properly gave the new employer a full written statement about the self-medicating incident. At Dr A's request, the MD telephoned the Medical Director at the new Trust to ensure there was full disclosure of all the circumstances. Unfortunately, the normal GMC Medical Practice Information Transfer (MPIT) Form was not completed by the Trust and sent to the new employer.

15. The MD did not make any written record of the information given to the new employer but did produce to me a copy of an email from the other Trust which confirmed a conversation had taken place. The only written disclosure to Dr A's new employer was made by Dr A himself.

The response to the initial concerns raised about the self-medicating incident

16. The MD and DWC failed to take account of the significant and legitimate concerns of other, senior anaesthetists as to the wellbeing of Dr A and the risk to patient safety posed by his conduct. (See chapter 6 for a full account).

17. The first to raise concerns was the CDA, who twice emailed the MD and DWC on 23 and 24 March 2018. Warning about a potential patient safety risk, he suggested Dr A be given a period of administrative leave. He did not receive a response. In the meantime, he asked Dr A to undertake administrative duties, and at Dr A's request agreed he could work from home. The CDA told us he was later told he should not have *excluded* Dr A without authority and was informed that Dr A should resume unrestricted clinical practice.

18. Dr E (then College Tutor for anaesthetics) telephoned the MD to express her view that Dr A needed support and for reasons of patient safety should not be working with patients until a decision was made about his fitness to practice once the investigation was complete. She followed up her conversation in writing, adding that she had also called the GMC helpline, and had been advised that it was often appropriate to place a consultant on leave while an investigation into an event of that nature was undertaken.

19. On 26 March 2018 Dr E, Dr C (the former CDA) and another senior anaesthetist, Dr F (a former Head of School for the regional training programme and Council Member of the Royal College of Anaesthetists), together approached HR to express their concern for Dr A's wellbeing and for patient safety if he was permitted to undertake unrestricted practice. They were informed that they should respect the process by then underway.

20. It is extraordinary that the input of such senior consultant colleagues, in particular that of the CDA, was ignored and rejected. Clinical leadership and engagement in hospital management are extremely important, and clinicians are often better placed to advise on patient safety and on the welfare of their colleagues. Time should have been taken to reconsider the decision to permit Dr A to continue with unrestricted clinical duties before a fuller investigation and an occupational health assessment had been undertaken.

21. In our interviews with Trust executives, we were told that the Trust tried to avoid excluding staff because of the impact this has on the individual concerned. In a letter to NHSEI's Head of Complaints and Whistleblowing sent on 27 September 2019, the Trust's CEO stated that he was uncomfortable with *the campaign for either the Trust or the GMC to exclude or remove* [Dr A] *from unsupervised clinical practice or reach a career ending decision about* Dr A. However, I found no evidence whatsoever that any of Dr A's colleagues believed that a *career ending decision* would have been appropriate still less that they *campaigned* for one.

22. I did find that a number of Dr A's senior colleagues believed the Trust should have restricted his clinical practice pending fuller investigation. They took the view that self-medicating whilst responsible for an anaesthetised patient rang

alarm bells suggesting a colleague manifesting signs of personal difficulty and were genuinely concerned for him and his patients if he continued in unrestricted practice pending an investigation.

Further Speaking Up about the self-medicating incident

23. Drs E and C continued to raise their concerns in the following weeks. They were correct to do so, because the GMC, in its document *Good Medical Practice,* requires doctors to report any concerns about whether a colleague may be putting patients at risk. I saw no evidence that the Executive Directors to whom they spoke (CEO, MD and DWC) recognised that their concerns fell within the Trust's Freedom to Speak Up (FTSU) policy, which was modelled on the National FTSU policy dated April 2016. However, the concerns did: under the heading *What concerns can I raise?* both policies included*: lack of, or poor response to a reported patient safety incident.*

24. Concerned that *patient safety and the appropriate support of a colleague* had not been prioritised, and that the concerns of senior clinicians had been ignored, over the coming months Dr E subsequently met separately with the CDA, MD, and CEO; and contacted the Board's Senior Independent Director (SID) who at the time was the non-executive director (NED) responsible for FTSU. He arranged for the Board to discuss her concerns in the private section of their meeting on 2 November 2018.

25. Dr C also remained troubled about the self-medication incident and Dr A's engagement with his colleagues, and continued to raise her concerns with the MD and at an impromptu meeting with the CEO in May 2018, which was joined by the DWC and Dr E. Dr C also contacted the GMC, who informed her that they understood a local investigation was underway (with which they did not intend to interfere).

26. Eventually, Dr C sent an email marked *In Confidence* to the Chair of the Trust on 27 July 2018. Attaching her correspondence with the GMC, Dr C asked for a meeting to discuss her concerns. Her email read, in part:
    26.1. The GMC is primarily guided by the Trust in its handling of concerns of this nature and seeks reassurance from the hospital that the doctor is safe to practice.
    26.2. [Dr A's] erratic behaviour has caused considerable concern to the anaesthetic department and repeated entreaties to HR and the MD have been disregarded. The Trust is not acting in either [Dr A's] or his patients' best interests by suppressing the investigation results and permitting him to take up employment [elsewhere]…

27. The Chair of the Trust passed this confidential email to the CEO without seeking Dr C's permission. The CEO, with the DWC, failed to see the email as an exercise in Speaking Up, instead taking the view that Dr C was seeking to undermine the MD. Yet Dr C was by no means alone in being troubled by the way the self-medicating incident had been handled, and about its implications for patient safety and the welfare of a colleague.

28. The CEO arranged to meet with Dr C on 31 July 2018, together with the DWC. Dr C was misled as to the purpose of that meeting. Rather than being solely a discussion about the matters contained in her email to the Chair of the Trust, the CEO intended to use it to raise with her various concerns he had about her conduct. Dr C was not informed that such matters would be raised and was not advised that she may wish to be accompanied. That meeting set in train a cascade of adverse consequences for her as detailed in the main body of my report.

29. There were serious flaws in the handling of Dr C's concerns. The *In Confidence* email should not have been passed on without her agreement. I found the use of the meeting on 31 July to address a string of conduct concerns to be unfair and in direct contravention of the Trust's FTSU policy, which states that staff raising genuine concerns will not face any form of reprisals or disciplinary action. The CEO and DWC quite wrongly mingled Dr C's attempt to Speak Up with an attempt to address their perceptions about conduct.

30. Just over two months later, Dr C tried to exercise her right to Speak Up once more, this time contacting a second NED (the Deputy Chair of the Trust - DC) whom she was wrongly advised was the one responsible for FTSU. The DC recognised, and acknowledged, that Dr C was Speaking Up. He arranged to meet with her, together with the FTSU NED, and conscientiously took up the concerns she had raised about the Chair of the Trust passing on her *In Confidence* email without reference to her. He also followed up on her concerns about the CEO 's and DWC 's conduct of the meeting on 31 July. Dr C's actions in contacting the DC secured some acknowledgement, and correction, of flaws in the Board's governance arrangements.

31. However, having reached an impasse in relation to the differing accounts of what had happened in the meeting of 31 July 2018, the DC decided to commission an external investigation into the manner in which the CEO and DWC had conducted the meeting and whether they were justified in raising issues in that meeting about Dr C's conduct.

32. One direct consequence was that the matters Dr C had Spoken Up about (relating to the handling of the self-medicating incident) were never investigated separately to the overlapping but different concerns that had been raised by her

colleague, Dr E. Further, Dr C's exercise in Speaking Up led directly to an investigation into concerns held about her conduct. That derailment was wholly contrary to the FTSU policy (particularly its requirement that no one is victimised for Speaking Up).

33. See chapters 6, 7 and 8 for the full narrative and my findings about the way that the Trust responded to Speaking Up in relation to patient safety concerns arising from the self-medicating incident.

The Board's review of the self-medicating incident

34. As a result of Dr E's contact with the SID, reports authored by the DWC and CEO were presented at the 2 November 2018 closed Board meeting. However, these did not fully address Dr E's questions and concerns, omitted some significant pieces of information, and potentially gave false reassurance. As a result, I found that the Board were not fully sighted on the breadth and depth of the concerns being expressed by senior anaesthetists about the handling of this matter (See chapter 8 paragraphs 47-59 for a description of the Board's considerations and my conclusions).

35. As a result of Dr C's prior discussions with the DC and the SID, she was informed that *her speaking up had…. made a difference.* The role of NEDs in overseeing MHPS cases was strengthened, and confirmation was sought from the MD about the information passed on to Dr A's new employer. However, Dr C's attempts to Speak Up did not lead to a thorough investigation of all of her concerns.

The investigation into the 31 July meeting

36. I was impressed by the accessibility and conscientiousness of the DC and SID in relation to both Dr C and Dr E. Both non-executives welcomed the approach by Dr C and Dr E and made significant efforts to understand and address their concerns.

37. It was therefore regrettable that, directly in consequence of the DC looking into the concerns raised with him, Dr C herself came under detailed scrutiny in the investigation commissioned by the DC and undertaken by the first external investigator (ExIn1). This focused partly on Dr C's concerns about the way in which the CEO and DWC had conducted the meeting with her on 31 July 2018, which had been arranged as a result of her email to the Chair of the Trust about the self-medicating incident. In addition, however, it was set up to determine whether the CEO and DWC were **right** to hold concerns about Dr C's conduct and therefore right to conduct the meeting in the way that they did.

38. As a result, a range of concerns about Dr C's conduct over the previous two years, none of which had been taken up with her prior to her meeting with the CEO and DWC in July 2018, were described to ExIn1 in the course of his investigations. That this would happen was not clear from the Terms of Reference for the Review (described more fully in chapter 10), nor from the list of three witnesses to be interviewed (Dr C, the CEO and DWC) which appeared within the Terms of Reference. In the event however, five witnesses were interviewed. The two additional witnesses were proposed by the CEO: the MD, and a consultant anaesthetist who was granted anonymity.

39. Dr C was not consulted about the proposal to add two witnesses and whilst she later learnt that the MD had been interviewed, she was not informed about the addition of the anonymous consultant. Possibly because of the perceived need to conceal their involvement, the allegations that were raised by that individual (a number of them based on hearsay) were never put to Dr C and so she had no opportunity to respond to them. This departure from normal fair practice may have led to the decision not to disclose a complete copy of the resulting report to Dr C; she was supplied only with excerpts. This meant that even at the conclusion of the process she did not know all of the allegations which had been raised.

40. We had the opportunity to interview a much wider range of witnesses to obtain their direct evidence on these matters, including those with first-hand accounts, from which it is clear that many of the allegations raised about Dr C would have been subject to robust and credible challenge had they ultimately been pursued to a hearing – and indeed for some there was little or no evidence at all. (See chapter 7 for my consideration of these allegations).

41. It would have been considerably fairer and more transparent if the external investigator whom I have described as ExIn1 in this report had been allowed to put the allegations to Dr C and allow her to tell her side of the story. But the Terms of Reference agreed by the DC determined that this was not necessary because ExIn1 was only required to establish whether it was reasonable for the CEO and DWC to hold concerns about Dr C, and not whether the allegations were true or not.

42. The ExIn1 investigation subsequently led to the triggering of a disciplinary investigation under the provisions of MHPS against Dr C. I found the launch of an investigation (not into the matter about which she had Spoken Up, but rather in relation to broader conduct concerns) to be inappropriate, and contrary to the FTSU policy. I also conclude that, because the investigation and subsequent MHPS process resulted directly from her Speaking Up to the Chair of the Trust

in July 2018, the commissioning of the first external investigation had the potential to be victimisation of Dr C.

43. See chapter 10 for a fuller account of the ExIn1 investigation and my findings.

The Anonymous Letter investigation: Stage 1

44. On becoming aware of the anonymous letter, there were two clear questions open to the Trust to pursue:
    44.1. Why was the letter sent?
    44.2. By whom was the letter sent?

45. The letter referred to the administration of the wrong arterial fluid to the deceased patient. This had been fully investigated, the Duty of Candour disclosure had been made to the patient's family, and the death reported to the coroner. The Trust executives concerned also considered that the self-medicating incident had been dealt with appropriately. They therefore chose not to investigate the first question, believing that the motivation for the letter had been a malicious attempt to undermine colleagues. They focused instead on attempting to identify the author of the anonymous letter, in a highly flawed investigation process.

46. The DWC and Chief Operating Officer (COO), who led the investigation, started from the proposition that they could identify the writer of the anonymous letter by ascertaining who had accessed the patient's electronic notes to obtain their address. This approach was flawed because it was predicated upon:
    46.1. an assumption that the address had been discovered by accessing the electronic notes; and
    46.2. that all of those who had accessed the electronic notes could be identified.

47. In relation to the first proposition, they overlooked the continuing maintenance of paper records and labels throughout the Trust (including in ICU where the patient had been treated for several weeks) which could have been accessed by employees without leaving any *digital footprint*. In relation to the second, they overlooked the existence of computer terminals in the theatre suite that anyone could access without the need to use their personal login.

48. Accordingly, the methodology was unfit for purpose. I describe these matters more fully in chapter 9 and my findings are in paragraphs 30 - 31.

The Anonymous Letter investigation: Stage 2

49. Matters were made worse by the approach to a decision to narrow the field of suspects. The initial Information Governance (IG) analysis had identified 201 staff who had accessed the patient's records. That was then reduced by an opaque process to a list of 131 staff, all of whom were written to to establish their reason for accessing the records. As many were clinicians who had been responsible for aspects of the patient's care, there was in some cases considerable incredulity that they were asked to justify accessing the records of a patient for whom they were responsible.

50. In any event that process did not, of itself, take matters much further. At that point further criteria came to the fore. The numbers would be reduced by focusing upon those who:
    50.1. had for no clear or obvious reason accessed the records.
    50.2. knew about the issues referred to in the letter; or
    50.3. their name was provided by another individual as potential justification for their accessing the records.

51. In relation to the second criterion, a number of interviewees expressed the view that, at least within the anaesthetic team and in theatres, there would be relatively few who had not heard something about the self-medicating incident. Nevertheless, the investigation team proceeded (via a process that was not detailed in any document produced to me and which – beyond giving the above three further criteria listed above - none of the interviewees was able to explain) to narrow the field of 131 to 7. Five of the seven were consultants who had been involved in the patient's treatment in ICU or who had a declared reason for accessing her notes.

52. Despite having given verifiable and legitimate reasons for having accessed the patient's notes, four of the consultants were retained as suspects (one of the original five being eliminated when they provided their fingerprints). Of the remaining four, three had raised direct concerns about the self-medicating incident (Drs B, C and E) whilst the fourth had earlier raised other concerns about Dr A in addition to being named by another suspect who said they may have accessed the notes at their request. It was clear that a number of them could argue they were being victimised for raising concerns about Dr A.

53. As a consequence of its poorly designed process, the investigation not only lacked credibility internally, but also any disciplinary action taken in the light of it was likely to be susceptible to robust and credible challenge.

54. Notwithstanding these inherent shortcomings (which could and should have been foreseen) several members of staff were subjected to an interview process which was perceived to be aggressive by the majority. All those

interviewed were also asked to agree to being fingerprinted and provide handwriting samples.

55. Ultimately all but one of the five consultants refused to provide fingerprints in common with the two additional suspects. Those who had refused their consent to submit to fingerprinting received a letter warning them that failure to provide a rationale for refusing *could be evidence which implicates you as being involved in the writing of the letter.* Despite this intimidating message, in the event the remaining six suspects all continued to refuse their consent.

56. The requests for handwriting samples came into a different category. Whilst the *suspects* were unhappy about that as well, all consented to supply a sample or authorised the Trust to identify a sample from manuscript records already in their possession.

57. The suspects were not however aware that those leading the investigation had jumped the gun by sending their handwriting expert a single handwriting sample right at the start of the investigation, in January 2019 – a handwritten envelope the DWC found on her desk which she thought had contained the petition supporting increases in junior doctor pay (see chapter 9 paragraphs 44 - 60). In the event it did not advance matters as the handwriting expert indicated the sample was insufficient to permit analysis. On learning that, the DWC then considered sending a further single sample of Dr C's handwriting but accepted internal advice that to do so might *reflect badly upon the Trust.*

58. We learnt of the premature despatch of a single sample of handwriting (before consent to the despatch of *any* sample had been sought or given) in the course of our interviews (there had been no reference to it in the papers disclosed to the Review Team prior to the commencement of the interviews). I then sought and obtained all relevant correspondence which confirmed the account we had received from several people.

59. Six months after the despatch of the single sample, handwriting samples from five suspects were sent to the same expert. The expert was not made aware that the potential group of *suspects* - i.e. those who had accessed the patient's electronic notes - was 131 strong, thus considerably larger than the group of five from whom samples were sent. The expert concluded that *whilst the opportunities for comparison are limited,* he had *found a significant number of similarities* and therefore that it was *more likely than not* (that one handwriting sample came from the writer of the envelope containing the anonymous letter). The term *more likely than not* referred to the 4th out of 5 levels on the scale of opinion agreed by the UK Forensic Science Service, with the terms *Conclusive Evidence, Very Strong Evidence, and Strong Evidence* describing the three

higher levels. This outcome was the subject of challenge by a second handwriting expert retained by the suspect whose handwriting that was.

60. The requests for fingerprints were incendiary. No evidence was produced to me that fingerprinting had previously been used in the NHS in a potential disciplinary investigation such as this where the police had already confirmed that there was no evidence that a criminal act had been committed. Indeed no one to whom we spoke was aware of any case of fingerprints being sought in any NHS investigation.

61. In contemplating the use of biometric data to identify the author of an anonymous letter prior to writing it into the Terms of Reference for the investigation, no guidance was sought by Trust executives from NHSEI on the appropriateness or otherwise of such a move. The MD did consult the Practitioners Performance Advisory Service (PPA) prior to launching the request for fingerprints and handwriting samples but gave them incorrect information when they did so (see chapter 12 paragraphs 47-60). The existence of fingerprints on the envelope of the anonymous letter was mentioned to PPA again by the COO in October 2019, in the context of adding an allegation - that Dr C had sent the anonymous letter - to MHPS proceedings which were by then underway against her.

62. We interviewed all seven of those who were classed as suspects, and, with one exception, they remained distressed and angry about the process fifteen months later.

63. The majority of the executives we interviewed indicated that they could not envisage ever taking such a step again. What is more surprising was that they had not anticipated, before they embarked upon the process, the scale of the opposition they would face.

64. The efforts to identify the author of the anonymous letter are described in chapter 9.

The impact of the Anonymous Letter investigation

65. Wrong as it was to send an anonymous letter to a deceased patient's family, that does not mean that it was appropriate to seek to identify the author. Identifying the author of an anonymous letter would in any circumstances be very difficult, but for an NHS Trust to choose to divert its resources and the time of executive members of the Board in an attempt to do so (in what was likely to, and did, prove a futile attempt) was disproportionate and inappropriate.

66. On learning of the receipt of the anonymous letter, the CEO and the executive directors concerned should first have considered **why** one (or more) members of its staff had chosen to raise a concern about patient safety in this way, and what steps it should take to ascertain why they had not felt able to raise their concern directly with the Trust's well-established Patient Safety team and /or via FTSU. The Executive Directors we interviewed believed that writing the letter was malicious: but I concluded that not all staff who were aware of some of these matters would have known the two incidents referred to in the letter had not been covered up. It would have been an opportunity to look back at its handling of the self-medicating incident and the confidence its staff might have had about their ability to raise concerns through appropriate channels.

67. I received no evidence that any consideration was given to the **why** (as opposed to **who)** question at any point.

68. Many to whom we spoke considered the attempt to unmask the *culprit* was doomed from the start – absent a confession it was very unlikely to have been successful. I received no indication that due weight was given to the practicality of the exercise and indeed when we conducted our interviews in July 2020, the CEO, DWC and COO still thought (at the very least) they had had to make the attempt.

69. Unfortunately, that ultimately led them to embark upon a flawed and intimidating process that damaged individual staff members and went against any semblance of an open culture in which staff were free to raise concerns. It also unjustly led them to raise an allegation that one of the group of seven had written the anonymous letter, which was then further pursued in a disciplinary investigation.

70. The impact of these actions was nothing short of disastrous, not only for the staff directly caught up in the process, but for other members of the Trust's staff, the working environment more generally, and for the Trust's reputation internally and externally.

71. Although the CEO informed the Chair of the Trust that the Terms of Reference for the investigation into the despatch of the anonymous letter included the use of biometric data, this information was not conveyed to the full unitary Trust Board. In general, the non-executive directors (NEDs) of NHS Trust Boards are often well-placed to give constructive challenge and criticism to the executive team. As experienced individuals from a range of backgrounds, they can offer different perspectives, and private discussions of a Trust Board are an opportunity to test out plans and strategies. I was surprised, given the highly unusual proposal to seek fingerprints from members (and in one case a former member) of staff to identify the author of an anonymous letter raising patient

safety concerns, that the Board were not made aware of the controversial path upon which the Executive Directors had embarked.

72. The majority of the NEDs were not informed about the proposed use of biometric data until it came to light in the national press in December 2019. Even then, and despite the reputational damage that this was causing, the Board did not discuss it because it was by then part of a confidential MHPS process.

73. See chapter 9 for my findings in relation to the investigation.

The launch of formal MHPS proceedings against Dr C

74. Once the DC had received the ExIn1 Report in February 2019, he met with Dr C and subsequently wrote to her, noting her disappointment that the report had not acknowledged any *shortfalls on the part of the CEO in the way the meeting* [of 31/7/18] *…had been called or conducted,* but also that she had emphasised her wish to avoid conflict and to normalise her working relationships and was therefore willing to sign a letter of expectations/behaviour plan if required.

75. The DC handed the report over to the Trust Executive, summarising the key issues that needed to be taken forward as:
    75.1. *serious concerns about the conduct of Dr C and her working relationships with members of the Executive Team; and*
    75.2. *the divided and unhappy state of the anaesthetics department.*

76. The COO was appointed as case manager for the MHPS investigation which then ensued. One of the Trust's NEDs (MHPS NED) was appointed to oversee the process. The COO at this point had the option of pursuing an informal resolution, but despite Dr C's offer to sign a behaviour agreement, decided after consultation with the CEO and DWC to launch a formal process. There is no written record of the rationale for this decision. The reasons for it were described to us in the course of our interviews as including:
    76.1. the concerns conveyed to ExIn1 by the consultant anaesthetist granted anonymity (which had not been put to Dr C).
    76.2. divisions and tensions in the anaesthetic department.
    76.3. Dr C's *repeated escalation* of concerns about the self-injecting incident; and
    76.4. The DWC stated that the executives were now aware of the anonymous letter and believed that it was therefore important not to *brush the issues under the carpet.*

77. I would note that the investigation into the anonymous letter was still ongoing at this point, with a number of suspects still regarded as possible culprits.

Therefore, it was wrong to take the authorship of the letter into consideration in relation to the launching of an MHPS investigation against one of those suspects. Nor was it at all appropriate to use concerns about perceived divisions in the anaesthetic department as part justification for a disciplinary investigation into a single member of the department. Above all it was not permissible to include in a disciplinary process the concerns which Dr C had raised in an attempt to Speak Up.

78. I concluded that there was inadequate consideration of the potential to resolve the perceived concerns about Dr C informally. See chapter 11 for further detail and my findings on the launch of the MHPS process.

The MHPS process

79. The extensive allegations initially set out against Dr C were (in summary) that she had, since 2017, sought to undermine the MD in relation to a number of matters that had been considered by ExIn1 (and which we have briefly considered in Chapter 7), and that she had, since mid to late 2018, sought to undermine the senior leadership or Executive Team at the Trust collectively. Specific details included:
    79.1. The process to seek a replacement for Dr C as Clinical Director;
    79.2. *Leading a disproportionate and unreasonably hostile response* to the MD's investigation into annual leave;
    79.3. Leading the production of an anonymous petition about pay rates for junior doctors;
    79.4. Undermining the MD's clinical competence including questioning a colleague in the Emergency Department;
    79.5. making various derogatory remarks about the MD and also about the Executive, including referring to the latter as *Quince House,* and circulating a WhatsApp message to a small group of colleagues in August 2018 stating *Honestly, the only thing cheering me up right now is making Quince House suffer.*

80. Three further allegations were added later, in August, September and October 2019: that Dr C had:
    80.1. in October 2018 sent the anonymous letter and that she had, in doing so, sought to undermine the Trust's own investigations into the death of the patient and responses to its Duty of Candour.
    80.2. disclosed to the Sunday Times confidential and/or sensitive data about a patient, and staff data (the MHPS investigation correctly concluded that there was insufficient evidence to pursue this, because it was based on third hand accounts); and

80.3. during the investigatory process sought to inappropriately discuss and/or influence and/or undermine the investigation and /or use incentive, pressure and/or intimidation to do so.

81. I have grave concerns about the validity and appropriateness of the MHPS process that was pursued.

82. The conduct complained of had not been the subject of any prior warnings or grievance processes. Some of the allegations were raised with Dr C for the first time in the course of a meeting which had ostensibly been convened to respond to her having exercised her right to Speak Up about the Trust's handling of the self-medicating incident.

83. The FTSU policy is explicit that those who Speak Up will not be at risk of losing their job or suffering any form of reprisal as a result (page 2 of the Trust's policy) and that FTSU processes will be kept separate from any disciplinary or performance management action (page 8 of the policy).

84. Despite that, the ExIn1 investigation had provided a means of gathering information about concerns held by the CEO, DWC, MD and an anonymous consultant, as the basis for many of the subsequent allegations which were relied upon in the MHPS investigation. This approach clearly risks victimisation for Speaking Up and/or deterring staff from raising concerns.

85. The decision to launch formal proceedings was made in the light of the ExIn1 Report (see chapter 10 for my analysis of this report), which due to its limited Terms of Reference was neither balanced nor transparent, and which had been undertaken as a result of Dr C Speaking Up. As a result, I consider that it had the potential to amount to victimisation of Dr C.

86. The second external investigator (ExIn2) interviewed 25 witnesses nominated by the Trust. Only 6 of the 19 witnesses proposed by Dr C were interviewed, and unlike the Trust's witnesses were only interviewed over the telephone. One of Dr C's proposed witnesses, the DC, who had received her second attempt at Speaking Up, was not interviewed – on the instructions of the Trust.

87. Whilst the COO was endeavouring to take a proportionate view as to which witnesses should be interviewed, I concluded that there was a lack of balance in the investigation's approach to witnesses, and that it was not reasonable, in what were from Dr C's perspective very serious circumstances, to refuse to agree to her nominees being interviewed.

88. Despite a previously exemplary sickness absence record, Dr C was on stress-related sick leave for two months between September and November 2018,

and again, following the launch of the MHPS process, from March until September 2019, when she came back to work on a *phased return*. Several colleagues came forward to tell me how seriously unwell she had been during this second period of sickness absence, and both the MD and COO were also aware of this (as the MD had informed the GMC). Despite this, the COO disregarded unambiguous Occupational Health advice that Dr C was not yet fit for interview and put pressure on her to be interviewed earlier than Occupational Health had advised.

89. Incorrect information was given to PPA in the course of the investigation:
    89.1. The MD told them Dr C had accessed Mrs W's electronic patient notes without a legitimate reason – which was untrue: he had not been involved in the anonymous letter investigation and told me he did not know that this was not true, and
    89.2. The COO incorrectly informed the PPA that Dr C had raised a grievance about the handling of the meeting on 31 July 2018 by the CEO and DWC. Whilst the COO told me she had believed this to be the case, Dr C had in fact Spoken Up about the use of a meeting, intended to discuss patient safety concerns, instead to raise with her concerns about her conduct over a two-year period.

90. I have not been asked to ascertain who sent the anonymous letter to Mr W; this would have been an impossible task. However, it is important to record that I do **not** believe that it was Dr C. See chapter 9 for my consideration of this matter.

91. For all the reasons listed above and described more fully in the body of my report I concluded that the MHPS process in relation to Dr C lacked fairness, balance, and compassion.

92. The MHPS process was put on hold when the independent Review was announced, and was eventually dropped, some 20 months after its launch in March 2019. However, for all of that period it was the cause of considerable anxiety and mental distress for Dr C.

3: Reflections and Learning

1. This Review describes a series of unique circumstances that took place, in the main, between late 2017 and early 2020. More recently, the Trust has made a number of positive changes in its HR and management practice in the light of its learning. However, some key themes emerged from my detailed review of the events which gave rise to this Review which those in leadership positions in NHS organisations might find it useful to reflect upon. I have also offered some suggestions about how to improve practice in encouraging and supporting staff to raise concerns about patient and practitioner safety.

Freedom to Speak Up (FTSU): The National Policy

2. The introduction of the NHS's FTSU policy was recommended by Sir Robert Francis' Freedom to Speak Up Review in 2015. He reported an ongoing problem in the NHS, with staff being deterred from Speaking Up when they had concerns and sometimes facing shocking consequences when they did so.

3. The freedom of all staff to raise concerns about issues affecting patient safety, without fear of reprisals, disciplinary action, or other detriment, is extremely important. Staff who do Speak Up may not always be *right*, but that should not matter. Important patient safety concerns would be less likely to be raised if staff feared being wrong and facing disciplinary action (or simply being castigated as a *troublemaker*). As NHS patients, we can all feel more confident in those organisations where those directly looking after us know that if they believe anything is wrong, they can raise their concerns without fear, in the expectation that they will be properly looked into and dealt with, and that those who raise them will not be discriminated against for doing so.

FTSU at the Trust: and learning for NHS organisations

4. The West Suffolk Trust's FTSU policy replicated the National policy. The FTSU Guardian in post at the time of these events had attended relevant training, participated in a regional FTSU reference group and was well-versed in the policy and the protection it afforded those who Spoke Up. However, he was not aware of the matters that had arisen in relation to the concerns raised by Dr C and Dr E, as at no point was he consulted by either them or by any of the Board members who became involved. I was assured that had these instances of Speaking Up been reported to him, he would have logged them and ensured that the process set out in the policy was followed.

5. My Review considers three distinct occasions on which attempts were made to make use of the Trust's Speaking Up arrangements:
   5.1. Dr C's email dated 27 July 2018 addressed to the Chair of the Trust, raising concerns about the handling of the self-medicating incident. This is discussed in chapter 7 and my findings in relation to it appear at paragraphs 28-34.
   5.2. Dr C's telephone call on 1 October 2018 to the non-executive named in the Trust's policy as having responsibility for whistle blowing, once again raising concerns about the handling of the self-medicating incident and the way in which she had been treated in her attempt to Speak Up previously. This is discussed in chapter 8 and my findings in relation to it appear at paragraphs 60-66.
   5.3. Dr E's email dated 23 October 2018 to the non-executive with responsibility for FTSU, also relating to the self-medicating incident and raising her concerns about patient and practitioner safety. This is discussed in chapter 8 and my findings in relation to it appear at paragraphs 60-66.

6. The policy enabled both Dr C and Dr E to make contact with non-executives on the Board, and both of the individuals approached invested time in listening to their concerns and taking action. However, it was not effective when Dr C's made her disclosure in her confidential email to the Chair of the Trust. Dr C made no reference to FTSU in her email; but the concerns she was raising related directly to matters of practitioner and patient safety which are central to the purpose of FTSU policy. Her email was not treated as Speaking Up partly because that term was not used, and also because senior executive colleagues questioned Dr C's motivation for raising the concerns. They proposed that the matter should be dealt with by them as it was *operational*. But I would observe that many matters of patient safety and practitioner safety are similarly operational, but that should not prevent concerns about these matters being considered as part of the FTSU arrangements.

7. Of those three reasons, the one most central to the events that followed was that the CEO and DWC had had concerns about Dr C's previous criticism of the MD and assumed that it was *just another instance of* [Dr C] *trying to undermine* him*.* I do not doubt that that was what they sincerely believed. However, as I concluded, Dr C's concerns about the handling of the self-medicating incident were both well-founded and shared by several of her colleagues (although, as the FTSU policy states, *it does not matter if you are mistaken or if there is an innocent explanation for your concerns).* Regardless of any concerns about her, Dr C should have had the opportunity to have her own concerns heard and looked into, in line with the Trust's FTSU policy. That this did not happen was contrary to the FTSU policy and the spirit of an open culture.

West Suffolk Review

8. The events considered by this Review have more recently led the Trust to make a number of improvements to its FTSU arrangements and make a number of improvements, including in relation to the visibility and accessibility of the FTSU Guardian, and a clear appreciation of the need to separate the investigation of FTSU concerns and performance management or disciplinary proceedings. But I think there is learning from this, not just in West Suffolk but also in the NHS more widely.

9. The national FTSU policy and arrangements are relatively new, having only come into existence in 2016. The approach to FTSU by NHS organisations continues to develop. Those responsible for its operation on the ground may need further support in some important areas. For example,
   9.1. understanding the importance of separating FTSU from performance and disciplinary matters, and how to approach the matter of individuals raising concerns where there is a suspicion – whether well-founded or not – that the concerns are not genuine. As I discuss in chapter 7 there is a high threshold for a Trust to satisfy if it is inclined to take disciplinary proceedings against an individual believed to have raised concerns maliciously. Trusts should be extremely slow to question the motives of anyone Speaking Up as doing so undermines the culture of openness and transparency that the FTSU policy is intended to create.
   9.2. understanding the need to recognise that even where staff raising concerns do not specifically cite FTSU, the concerns should be treated in the spirit of the organisation's FTSU policy.
   9.3. ensuring that the FTSU policy is followed, through the involvement of those in the organisation with the appropriate expertise. NHS organisations have invested in the development of specialist expertise in their FTSU Guardians, but that knowledge cannot be deployed if the FTSU Guardian is not made aware of instances of Speaking Up. FTSU Guardians are an important safeguard of a healthy Speaking Up culture.

10 It is also important that all NHS organisations are aware of and have implemented the May 2018 Guidance for NHS Boards. This requires them, where concerns raised are wholly or in part about members of the Board, to inform the Trust's FTSU Guardian in confidence so that they could obtain advice on process and record-keeping; and also to inform NHSEI and the CQC. In the case of West Suffolk, this course might have given them ready access to advice on the wisdom of undertaking the first external investigation and the casting of its Terms of Reference.

Checks and balances

11 Like many large organisations, NHS Foundation Trusts have within their governance structures, whether formally or more informally, a series of checks and balances that are intended to ensure that they operate fairly and effectively. These provide the opportunity for collective or individual reflection and second thought, making it less likely that a Trust departs from well-established (and mandatory) policies.

12 In my review of this matter it was evident that these checks and balances did not work effectively. I am conscious that I have had the opportunity to review the matters in question with the benefit of some hindsight. But it is clear that the unfortunate train of events described has led to considerable distress for many, and to the Trust's reputation being seriously damaged. All that might have been avoided if, for example:

12.1 due attention had been paid to the initial concerns of the senior anaesthetists immediately following the report of the self-medicating incident. I saw no evidence that the MD or the DWC, either then or at any point subsequently, questioned whether the senior anaesthetists raising concerns contemporaneously might have had a valid point.

12.2 rather than passing Dr C's email to the CEO to deal with, the Chair of the Trust had met with her, listened carefully to the concerns she raised and asked the Trust executives to address them.

12.3 the Board's discussion on 2/11/18 had not been so circumscribed. The decision by a Non-Executive Director to trigger a focused discussion on one matter in the private section of the Board is, to say the least, unusual. It should have given the executives pause for thought - and provided an opportunity to re-visit the decisions made. Unfortunately for all concerned it did not in this instance.

12.4 when the anonymous letter came to light, the Executive had started by asking **why** such a letter had been sent rather than **by whom** it was sent**.** Its discovery clearly indicated (at the very least) that there was continuing unease about the approach which had been taken to the self-medicating incident A discussion by the Board beforehand might have triggered more reflection before embarking on an approach – including asking Trust staff to consent to fingerprinting and handwriting analysis - that (with the benefit of hindsight) the executive directors doubted they would do again.

13 In the end, the only check and balance that did work, higher up the chain and outside of the Trust itself, was the result of the matters being taken by two members of staff to NHSEI and the CQC. The CQC subsequently downgraded the Trust's rating from *Outstanding* to *Requires Improvement* in the light of its inspection in September 2019*,* and that was then followed by the commissioning of this Review.

14 All involved in leading and managing NHS organisations frequently find themselves called upon to make decisions quickly. In the heat of the moment, the wrong call can sometimes be made. It is important that the culture of the organisation and the leadership environment and approach allows for individuals to feel comfortable with the various checks and balances operating effectively – such as challenge from their Boards - and to change direction if, on further reflection, that is appropriate.

Organisational culture and even-handed leadership

15 Effectively operating FTSU arrangements might have prevented the undoubted damage to the Trust and some of its staff. But FTSU is about much more than policies and infrastructure. Above all, the whole organisational culture it sits within needs to be open and transparent and to permit the open and respectful conversations – regardless of hierarchy - that are part of a healthy NHS organisation. Leaders in NHS organisations should lead by example; and the overall tone and climate, within which day to day management and decision-making take place, are the direct responsibility of their Boards, in particular the Chief Executive and Chair.

16 The initial trigger for the unfortunate events that sparked this Review was the failure to have such open and respectful conversations about how best to handle the self-medicating incident. Those senior anaesthetists who – as I have found, with justification – raised their concerns were not effectively listened to when they raised concerns immediately after the incident came to light. They were asked to *trust the process*: to accept, without being offered any further information, that the process in train was in fact the correct way to proceed.

17 This raises several points:

17.1 **First, the importance of real and empowered clinical leadership.** When a Trust has to address a serious incident, it is of course important that it receives the attention of its most senior executive directors. But in considering the immediate handling of the self-medicating incident in March 2018, the Clinical Director should have been involved and consulted. He had important information to bring to the table: instead, his advice was ignored. If clinical leadership is to have any real meaning, senior executives need to allow clinical leaders to be respected participants in the decision-making and management process.

17.1.1 **In this case, the duty upon registered medical practitioners to raise concerns about patient safety was overlooked.** The two principal "Speakers Up" in this instance were Drs C and E and they believed, in the context of their obligations under the GMC's

Good Medical Practice, that they had a duty to persist. Being told to *trust the process* was a naïve and ill-judged injunction in the circumstances; whilst there was an issue of confidentiality in relation to Dr A to consider, it should have been possible to balance that against the need to demonstrate that patient and practitioner safety issues were being appropriately considered.

17.2 The second point is a broader one: it concerns **the importance of NHS leaders being self-questioning, open to criticism and to listen to staff. In short, to understand the value of dissent and disagreement.**

18 Listening to staff on the ground is not always easy; indeed, it can be an uncomfortable experience. It can be hard not to take criticism personally and sometimes even to feel threatened by it. Some individuals in NHS organisations may be particularly prone to offering criticism and even seen as *the usual suspects* - but often they may be making a valid point that had not been apparent to those in charge. However difficult, leaders need the ability to get over whatever personal discomfort they may feel and appreciate the potential value of the advice being offered. If it turns out to be correct, then the matter in question can be addressed and everyone will be better off as a result. NHS leaders need to value those who raise concerns. They also need to be seen to be even-handed in their approach.

19 I would observe that Dr C and Dr E, as well as the CDA and others who raised concerns at the time of the self-medicating incident, were correct in the advice they offered, from the viewpoint of both patient safety and practitioner welfare. But even if they had not been correct, that should not have mattered. **Where concerns and criticisms appear or do turn out to be misguided, NHS leaders must avoid jumping to any conclusion that the individual raising them is simply making trouble.**

20 There can be particular difficulties for Medical Directors who are in the sometimes awkward position of being part of the overall corporate Trust management, but at the same time seen by their colleagues as one of the consultant medical body who should see things from their perspective. They may sometimes feel they are caught in the crossfire and need to have a thick skin. Support and mentorship for new and inexperienced Medical Directors – ideally from an experienced Medical Director from outside the Trust – would be of value and should perhaps become standard.

Free to raise concerns?

21 Despite the unfortunate circumstances that led to the Review, the Trust had in many ways performed extremely well on staff engagement. For example, the

NHSEI Regional Director told us that *their staff survey was one of the best in the country.* The CQC press release issued after their inspection visits in December 2017 quoted the Chief Inspector of Hospitals view that *Staff engagement was exceptional and communication between senior leadership and its teams gave a clear understanding of the vision …staff recognised incidents and reported them appropriately.*

22 Within two years, (as noted in chapter 9) this had unfortunately changed. The CQC downgraded the Trust's inspection rating to *Requires Improvement,* noting that *Not all staff felt respected, supported and valued or felt that they could raise concerns without fear. Communication and collaboration to seek solutions had not always been effectively undertaken. An open culture was not always demonstrated. Staff that raised concerns were not always appropriately supported or treated with respect.* The CQC's press release published on 3 February 2019 stated that *the style of executive leadership did not represent or demonstrate an open and empowering culture. There was an evident disconnect between the executive team and several consultant specialties.*

23 Two further issues might suggest that the leadership and management culture at West Suffolk in the period in question was not always one which encouraged staff to raise concerns, both of which offer reason for reflection more widely in the NHS.

24 The first of these issues is about the delay in reporting the self-medicating incident – the *late Datix*. Rather than see this as a possible indication that the incident was not serious, there were real questions to be addressed about an apparent reluctance to raise a Datix in this instance. In the best NHS organisations, there should be a high level of incident reporting combined with low levels of harm to patients and risks to patient safety. Datix reports help to identify and address patient safety risks.

25 It was not in my remit to look into the reporting of patient safety incidents and risks at the Trust. However, I note that even when Dr B was reminded that she should consider reporting the self-medicating incident, there followed several days of consulting with her colleagues before she did so. It is entirely understandable that there may have been some reluctance to *tell tales*. The Medical Director told the GMC in his first telephone call to them on 23 March 2018 (though without any evidence that has been produced to me and without having raised it with Dr B) that he thought that the Datix report might have been raised *in retaliation.* I do not believe that was the case. Be that as it may, action may be needed – and I believe has since been taken at West Suffolk - to address an apparent reluctance to report patient safety incidents.

26 The need for an open culture in which staff understand the importance of incident reporting, confident that all will be dealt with fairly, is one that applies to all NHS organisations. A culture where staff feel the need to keep their heads down has to be addressed.

27 The second issue concerns the behaviour of management and how it reacts to concerns raised by staff. Sending an anonymous letter to the family of a deceased patient was not the right way to raise concerns. But the decision not to look again at the issues identified in the letter and instead to attempt to identify the *culprit* was a huge mistake which will have had a disastrous impact on the way staff perceived their ability to raise concerns. This will have been greatly magnified by the extraordinary decision to deploy fingerprinting and handwriting analysis in the process.

28 The opportunity was missed to first consider why any of its staff might choose to raise a concern about patient harm anonymously rather than through its own investigatory process or the Freedom to Speak Up procedure. An assumption was made that the motive for the letter was malicious; but (as set out in chapter 9) it is completely possible (and in my view much more likely) that the letter writers genuinely believed there had been some kind of *cover up* that needed to be exposed. Had the management focus been upon the question of *Why* rather than *Who,* it would have helped to foster a culture where those who have what they believe to be a legitimate patient safety concern feel free to express it through an appropriate channel. In any event, I believe it is virtually impossible for an NHS organisation to identify the writer of any anonymous letter with any degree of reliability, as I believe the events set out in chapter 9 of this report demonstrate.

29 On a final note I would like to comment upon record keeping – particularly as it applies to management meetings and important decisions. A cursory review of the papers that were initially supplied to us revealed significant gaps and omissions in important processes and decision making that had the capacity to seriously impact on individuals' careers. Despite the seriousness of the matters under consideration – not least for Dr C - records were not made (or if made not retained) of important meetings and decisions. It became clear that whilst individual executives may have been keeping records of matters they considered important they were not centrally filed and, when many months after the event I asked to see notes of key telephone calls, meetings or decisions, in some cases no such records could be found. Some eventually emerged but only at the cost of senior colleagues having to divert from other tasks to search for them. Others may not have been made in the first place. In a service in which clinicians are routinely told *if it is not written down it did not happen* if is simply not acceptable for management colleagues to regard themselves as exempt from such strictures.

4: Summary of Findings

Chapter 6: The handling of the self-medicating incident: colleagues Speaking Up

6.1 The self-medicating incident was a red flag event raising questions about patient and doctor safety.

6.2 Given the seriousness of the self-medicating incident, there was inadequate consideration and consultation before allowing Dr A to continue to undertake unrestricted clinical duties.

6.3 Concerns about patient and practitioner safety should have led to a restriction of clinical duties during the initial incident investigation.

6.4 The concerns raised by senior clinical colleagues – including the Clinical Director – were effectively ignored.

6.5 The late reporting of the incident should not have been seen as grounds for reassurance.

6.6 The MD's consultations with the GMC omitted key facts which might have changed the GMC's advice.

6.7 No written record of the full details disclosed by the Trust to Dr A's new employer exists other than the account provided by Dr A himself.

6.8 Dr C and Dr E were correct to report their concerns to the GMC and to members of the Trust Board.

6.9 Freedom to Speak Up means that staff should be free to challenge without fear. It was wrong to accuse Dr C, in raising concerns, of undermining the MD, and a breach of the FTSU policy to include this alleged undermining in a later MHPS, potentially disciplinary, investigation.

6.10 Dr C's letter to the Chair of the Trust was a clear exercise in Speaking Up, and it should not have been shared with the CEO without Dr C's permission.

Chapter 7: The July 2018 Meeting

7.1 Dr C's email to the Chair of the Trust was an exercise in Speaking Up and should have been treated as such.

7.2 The concerns raised in the letter to the Chair of the Trust had been raised previously but had not received proper consideration, due to an assumption that Dr C's motivation in raising concerns was to undermine the MD.

7.3 The assumption was made, wrongly, that the concerns were being raised maliciously.

7.4 Dr C and other senior colleagues were concerned about the safety of patients and the welfare of a colleague, yet the CEO wrongly assumed they simply wished to see more stringent action against Dr A.

7.5 The concerns raised in Dr C's email to the Chair of the Trust were well-founded.

7.6 The CEO's and DWC's meeting with Dr C on 31 July 2018 was ill-conceived, unfair, and in contravention of FTSU guidance.

7.7 The Trust wrongly mingled the process of Speaking Up with an attempt to address perceptions about poor conduct.

7.8 For the NHS FTSU to have real meaning, there must be a clear separation between the consideration of concerns raised under the policy, and the addressing of concerns about performance or behaviour. This did not happen.

Chapter 8: Speaking Up

8.1 The reports by the DWC and CEO to the 2 November 2018 Board meeting about the handling of the self-medication incident and the concerns raised about it did not reference some of the concerns which had been raised by Dr C about the handling of the self-medicating incident. Whilst this in part flowed from the fact that the meeting had been convened by the SID to discuss Dr E's concerns rather than Dr C's, it meant that Board were not fully sighted on the breadth and depth of the concerns being expressed by senior anaesthetists about the handling of this matter.

8.2 Some positive changes were made to Board processes as a result of Dr E and Dr C having Spoken Up, and of the DC and the SID paying attention to their concerns. However, significant questions went unanswered.

8.3 The proposed investigation into the 31 July 2018 meeting was in direct contravention of the Trust's FTSU policy. Dr C's email raising concerns to the Trust Chair led to her Speaking Up to the DC and SID about those concerns and also about the way she had been treated in raising them; this in turn led to the commissioning of the investigation. Thus, it contained, at the very least, an inherent risk of victimisation of Dr C for Speaking Up.

8.4 Dr C was not told about the scope and breadth of the investigation to be undertaken and was given no information about the concerns about her own conduct which were to be considered.

Chapter 9: The Anonymous Letter

9.1 Whilst it is acknowledged that the Trust were under an obligation to investigate the letter as evidence of a possible data breach, that was only was only one aspect of the matter. Another was why any of their employees would choose this device to raise a potential patient safety matter (at its heart the letter was advising the patient's widower to ask questions about his wife's care). That second question – about the quality of the patient's care - was in fact already the subject of a SIRI investigation and to be considered by the coroner but it appeared that the letter writer was not aware of those investigations already in hand. In the interim the Trust's efforts to identify the letter writer were controversial and fundamentally flawed.

9.2 Whilst the anonymous letter will have caused clear distress to the patient's family, the decision to seek to identify the letter writer was impractical and unwise.

9.3 The initial investigation to uncover the letter-writer's identity through analysing access to electronic patient records was flawed and not fit for purpose.

9.4 No objective or reasonable rationale has been supplied as to how the initial list 131 suspects was then narrowed down to seven. In the event, four of the seven individuals singled out for further investigation were those who had raised concerns relating to Dr A.

9.5 The investigation adopted an intimidating process that distressed and damaged individual staff members.

9.6 The sending of one sample of handwriting for analysis six months earlier than samples from other staff under suspicion was a highly irregular step for which no credible explanation has been given. One inference is that Dr C was being unfairly targeted.

9.7 The conclusion that Dr C wrote the letter was not robust. It was based on a flawed internal investigation, and at least in part based on her having Spoken Up.

9.8 All the evidence presented to me suggests that Dr C did not write the anonymous letter.

9.9 The decision to use fingerprinting and handwriting analysis in an NHS hospital, in the context of an anonymous letter and where no crime has been committed, was highly unusual and without doubt extremely ill-judged.

9.10 Whilst the executive directors, the Chair, and one of the non-executive directors were aware of the proposed use of biometric data, other non-executive directors we interviewed did not learn of it until media reports started to appear in December 2019. Even then – and despite the reputational damage being done to the Trust – the Board did not discuss it because by then it related to a live disciplinary process.

Chapter 10: The ExIn1 Investigation

10.1 The design of the ExIn1 investigation was unfairly balanced. The DWC and CEO understood the questions about their conduct that were to be investigated, which were limited to their actions in a two-hour meeting, where only they and Dr C were present and of which there is no record. However, in seeking to establish whether the CEO's concerns about Dr C were reasonable, it provided the opportunity for allegations about her behaviour going back over a two-year period to be detailed without the opportunity for investigation as to their veracity. Further ExIn1 later sought clarification of the Terms of Reference from the DC in consequence of which the scope of one of the allegations was widened, without Dr C being informed.

10.2 In my view the commissioning of the investigation breached FTSU Policy: in setting out to investigate Dr C's conduct, it inappropriately – and in an act of potential victimisation - connected the disciplinary process to Dr C's exercise in Speaking Up.

10.3 As has already been noted the DC had concluded, having spoken to the CEO, DWC and Dr C, that he could not comment further on Dr C's, the CEO's or the DWC's perspectives of the meeting on 31 July 2018. That was unsurprising given there were only three people in the room and no agreed record of the meeting. Given those circumstances, an external investigator would be in no better position to reach an objective conclusion into what had happened. However I accept the DC's view that it is difficult for an NHS Board Director to objectively conduct an investigation into a complaint raising concerns about fellow Board members, and that the involvement of an external investigator in such circumstances was a possible way forward.

10.4 In the event however – due largely to the increase in scope of the external investigation into Dr C's behaviour over a lengthy period, wholly unrelated to her Speaking Up to the Chair of the Trust – the ExIn1 report provided a means of listing further allegations against her from those interviewed.

10.5 The consequence of her not being told about the expansion of the Terms of Reference and the subsequent decision of the DC that the new allegations raised by the Consultant granted anonymity resulted need not be " put" to her resulted in Dr C being unaware of the scope and nature of ExIn1's investigation.

10.6 The limitations placed on the ExIn1 investigation meant that there was no scope for triangulation of the concerns put to the investigator. It would have been fairer and more transparent if ExIn1 had been allowed to put matters raised about Dr C's conduct to her so that she could respond to them. But ExIn1 had not been asked to determine whether the allegations were true or not; simply to establish whether the CEO and DWC had reasonable grounds for concern about Dr C's conduct.

10.7 Given the asymmetric nature of the allegations in the Terms of Reference, and the lack of transparency and imbalance in the selection of witnesses in the ExIn1 investigation, the conclusions reached could not be used as a robust basis for any management action without further investigation. ExIn1 clearly caveats, in his Report, that further investigation would be needed, including interviews with the CDA and with Dr C herself.

10.8 Some of the evidence submitted to ExIn1 was based on hearsay accounts which could not be triangulated because of the limited scope of the Terms of Reference.

10.9 The Terms of Reference of the ExIn1 investigation failed to give notice of all the matters that would be explored.

10.10 Conclusions were reached based on allegations made by the CEO which were not presented to Dr C so that she could respond.

10.11 Yet despite these defects, the ExIn1 report was used as a trigger to launch formal MHPS proceedings, with the potential for disciplinary action, against Dr C – who even then was not shown a complete copy of the report.

Chapter 11: The MHPS Process

11.1 It was not reasonable to trigger a formal investigation under the provisions of MHPS without exploring the possibility of a behaviour agreement (which had been volunteered by Dr C) or other informal options.

11.2 It was unreasonable and unfair to use anonymised concerns about the anaesthetic department as part justification for a disciplinary investigation into a single individual.

11.3 There was no evidence to implicate Dr C in writing the Anonymous Letter, and it should have been irrelevant in the decision to pursue a formal MHPS process.

11.4 The use of a formal MHPS process to explore the potential for further problems to become evident is inappropriate.

11.5 I have serious concerns about the validity and appropriateness of this MHPS process. The decision to launch formal disciplinary proceedings was made on the basis of the ExIn1 report, which had been undertaken as a result of Dr C Speaking Up; if pursued to the disciplinary stage it would therefore have amounted to victimisation of Dr C in terms of the Trust's FTSU policy. Because of the design of its Terms of Reference, the report contained a number of unsubstantiated allegations made by those whose conduct was also under scrutiny.

11.6 The selection of witnesses was unfair and unbalanced.

11.7 Undue pressure was put on Dr C to agree to be interviewed earlier than Occupational Health advised. This was unjustified and inappropriate, and paid inadequate regard to Dr C's welfare.

Chapter 12: Advisory Recommendations for External Bodies

NHS England and NHS Improvement: Enquiries Complaints and Whistleblowing (EWC)

12.1 I recommend that ECW should make formal records of all meetings with NHS bodies convened to address possible Speaking Up concerns (there is no agreed record of the meeting on 15 October 2019 although it is possible that the Trust's solicitors made a note that was not agreed with ECW).

12.2 I recommend ECW should ensure that any proposed communication referring to them must be agreed with them in advance. Had they done that on this occasion they would have had the opportunity to correct the account given by the Trust which they considered to be erroneous.

NHS England and NHS Improvement (East of England) NHSEI

12.3 I make no advisory recommendations in relation to the Regional Office.

General Medical Council (GMC)

12.4 Whilst it is self-evident that it is a matter for the GMC to determine what advice it should give those who contact its Employer Liaison Service , Confidential Helpline and Fitness to Practice team it is clear that, in this instance, the advice might not have been fully triangulated in consequence of which apparently conflicting advice was given to three separate registered medical practitioners seeking GMC advice and guidance. With a view to reducing the risk of that happening in the future I recommend that the GMC give further thought to improving the triangulation (and thus robustness) of their advice.

Practitioners Performance Advice (PPA)

12.5 I considered whether to recommend that henceforth PPA should, as a matter of routine, copy any letters of advice addressed to an NHS employer to the practitioner who is the subject of that advice so that they can be assured they are being given an accurate account by the employer.

12.6 Having discussed this possible recommendation with PPA I was told that they did not think it would be appropriate as it may discourage some NHS employers from seeking advice. I accept that is a possible risk and so **do not propose to make that a formal recommendation here**, but I would suggest PPA give further consideration to adopting such an approach in the spirit of transparency.

12.7 PPA told us (and I saw evidence of it in their letters to the Trust) that they already encourage NHS employers to share the contents of their letters and routinely inform Trusts: *The [PPA]…encourages transparency in the management of cases, and advises that practitioners should be informed when*

their case has been discussed with [PPA] I am happy for you to share this letter with [the practitioner] if you consider it appropriate to do so. [The Practitioner] is also welcome to contact [PPA] for a confidential discussion regarding the case. I do not know how often Trusts act upon this encouragement and would suggest that PPA might wish to explore that further with the NHS bodies who seek their advice.

12.8 I do however wish to make a recommendation to PPA that if they are informed the practitioner has made a disclosure under the provisions of Freedom to Speak Up – or may have done so – that the employers be advised as to the terms of the National Policy which is to encourage Speaking Up and assure those who do that they will not be the subject of disciplinary action for having done so.

The Care Quality Commission (CQC)

12.9 I have no recommendations to propose for the CQC.

5: The Self-Medicating Incident and its aftermath

1. In November 2017, Dr A, a consultant anaesthetist, administered magnesium and parecoxib to himself via a cannula whilst on duty in the Trust's operating theatres. Within Issue 1 of the Terms of Reference, I am required to consider the circumstances that formed the basis of the October letter. The October letter is described later in this report (see chapter 9 and referred to throughout this report as the Anonymous Letter) but, in brief, it was an anonymous letter sent to the widower of a patient who had died whilst being treated in the Trust. The letter alleged there had been a *cover up* of a self-medicating incident earlier in the same year. This self-medication incident was the key event which set matters in train.

2. On Sunday 5 November 2017, a consultant anaesthetist, Dr A, was on duty in theatres. He told two Operating Department Practitioners (ODPs) that he was experiencing severe back pain.

3. Recollections differ slightly as to the exact sequence of events that then ensued, but on the basis of the evidence I have heard and read, what then ensued is set out below.

4. Rejecting one ODP's offer to get him some ibuprofen (as he had already taken some and had additional supplies to hand) , as well as a suggestion that he visit the Emergency Department for treatment, Dr A stated that the only thing which would alleviate his pain was magnesium. They questioned whether he should be on call and one of them suggested that he should go home sick. He responded that he could not get anyone else to cover at short notice. On this point, I observe that our interviews with other members of the anaesthetic department have indicated that it should have been possible to find cover had it been necessary.

5. A patient was brought to theatre and anaesthetised for surgery. Once surgery commenced, Dr A came out of the theatre into the anaesthetic room leaving the anaesthetised patient in the care of a more junior doctor. He informed an ODP that he wanted her to witness him drawing up magnesium to administer to himself. Upset at this request, the ODP called in a colleague, and both witnessed Dr A self-injecting what they later stated to be IV magnesium and IV parecoxib by means of a 22g cannula in Dr A's left hand. One of the ODPs challenged him as to what he was doing and left the anaesthetic room after reiterating her concerns.

6. In the meantime, and coincidentally, a senior trainee anaesthetist arrived in the anaesthetic room having come to see if anyone required his assistance. He

arrived as Dr A was drawing up magnesium sulphate and asked why. On being told by Dr A he had backache and intended to take IV magnesium, the senior trainee asked if there was anything he could do and offered to work in theatres while Dr A took some rest. Dr A declined his offers of help, but the senior trainee nevertheless stayed with him to ensure his safety. After a while, the senior trainee went in search of the ODPs (who had by then left the anaesthetic room) to ask them to return and stay with Dr A as he was concerned about him.

7. Both ODPs returned. When they did so Dr A reassured them that he felt fine.

8. In the meantime, the senior trainee had approached another consultant anaesthetist, Dr B, who was covering the Intensive Care Unit (ICU). He asked her to come and see Dr A. Coincidentally the ICU consultant had a clinical issue she wanted to discuss with Dr A (a patient in ICU who was suffering from severe respiratory failure). Having arranged cover, she entered the anaesthetic room and offered to take over from Dr A so that he could go home: he declined this offer. She also suggested that the senior trainee be contacted to see if he could assist with Dr A's duties. Dr A told her the senior trainee had already offered help and support, but he had declined them, as well as Dr B's offers of help, as he now felt much better. Drs A and B went on to have a discussion about the treatment of the ICU patient in severe respiratory failure. Dr B then received an urgent bleep notifying her she was required in ICU and she left to attend to that emergency. Dr A remained in the hospital and on call for the remainder of his shift.

The Datix system

9. In common with other NHS Trusts, West Suffolk NHS Foundation Trust (the Trust) operates a patient safety tool known as Datix. This system enables any member of staff observing an actual or potential risk or patient harm to log a report on the electronic system. Those reports are reviewed by different personnel depending on the nature of the safety issue raised. All staff are under a duty to report on the Datix system every incident with potential implications or risks for patient safety.

10. Whilst the self-medicating incident did not result in actual harm to any patient or to Dr A, there was nevertheless a clear risk of harm to either or both of them and it should therefore have triggered a Datix report.

11. However, no such report was raised contemporaneously in November 2017 by Dr A or by any of those who witnessed the self-medication incident or its immediate aftermath. It is unclear why no report was made at that time. However, I have received credible accounts from two of the staff members

mentioned above that they **were** highly concerned as to Dr A's actions and about his welfare at the time. Those accounts are supported by the statements they made later as part of the investigation into the incident.

The Report of the self-medicating incident

12. The self-medicating incident was later reported on Datix over four months later, on Thursday 22 March 2018 by consultant anaesthetist Dr B.

13. The immediate background to the Datix report was that the incident was brought up at a social event between anaesthetist colleagues over the weekend of 17-18 March 2018. On Monday 19 March 2018, Dr B sought advice from several senior colleagues in the anaesthetics department, including from Dr C, the previous Clinical Director. Dr C told Dr B that the incident was serious, and that she would therefore give some thought as to the appropriate action and consult with another colleague. Dr B also spoke to two other senior colleagues (the Clinical Director for Anaesthetics (CDA) and the Clinical Lead for Anaesthetics (CLA)). The CDA also sought Dr C's view on how to proceed in view of her previous experience as Clinical Director. The outcome of all these reflections was the clear conclusion that the incident should be reported on Datix.

14. Dr B raised a report on Datix on 22 March 2018.

15. The Trust's Datix system has a colour coding system which codes every Datix report as red, amber or green. This coding is automatic and will only code as red those events where **actual** harm has occurred to a patient.

16. When Dr B made the report on Datix, it was automatically coded by the Datix system as green, because no actual harm had occurred to the anaesthetised patient. However, this green Datix did not represent the degree of **risk** to the patient or to Dr A or the **seriousness** of the incident.

The Trust's initial reaction to the Datix report

17. At that time, Datix reports were initially reviewed by the Trust's Deputy Chief Nurse and Head of Patient Safety (DCN). He first viewed the Datix report on Friday 23 March 2018. Because it was serious and involved the misuse of medication by a colleague, he upgraded it and escalated it to the Medical Director (MD).

18. On learning of the incident, the MD telephoned the General Medical Council (GMC) and spoke to the Employer Liaison Advisor (ELA) for the Trust. Although

the MD made no contemporaneous record of the call, the ELA did. The ELA noted amongst other things that:

18.1. the administration was done openly.
18.2. the ODP (who observed it) *was not concerned as the doctor has a long-standing back pain issue.*
18.3. the drug used was not a controlled drug.
18.4. that the *ICU department fell out with [the doctor] over his patient advocacy.*
18.5. *there were no other concerns about the doctor's competence; and*
18.6. *the… issue may be being raised retrospectively in retaliation.*

19. The ELA advised the Review that the incident described was *borderline* (in the sense that it was close to, but did not meet, the threshold for a referral under the GMC's Fitness to Practise procedure) in the light of the description provided by the MD. The ELA nevertheless informed the MD that he wanted him to sp*eak to the ODP to clarify the context and to then update the ELA so that potential professional impairment [could] be considered.*

20. The same day, the MD, acting with the Director of Workforce and Communications (DWC) identified Dr B as the Datix author. Discovering that she was not on duty, they telephoned her; she offered to come into the Trust to speak with them but was told that was not necessary. Over the telephone, they asked her to confirm the content of the Datix report and queried why she had not raised it until several months after the date of the incident. Dr B explained that she had been distracted by clinical work but having been reminded of the incident recently she had sought advice as to the appropriate way to proceed. She was asked to send the MD and DWC a statement confirming her recollection. The MD told us that he asked both Dr B and another senior consultant anaesthetist, Dr D, whether they had concerns about Dr A's fitness to practice and recollected that neither raised any with him. He did not make a record of either conversation.

21. The MD also telephoned the CDA to ask that Dr A be replaced on the rota that day, so that he could attend a meeting to discuss the Datix report. The MD did not then (or subsequently) seek the CDA's advice or indeed any input from him into the decisions he and the DWC made into the handling of the matter.

22. The MD invited Dr A to meet with him and the DWC. The DWC told us that *as soon as he walked in he knew exactly why we wanted to see him.* No written record of this meeting was produced to the Review; the DWC told the Review she may have made a written note, but it could not be located.

23. Whilst the MD and the DWC recalled that Dr A readily admitted that he had self-injected magnesium whilst on duty in theatres, they were less clear in other aspects of their recollection. The DWC initially told us that Dr A disclosed

everything about the incident; but she accepted that she that could not recall whether Dr A had said that the ODPs tried to dissuade him from self-medicating. Had one of the ODPs been spoken to at this stage, they could have given evidence (as one of them subsequently did to us) that Dr A persisted with self-injection in the face of challenge. Similarly, had the senior trainee been spoken to, he could have described his offer to take over Dr A's duties. Had the MD accepted Dr B's offer to come into the hospital to give a full account of her involvement she, similarly, is likely to have told him that she advised Dr A to go home sick. The MD told us that he did not consider that he needed to speak with the witnesses because Dr A had already accepted that he had self-injected. However, this approach meant that critical aspects of the incident were not obtained on Friday 23 March 2018, and the MD and DWC were not in a position to conclude they had all the information necessary **before** making a decision that Dr A could (as they did – that same afternoon) continue in unrestricted practice (including on call duties).

24. After the meeting with Dr A, the MD and DWC concluded that Dr A did not pose a risk to patient safety and that he should continue with his normal duties on Monday 26 March 2018. In a subsequent Board Report prepared by the CEO in November 2018 three factors were identified in support of this conclusion:
    24.1. the incident was four months old (although without further information, for instance from an Occupational Health (OH) assessment, this could not indicate whether patients or the clinician were at risk in March 2018);
    24.2. there had not been any relevant Datix entries in the intervening period (however, that was not definitely known at the time, as the search results of the Datix record on Dr A were not available by the time of this Friday meeting – they were first received on Tuesday 27 March 2018);
    24.3. they believed Dr A had given a full account of the incident, had shown insight and was truly sorry.

25. The November 2018 Board report also noted that the Datix report was categorised as green, albeit that given its seriousness it was correctly escalated for the MD's attention.

26. Both executive directors had confidence in Dr A's assertion that he was fit and able to continue in unrestricted practice, and took the view that exclusion, even for a short period, was a potentially stigmatising act which was not warranted in this case. No discussion was reported to us about the possibility of temporarily restricting Dr A's practice. However, in reaching the view that Dr A did not pose any safety risks (whether to himself or to patients), they did not **first** seek clinical advice from a specialist in anaesthetics, whether from within the Trust or from outside. Nor did they insist that Dr A **first** attend an OH assessment which would have been an opportunity to identify any health issues relevant to his safety.

27. Subsequently, the MD did, on the advice of the Deputy Director of HR (Deputy HRD), take advice from a senior consultant anaesthetist in a London Teaching Hospital Trust. He did this by telephone on Monday 26 March 2018, but without making a written record of the call, which unfortunately meant that there was no contemporaneous record of what he told that consultant and what he asked him to advise upon. The MD told us that this discussion confirmed him in the view that he had taken that this incident was serious and should be investigated but did not warrant exclusion.

The Maintaining High Professional Standards (MHPS) process for Dr A

28. Maintaining High Professional Standards in the Modern NHS (MHPS) was published by the Department of Health in December 2003 as a framework for handling serious concerns about doctors' conduct and capability in the NHS.

29. The MD initiated an MHPS investigation, designating himself as the case manager.

30. The MD contacted the GMC again on the 27 March 2018. The MD did not make a note of that call, but the ELA did and later the same day sent the MD an email summarising their discussion. Having recounted the account given to him by the MD on 23 March 2018, including that *the ODP was not concerned,* he noted:
    30.1. *You met with trust Deputy CEO and HR Director ...and formally decided there were no grounds to exclude this doctor or restrict his practice. There are no other issues noted about this doctor, clinically or otherwise. I am therefore confirming the advice I gave to you over the phone that, given all of the above context, there is no basis for referral* [to the GMC]*.You mentioned that the operating department practitioner [ODP] who witnessed the event has not been spoken to as [they] are on leave until Thursday.* ***Please can you update me once you have spoken to the ODP, so that I am aware ...whether this conversation changes any of the above*** **[emphasis added]*.***

31. The MD has accepted, and apologised, he did not speak to the ODP and consequently did not revert to the ELA as he had agreed to do. If he had he would have learnt:
    31.1. of the level of concern experienced by those who witnessed all or part of the self-medicating incident.
    31.2. of the efforts all of those who witnessed it made to deflect Dr A from his chosen self-medicating path, and the offers made by the senior trainee and

consultant to take over from him so he could remove himself from duty after he had elected to self-medicate whilst on duty; and

31.3. that when Dr A embarked upon the self-medicating incident, he was responsible for the welfare of an anaesthetised patient on the operating table whom he had left in the care of a more junior doctor.

32. The MD drew up Terms of Reference for the investigation and assigned the Trust's Deputy Medical Director (Deputy MD) as case investigator. The case investigator's role was to make findings on the Terms of Reference set by the case manager. The Deputy MD conducted an investigation in which he interviewed Dr A directly and relied upon written statements from the four witnesses to the self-medicating incident (the two ODPs, the trainee anaesthetist and Dr B).

33. The Deputy MD delivered his report to the MD on 7 June 2018. He found that:

33.1. Dr A did self-administer magnesium and parecoxib intravenously.

33.2. this conduct was inappropriate and could have resulted in compromising patient safety and standards of care but on this occasion did not.

33.3. Dr A could have put his own health and safety at risk but did not. The health and safety of others was not compromised; and

33.4. two professional standards from GMC's *Good Medical Practice - ethical guidance* were potentially breached by Dr A's actions, namely standards under (a) Professionalism in practice and (b) Safety and Quality.

34. The investigation report concluded that although Dr A had fallen short of the relevant rules, he had provided reassurance that this would not happen again. The Deputy MD was satisfied that Dr A had been open and honest, and recognised his serious error. He recommended that Dr A be referred to OH for an assessment. That assessment was not disclosed to the Review.

35. In light of the Deputy MD's report, the MD and DWC met with Dr A and his representative from the Hospital Consultants and Specialists Association (HCSA) on 27 June 2018. They proposed to Dr A that a final written warning would be appropriate. However, they accepted the HCSA's representations that the sanction be reduced to a first written warning. The final outcome was that Dr A accepted the findings of the MHPS Report, and a first written warning was placed on his file.

Disclosures to a New Trust

36. Dr A decided to leave the Trust and applied for a post as a consultant anaesthetist in another NHS Trust. In May 2018 Dr A sent his prospective employer a detailed statement about the self-medicating incident, advising

them that he was expecting the outcome of the subsequent investigation to be a formal warning. Dr A also asked the MD to speak with the Medical Director and Responsible Officer of his potential new employer before his interview. The MD telephoned his opposite number. He did not make a written record of this conversation, but told the Review that he informed the other Medical Director that Dr A had self-injected with magnesium and parecoxib, and that a number of anaesthetists at the Trust did not get on with him, such that Dr A was no longer working on the Intensive Care rota.

37. Dr A was revalidated in August 2018 and joined the new Trust in the early Autumn. Although the MD had confirmed to the GMC ELA on 14 October 2019 that the GMC's Medical Practice Information Transfer Form (MPIT) in relation to Dr A had been completed, he later confirmed to us that in fact it had not been sent.

6: The handling of the self-medicating incident: colleagues Speaking Up

The Freedom to Speak Up Policy

1. In line with the national Freedom to Speak Up programme developed by NHSEI and the Care Quality Commission (CQC), the Trust operates a Freedom to Speak Up policy (the FTSU policy).[1]

2. Freedom to Speak Up is intended to ensure that there are Speaking Up arrangements which NHS staff can use to disclose any information and/or concerns they have relating to, inter alia, patient safety. The purpose is to foster a culture of openness within the NHS and enable potential problems to be identified and addressed as soon as possible, to ensure higher patient safety standards. It is therefore essential that staff feel safe to raise a concern.

3. The FTSU policy emphasises the importance of raising concerns. It asserts that staff do not need to wait for proof before raising a concern and that they *can raise a concern about risk, malpractice or wrongdoing **if [they] think [it]** is harming the service [the Trust] deliver[s] **(emphasis added).***

4. Assurance is provided in the FTSU policy that there will be no retribution against those who speak up if they are genuinely intending to do so **(emphasis added)**:
   - 4.1. *It doesn't matter if you turn out to be mistaken as long as **you are genuinely troubled**.*
   - 4.2. *If you raise a genuine concern under this policy, **you will not be at risk** of losing your job or **suffering any form of reprisal as a result**.*
   - 4.3. *We will not tolerate the harassment or victimisation of anyone raising a concern. **Nor will we tolerate any attempt to bully you into not raising any such concern**. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.*
   - 4.4. *Provided **you are acting honestly**, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.*

5. The FTSU policy lists the individuals internal to the Trust to whom an employee can Speak Up. These include the Trust's Freedom to Speak Up Guardian, the

[1] The Terms of Reference of this Review ask me to consider the Trust's use of its Speaking Up arrangements. Throughout this report I refer to various examples of Speaking Up and capitalise any references to Speaking Up which fall under the definition as set out in the national Freedom to Speak Up programme developed by NHSI and the CQC, and contained in the Trust's Freedom to Speak Up policy.

Executive Director with responsibility for whistleblowing and the Non-Executive Director with responsibility for whistleblowing.

6. However, I also consider that a staff member is Speaking Up within the meaning of the policy whenever they raise concern relating to potential risks, malpractice or wrongdoing to a person in a position of authority at the Trust. To treat a concern which otherwise deals with these matters as falling outside the policy, merely because a person listed in the policy has **not** been spoken to, would prioritise form over substance and defeat the purpose of the policy. In practice, it may be reasonable for a person who receives a disclosure to redirect it to one listed within the policy. However, when staff at the Trust raise concerns, these cannot be ignored by relying on an overly technical and literal interpretation of the policy.

7. When a staff member Speaks Up, the Trust is required to *carry out a proportionate investigation… and… reach a conclusion within a reasonable timescale (which [the Trust] will notify* the individual of. The investigation will produce a report that *focusses on identifying and rectifying any issues and learning lessons to prevent problems recurring).*

8. The policy commits to protecting the confidentiality of a person who Speaks Up if *that is what [the individual] want[s].*

General Medical Council (GMC) Duties of a doctor

9. For medical staff there are further requirements of them in relation to raising and reporting concerns about patient care and safety. In its guidance, *the duties of a doctor registered with the General Medical Council,* the GMC describes the values and behaviours expected from all registered practitioners. It requires all doctors to *make sure their practice meets the standards expected...in four domains.* One of these four domains is that of safety and quality, where doctors are required to *Take prompt action if you think that patient safety…is being compromised*.

10. In its section entitled *Respond to risks to safety,* doctors are advised that if they *have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body or us. If you are still concerned you must report this, in line with our guidance and your workplace policy.*

Patient safety concerns raised by multiple consultants
The CDA

11. Dr A was scheduled to work on Monday 26 March 2018. The CDA was concerned that no change to this had been communicated to him by late afternoon on the Friday, and he therefore emailed the MD, copying in the DWC and the CLA. In his email, he wrote that he had discussed the matter with one of the Matrons and considered that:
    11.1. *the events would appear to be part of a general behaviour that had been discussed at length recently.*
    11.2. *rapid IV administration of magnesium can cause arrhythmias and hypotension and it is only given in this way in monitored patients.*
    11.3. *the self-administration of this drug intravenously whilst being on call can therefore only put patient safety at risk*.
    11.4. there could be no certainty that the behaviour was not ongoing.
    11.5. that the behaviour could be *part of an underlying illness*; and finally
    11.6. suggesting that the Trust allow Dr A *a period of leave whilst all doubts are put to rest.*

12. As neither the MD nor the DWC responded to this email, the CDA sent another on Saturday 24 March 2018. Again, no response was received. The MD told us that he did not know whether he saw the email from the CDA on Friday afternoon, that he tried not to look at emails over the weekend but thought he would have read it by Monday 26 March 2018.

13. Concerned that Dr A was on the rota to work from the afternoon of Monday 26 March 2018 and that he had not heard back from the MD, the CDA attempted to call the MD that morning, to be told by his secretary that the earliest they could meet would be at the end of the following day (Tuesday 27 March).

14. The CDA went to see Dr A who was by then in the Trust. He told Dr A that he needed to discuss his concerns about the incident with the MD, and asked that in the meantime, Dr A undertake administrative work that afternoon. Rather than work in his office, Dr A asked if he could work from home, to which the CDA agreed.

15. Soon afterwards, the CDA was called to a meeting with the MD, the DWC and the Deputy CEO. At the meeting, the CDA was told that he should not have excluded Dr A; he objected to this, explaining that he had only removed Dr A from clinical duties pending an opportunity to discuss the matter with the MD. The executive team members advised that they had decided not to exclude Dr A, because the incident happened four months ago with no one highlighting it at the time, no incidents had been recorded in the meantime, and because Dr A had displayed considerable contrition and insight.

Dr E

16. Dr E learnt of the self-medicating incident on Saturday 24 March 2018 and was aware that Dr A was scheduled to be working in the operating theatres the following week. Considering the self-medicating incident to be a *red flag*, Dr E spoke to the MD over the telephone on 24 March 2018. She also telephoned the GMC Helpline for guidance. The person to whom she spoke told her that in the circumstances Dr E described it was often appropriate to place the doctor on leave pending the investigation, but that they could not comment on a specific incident until a concern was logged.

17. Dr E made a record of her call to the MD in an email, which she sent to him later that same day, copying in the DWC. In the email, she:
    17.1. noted the Trust did not as yet know whether the self-injection incident was an isolated one or an ongoing situation, nor what medication (was) involved.
    17.2. suggested that by his behaviour Dr A was showing that he *needs support and for reasons of patient safety should not be working with patients until a decision can be made about his fitness to practice once the investigation is complete*.
    17.3. informed the MD that she had called the GMC, and that the GMC had stated that in general terms it is often appropriate to place a consultant on leave whilst a matter such as this was investigated; and
    17.4. told the MD that she would *report this as a fitness to practice issue to the GMC on Monday if [Dr A] is not taken out of clinical work, until patient safety can be assured*.

18. The MD thanked Dr E for her email on Monday 26 March 2018, stating that appropriate processes were being followed so that the matter could be investigated; and that he could not say any more at that time.

Other consultant anaesthetists

19. In the afternoon of Monday 26 March 2018, Dr E (then the College Tutor) , Dr C (the former CDA) and Dr F (a former Head of School for the regional training programme and Council Member of the Royal College of Anaesthetists) went to meet with the Deputy HRD, to outline their concerns in relation to the Trust's handling of the self-medicating incident. The Deputy HRD informed them that she could not discuss the detail of this incident for reasons of confidentiality but implied to them that external advice was being sought and that they should trust the process.

Findings: The Trust's handling of the self-medicating incident

The self-medicating incident was a red flag event raising questions about patient and doctor safety

20. Several witnesses described the self-medicating incident to us as a *red-flag event*. The self-prescription and self-medicating of magnesium and parecoxib by a consultant anaesthetist whilst on duty and responsible for a patient *on the table* is significant for a number of reasons; chief among them are the following:
    20.1. We were told one effect is that the recipient could experience a profound, albeit temporary lowering of their blood pressure. It is for this reason that within the Trust these drugs would only be administered in this way to patients under direct medical supervision.
    20.2. If temporarily incapacitated due to the known effect of the drugs, a consultant anaesthetist would not be able to respond effectively to any medical emergency affecting any patient for whom they were responsible.
    20.3. All doctors to some extent, but particularly consultant anaesthetists, have access to potentially dangerous drugs, and taking advantage of that privileged access by self-medicating with drugs taken from hospital supplies is a breach of trust.
    20.4. Consultant anaesthetists will be on call with various teams rather than consistently with the same team, which reduces the level of oversight of their actions; and
    20.5. As an autonomous professional and the most senior clinician on duty in the anaesthetic room (where the self-medication incident occurred), consultant anaesthetists have a duty to be responsible for the team reporting to them and to lead by example. Junior members of staff observing this incident may not have felt able to intervene.

21. A number of interviewees were concerned that this incident potentially indicated a doctor in significant difficulty and mentioned reports of suicides and self-harm among anaesthetists with access to hospital drugs. As noted above, the CDA had described the incident involving Dr A as *part of a general behaviour that has been discussed at length*. Several colleagues described their concerns about the self-medicating incident because of the alarm bells it rang not only for patient safety but also for the safety of Dr A himself.

22. We were also told by several interviewees that there had been a history of some difficult relationship issues involving Dr A. For example.
    22.1. Dr A had left the critical care consultant group in March 2017 due to strained relationships with colleagues.
    22.2. concerns had been raised by the ICU consultants' group collectively about Dr A's role as a medical reviewer of deaths. These concerns were described in an email sent by Dr C on behalf of the whole group to the MD dated 19 March 2018 (thus only a few days before the Datix was raised) and was

copied to all consultant members of the group, following on from a meeting she had had with the MD.

Given the seriousness of the self-medicating incident, there was inadequate consideration and consultation before allowing Dr A to continue to undertake unrestricted clinical duties

23. As the CEO later advised the November Trust Board meeting, having interviewed Dr A and discussed the matter with the Deputy CEO, the MD and DWC it was decided that Dr A could return immediately to on call duties , but that - quite properly - he should be subject to an MHPS investigation. I concluded that the potential seriousness of the self-medicating incident may not have been fully recognised. At the time that the decision about Dr A returning to full clinical duties was made, they had not **first** taken any of the steps listed below that we believe were required. They should have:
    23.1. sought internal or external anaesthetic advice.
    23.2. spoken with the direct witnesses to the events in question. Except for a brief call with Dr B, they did not do this and were thus unaware that those present from the start had tried to dissuade Dr A from adopting that course.
    23.3. consulted with the CDA, as to whether they believed that this practitioner should be permitted to resume clinical practice and, if they did, what restrictions (if any) on their practice they would recommend the practitioner be subject to, in order to ensure patient safety, pending completion of the MHPS investigation;
    23.4. sought further information from the CDA as to the nature of the *potential issues* and *doubts* referred to in his email of 23 March 2018 (paragraph 11 above).
    23.5. ascertained whether any other concerns had been raised about Dr A.
    23.6. arranged an urgent OH assessment of Dr A and acted upon any recommendations of that assessment; and
    23.7. ensured the GMC were given a detailed account of the self-medicating incident with full disclosure of all the relevant circumstances.

Concerns about patient and practitioner safety should have led to a restriction of clinical duties during the initial incident investigation

24. Further consideration should have been given to restricting Dr A's practice until all of those investigatory steps had been taken and documented. The CDA was correct to suggest that consideration be given to a short period of special leave whilst the initial investigation was undertaken, and potentially, a safe system of working could be put in place for him if required. In my view, the MD's and DWC's reasons for not doing this (set out in paragraph 24 in chapter 5) do not provide a sufficient basis for the decision they made given the seriousness of

the self-medicating incident. This raised grave concerns amongst D A's senior colleagues for his welfare and for patient safety.

25. The MD did not believe a formal exclusion was warranted and told us that to send Dr A on special leave would effectively have been tantamount to excluding him without the safeguards of the MHPS process. I understand his and the DWC's reluctance to take the major step of excluding Dr A, particularly given the insight and contrition Dr A had clearly demonstrated, as well as the delay in the incident being reported at all. I also understand that they appeared to feel they had to make a rapid decision about what to do and recognise that they did quite properly set in train an MHPS investigation led by a senior consultant.

26. In my view, however, a Trust does have the power to temporarily restrict a clinician's practice or remove a clinician temporarily from clinical duties, even if only for a very brief period while further investigation takes place, if there is reason to consider that they pose a risk to the safety of patients or their own safety.

The concerns raised by senior clinical colleagues – including the Clinical Director – were effectively ignored

27. Having not taken the first six of the above steps – and only partially satisfied the seventh - serious consideration should have been given to the concerns that were subsequently raised by Dr A's colleagues. Those raising concerns were simply told, effectively, to trust the process then in train.

28. The MD and the Trust have since recognised that the CDA should have been consulted before the decision to return Dr A to unrestricted duties (and indeed, Trust policy in relation to MHPS has since been amended accordingly). They subsequently received e mails from the CDA and College Tutor over the weekend raising significant concerns but nevertheless did not re-visit the decision they had reached on 23 March 2018 solely on the basis of one meeting with Dr A. The CDA's email of 23 March 2018 to the MD raising serious concerns about the incident was not discussed until 26 March 2018, and no consideration appears to have been given, even at that point, as to whether the decision to permit Dr A to continue in unrestricted practice had been appropriate.

The late reporting of the incident should not have been seen as grounds for reassurance

29. That in the four months since the original incident there had been no reports of anything untoward happening is not a good enough reason to account for the late reporting of the self-medicating incident, given the serious circumstances

and the fact that patient safety had been put at risk. Dr A's failure to pursue a different course of action on 5 November 2017 – despite a number of alternatives having been proposed to him – raised serious questions about his judgement at that time which should have – albeit belatedly - been investigated and explored with him.

30. I do not consider the late raising of the Datix to be material. It should not be assumed that those raising the matter were not seriously concerned. Clearly it would have been far better if the Datix had been lodged promptly but the fact that it was not in no way diminished the seriousness of the incident nor did it prevent the Trust from investigating it – all of the witnesses still worked at the Trust and could have been interviewed **prior** to any decision being made to permit Dr A to continue in unrestricted practice. The gap of five days in March between members of the anaesthetic department starting to discuss the incident and the actual raising of the Datix – which members of the executive team later mentioned as a further reason why the incident was likely to be less serious than some of the senior anaesthetists were saying – was, in my view, explained by the professionals involved conscientiously considering the issue. Whilst in some respects unfortunate, the delay of a further few days in raising the Datix whilst they considered whether – despite the delay - they should do so - was not significant.

The MD's consultations with the GMC omitted key facts which might have changed the GMC's advice

31. The MD's telephone calls to the GMC ELA on the 23 and 27 March 2018 did not give a full account of the situation with regard to Dr A.
    31.1. The ELA was not made aware that while Dr A was self-medicating, he had consultant responsibility for an anaesthetised patient; indeed, the ELA did not become aware of this fact until 31 August 2018 some five months later when he was made aware by colleagues in the Fitness to Practise team of the content of Dr C's letter to them several weeks before.
    31.2. It was not the case, as was noted in the ELA's email recording the discussions with the MD on 23 and 27 March 2018 that *there were no other issues with this doctor, clinical or otherwise*. In addition to the above mentioned email (see paragraph 22.2) sent by Dr C on 19 March 2018 expressing concerns on behalf of the ICU consultants, the MD had also received the CDA's email of 23 March 2018 (see paragraph 11) which had set out significant concerns about the self-medicating incident. The MD told us at interview that he wasn't sure he saw the email on Friday 23 March or even over the weekend; but even if that were the case its content must have been discussed in the meeting on 26 March 2018 involving the MD, DWC (to whom the CDA's email had also been copied) and Deputy CEO, when (in the CDA's view at least) the CDA was criticised for having temporarily

prevented Dr A from undertaking clinical duties earlier that afternoon (see paragraph 15). The CDA's email had suggested that the incident *would appear to be part of a general behaviour that has been discussed at length recently.* We accept that the MD may have received, or at least learnt of, that email after he had with colleagues already decided Dr A could continue in unrestricted practice but on any version of events he had been made aware of its content prior to Dr A resuming his unrestricted duties on the afternoon of 26 March 2018. He could therefore have paused and reflected – but did not.

31.3. Nor was it the case that the ODPs who had witnessed the incident were *unconcerned*: We were able to interview one of the ODPs who confirmed she had been extremely concerned and the other ODP produced a witness statement for Dr A's MHPS investigation in which she noted she felt *extremely uncomfortable and* [she] *vocalised that* [she] *didn't think he should* [self-medicate] *especially as there was an anaesthetised patient on the table in theatre whom he was responsible for*. Had the MD done as had been suggested by the ELA and spoken to the ODPs (he has accepted and apologised that he did not do so) he would have known that. He would also then have been able to update the GMC and clarify the context, as the ELA had asked him to do, in order that *potential professional impairment could be considered*. In any event, in my view, all of the direct witnesses should have been spoken to before making any decision to permit Dr A to continue to undertake unrestricted duties.

32. This point about incomplete disclosure to the GMC is significant. The whole aim of the GMC's employer liaison process is to have a shared overview of the management of any doctors with difficulties. Those anaesthetists raising concerns about the incident were told that the GMC had been properly consulted; as were the Board, in a report by the CEO to its meeting of 2 November 2018 (see chapter 8). In fact, the advice given by the GMC was based on the MD's description of the incident that omitted certain key details. The MD told me that he did not believe it was his responsibility to provide other people's impressions to the GMC; but I do not accept that the GMC would have found colleagues' views to be irrelevant, and indeed the ELA clearly believed that the ODPs' views **were** important.

No written record of the full details disclosed by the Trust to Dr A's new employer exists other than the account provided by Dr A himself.

33. The disclosure to Dr A's new employing Trust was similarly potentially deficient. Dr A provided his own full written account of the incident, and this was followed up by a telephone call from the MD to his opposite number, of which no written record was made by him. When I sought details of what had been

communicated, I received a copy email sent to the MD by his opposite number in the new Trust, which confirmed their conversation.

34. The MD also told us that the normal practice for Responsible Officers in sharing information about an individual doctor with a potential new employer is for the new Trust to request information; in the case of Dr A, he shared the relevant information voluntarily, without any such request having been received. However, having confirmed to the ELA on 14 October 2019 that the MPIT Transfer *had been fulfilled,* he was not able to produce a copy of the MPIT transfer form to the Review. He later told us he did not think a form was completed and that he was tightening their processes to ensure that all MPIT requests were tracked from receipt to completion.

Further Speaking Up by Dr C and Dr E

35. As set out in chapter 5, Dr A remained assigned to unrestricted clinical duties following his meeting with the MD and DWC. In the subsequent days and weeks, a number of senior clinicians at the Trust continued to be concerned that the potential risks to patient safety and to Dr A had not been adequately addressed. The following instances of those clinicians raising their concerns were further exercises in Speaking Up under the policy:

Dr E

36. Having initially raised concerns with the MD on 24 March 2018 and then the Deputy DHR on 26 March 2018 Dr E remained troubled.

37. On 24 August 2018 she wrote to the CDA. Her letter read in part: *I have significant concerns and I am not reassured that patient safety concerns have been addressed…. I am knowingly working in a department where a vulnerable colleague has been allowed to continue to work as an independent practitioner, out of hours, in the high risk speciality of anaesthesia…how could we say we were protecting him or the patient[s]?*

38. She asked the CDA to raise the matter again with the clinical leadership team at the Trust.

39. On 26 September 2018 she wrote to the MD and met with him on 2 October 2018 confirming their discussion in an email dated 3 October 2018 which read in part:

39.1. …My concerns remain that despite approaches being made by senior consultants with relevant and significant experience, the senior management team's decision was that Dr A remained at work with no

restrictions in place. Thus, we were placed in the position of knowingly working with a colleague [who]…continued …to be responsible for the most vulnerable patients in the hospital with no support in place…

39.2. I said I could not see that either patient safety, or appropriate support of a colleague in difficulty, had been prioritised in this case….

39.3. As I have not been reassured by your email or by our conversation that any processes have been put in place to prevent this situation recurring in the future, I asked you to advise me how to proceed. You suggested I take these concerns to [the CEO].

39.4. …. I shall request a meeting ...with [the CEO] ...

40. Dr E subsequently met with the CEO and following that meeting wrote to him on 11 October 2018: *…I would like there to be [a] review of local process that resulted in a situation where I feel that patient safety and appropriate support of a colleague were not made the first priority and that concerns raised by senior clinicians in the speciality to the Medical Director have not been given appropriate consideration…*

41. Dr E went on to contact the non-executive director responsible for FTSU in the final week in October 2018 who arranged for the Board to discuss her concerns in a Private Board Meeting on 2 November 2018.

42. The Board's consideration of the matter is discussed in chapter 8.

Dr C

43. In the meantime, Dr C was concerned that Dr A was not engaging appropriately with other colleagues, with the consequence that in a clinical context, in her view, he was either failing to, or was at serious risk of failing to, correctly and fully communicate patient information. This underlined her original concern that Dr A was potentially not fit to be working independently including out of hours. It is important to note that Dr C was not alone in these concerns.

44. Dr C told us that she raised her concerns to the MD, informally, about whether Dr A was well enough to be on clinical duties and was assured that an investigation was underway. The MD does not recall this discussion but did tell us that he met some of those raising concerns at various times, but that there was a tension in discussing these matters in view of the need to keep the MHPS investigation confidential.

45. Dr C also remained troubled about Dr A's engagement with his colleagues. In May 2018, she had an impromptu meeting with the CEO, when they were joined by Dr E and the DWC. Dr C recalled saying that she remained concerned: Dr

A should not be undertaking clinical duties independently; that the relationship with some colleagues in the department had broken down; and that this combination of factors was giving rise to patient safety concerns. The CEO and DWC did not accept that there was an ongoing safety issue connected to Dr A. The DWC told us that at this meeting *we had previously explained to her exactly what we had done with* [Dr A]. She and the CEO had pointed out that the self-medicating incident had been discussed both with the GMC and with an independent anaesthetist from London, that it had been properly investigated in the subsequent MHPS process, and that no other safety issues in relation to Dr A had arisen.

46. The CEO later told an external investigator that he considered that Dr C questioned the MD's competence and credibility in the course of this meeting. No note of the discussion made by either him or the DWC was produced to the Review. But later, in March 2019, when it was decided to pursue an MHPS disciplinary investigation into Dr C's conduct, the Terms of Reference included the allegation that Dr C questioned the MD's competence in that meeting.

47. Dr C was concerned by the CEO's response in the meeting in May 2018. In particular, she believed that the GMC's advice to the Trust would depend on the way in which the self-medicating incident had been relayed to them. She recalled that the CEO suggested that it was on GMC advice that the decision was made not to suspend Dr A from clinical duties, even for a short time to allow for initial investigations, despite an incident having taken place that could have had serious patient safety implications. Notwithstanding the CEO's reassurance Dr C remained surprised that the GMC had not thought that the self-medicating incident required investigation before sanctioning (which was her understanding of what she was being told) the decision not to restrict Dr A's practice. Concerned that the complete factual matrix of the incident may not have been presented to the GMC, Dr C referred the matter to the GMC herself, subsequently informing the MD that she done so.

48. On 25 July 2018, the GMC wrote to Dr C and informed her that it would not be taking matters further at that time. It explained that the GMC had previously been notified by the Trust when *it was confirmed that the incident was considered at a local level,* and that the senior staff at the Trust determined that Dr A had complied with *all local discussions and investigations.*

49. Dr C remained concerned that the assurance provided by the GMC was based on an account of events that may not have fully represented the seriousness of the self-medicating incident (particularly in light of the decision not to exclude Dr A or restrict his practice whilst it was investigated). On 27 July 2018, she emailed the GMC to say that she was not satisfied with the local investigation being undertaken by the Trust and therefore wished to re-refer the matter to the

GMC. She queried how a medical practitioner injecting stolen, intravenous access drugs whilst on duty did not reach a fitness to practise threshold.

50. The same day, and whilst on annual leave, Dr C sent an email headed *In Confidence* to the Chair of the Trust attaching her correspondence with the GMC. She asked the Chair of the Trust to meet with her to discuss it upon her return from annual leave. She noted that the GMC's response would have been guided by the way in which the Trust relayed information about Dr A's case. Further, she set out her concerns within that email that:
    50.1. Dr A's behaviour had caused *considerable concern to the anaesthetics department.*
    50.2. her entreaties to HR and the MD in respect of the matter *have been disregarded.*
    50.3. *the Trust is not acting in either [Dr A's] or his patients' best interests by suppressing the investigation results and permitting him to take employment in [another] Trust*; and finally
    50.4. the transfer of information to the new employing Trust would be *softened* because the MD had repeatedly *championed* Dr A.

51. Dr C explained to us that she raised the matter to the Chair of the Trust because she was concerned that by July 2018 there were ongoing red flags around Dr A and that, although she had been told that there was an investigation, he remained on unrestricted clinical duties. She was seeking assurance from the Chair of the Trust that processes were in fact being properly followed, and that full disclosure of all relevant information would be made to Dr A's new employing Trust.

52. The Chair of the Trust took advice from senior colleagues on what she should do in response to this email. They considered whether the email represented Speaking Up and concluded that it did not. The Chair was conscious that it addressed a set of circumstances that the CEO knew much more about than she did; she was also aware that there were relationship difficulties in the anaesthetic department and other matters that were viewed as operational. She forwarded the confidential email to the CEO without first seeking Dr C's consent and stated that she wished to discuss it with him.

Findings: Speaking Up about the incident

Dr C and Dr E were correct to report their concerns to the GMC and to members of the Trust Board

53. I conclude that Dr C and Dr E were correct to report their concerns about Dr A and the self-medicating incident to the GMC; this was in accordance with the

GMC's guidance on the *Duties of a Doctor.* This is not disputed by the MD. In doing so they were concerned not only about patient safety by also about the wellbeing of Dr A. It is clear that their concerns were shared by several other colleagues.

54. Similarly, I conclude that they were correct to raise their concerns with members of the Trust Board; and that this was in line with the Trust's Freedom to Speak Up policy. As noted above, staff members *can raise a concern about risk, malpractice or wrongdoing if [they] think it is harming the service [the Trust] deliver[s].* That they did not specifically mention the policy when they were raising their concerns does not – as I have stated in paragraph 6 above – mean that they were not Speaking Up.

55. Concerns raised under the Trust's Freedom to Speak Up policy do not have to be correct: as the policy notes, *It doesn't matter if you turn out to be mistaken as long as you are genuinely troubled.* In fact, Dr C was in my view correct to be concerned that the GMC had not received a full account of the wider circumstances surrounding the self-medicating incident, including the concerns of the ODPs who witnessed the incident, as well as the concerns about Dr A referred to by other colleagues as I have outlined in paragraph 11 above.

Freedom to Speak Up means that staff should be free to challenge without fear. It was wrong to accuse Dr C, in raising concerns, of undermining the MD, and a breach of the FTSU policy to include this alleged undermining in a later MHPS, potentially disciplinary, investigation

56. As noted in paragraph 45 above, at the impromptu meeting in May 2018 the CEO later told an independent investigator that Dr C's questioning of the MD's credibility had been inappropriate and undermining. There is no record of the May meeting so I cannot know exactly what was said. Insofar as the suggestion by Dr C was that the Trust (including the MD) was not responding appropriately to the self-medicating incident and the potential patient safety implications associated with it, I find that Dr C's conduct was (in this sense) challenging of the MD. However, I do not consider that this in itself was a negative action. In the context of Freedom to Speak Up, it is anticipated that the raising of a patient safety concern can involve challenging a decision taken or action omitted by a superior, including that of the MD. Effective Speaking Up arrangements require that those in positions of authority at the Trust are not beyond challenge.

57. Given that the impromptu meeting discussed Dr C's and Dr E's concerns about the self-medicating incident, I conclude that this alleged undermining of the MD should not have been included in the MHPS investigation initiated in respect of Dr C in March 2019 (and discussed more fully in chapter 11). As noted at the beginning of this chapter, staff should be able to speak up about their patient

care concerns without fear of them being used against them in a disciplinary process.

Dr C's letter to the Chair of the Trust was a clear exercise in Speaking Up, and it should not have been shared with the CEO without Dr C's permission

58. In heading her email of the 27 July 2018 *in confidence*, I consider that Dr C intended to raise the matter on a confidential basis with the Chair of the Trust. This email is, in my view, a clear exercise in Speaking Up, although I appreciate that following discussion with colleagues that was not the conclusion the Chair reached. It should also be stated she has since acknowledged the decision was a *misjudgement on my part*. Under the terms of the FTSU policy, it should have been kept confidential and should not have been passed on to the CEO without first seeking Dr C's express permission.

7: The July 2018 Meeting and immediate aftermath

The 31 July 2018 Meeting

1. Following on from her email to the Chair of the Trust of 27 July 2018, as noted in chapter 6, the CEO sent Dr C an email inviting her to meet informally with him and the DWC to discuss its contents.

   1.1. Dear [Dr C] [The Chair of the Trust] has passed your email to me to discuss the contents with you. I am due to go on annual leave on Thursday and I would like to informally meet with you before I go. Please can you free yourself up late tomorrow afternoon. Can you urgently contact [the CEO's PA] to make appropriate arrangements? I have also asked [the DWC] to join the meeting.

2. The CEO's email was, on an objective view, an invitation to meet with him to discuss the Trust's handling of Dr A and the self-medication incident. He did not refer to any alternative or additional purpose for the proposed meeting.

3. Despite the expectation reasonably generated by his invitation, the CEO did not intend to discuss solely the Trust's handling of the self-medicating incident with Dr C. He planned to discuss his concerns relating to her alleged conduct over the previous two years. Specifically, he wished to raise his concern that Dr C had been undermining the MD and that her email of 27 July 2018 was the latest instance of this. The DWC told us that she and the CEO considered whether the email to the Chair of the Trust was an exercise in Speaking Up but formed the view that it was not, and that it was instead *just another instance of [Dr C]… trying to undermine [the MD].* The CEO confirmed that he did not, at the time, recognise Dr C's email to the Chair as an exercise in Speaking Up.

4. The CEO had a typed speaking note which he planned to use at the meeting. This set out that he planned to provide Dr C with an opportunity to explain the content of her email and specific concerns; he would then proceed to make clear to her that:

   4.1. it was *not appropriate for [her] to discuss another employee and/or any process which they may have been involved in.*

   4.2. that without further grounds to support her allegations against Dr A, HR, the MD and the Trust, more broadly *it [was] not appropriate to make sweeping generalisations about a colleague… contrary to [her] professional obligations (set out in Good Medical Practice);* and

   4.3. he *wanted to convey the impression that [he was] getting as it might lead [him] to have to take action in the future if [he] perceive[d] that these do constitute a wider set of unacceptable behaviours.* He then listed matters

relating to Dr C allegedly being *engaged in a wider campaign to undermine* the MD.

5. In addition to the meeting plan, the CEO also had a four-page handwritten list relating to Dr C's alleged inappropriate conduct, principally relating to the MD, which was placed on the table. This list ran from points 0 to 10 (11 points), some containing sub-points. Many matters were not drawn from the CEO's direct experience of Dr C, and therefore were second-hand allegations raised by others. The next section of this chapter considers some of the issues that were of concern to the CEO and his colleagues in relation to Dr C. The handwritten list was significantly more detailed and extensive in its description of these issues than the typed meeting plan, including:
   5.1. Dr C's opposition to the MD's appointment as Medical Director.
   5.2. Dr C's disproportionate reaction to the suggestion that the MD was not immediately replacing her as CDA following her resignation from this position.
   5.3. the concerns Dr C had expressed about the Employer Based Awards Committee (EBAC) (clinical excellence) award process.
   5.4. *relationship breakdown* in the ICU; and
   5.5. in capital letters, and circled on the page, the word **LIBEL**, in relation to *calling* [Dr A] *an IV drug user*. This appears to be a reference to Dr C's email to the Chair of the Trust, in which she refers to Dr A's *IV drug usage.*

6. The meeting took place in the CEO's office on the evening of 31 July 2018, when Dr C had just finished a shift. On her arrival, Dr C was invited to sit between the CEO and DWC. A printout of the Trust's Values had been placed on the table in front of her chair and on her left, the CEO had placed the manuscript notes he had prepared which listed aspects of her behaviour he intended to raise with her. Unfortunately – and I do not believe this was the CEO's intention – Dr C noticed this note early on in the meeting and was able to read some of its content. As it was incongruous with what she understood the purpose of the meeting to be, she began questioning what the note was, and there ensued a considerable amount of back and forth about its contents in the course of which Dr C became upset.

7. Dr C's recollection is that the CEO proceeded to go through some of the list of alleged behaviours. However, the DWC recalls that this process was led in part by Dr C, who kept asking what else was written about her. Dr C was surprised to see the CEO's list of her alleged misconduct in this meeting (which she thought had been arranged to discuss the Trust's handling of the self-medicating incident), and it was inevitable that she would question it.

8. The meeting quickly became antagonistic. We received differing accounts of what was said (despite the DWC being in attendance no minute was made of

the discussion) from the three participants. Dr C recalled it began with the CEO expressing dissatisfaction with Dr C having raised her concerns to the Chair of the Trust.

9. We interviewed all three of the attendees who were unanimous in their view that the meeting on 31 July 2018 had gone badly. Dr C described the CEO as being visibly angry with her. The CEO told the External Investigator (ExIn1) that Dr C had been *extremely disrespectful* toward him and the DWC, and the DWC described Dr C as being in turn challenging and distressed.

10. The meeting lasted for a little more than two hours. Twice Dr C tried to leave (she told us because she was so distressed), but each time, the CEO and DWC exhorted her to stay. The DWC maintained to us that the meeting had been arranged because Dr C *obviously* had *a problem* with the MD, and that they pressed her to stay to sort things out. Dr C wanted to leave but told us she stayed as she believed she had been instructed to.

11. There was no meeting of minds in this meeting. Dr C told us that she felt *overwhelmed and side swiped by what had happened*. With the benefit of hindsight the DWC told us that she could now see Dr C's email to the Chair of the Trust had been *Speaking Up* (the term she used was *whistleblowing*) and that she and the CEO had *chosen the wrong route* - which Dr C saw as an *ambush.* She was nevertheless clear that the CEO had not been angry in the meeting. The CEO told us his motivation for the meeting was to *nip things in the bud.*

12. Ultimately, Dr C left the meeting and told us that this was one of the worst days of her life.

The concerns that the CEO wished to discuss

At this point, it is necessary to provide some further context for the list of concerns that the CEO wished to discuss with Dr C. Not only do they explain the background to the meeting described, but they also have relevance for the later actions taken by the Trust. This section therefore addresses some of the issues that were concerning the executive leadership.

a) The MD joins the Trust as Medical Director

i. The MD joined the Trust in October 2016. At that time, Dr C was Clinical Director for Anaesthetics (CDA), Critical Care and Theatres, a senior leadership role requiring her to work closely with the MD.

ii. Sometime after joining the Trust, the MD was told by a colleague that Dr C had openly opposed his appointment. The MD was told that this followed Dr C having researched his name online and confusing him with a different doctor of the same name, who had had significant and well publicised professional and personal difficulties. The MD never raised this point directly with her, but he told us that it had (understandably) coloured his view of her.

iii. In contrast Dr C told us that she had not opposed his appointment – indeed she had thought him the strongest of the candidates. The incident that the MD had been told about occurred when she had, along with other colleagues, conducted an internet search on his name during a meeting held as part of the recruitment process. This search returned results for a different doctor of the same name. Dr C told us it was clear from the photos and other information she viewed that that this was a different person to the one who was interviewing at the Trust. This account was corroborated by another witness who had been with her at the time. I have not received any evidence of Dr C having taken a position against his appointment, but unfortunately, for whatever reason, the MD was given to understand that Dr C had opposed his appointment.

b) Dr C steps down as Clinical Director (CDA) for Anaesthetics, Critical Care and Theatres

i. On 5 June 2017, Dr C emailed the MD stating her intention to step down as CDA after three years in the role, with effect from 1 September 2017. A three-year term was typical, and she wanted to focus on other challenges. It fell to the MD to initiate the appointment a new CDA via a competitive process.

ii. On 17 July 2017, there was a routine CDs' (Clinical Directors') meeting, at which Dr C raised the issue of her successor. The MD told us he didn't remember having received her resignation letter, nor that there was a firm date, and in consequence he had not advertised the vacancy at this point. Separately (but unbeknownst to the CDs), he had been considering a possible restructuring of the Clinical Directors' role, which would have meant amending the job description before advertising the role.

iii. The MD told us he felt put on the spot in the meeting and responded that he would arrange for the Deputy MD to fill the gap if necessary. However, as the Deputy MD, who was not an anaesthetist, had a split appointment with another Trust and his job plan only allocated two sessions per week for his Deputy MD role, in Dr C's view he was unlikely to be able to fulfil the CDA role in addition. She thus reacted badly, interpreting the MD's suggestion as devaluing her role and contribution, and the MD recalls having then apologised in the meeting. The Deputy MD (who had not been present) recalls being astonished when he later learnt of the suggestion that he could have taken on the CD role in Anaesthetics

and understood why Dr C would have felt undermined by the suggestion that he - a non-anaesthetist - should do so.

iv. The following day there was an antagonistic email exchange between Dr C and the MD. In a message to those attending the meeting, the MD apologised that he had been *slower than [he] should have been* to begin finding a replacement CDA, but that he would *put that right this week*. Dr C remained upset and, having found out that the Deputy MD had not been asked about the replacement arrangement prior to the meeting, responded to the email copying it to all the other attendees stating that her recollection of the meeting was different and setting out why she disagreed with the MD. She also stated that his conduct at the meeting *and this subsequent disingenuous e-mail does not reflect well on the role of MD*.

v. In my view, Dr C's comments were inappropriate in relation to a colleague, and she was wrong to copy her email to the other attendees at the meeting. However, this matter was not addressed at the time by either the MD, HR, or any other person in the management hierarchy. Accordingly, this negative interaction was allowed to become an issue between the two and it appears to have contributed to a build-up of antagonism in their relationship. In retrospect, it might have been better to have challenged Dr C and request a retraction and apology at the time.

c) Employer Based Awards Committee – (EBAC)

i. The Clinical Excellence Award scheme in the NHS aims to reward consultants who consistently perform over and above their contractual duties. At the Trust, the EBAC is responsible for deciding on the allocation of *points* to clinicians who then receive a salary uplift.

ii. An EBAC meeting was held on 10 November 2017. Dr C had applied for an award and was also a member of the EBAC assessment panel. In common with other Committee members who were also applicants, Dr C left the room whilst her potential award was being discussed. In her absence, a decision was made to allocate her one point rather than the two for which she had applied. On her return, however, she was given an informal indication from another Committee member that she had been successful. This should not have happened; the Committee Chair having warned all members that they should await formal notification of the results and avoid communicating the outcomes informally.

iii. Dr C first learned that she had received one additional point not two in the official outcome email sent the following week.

iv. Directly after the meeting, Dr C attended a dinner with the MD and others. He did not inform her that she had been awarded one point not two, because he rightly considered the EBAC process to be confidential – and he was not aware that Dr C was labouring under a misapprehension.

v. On 20 November 2017, Dr C sent a letter to the EBAC Chair, in which she set out a number of criticisms of the EBAC meeting, describing aspects of the process as *flawed*, and requested that the next EBAC meeting have the chance to discuss it and reflect on how it could be better managed, including better communication of the outcomes. The MD emailed to support Dr C's request, saying he entirely understood how she felt.

vi. EBAC reviewed Dr C's letter on 15 December 2017 (Dr C had sent apologies). The draft minutes of this meeting were later circulated on 22 December 2017 to a list of people including Dr C. At this point she had not yet had a response to her earlier email of concern. She wrote again to the Chair to express disappointment at the manner of notification through the draft minutes. The DWC was copied into this email and responded later the same day, apologising *unreservedly* for the manner of the communication.

vii. I learnt that some of the executive directors believed Dr C had behaved badly; Dr C's reaction was described in both the typed and handwritten briefing notes for the 31 July meeting as *disproportionate*. However, the MD was clear, when interviewed for this Review, that he did not consider that to be the case, and further that he did not perceive Dr C to have an issue with him in relation to it, rather with *the organisation*. From the evidence I have received, it appears that the Trust has subsequently taken steps to improve the EBAC award allocation and notification process.

d) Relationship issues in ICU

i. The CEO's list of concerns about Dr C referred to a *relationship breakdown in the ICU:* this is a reference to the relationship between Dr A on the one hand and the other ICU consultant anaesthetists – *intensivists* – on the other. It is important briefly to explain the background to this because of its relevance to other matters under consideration by this Review.

ii. On his appointment as a consultant at the Trust in 2013, Dr A told me that he decided to take a particular interest in the governance of ICU and involved himself in reviews of Morbidity and Mortality – *M&M* – as well as in the hospital's Deteriorating Patient Group. In 2018 he was appointed as a Learning from Deaths reviewer; *Learning from Deaths* is a national framework published in 2016/17, aimed at improving *the way NHS trusts investigate and learn from the deaths of people in their care, and the extent to which families and carers are*

involved in the investigations process (*Learning from Deaths: A review of the first year of NHS trusts implementing the national guidance*. CQC, 2019).

iii. Through this work, Dr A told us that he had *creeping concerns* about the clinical practice in the Trust's ICU and felt that the *reflective practice wasn't as it should be.* By early 2017, he believed that the national audit for ICU outcomes produced by ICNARC (Intensive Care National Audit and Research Centre) showed that the Trust was *creeping the wrong way.* Dr A discussed his concerns, particularly in relation to a few of the other intensivists, along the way with Dr C (the CDA at the time) and the Clinical Lead for ICU, Dr D.

iv. We interviewed a number of Dr A's colleagues, who saw things differently. They believed that Dr A was unreasonably hypercritical of some of the other clinicians. We were told that Dr A had had some difficult personal circumstances of which they were aware, and thought might be relevant; and that he was *struggling to get along with two of his colleagues…. he didn't like their way of operating.* We were told that he did not want to hand patients over to these colleagues in particular.

v. Towards the end of 2016 there were a number of conversations between Dr C (in her role as CDA), Dr D (as Clinical Lead for ICU) and Dr A. At a meeting between the three of them on 19 February 2017, Dr C and Dr D told Dr A about the concerns expressed by the other intensivists about his approach which they believed suggested that he thought *his clinical opinion had greater validity* than that of other clinicians. They asked if his concerns about certain colleagues were such that they should be reported to the GMC: Dr A said they were not. Dr C and Dr D said that therefore he would need to find a way of working with his colleagues. On that basis Dr A, believing that he was being asked to prioritise team morale and dynamics over patient care, said he would prefer to leave the ICU rota and would be happy to focus instead on anaesthetics. Dr A told me that Dr C and Dr D *tried to talk me out* [of coming off the ICU rota].

vi. I have not been asked to investigate this matter, and I am not making any judgment on the perspectives held on it. However, from the evidence I have received, there was clearly an issue that needed to be resolved in terms of Dr A's relationships with some of the other intensivists; and as the CDA at the time, Dr C had a duty to seek that resolution, which she did, along with Dr D, at the February 2017 meeting. I have concluded that there were indeed relationship issues among the intensivists; but not that Dr C was personally responsible for the relationship *breakdown*, as noted on the CEO's handwritten list. Indeed, after Dr A had decided, contrary to Dr C and Dr D's urging, to step down from the ICU rota Dr A asked Dr C to act as his professional referee when he applied for a role as an ICU consultant in another Trust in May 2017. Dr C prepared a

favourable clinical reference for Dr A and although Dr A's application was successful, he subsequently withdrew from the recruitment process. Dr A's decision to cite Dr C as his referee suggests that he did not think at that time that she was hostile toward him – and the terms in which her reference was couched suggest that she was not.

e) Annual leave in the Anaesthetics Department

i. In late 2017, the Executive Director of Resources and Deputy CEO sent an email to the MD seeking an explanation for the consultant anaesthetists' annual leave patterns. An analysis had been produced by a divisional finance manager, which suggested that annual leave taken did not appear to match entitlement. In the email, the Deputy CEO remarked *it looks like deliberate manipulation of leave to gain a financial benefit! I hope that there is a flaw in the logic because if you can't find one then I will not have any choice but to recommend a referral to Counter Fraud*.

ii. The MD discussed this issue with the CDA (who had taken on the role after Dr C stood down from it in September 2017), and on 4 December 2017, forwarded to him the Deputy CEO's email, with the spreadsheet attached, which was then forwarded on to all the consultant anaesthetists. The MD told us that he did not expect this to happen, and that it had been a mistake for the email to be circulated at all; I accept his account and am not making any criticism of him in relation to that circulation. The MD did not believe that there was any fraud taking place, nor did he consider the circulated email to be raising an allegation of fraud. However, having reviewed the email, I do find that it is reasonably read as suggesting that fraud *might* be taking place in the anaesthetics department.

iii. The email caused serious discontent. On 12 December 2017, there was a departmental meeting which the MD attended to explain the reasons for looking into annual leave. By that stage, the annual leave issue had been tied in some consultants' minds to an allegation of fraud. At that meeting, Dr C read out the emails from the Deputy CEO and the divisional finance manager and challenged the MD on their content and the approach being taken. She also challenged him to stand up for the doctors. The MD considered that Dr C was very, and unnecessarily, hostile towards him.

iv. From the evidence I have received, it is clear that a number of consultants were extremely upset at the suggestion of fraud. Dr C appears to have taken the lead in raising their objections to the way in which this matter was being handled (and how the MD could better handle it). Some of those present recalled Dr C as going beyond the level of upset they felt when making these points, but others considered her to be accurately representing the strength of feeling, and not out of step with the behaviour of some of the other consultants present.

v. Clearly, the meeting was heated, and there was a tense exchange between Dr C and the MD, which left him feeling under attack. However, I consider that the weight of evidence does not lend support to the view that Dr C's approach was markedly different from that of a number of her colleagues; indeed, others have praised it. The MD and some of his executive colleagues may not have understood in the first instance the level of offence caused by the email, and the repercussions for their relations with consultants. Dr C was representing the staff perspective to management. She did so in strong terms, and whilst it may not have been how every consultant would have put the issue, it was not disproportionate to the strength of feeling in some parts of the department at that time.

vi. If it was felt contemporaneously by the MD or anyone else on the Trust's executive that Dr C had behaved inappropriately to the point of *misconduct* warranting management action, this was not a matter raised with her at the time. Regardless, even if it was not considered to amount to misconduct, with the benefit of hindsight it is perhaps unfortunate that it was not the subject of discussion at the time with a view to clearing the air.

vii. Subsequently, the MD told us that the figures were all reconciled, and the position was clarified. There was no evidence of fraud having taken place although there were subsequently changes to the way that clinical time was accounted for.

f) Petition on junior doctors' pay

i. In March 2018, Dr C took on the role of the Trust's Guardian of Safe Working (GOSW). The NHS Employers sample job description for this role describes its purpose as follows: *The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard…The safeguards around working hours of doctors…. are designed to ensure that this risk is effectively mitigated ….The guardian is a senior person, independent of the management structure….will ensure that issues of compliance with safe working hours are addressed as they arise with the ….employer….and provide assurance to the trust board ….that doctors' working hours are safe.*

ii. Throughout 2017-18, many senior clinicians in the Trust, including Dr C, had concerns about the locum pay rates for junior doctors. The shortage of junior doctors providing locum support was leading to rota gaps which in turn placed pressures on those junior doctors who were working, and also on consultants who often needed to *act down* in order to fill in, on top of their own timetabled commitments. The perception was that the Trust's locum rates were relatively

low compared to those in nearby hospitals, and that this was causing junior doctors to prefer to provide locum cover outside the Trust.

iii. Following an exchange of emails along these lines among a group of senior clinicians in early July, Dr C thought that the MD should be made aware. She emailed him on 4 July 2018, seeking his support for safe staffing in the light of a number of exception reports she had received. She offered some support for the view that other hospitals were offering better pay for junior doctors and asked that the matter be discussed at the next CDs' meeting.

iv. On 5 July 2018, Dr C circulated an email to all consultants. Despite holding a part-time consultant post at the Trust, the MD was not included on the copy list. In her email Dr C stated that she was *receiving increasingly concerning exception reports in relation to inadequate staffing on the wards*; that pay rates were insufficient to attract junior doctors to do locum shifts; and that she believed that consultants needed to *apply collective pressure to urge revising these rates*. Attaching details of the rates, she asked the email recipients whether they would be prepared to sign a letter to the MD asking him to look at the issue again and informed them that the letter was in her office.

v. 58 consultants signed the letter/petition, which Dr C then asked her secretary to send to the MD and other members of the Executive including the DWC. The petition stated that a further 21 consultants were sending emails in support as they could not sign it in person. The signatories asked *that the rates of pay that we offer to the junior medical staff to undertake work in addition to their contracted hours are revised to reflect the level of responsibility and difficult working conditions that they endure. A rate of pay commensurate with their professional position should be offered both internally and externally to ameliorate the shortage of staff providing acute medical care*. Nowhere was it stated that the petition had been instigated by Dr C and it was later described by the Trust executives as *anonymously delivered*.

vi. On 9 July, locum pay rates were discussed at a CDs' meeting. The minutes record that the MD said it would be wrong to make *offers that could not be refused* by offering higher monetary incentives to take shifts, and that HR had *advised that this Trust pays the highest rates in the region*. One of the CDs queried whether the pay rates cited were correct and asked the MD to double check the correct rates across the region

vii. The MD told us that he considered the process followed by Dr C - first asking him to address junior doctors' pay at the Clinical Directors' meeting, and then proceeding to circulate a petition - was done to undermine him: it was not to get a pay rise for junior doctors but instead to create the perception that the Trust

was not addressing the issue. In his view, the matter was already being addressed and the petition did not add to the case for change. He also believed it was significant that his name was not on the list of consultants asked to sign the petition.

viii. The minutes of the next CDs' meeting, held on 16 July 2018, record that the MD advised that the Trust was not paying less than the regional average, and that in his view trainees should not be pressured to provide cover by a monetary offer which they could not refuse.

ix. The Medical Director's Bulletin, sent on 25 July 2018, set out details of regional locum rates, which he stated showed that the rates paid by the Trust were above average. Dr C responded to the MD copying in seven other consultants, stating that the *standard line* from other Trusts in the region was different to the rates which they in fact paid, and for which she had evidence in the form of wage slips. Dr C was not alone in raising this issue in response to the bulletin. I have seen a response from another consultant describing the Trust's rates as *disappointing and derisory*.

x. I conclude that in view of Dr C's then role as GOSW, her concern about the need to address significant rota gaps which were increasing the pressure on doctors was both genuine and appropriate. The suggestion that she was seeking to do so *anonymously* was hardly credible, given she sent an email to the *all consultants* address list inviting them to sign the letter/petition in her room. The MD's perception is rather different: he told us that the petition was *presented anonymously*….*it just landed on my desk…I didn't know that it had come from* [Dr C].

xi. At the time the petition was delivered no decision (as far as Dr C was aware) had been made as to whether it was appropriate to increase locum rates or to *hold the line.* If the MD had decided that an increase was indicated, a petition organised by the GOSW and delivered directly to him and his fellow executives would undoubtedly have aided his case. Further, if he was undecided, the delivery prior to him reaching a conclusion might have been persuasive. It was only potentially undermining if (1) he was firmly set against advocating for any increase and (2) Dr C was aware of his decision. As far as she knew neither was the case. The petition did not accuse the MD of failing to take any action. I have therefore concluded that the delivery of the petition was not an attempt by Dr C to undermine the MD but if he or his colleagues believed that it was it would have been appropriate for him/ them to take that up with Dr C at the time and seek her explanation for her action. That is not what happened.

g) Alleged comment about *getting [the MD] sacked*

i. The typed briefing prepared for the CEO's meeting with Dr C on 31 July 2018 included a statement that *I have heard from a credible source that drunk you told a registrar that you was going to make it* your *lifes work to get [the MD] sacked* (sic). It would later be put to Dr C in the MHPS investigation launched in March 2019: that she had made this statement in or around December 2017.

ii. Neither I nor the MHPS investigator received any first-hand evidence of anyone having heard this comment. Accordingly, the MHPS investigator reached no clear conclusion on this allegation in his report. I agreed with the MHPS investigator's conclusion that this type of allegation would require a first-hand witness able to substantiate it; without it there is no rational basis to conclude that it was said.

h) Alleged undermining of the MD's clinical competence

i. The typed briefing for the 31 July 2018 also contains a reference to *several consultants* who *felt like you was actively trying to unearth poor clinical practise issues (*sic). One of these was one of the Emergency Department consultants, Dr H. The MD told us that in or around May 2018, he was in the Emergency Department when Dr H advised him that Dr C was trying to dig up trouble against him. The MD said that learning this troubled him to the extent that he was unable to work and so he went home from his shift.

ii. Later in this chapter I will set out what happened when Dr C learned of this allegation on 1 August 2018. Dr H then stated in writing, on 15 August 2018, that Dr C had never questioned him about the MD's competence, and he repeated this denial several months later to the MHPS investigator.

The 1 August 2018 Meeting

13. The day after meeting with the CEO and DWC on 31 July 2018, Dr C resigned her leadership role in relation to the Deteriorating Patient Group. Two days later, she resigned her role as the Guardian of Safe Working as well. Although in the days that followed both the CEO and DWC told her that this was not what they wanted, Dr C explained to us that she could not take the risk of being called in by members of the Trust's Executive again and specifically she could no longer effectively raise patient safety concerns as it would be *misconstrued* as her seeking to undermine the MD and the Executive.

14. Also, on 1 August 2018 there was a meeting between the CEO, DWC and the current CDA and possibly others. No note of that meeting was produced to me nor was any reference made to one having been made. The CDA told me that he and a colleague exhorted the CEO and DWC not to take any action against Dr C and warned them that she was under stress.

15. Other consultants noted Dr C's distress. The Deputy MD told us that he also met with the CEP and DWC on the same day. Concerned at the effect of the previous day's meeting on Dr C, he suggested they apologise to her.

16. In the course of a telephone call with Dr C that day, the Deputy MD informed her that he understood that the Executive team believed that she had been questioning the MD's clinical competence, in the light of a conversation she had had with one of his fellow consultants in the Emergency Department. (This is the allegation described in paragraph h.i above)

17. Dr C told us she was surprised and upset to learn this because she did not consider it to be true. This matter had not been raised with her in the 31 July 2018 meeting, but she was concerned that it was now being discussed among members of the Executive.

18. Dr C spoke with Dr H, who told her that this was a misunderstanding and he had not made the alleged statement. Following this assurance, Dr C emailed several Executive Directors refuting the allegation and advising them that she had confirmed this with Dr H, to whom she copied the email. The latter replied to all recipients, stating that he *completely agreed* with Dr C and that she had never asked him about, or questioned, the MD's clinical competence or ability.

19. In addition to the above email, I have seen a subsequent statement taken from Dr H (provided to the second External Investigator (ExIn2) in the disciplinary process which I address later in this report). The consultant is clear that there was one occasion on which Dr C asked him about the MD's hours in the Emergency department and whether he was helpful. The consultant did not consider that it was undermining of the MD. He stated that he felt *bad* for mentioning it at all to the MD, and that other consultants had also asked him about the MD's whereabouts other than Dr C.

The 2 August 2018 meeting

20. On the morning of 2 August 2018, Dr C emailed the CEO, DWC, the Executive Chief Nurse (ECN) and the MD to request an urgent meeting to address the *totally unfounded allegations about [her] professional behaviour*. This was subsequently organised by the DWC for the same day and was also attended by the Deputy CEO. We spoke with most of those present. It was described to us as a *car crash* by one witness.

21. I have been shown a minute of this meeting which was made by the MD's secretary. The meeting opened with Dr C describing her *bruising encounter* in

the 31 July meeting and raising the *totally unfounded* allegation about her having questioned the MD's clinical competence in conversation with Dr H. Dr C stated that she considered Dr A was an unsafe and unwell clinician and that she would not retract this as she considered she was following due process. There was then a significant amount of back and forth between Dr C and the CEO, discussing both the content of the allegations against Dr C and her (alleged) conduct in the 31 July 2018 meeting.

22. Dr C was visibly distressed and at one stage left the room. When she returned, the Deputy CEO apologised and stated that it was *tough* being talked to *serially* by so many Executive directors (there were four Executive Directors present). However, after this, the meeting continued in the same vein as before - with further back and forth as to the underlying allegations of misconduct. The meeting concluded without resolution, and with Dr C reiterating that she would resign her leadership roles in the Trust because she did not feel that she could perform them in the light of the approach taken by the Executive.

23. On 4 August 2018, Dr C emailed the CEO and DWC and referred them to the FTSU policy. She indicated that *nowhere in the policy does it mention that you will be greeted with "we are very disappointed" when a concern has been raised via email to the chairman of the hospital.* Dr C was describing her email of the 27 July 2018 as an exercise in Speaking Up and alleging that the Trust had failed to follow its FTSU policy.

24. On 13 August 2018 (in a letter dated 9 August 2018), the CEO wrote to Dr C in relation to the 31 July 2018 meeting. He:
    24.1. stated that he was unable to disclose confidential details relating to another employee, but that appropriate and necessary steps were being taken in relation to her concerns, to the satisfaction of the Trust.
    24.2. stated that he had reflected on the *other matters* he raised in the meeting, that it was *important to raise these matters with you* but that he acknowledged that Dr C was unhappy *with the conclusions that [he] had reached and for this he apologise[d];* and
    24.3. informed Dr C that he would be happy to meet with her again to discuss any concerns.

25. Dr C responded to the CEO's letter, stating that she wanted to *bring the episode to a close as a protracted period of disharmony [was] not in the interests of the executive team, medical staff and ultimately the patients*. Dr C volunteered her contact numbers to the CEO if he wanted to speak. The CEO was away on holiday but returned on 22 August 2018 and emailed Dr C on 28 August 2018 to reiterate his offer to *catch up* if Dr C wanted.

26. These exchanges appeared to suggest a degree of rapprochement between Dr C and the CEO in late August 2018. However, the issue of how the Trust would proceed to deal (if at all) with the allegations the CEO had raised through the 31 July and 2 August 2018 meetings and Dr C's concerns about the way the Dr A matter had been handled remained unresolved.

27. In the event Dr C and the CEO did not arrange to meet in August 2018 and Dr C was signed off with work-related stress on 3 September 2018.

Findings

Dr C's email to the Chair of the Trust was an exercise in Speaking Up and should have been treated as such.

28. As set out in chapter 6, Dr C's original email was (properly considered) an exercise in Speaking Up. The CEO and DWC have accepted that they did not at the time recognise the email to the Chair of the Trust as an exercise in *Speaking Up*. They have pointed out that *it did not reference speaking up nor had the Trust Speak Up Guardian been copied in*. Nor was the Chair of the Trust one of the people listed in the Trust's policy as someone to whom such concerns should be addressed. However, I conclude that this does not mean that Dr C was not raising concerns within the scope of the policy or in accordance with its spirit. The concerns were about *lack of, or poor, response to a reported patient safety incident* – a concern expressly designated under the FTSU policy. Dr C's concerns clearly fell to be addressed under it. Further given Dr C had previously raised concerns about the Trust's handling of the self-medicating incident with HR and the CEO to no avail it was wholly appropriate that, if still not satisfied, she would raise them with the Trust Chair.

The concerns raised in the letter to the Chair of the Trust had been raised previously but had not received proper consideration, due to an assumption that Dr C's motivation in raising concerns was to undermine the MD.

29. As noted above, I consider that the CEO's invitation to Dr C to meet with him was to discuss matters raised in an exercise in Speaking Up. Yet he and the DWC took the view that Dr C was not raising *anything particularly factual or new.* In their view, they had already provided Dr C with reassurance at their impromptu meeting in May 2018 (see paragraph 45 in chapter 6) that correct processes were being followed in relation to the self-medication incident. However, the May meeting was by its nature not a formal meeting to consider the concerns in any detail.

30. The concern which Dr C continued to have was about the treatment of Dr A following the disclosure of the self-medication incident. At no point during the Speaking Up attempts by Dr C and other colleagues detailed in chapter 6 was any further rationale provided for the incident being handled in the way that it was: i.e. without having obtained an Occupational Health assessment before sending back to unrestricted practice a consultant about whom his colleagues had genuine concerns, in terms of the risk to patients if the self-medicating incident was repeated, and also in relation to his health and wellbeing as well his relationships with his colleagues.

31. I acknowledge that the executives were observing strict confidentiality because they were attempting to deal appropriately with a confidential HR matter. However, those raising concerns were senior and respected members of the anaesthetic department: the current and former CDAs, the College Tutor, and a former Council member of the Royal College of Anaesthetists. It should, in my view, have been possible for either the MD or one of his executive colleagues to hold a private and confidential discussion with one or more of these individuals as to why in his judgment this serious incident had in fact been appropriately handled. This would either have allayed their concerns or given rise to a fuller and illuminating conversation about the recent issues that had been troubling Dr A's colleagues and had been referred to, for example, in the recent emails to the MD sent by the CDA, Dr C and Dr E (as described in chapter 6). As it was, however, Dr C and her colleagues remained unconvinced that the correct steps had been followed, and it was therefore legitimate to continue to escalate matters through the process of Speaking Up.

32. The CEO told us he was genuinely concerned that Dr C's email to the Chair of the Trust, rather than being an exercise in Speaking Up, instead related to the *concerns [the CEO] had about how [Dr C] was… undermining and bullying* the MD. Similarly, the DWC was clear that she saw Dr C's email as *an attack on [the MD].* The CEO's recollection was that the MD felt that *people wanted to destroy his career.* The MD told us that he had raised with the CEO his *feeling of being undermined* over a period of time prior to July 2018. Dr C did not however know that. It was not suggested to us by any witness that the MD had raised that with Dr C – still less were we supplied with any evidence that the MD had raised a grievance against Dr C.

The assumption was made, wrongly, that the concerns were being raised maliciously

33. The CEO and DWC did not believe that Dr C was Speaking Up in her email to the Chair. However, as the CEO later stated when being interviewed in the context of an external investigation of the 31 July 2018 meeting, the executive was *sensitive to the fact that* [Dr C] *may seek to use whistleblowing as a cover*

to allow her poor behaviours and undermining of [the MD] to go unchecked. That had been the reason for taking legal advice *on the best way to sensitively raise the perception of undermining behaviour.* Because the CEO had found no evidence that the appropriate process had not been followed in relation to Dr A, and because he also had a number of concerns about Dr C undermining the MD, he therefore suspected that her allegations in the email were *malicious.*

34. I consider, however, that this is in contravention of the Trust's FTSU policy which, as has been noted, advises staff that *It doesn't matter if you turn out to be mistaken as long as you are genuinely troubled…Provided you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.* On this construction the CEO should, on seeing Dr C's email to the Chair of the Trust have recommended that the matter be referred (with Dr C's permission) to the Trust's FTSU Guardian for investigation. He did not do that then or later and indeed Dr C's specific concerns about the information the MD had supplied to the GMC and what he told Dr A's subsequent employer were never the subject of a proper, separate investigation in accordance with the Trust's FTSU policy.

Dr C and other senior colleagues were concerned about the safety of patients and the welfare of a colleague, yet the CEO wrongly assumed they simply wished to see more stringent action against Dr A.

35. The CEO asserted that, *the essence of the concerns…. appears to have been that more stringent action should have been taken against [Dr A], not that we were not treating it seriously or sensitively.* I do not accept that assessment.

36. As has been demonstrated, Dr C's concerns about the handling of the incident were shared by other senior consultant colleagues including the CDA. For example, the CDA had suggested in his email to the MD of 23 March 2018 that the incident could be *part of an underlying illness* and therefore that it might be appropriate to consider *a period of leave while all doubts are put to rest.* Dr E, in her email to the MD on the 24 March 2018, stated that Dr A, *by his behaviour, is showing he needs support and that for reasons of patient safety, should not be working with patients until a decision can be made about his fitness to practise.* Dr C herself, in her email to the GMC dated 27 July 2018, refers to her concern about the self-medication incident, drawing their attention to a *recent high profile case where an anaesthetist died as a result of injecting medication he had stolen from work*, and stated that Dr A was now *further isolated* and *vulnerable.*

37. From all of the interviews we conducted with consultants who were involved in these discussions at the time, we heard a concern both for Dr A as an individual and also for the paramount importance of patient safety. All who raised

concerns considered it would have been appropriate to give Dr A a period of leave while an Occupational Health assessment was undertaken, and the circumstances of the incident more fully investigated. This was not a call for punitive action.

38. At interview, the DWC accepted that, in hindsight, they *chose the wrong route* under which to treat Dr C's email to the Chair.

The concerns raised in Dr C's email to the Chair of the Trust were well-founded

39. As noted in paragraph 34 above, the Trust's FTSU policy, in line with national guidance, does not require those speaking up necessarily to be correct in the concerns that they raise. The whole point of FTSU is to encourage staff to raise concerns so that they can be addressed in case there is really a problem.

40. I conclude that, in fact, Dr C was correct in at least some of what she set out in her email to the Chair of the Trust which referred to shortcomings we have already noted (see chapter 5) in relation to the handling of the self-medication incident. These include the ignoring of the concerns of colleagues, including the CDA, about Dr A's behaviour, as well as the potential failure to pass on a comprehensive account, including these concerns, to the GMC.

41. In her email to the Chair of the Trust of 27 July 2018 Dr C refers to Dr A's alleged *IV drug usage.* If this is intended as a reference simply to the self-medication incident, then technically this is correct. However, I accept that at first sight it might be read as implying that Dr A had an ongoing problem with IV drug use; and as noted above, the CEO's handwritten list of Dr C's misconduct included a reference to this as *LIBEL.* Whilst that is an overstatement, I consider that Dr C's wording here is unfortunate and should have been omitted or made clearer.

The CEO's and DWC's meeting with Dr C on 31 July 2018 was ill-conceived, unfair, and in contravention of FTSU guidance

42. The CEO and DWC told us they intended that this should be an informal meeting, outside of a disciplinary process and designed to *nip in the bud* what they saw as Dr C's poor conduct and behaviours, and her undermining of the MD. I acknowledge that as they had concluded Dr C was not Speaking Up, it was not their intention to mingle conduct concerns about her with Speaking Up. Nevertheless, that is what I conclude happened.

43. Whether or not this meeting could be seen truly as being outside of a disciplinary process, it was undoubtedly set up as a way for the CEO to conduct a discussion about what he perceived to be multiple examples of Dr C's poor

conduct over the last two years. Given that the meeting was arranged in the context of Dr C Speaking Up about her concerns, I consider that it was in direct contravention of the Trust's FTSU policy which tells staff that *If you raise a genuine concern under this policy, you will not be at risk of ….suffering any form of reprisal as a result.*

44. No matter the label applied and whatever the intention, as a matter of substance, I also do not agree that the meeting was an *informal* one for several reasons:
    44.1. It was initiated by the CEO and held in his office.
    44.2. He was accompanied by the Trust's DWC.
    44.3. Legal advice had been obtained (NB Due to legal privilege, I am of course not aware of the content of that advice, or how far it was eventually followed).
    44.4. There was a typed meeting plan as well as a handwritten list of allegations; and
    44.5. It was at least in part to discuss wide ranging concerns about Dr C's conduct.

45. In contrast, Dr C was not aware of the true agenda, and consequently attended wholly unprepared. She was not accompanied and had not been advised she might wish to be. During interviews with Trust directors we were told that to have suggested Dr C may wish to be accompanied would have represented an escalation of an informal attempt to *nip things in the bud*. I do not accept this. Given the way in which the meeting was arranged, the preparation that had been done, the presence of two members of the executive to interview a single consultant anaesthetist, and the serious conduct issues that were to be raised, whatever the intention this could not be characterised as an informal meeting. Further, a one off meeting was unlikely to resolve every (or even most) items on the CEO's list of alleged concerns and, given the historic nature of some of them it could not be suggested that this was a way to *nip in the bud.* Nor was there any objective urgency to address them (see paragraph 1 above which sets out the terms of the CEO's email to Dr C which had asked her to attend a meeting with him *urgently*. From Dr C's perspective the only *urgent* matter was to discuss the content of her email to the Chair dated 27 July 2018.

The Trust wrongly mingled the process of Speaking Up with an attempt to address perceptions about poor conduct

46. It is clear from both the typed and manuscript documents that the CEO wanted to raise with her a number of aspects of her behaviour that he perceived to be unacceptable, and as bullying and undermining in relation to the MD and others. The meeting plan suggests that disciplinary action was a **potential** consequence ***if*** the CEO perceived her wider actions to be unacceptable. The DWC confirmed that there were *several examples* of Dr C undermining the MD.

She considered that by discussing these examples with Dr C it may de-escalate the situation.

47. It was not appropriate for the CEO to arrange a meeting, ostensibly in response to Dr C's email to the Chair, in which wide-ranging allegations of misconduct were put to Dr C and used as the basis of an allegation that individually or collectively, they were evidence of her wish to undermine the MD. That was a very serious allegation with the potential to affect her career.

48. In my view, it was also unrealistic to expect that discussing examples of alleged poor behaviour in this situation would *de-escalate the situation*. The DWC told us that the meeting was intended to provide Dr C with an opportunity to discuss what *her problem* was with the MD. However, that assumes that Dr C did have a wider *problem* with the MD beyond her concerns raised in relation to the self-medicating incident, and that she was acting inappropriately because of that *problem*. The DWC later accepted that the meeting ultimately went *wrong*.

49. None of this means that, in my view, it is not possible to have an informal discussion with a member of staff if there are concerns about their behaviour. But it needs to be **clearly** informal. The problem in this case was that the meeting with Dr C on 31 July 2018 – quite apart from the fact that it was supposed to have been about her Speaking Up – was by no stretch of the imagination set up to be an informal meeting. If the CEO wished to informally discuss his concerns with Dr C he should have arranged a separate meeting with her unconnected with her Speaking Up and **after** her Speaking Up had been investigated and she had been informed of the outcome of that investigation. Indeed, he has told me that he intended in any event to arrange to meet Dr C to discuss his concerns about her conduct: but she was unaware of that. In preparation for that, separate, meeting he should have told her the purpose of the meeting and given her the opportunity to be accompanied. It was not proper, or defensible for the CEO and DWC to attempt to circumvent standard NHS procedures. In the end, the concerns – whether well founded or not – were brought together in a disastrous discussion that made matters and relationships very considerably worse.

For the NHS FTSU to have real meaning, there must be a clear separation between the consideration of concerns raised under the policy, and the addressing of concerns about performance or behaviour. This did not happen.

50. How could the concerns about possible undermining of the MD have been dealt with?

51. The CEO told us that he did not think it was reasonable, just because Dr C had sent an email raising concerns, that he should have been prevented from

raising concerns about her alleged behaviour. He pointed out – and I agree with him – that *it can't be right that our FTSU policy, or the broader NHS policies are intended to give individuals who raise concerns a blanket exemption to behave unacceptably or, for example, to bully and undermine colleagues…. Even if the bullying or undermining behaviours are ostensibly linked to their raising of concerns.*

52. However, if the NHS overall FTSU framework is to have real meaning and enable all staff to speak out where there is a problem, then it is vital that it is not confused with performance management or disciplinary processes. Clearly it is not a matter for the Review to determine how the concerns about the alleged undermining of the MD should have been dealt with. But where a member of staff raises a potential concern under the FTSU policy it would be prudent, and good practice to:

52.1. Investigate that as a stand-alone matter without raising any issues as to the possible motivation of the person raising the concern.

52.2. Complete the investigation into the matter raised and inform the person who raised it as to the outcome; and

52.3. Take any necessary action in response to any concerns raised that were found to have substance.

53. If then there are outstanding concerns about the behaviour of the person who raised the concern, they should be told of those and given a proper opportunity to refute or admit them. If such concerns relate to actions taken in or related to Speaking Up, then the FTSU policy is unclear on whether it is permissible for the Trust to take any further action or whether, instead, any such action would constitute victimisation.

54. However, there is a suggestion that the Trust may take further action on a concern that relates to Speaking Up in the policy where it states that *it doesn't matter if you turn out to be mistaken [in Speaking Up] as long as you are genuinely troubled*. This suggests that **if** the Trust investigates a concern raised by Speaking Up thoroughly and finds it to be *mistaken*, or without basis, then **if** the concern did not genuinely trouble the person who raised it (on a subjective view), the Trust may take action. However, even if this is a correct interpretation of the policy, it is clear that it imposes an extremely high threshold for the Trust to establish in order to proceed (i.e. evidence to the civil standard of proof that the person Speaking Up was not subjectively genuinely troubled). This threshold is rarely likely to be satisfied and the spirit of the policy is that the Trust should be extremely slow to question the intention of anyone who Speaks Up as doing so undermines the culture of openness and challenge which the policy is intended to create.

55. Notwithstanding that, if at that point the employer does conclude that disciplinary action is appropriate, they can take that in accordance with the relevant procedure.

56. As noted above, we were told that, in his 1:1 meetings with the CEO, the MD had raised his concern that Dr C was undermining him. However, whilst I have seen a number of these notes, nothing was produced to me that enabled me to understand – further than I have learned from the process of undertaking this Review and the issues relating to Dr C I have described in the boxed section of this chapter - the specific concern(s) raised by the MD nor the date(s) upon which the concern(s) were raised. No formal grievance was raised by the MD, in consequence of which Dr C was at no stage given a written account of his concerns and an opportunity to accept or refute them. Neither party was well served by this approach.

8: Speaking Up (2) and the decision to commission an External Report (ExIn2 Report)

Dr E's continuing efforts to Speak Up

1. As already noted, Dr E was one of the consultant anaesthetists concerned about the adequacy of the Trust's response to the self-medicating incident. She was not reassured by what she described as the very *firm* response from the HR team that *processes* were being followed and continued to raise her concerns with the MD and CEO.

2. After a period of leave Dr E wrote to the MD on 13 August 2018 to draw his attention to GMC Guidance that, having raised a concern, she should be told *what action has been or will be taken to prevent a recurrence of the problem* and asked to be told what measures had been taken as a result of the investigation. In his response two days later, the MD told her he could not, for reasons of confidentiality, share details of the investigation or its outcome but he was able to confirm that he had *fulfilled* [his] *obligations as… Responsible Officer.* Still concerned, Dr E raised the matter again with the CDA, who forwarded her letter to the MD, who in turn emailed Dr E once more on 17 September 2018 indicating he was unable to provide any further information other than that there would be *no recurrence of the issues complained of* and that *there have been no further causes for concern.*

3. Dr E arranged to meet with the MD and after their meeting sent him a long email, dated 3 October 2018, detailing the history of the matter and her continuing concerns, including that Dr A:

   3.1. had a history of poor relationships with intensivist colleagues; and

   3.2. had suffered a tragic bereavement. She noted that *despite approaches made by senior consultants with relevant and significant experience, the senior management team's decision was that* [Dr A] *remained at work with no restrictions in place* and that *he…continued… to be responsible for the most vulnerable patients in the hospital, with no support in place.* She went on to say *..I am concerned that local process in this case has resulted in a situation where patient safety and the health of a colleague has not been the priority of the Trust , and that concerns raised by senior clinicians in the speciality have not been given appropriate consideration.*

4. The MD advised her to speak to the CEO. Dr E contacted the CEO on 3 October 2018 reiterating her concern that this was *a situation where patient safety and the health of a colleague has not been a priority of the Trust*.

5. The CEO and Dr E met on 5 October 2018, when Dr E requested a *review of the local processes that resulted in a situation where [she felt] that patient safety and appropriate support for a colleague were not made the first priority, and that concerns raised by senior clinicians in the speciality to the Medical Director have not been given appropriate consideration*. The CEO informed Dr E that she could speak with the Trust's then Senior Independent Director (SID), if she remained concerned. They agreed that she would do so.

6. The CEO wrote to Dr E on 15 October 2018, responding formally to her concerns, and providing some information about the processes undertaken in relation to the self-medicating incident. He noted that it was not clear to him that *exclusion was unequivocally the only appropriate action that* [the MD] *… could have taken* in response to the Datix, but at Dr E's request he would continue to consider whether the decision not to *exclude or restrict* Dr A was taken too early, whether all relevant information was considered, and the impact of the incident on staff. However, he noted that she would now be taking her concern to a NED, and he suggested that she speak to either the Chair of the Trust or the SID.

7. It is clear from this letter that the CEO was aware that the MD had a power to *restrict* Dr A's practice as an alternative to excluding him. One of the objections raised by Dr E (in common with the CDA and Dr C) related to the absence of restrictions on Dr A's practice, rather than exclusion: specifically that Dr A should have had restrictions placed on his practice until the incident and associated circumstances had been fully investigated.

8. Dr E arranged a meeting with the SID on 26 October 2018, who subsequently arranged for her concerns to be considered by the Board in private session on 2 November 2018. The SID told us he wished to distil the questions she wanted answers to, so that there could be a robust discussion at the meeting of the Board. He emailed Dr E summarising the questions to be considered by the Board:
   - 8.1. Why such an apparently serious incident was not reported immediately?
   - 8.2. Whether, when deciding not to exclude the individual due consideration was given to alternative measures, his personal protection /well-being and that of his work-place colleagues?
   - 8.3. The extent to which, during the investigation, an optimum balance between confidentiality and transparency of progress to stakeholders was maintained.

Dr C's continuing efforts to Speak Up

9. Whilst she was on sick leave, Dr C asked the Chair of the Trust's office to supply her with the contact details of the non-executive named in the Trust's FTSU Policy. That non-executive had now become the Trust's Deputy Chair (DC), and no longer held the FTSU responsibility, but he confirmed he did not mind being contacted, and his details were accordingly suppled to Dr C.

10. On 1 October 2018, Dr C telephoned the DC mentioning that she was contacting him in his capacity as the Freedom to Speak Up NED. After Dr C had indicated the nature of her concerns, he asked her to produce a written account. He then proposed that they meet to discuss these. He requested that the SID also attend, and Dr C agreed.

11. The DC, SID and Dr C met on 12 October 2018, off Trust premises. All three agree that the meeting was productive and positive. Dr C was buoyed by the meeting: she felt she had finally been listened to and she was looking forward to learning of subsequent developments as they unfolded.

12. Both the DC and the SID told us when we interviewed them that they considered Dr C had Spoken Up by her email of 27 July 2018 to the Chair of the Trust. They also confirmed their view that she was Speaking Up in her communications to them.

13. Dr C told us that the matters she raised orally in the meeting with the DC and the SID were:
    13.1. a concern for Dr A's welfare and whether appropriate steps had been taken to help him.
    13.2. whether the Board had full knowledge of and effective oversight over the investigation and processes relating to the self-medicating incident.
    13.3. whether the CEO had treated Dr C appropriately in the meeting of 31 July 2018; and
    13.4. whether the Chair of the Trust's decision to pass Dr C's email marked *In Confidence* to the CEO was appropriate.

14. The DC later recorded in a letter to Dr C that he understood that in the course of their discussions she had raised six points:
    14.1. whether the Board had been made aware of the self-injecting incident and investigation.
    14.2. whether the investigation has been *as thorough as it could and should have been*. Dr C told us that this was not an entirely accurate summary, although she did not raise that with the DC: her complaint was that the clinicians raising concerns were entitled to know a greater level of detail than merely an assertion that a *process had been followed*.
    14.3. a concern that the Chair of the Trust had passed on a confidential email, thereby breaching confidence and governance processes.

14.4. whether Dr C was badly treated and *heavily pressured* in the meeting of 31 July 2018 and that this treatment *belies* the Trust's espoused behavioural values.
14.5. whether the Trust to which Dr A had now moved were properly informed about the nature of his actions in the self-medicating incident; and
14.6. whether it was appropriate for Dr A to remain engaged as a Medical Reviewer in the Learning from Deaths programme of a Trust by which he was, by then, no longer employed.

15. The DC and SID agreed the following action points with Dr C:
15.1. That the Board should improve governance so that a clear trigger was created to ensure that investigations relating to clinicians' practice were flagged upwards and allocated to a NED to oversee.
15.2. That the self-medicating incident and subsequent process be discussed with the MD (and possibly others) to ensure that learnings were openly revealed.
15.3. That discussions would take place between the SID, Chair of the Trust, CEO and *other executives* to ensure that there was reflection on how Dr C's Speaking Up had been handled because *on the evidence so far, there were behaviours that were not consistent with espoused Trust values*; and
15.4. The DC and SID would *form a plan of engagement with appropriate senior Trust staff to progress the proposed actions*.

16. It was left as an unresolved question whether the Trust should, in addition to the stated action points, address Dr A's continuing involvement in the Trust's Learning from Deaths programme and whether the Trust to which Dr A had moved been properly informed about the self-medicating incident (although those points were subsequently addressed – see paragraphs 18, 38 and 39 below).

17. After the meeting, Dr C provided the DC with a copy of her email of 27 July 2018 addressed to the Chair of the Trust, to demonstrate that it had been marked *In confidence*. The DC and the SID then spoke with the Chair of the Trust on 23 October 2018 to ascertain what had happened. The DC, who told us that he could understand Dr C's objection to the email being passed on, described the nature of the discussion with the Chair of the Trust as *firm*. The Chair of the Trust was candid with them that when she received the email, she thought it was a management issue more appropriate for the CEO: with hindsight she stated that passing the email direct to him may not have been the right thing to do.

18. On 30 October 2018, a few days before Dr C's planned return to work, the DC sent her a message updating her on his and the SID's actions thus far and to say he was pleased she was going back to work and that her Speaking Up had already made a difference. He referred to the Board meeting scheduled for 2

November 2018. He stated that the SID had already had meetings with the CEO and Chair of the Trust about improving governance. He stated that *partly as a result of your speaking up,* [SID] *and I have put forward proposals to ensure that going forward ALL cases of doctors under investigation (or similar) will be referenced (with confidentiality respected) at every closed Board meeting. The selected NED overseeing the case will be named… each case will be referenced every month until "completed".* In relation to onward reporting of the self-medicating incident, Dr A's new employer was *transparently aware of the issues* with Dr A. He further stated that *the indication from* [SID] *is that further discussions will continue with appropriate NEDs and Execs on any other issues and learning and actions arising from this case, including issues you have raised.*

19. It is noteworthy that this summary did not provide any update on Dr C's point captured at point 2 in paragraph 13 above – there was no reference to any discussion with the MD about the handling of the self-medicating incident.

20. Dr C's concerns were not substantively or comprehensively addressed at the meeting on 2 November 2018. The DC told us that he decided that he would consider her concerns and provide a response in writing.

The 2 November 2018 Board Meeting

21. I was supplied with copies of the 2 November 2018 Board paper from the DWC addressing three questions raised by Dr E, in addition to a detailed review written by the CEO. We also had an opportunity to ask a number of the Directors about their recollection of the Board's discussion in addition to reviewing the contemporaneous minute of the meeting.

22. Whilst Dr E and Dr C had overlapping concerns in relation to the way the self-medicating incident had been dealt with, Dr C's concerns were wider, as they also related to the events immediately following her Speaking Up in July 2018, and thus effectively included complaints about the actions of the Chair of the Trust, CEO and DWC. Notwithstanding the overlapping nature of their concerns and parallel timing, the concerns of Drs C and E were treated as a distinct matters and processes.

23. The SID arranged for Dr E's three concerns to be addressed in the Private session of the 2 November 2018 Board. The agenda item for the meeting states that it was triggered in relation to a recent incident (i.e. the self-medicating incident) and the purpose was to explore three specific questions that had been raised by her with the SID. We were told by the DC that the item was not intended to consider the concerns raised by Dr C.

24. The three questions addressed were identical to those set out in paragraph 8 above, except that the first question had been expanded to include the question of *why, on being formally reported was it rated as 'Green' in Datix.* It is not clear why this was added: Dr E did not ask that question, no doubt because anyone familiar with the Trust's operational processes would know that, as already noted in chapter 5, the Datix system defaults to Green if no patient harm has been sustained, regardless of the actual level of risk of the relevant incident.

25. The DWC's paper provided her account of the self-medicating incident and the MHPS process that followed in relation to Dr A. She expressed her view that governance *processes would appear to be robust and the Trust identified and acted on incident reporting swiftly*. She noted that both Dr C and Dr E had concerns about these processes, but states that *Their principal concern appears to be that exclusion was the only action the trust should have taken*.

26. The DWC reported that on the next working day after the self-medicating incident was reported, the CDA was informed about *the decision*. It would appear that this refers to the MD's decision to institute an MHPS process without in the meantime restricting Dr A's practice in any way. The DWC continued that the CDA *did not dissent from the decision but would have liked to have been consulted*. This omits that the CDA had a more immediate objection which he did raise with both the DWC and MD on 23 and 25 March 2018 (although the CEO told me he was not aware of this). Namely, that he thought it was inappropriate for Dr A to undertake clinical duties without some further investigation.

27. The CEO's report noted that the Datix had been categorised as Green and that this indicated a *near miss or low-level harm to patients*. He explained that the DCN recognised its seriousness and escalated it to the MD.

28. In providing his narrative, the CEO referred to the meeting of 31 July 2018 with Dr C in the following terms: *the primary purpose of the informal meeting was to discuss* [Dr C's] *email to the Chair which had been handed to me to deal with as an operational matter. I explained that I was unable to disclose confidential details regarding another employee but sought to reassure* [Dr C] *it was my understanding that the Trust had taken all reasonable and necessary steps, in accordance with relevant processes*. His summary made no reference to the extensive performance management concerns he had decided to raise with Dr C at the meeting and the evident distress and discord that followed; he told me that considered this was not material to the issues under consideration.

After the 2 November 2018 Board meeting: The outcome for Dr E

29. Following the Board meeting, the SID wrote to Dr E on 23 November 2018 to confirm the follow up actions which the Trust would take in response to her concerns. These were that:
    29.1. an externally facilitated session would be scheduled to clarify the reporting processes under the MHPS Policy.
    29.2. ongoing coaching would be arranged for senior leaders to support them in engaging staff in governance; and
    29.3. all MHPS decisions would be discussed with the relevant Clinical Director (which had not happened in this case).

30. The SID also stated that:
    30.1. the *self-injecting* incident had been reviewed with the individual who had reported it to understand the reasons for the delay in reporting.
    30.2. all MHPS cases would be signalled to the Board in its private session, although because *the individual's right confidentiality outweighed the interests of all other parties, this would limit communications to only simple progress updates*; and
    30.3. the Board was assured by the answers that had been provided to Dr E's questions, and that the approach taken towards Dr A had been robust and appropriate.

31. The SID met with Dr E in person on 13 December 2018 to discuss the outcome of the Board meeting. He reiterated the points he had set out in his email dated 23 November 2018. Dr E told us that the only point she expressed dissatisfaction with was the approach taken to the absence of workplace restrictions on Dr A. She was concerned that a similar approach would be taken with other doctors in the future. However, she decided to move on from the matter as she considered that she had taken it as far as she could.

The outcome for Dr C

32. The DC told us that the first time he discussed Dr C's concerns with the CEO and DWC was in a private meeting with them and the Chair of the Trust after the 2 November 2018 Board (the SID had previously had a separate meeting with the CEO and Chair of the Trust in relation to the points raised by Dr E – see paragraph 8 above). In the former meeting, on 2 November 2018, the CEO and DWC told the DC they had a list of issues that had been prepared for the 31 July 2018 meeting, that the meeting had become heated *on both sides*, but that the intention had been to raise the issues on the list with Dr C, rather than chastise her for writing the email to the Chair of the Trust. Although the DC later accepted at interview (see paragraph 12 above) that Dr C's email to the Chair of the Trust had been an exercise in Speaking Up it does not appear from

that account that the CEO and DCW then accepted that Dr C's email to the Chair constituted an exercise in Speaking Up. .

33. The DC's view was that there was an *impasse* in relation to the concerns Dr C had raised about the 31 July 2018 meeting and the views expressed by the CEO and DCW, and that feelings were strong on both sides. In consequence the DC considered that the only way to proceed was to conduct a *balanced investigation* to determine what had happened. The DC's notes from that day record that he discussed this approach separately with the DWC and she agreed.

34. On 7 November 2018 the DC wrote to Dr C. He summarised the concerns she had raised and the Trust's response. He considered that this response *complet[ed his] response to [her] concerns*.

35. Dr C's first concern was whether the Board had been made aware of the self-medicating incident and subsequent investigation. The DC's response was that the Board had **not** been made aware of this at the time. However, it considered that the MHPS Policy was substantively followed, and a NED was appointed to oversee the case. The Trust had now reflected and agreed with Dr C that the Board should be informed if a decision was made to pursue an MHPS investigation and that the first speaker in the following Board discussion should be the NED appointed to oversee the investigation.

36. Dr C's second concern was whether the investigation has been *as thorough as it could and should have been*. The response, through the DC, was that there had been a detailed Board discussion on this to gain full assurance as to the thoroughness of the investigation into the self-medicating incident, and that the Board was satisfied that it was *robust and appropriate*.

37. Dr C's third concern was that the Chair of the Trust had passed on her email which had been marked *In Confidence* without reference to her and in breach of confidence and governance processes. The Trust's response was that the Chair of the Trust had understood the email to relate to operational matters, and that whilst it was marked *In confidence* there was nothing to suggest that the *In confidence* excluded the CEO. The DC stated that the Chair of the Trust stood by her decision to forward the email, even though she accepted it *could be questioned*.

38. Dr C's fourth concern was whether Dr A's subsequent employing Trust were properly informed about the nature of his actions. The DC stated that the Board *heard a clear confirmation that the Medical Director of the other Trust had been given a full and transparent briefing*.

39. Dr C's fifth concern was that Dr A had remained engaged as a Medical Reviewer in the Trust's Learning from Deaths programme. The Trust's response was that Dr A's conduct had been investigated and his right to practice continued, so there was nothing to warrant the termination of his engagement.

40. Dr C's sixth concern was that she was badly treated and *heavily pressured* in the meeting on 31 July 2018 and that this treatment *belie[d] the Trust's espoused behavioural values*. The DC's response was that the CEO and DWC had stated that their focus was to *raise serious concerns that [Dr C] was undermining* [the MD] and not to criticise Dr C for escalating her concerns. This response did not note that the decision to *raise serious concerns* about Dr C's behaviour in response to an unresolved exercise in Speaking Up was in breach of the Speaking Up policy.

41. The DC observed that although he and the SID had not *performed a very formal and exhaustive process,* he had sought to understand Dr C's concerns and make recommendations to improve governance. He stated that a different approach was required to address both:
    41.1. Dr C's concern about the CEO's and DWC's behaviour in the 31 July 2018 meeting; and
    41.2. their *serious concerns* about her *behaviour and working relationships*. He informed Dr C that he would therefore initiate a *balanced investigation into both perspectives*, and that he would be appointing an independent investigator and seeking her views on the Terms of Reference in due course.

The initiation of an External Investigation

42. The DWC advised the DC that he should be the one to commission the investigation because the Speaking Up disclosure had been made to him. The DC had not commissioned such an investigation before. He did not discuss it, nor his decision to commission it, with the other NEDs, including the SID.

43. The DC received a recommendation from the Trusts' external solicitors who, having made enquiries of three possible investigators proposed one to the DC who they indicated had availability. Having considered the proposed investigator's CV and spoken with a referee, the DC decided to appoint him.

44. The investigation process was that the DC would be the point of contact for the investigator and would receive the final report. The DC would then report back to the Board as to whether he was satisfied or not with the findings. The Board did not receive the Report; indeed, Dr C did not receive it until she pursued a Subject Access Request many months later – and even then, she only received

a redacted version. The original Terms of Reference for the report were not discussed by the Board. This appears to have been for reasons of confidentiality.

45. The DC sent Dr C, the CEO and DWC the Terms of Reference. Dr C did not provide any comment on them. As noted elsewhere, she was not legally represented. The Terms of Reference were finalised, and the External Investigator (ExIn1) began his investigation in late 2018.

46. The National Guardian's *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* provide that, where the non-executive lead for FTSU is overseeing an investigation into a board member [as here], the non-executive director should inform NHS Improvement and [the] CQC so they can provide support and advice. The DC confirmed that this guidance was not followed as he had not been aware of it at the time.

Findings: The Board's review of the self-medication incident

The reports by the DWC and CEO to the 2 November 2018 Board meeting about the handling of the self-medication incident and the concerns raised about it did not reference some of the concerns which had been raised by Dr C about the handling of the self-medicating incident. Whilst this in part flowed from the fact that the meeting had been convened by the SID to discuss Dr E's concerns rather than Dr C's, it meant that Board were not fully sighted on the breadth and depth of the concerns being expressed by senior anaesthetists about the handling of this matter .

47. The first question put by Dr E was **why the self-medicating incident took four to five months to be reported,** but the question in the Board paper expanded this to ask *why, upon being formally reported, was it rated as green in the Datix?* However, the papers failed to explain that any incident without actual patient harm would be automatically *green,* prior to review by the Head of Patient Safety. In his review the CEO noted that Green *incidents are either a near miss or low-level harm to patients,* but in our interviews with Board members, the fact that the Datix was reported as green appeared to be seen as reassurance that the incident had not been seen as that serious by the individual who entered it.

48. The fact that the incident was not reported for four to five months was also *taken into account in deciding whether there was an immediate patient safety issue.* Whilst this was understandable it did give rise to another possible question. Dr E told us she had wondered whether the late reporting resulted from consultants feeling unable to raise concerns. If that were the case then the

delay in reporting should not have given grounds for reassurance. The CEO did, state in his report that *the reasons for* [the delay] *should be examined and addressed*, and he noted that a coach had been secured to support the CDA and the anaesthetic team more widely. In the minute of the Board discussion the MD is recorded as having said that *he had reviewed the case with the individual who had reported the incident to understand the reasons for their delay*; however, what he understood those reasons to be is not recorded. The individual concerned told us she was telephoned while she was off duty and in a restaurant in town on the day the Datix was brought to the MD's attention, and said that she told the MD and DWC that she had simply been distracted by clinical work until the issue came up in conversation months later. She did not recall any further discussion about the issue, apart from being asked to write a statement for the purposes of the MHPS investigation into the incident (where she gave a similar explanation).

49. Dr E's second question was about ***whether, when deciding not to exclude the individual, due consideration was given to alternative measures, his personal protection/well-being and that of his workplace colleagues***. As noted above, the reports to the Board omit any reference to the fact that the CDA had immediately proposed that the Trust *allow the individual a period of leave whilst all doubts are put to rest;* in his email to the MD and the DWC of 23 March 2018 he had set out his concerns and rationale for his view that Dr A should not have been undertaking clinical duties during the initial investigation. The DWC did not make any reference to this email (nor the follow up one sent by the CDA also sent over the weekend before Dr A turned up for duty on the Monday).

50. Dr C had also raised her concern that Dr A had been permitted to continue in unrestricted practice and the failure to make any reference to this in the paper prepared for the Board by the DWC is material. It is clear from the contemporaneous documentation that that concern was shared by the current CDA, the former CDA, the College Tutor, and a Council Member of the Royal College of Anaesthetists. That those concerns had been expressed by others was relevant background information which would have supported the Board in its consideration on the governance of the investigation of the self-medication incident and onward process.

51. **How far were possible alternatives to exclusion, and issues of the wellbeing of Dr A and his workplace colleagues, considered in the reports to the Board?** The DWC's report states that *MHPS was followed to the letter…. Including… consideration of whether the individual should have been placed on restrictive practice* whilst the report from the CEO refers solely to exclusion itself, noting that *it is not a neutral act and can have a significant impact on an individual's reputation and career.* There is no discussion about

what the alternatives in respect of restricted practice might have been that the DWC said were considered, or why they were not considered appropriate or necessary. Similarly, the minutes of the Board discussion recorded that there was discussion about exclusion itself, but nothing about lesser alternatives to exclusion. Nor, apart from a reference to the damaging effect of exclusion on an individual, does there appear to have been information given or discussion had about considerations of the wellbeing of Dr A or that of anyone else. No evidence was supplied to me by the MD or DWC about their having given any consideration of alternative measures to exclusion.

52. Dr E's third question was about **how far there was an optimum balance between confidentiality and transparency of progress to stakeholders.** In her report, the DWC states that Dr E, Dr C and their colleagues *have been listened to* but told that *for confidential reasons it is not possible to disclose the details.* She goes on to state that *their principal concerns appear to be that they believe that exclusion was the only action the trust should have taken.* Similarly, the CEO's report states that *Fellow anaesthetists felt poorly communicated with throughout although this might also be that* ***they were unhappy that*** **[Dr A]** ***hadn't been excluded due to prior poor relations****.* This suggests that fellow anaesthetists only proposed that Dr A be **excluded.**

53. The suggestion that those raising concerns were only complaining about the failure to exclude Dr A is incorrect. As has already been described at some length in chapter 6, their concerns included:
    53.1. the need for support for a colleague they saw as potentially being in difficulty.
    53.2. the need for full disclosure of the incident to Dr A's new employing Trust; and that
    53.3. without further investigation it was not clear that there was not an ongoing risk to patient safety.

54. To compound matters by suggesting that the concerns expressed might have been held simply because Dr A's poor relationships with some of the anaesthetists was potentially to play down a concern about these events that I have found to be genuinely held by several anaesthetists we have interviewed, including, of course, the CDA.

55. The minutes of the meeting on 2 November 2018 record that *the Board confirmed that it was assured by the answers provided to all three questions and that the Trusts' management of the MHPS process, and this specific case, was robust and appropriate.* The Board were in my view given incomplete information, and the review failed to expose the shortcomings of the investigation and subsequent actions already discussed in chapter 5.

56. In saying this, I completely – and humbly - acknowledge the challenges that face members of NHS unitary boards, especially the non-executive directors, in asking the right questions to help them understand the full circumstances of a given situation. NEDs very often have less knowledge of operational systems and situations than their executive counterparts, and therefore it can be difficult to provide the *rigorous but constructive challenge* that Board discussions are meant to display when they may not know the full story.

57. In this instance the report to the Board gave the assurance that *the incident was not brushed under the carpet:* the GMC had been advised of the incident, and advice had also been taken from an external anaesthetist. What the NEDs reading the reports provided by the DWC and CEO will not have known is the degree of concern about the decision to send Dr A straight back to his clinical work, including from the CDA. They might have noticed that the contact with the external anaesthetist was made **after** the initial discussions with Dr A on the 23 March 2018 and indeed after he had been permitted to undertake unrestricted duties. But on the briefings they were given, they would not have been aware that the GMC were not told about the CDA's email expressing concern that, as described in chapter 6, *the events will appear to be part of a general behaviour that has been discussed at length recently.* Nor were they made aware of Dr C's email to the MD of the 19 March 2018 – less than one week before the Datix came to light (also referred to in chapter 5), writing on behalf of the ICU consultants, when she wrote about their concern that they had *a disenfranchised, ex critical care colleague (with relationships that are fractured, to such an extent, with 3 critical care consultants, that he will no longer speak to them).* It is important to note that the CEO had not seen these two emails either.

58. These omissions are surprising. The agenda item concerning these matters for the Trust Board meeting on 2 November 2018 was not routine: it had been requested by the SID to discuss concerns brought to him by Dr E. Against that background I would have expected the Board to be comprehensively briefed.

59. In relation to the less than full description of the CEO's meeting with Dr C on 31 July 2018, on the other hand, two of the NEDs had met with Dr C on 12 October 2018, only three weeks previously, when she had told them about that same meeting from her perspective. The DC told us it was a coincidence that, after Dr E had raised her concerns and the matter placed on the agenda for the Board meeting, Dr C also raised similar (albeit broader) concerns. Both he and the SID understood the Board meeting item to relate to Dr E's concerns. In consequence, he *kept silent during [the] entire meeting because it wasn't … about* [Dr C]. But it did mean that an opportunity was lost to appraise the Board of the extent and range of concerns being raised.

Findings: The outcome for Dr E and Dr C: a mixed response to their concerns

Some positive changes were made to Board processes as a result of Dr E and Dr C having Spoken Up, and of the DC and the SID paying attention to their concerns. However, significant questions went unanswered.

60. It was undoubtedly positive that the Board made a number of changes as a result of Dr E and Dr C raising concerns, as set out in paragraph 29 above. The DC expressed to us his hope that *some recognition is made of how the early and appropriate action of* [Dr C] *in raising concern, did directly lead to some learnings and actions by the Board of the Trust - actions that I personally championed.* It is unlikely that some of these changes would have been made without the contribution of both Dr E and Dr C.

61. I would also like to commend the SID and DC, for making every effort to meet with Dr C and Dr E respectively, and for taking their concerns seriously.

62. As noted in paragraph 31 above, Dr E was not entirely happy with the outcome of the Board discussion in relation to workplace restrictions. However, she thought it helpful that the Board had decided to ensure the CDA would in future be involved in decisions about MHPS cases. She told us that she had taken it as far as she could: *I don't agree with all of it, but I do accept it, move on.*

63. For Dr C, as noted in paragraph 18 above, the DC told her that her *speaking up had already made a difference,* and that changes were being made to the Board's governance of MHPS cases, to allow better Board scrutiny in future. The changes were positive and represent the type of development that can arise from a well-handled set of concerns raised by members of staff.

64. She was further told that the Board had been assured that the *Trust's management of the MHPS process, and this specific case, was robust and appropriate,* and that Dr A's new employer had been given a *full and transparent briefing on all aspects of the ….incident and investigation findings.*

65. In relation to the response given in the DC's letter to Dr C of 7 November 2018 about her concern that her email to the Chair of the Trust had been passed directly to the CEO, as we have set out in chapter 6, I do not agree that on an ordinary reading of the email it could be suggested that it could be shared with the CEO without that being agreed by Dr C first. It is not reasonable to suggest that an email sent solely to the Chair of the Trust and most senior of the non-executive directors, in confidence, includes, within that confidence, other

unspecified individuals including the Executive Directors. Further, in this instance it was clear that Dr C was raising an issue about the handling of a matter by two executive directors.

66. As regards Dr Cs' sixth concern - **that she was badly treated and *heavily pressured* in the meeting on 31 July 2018 and that this treatment *belie[d]* the Trust's espoused behavioural values** – the CEO and DWC had stated that their focus was to *confront* [Dr C] *about a whole list of concerns they had (pre-prepared in writing), not to chastise her for the way she sent her concerns by an email to the Chair.* This misses the point: Dr C had reasonably understood the meeting had been convened to address the concerns about which she had Spoken Up to the Chair of the Trust. It should not have been used to raise performance concerns about Dr C about which she had been given no prior warning.

The proposed investigation into the 31 July 2018 meeting was in direct contravention of the Trust's FTSU policy. Dr C's email raising concerns to the Trust Chair led to her Speaking Up to the DC and SID about those concerns and also about the way she had been treated in raising them; this in turn led to the commissioning of the investigation. Thus, it contained, at the very least, an inherent risk of victimisation of Dr C for Speaking Up.

67. I consider the investigation into the concern about the 31 July 2018 meeting in chapter 10. I note, though, that the FTSU policy requires that the FTSU process will be kept separate from any disciplinary or performance management action. This proposed investigation was not a disciplinary process. However, as well as investigating the concern raised by Dr C about the meeting itself, it was looking into the concerns held by the CEO and DWC about her alleged historic behaviour, and it was therefore, by implication, connected to the disciplinary process. It was **not** intended to look into the issues about which she had Spoken Up. It could be argued that the Board Meeting on 2 November to a certain extent considered the matters about which Dr C had Spoken Up. But a discussion at the Board on the basis of limited information which was not focused upon all of the matters she (as opposed to the concerns expressed to the SID by Dr E) had raised in her Speaking Up to the DC meant, at the least, that an opportunity had been missed to get to the bottom of them. At worst it meant that the specific concerns Dr C had raised in the context of Speaking Up to the Chair had been lost sight of – and were never the subject of a proper, separate investigation.

68. Dr C told us that she was not aware of the required separation of the investigation of Speaking Up concerns and performance management at the time, and therefore did not feel in a position to object to the External investigation. Had she known; she would not have consented to go through the

process outlined by the DC. I note that Dr C did not seek legal advice on the process but that it would appear that the Trust did (albeit I have not sought sight of any advice requested or provided).

69. The investigation into the concerns about Dr C's conduct, which formed part of the investigation to be commissioned by the DC, had arisen as a direct consequence of the meeting convened to discuss Speaking Up. Between the end of July – the meeting with the CEO and DWC - and November 2018 when the investigation was commissioned, her only additional action of significance in this respect is that she Spoke Up directly to NEDs about the governance of patient safety and the Executive response to staff raising such concerns. It is difficult to avoid the conclusion that the decision to investigate Dr C at that time, four months after the July 2018 meeting, at the very least had the appearance of being taken because she had Spoken Up and complained about her treatment in so doing (alongside other concerns).

70. I therefore conclude that the FTSU Policy was not correctly followed, and that the investigation inherently contained a real risk of victimisation of Dr C for Speaking Up.

Dr C was not told about the scope and breadth of the investigation to be undertaken and was given no information about the concerns about her own conduct which were to be considered.

71. It is of note that whilst Dr C's concerns were clear, having been raised with and then fully documented by the DC, the concerns held by the CEO and DWC were not documented to the DC or Dr C. Dr C went into the external investigation unaware of its potential scope – but presuming it was to address two distinct issues:
    71.1. her concerns about the way the Trust had handled the issues arising from the self- medication incident; and
    71.2. the way she had been treated by the CEO and DWC in the meeting of 31 July 2018.

72. In the event the Independent Investigator understood his Terms of Reference to include the CEO's and DWC's justification for the concerns they raised. In practice, this meant he was asked to obtain accounts in support of those concerns that were not then shared with Dr C, thereby preventing her from adducing evidence in refutation. This is considered further in chapter 10.

9: The Anonymous Letter

Mrs W's Treatment

1. In July 2018, Mrs W was admitted to the Trust's Intensive Care Unit (ICU) following emergency surgery. An arterial line had been inserted into Mrs W in theatre which contained the incorrect maintenance fluid (dextrose saline as opposed to normal saline). Dr A was the consultant anaesthetist present. He was not involved in the preparation or checking of the fluid.

2. The error was not recognised and thus corrected for some 39 hours. Mrs W, whose condition had been critical, subsequently died in the ICU having been a patient there for nearly five weeks.

3. The Trust triggered a Serious Incident Requiring Investigation (SIRI) process in relation to Mrs W's death. A consultant anaesthetist, Dr G, was appointed to investigate, and his report was dated 21 November 2018 (the SIRI Report). He found that it was *unclear if the error involving the incorrect arterial line maintenance fluid and inappropriate treatment of hyperglycaemia* contributed to her worsening condition. The Trust reported Mrs W's death to the coroner.

4. At the Inquest into Mrs W's death the coroner found that she had *died as a result of the progression of a naturally occurring illness, contributed to by unnecessary insulin treatment caused by erroneous blood test results. This, in combination with her other co-morbidities reduced her physiological reserves to fight her naturally occurring illness*. The medico-legal report commissioned by the coroner and prepared by a consultant in Anaesthesia and Intensive Care from Dorset, found that *the critical incident regarding the connection of Dextrose Saline to the arterial line flushing system occurred…due...to Dextrose Saline being stored inappropriately on the trolley…compounded by the fact that at no stage did multiple practitioners come to check the infusion bag, either at ODP level, medical anaesthetic staff in theatre and ..a series of Critical Care nurses.*

The Anonymous Letter

5. On 19 October 2018, prior to the SIRI Report and inquest outcomes being available, the patient's widower, Mr W, received an anonymous letter in the post. The envelope was postmarked 15 October 2018. The letter was typed but the envelope in which it was sent was handwritten.

6. The letter stated that *We think you should know that the consultant anaesthetist who made the mistake with the fluid into the arterial drip in theatre should never have been at work. He had injected himself with drugs before whilst in charge of a patient and it was all hushed up and he was at work like nothing had happened – but we all knew the truth. You need to ask questions about this doctor and what investigations had been had about him before. We think there is a big cover up*. It was signed from *Operating Theatre Staff.*

7. This was, inevitably and entirely understandably, a very distressing letter for Mr W to receive. We did not interview a single witness who suggested that it was appropriate for the anonymous authors to have sent it.

8. Mr W reported his receipt of the letter to the Suffolk Constabulary on 22 October 2018 and provided the police with the original envelope and letter. The police identified that there were fingerprints on the envelope. In December 2018, Mr W was contacted by the DCN and Head of Patient Safety, who had telephoned him to ask whether he had any questions arising out of the Duty of Candour letter he had received from the Trust. In the course of the conversation Mr W referred to the anonymous letter which was the first the Trust had heard of it. He gave his consent to the letter being passed to the Trust by the police who had by then decided not to undertake a criminal investigation into its despatch.

The Trust's response to the anonymous letter

9. The anonymous letter was reported on Datix and escalated to the Executive Directors. The notes of the Day 2 investigation meeting, held on 21 December 2018, identified two lines of enquiry: *the allegation regarding the consultant and his fitness to practise, and the implication it may have had on Mrs W's care and the subsequent investigation;* and the potential data breach involved in the anonymous letter having been sent to Mrs W's address, which is held confidentially. Thus, in terms of any subsequent investigation, two clear questions stood out:
   9.1. why was the letter sent?
   9.2. by whom was the letter sent?

10. The Trust executive team did not pursue the first of these questions, as those who had been involved in handling the self-medicating incident were confident that it had been dealt with and closed. The CEO later wrote to NHSEI that *the incident had been fully investigated and concluded…*and that the *GMC had previously confirmed to the Trust…that they did not consider it necessary to investigate*. As set out below, it explained the same in high-level terms to Mr W. Further, that Mrs W had received the wrong maintenance fluid had by then

already been fully investigated by Dr G and was to be examined at a coroner's inquest.

11. That left, in the mind of the executive directors concerned, the second question - by whom had the letter been sent, and was that individual a member of the Trust's staff; and whether Mrs W's personal information had been accessed in order to send the letter (in other words, whether there had been a data breach).The Chief Operating Officer (COO) was appointed as case manager to lead the investigation.

The Information Governance (IG) investigation

12. The investigation commenced with an initial IG investigation in an attempt to establish who had accessed Mrs W's electronic notes to find her address. The IG investigation was initiated by the DWC and carried out by the Information Governance Manager (IGM) and the Governance Manager (GM).

13. The purpose of the IG investigation was to review *access to [Mrs W's] records, who has accessed them, when and why*. A high-level description of the investigation process is provided in the final Incident Investigation Concise Report (the Information Report), produced in March 2019. This report omitted material aspects of the process and I accordingly sought copies of the contemporaneous email correspondence and meeting notes, and also interviewed the staff involved.

14. The IG investigation interrogated all of Mrs W's electronic records held by the Trust on several different systems. The investigators applied a search parameter date range of 26 July 2018 (when she was admitted to the Trust) to 31 October 2018 (two months after she had passed away, and two weeks after the letter was sent). It searched for anyone who had accessed to Mrs W's electronic records using their personal log-in.

15. We were told during our interviews with the staff conducting it that they understood that the IG investigation was investigating one line of enquiry, using the Trust's electronic records as a *starting point*. However, they were clear that this process would not be capable of producing *a definitive list by any stretch of the imagination* of those who could be suspected of sending the anonymous letter. They believed that the Trust directors to whom they were reporting (the DWC and COO) would have been aware that the process was *not scientific.*

16. Access to electronic records (for whatever purpose) was not the only means of obtaining Mrs W's address. First, Mrs W's address could have been found in multiple locations within the ICU and elsewhere when she was a patient, for

example on sticky address labels and paper medical records. Second, there was a generic login which could be used by staff on a number of terminals within the theatre complex. It follows that any staff member with access to the theatre complex could have accessed Mrs W's electronic records without leaving a digital footprint. Since the letter was anonymous, there is a reasonable probability that its sender would have sourced Mrs W's address without leaving a digital footprint if they were able to do so.

17. Notwithstanding the possibility that the patient's address had been obtained from paper records or via a generic login, the initial search proceeded and established that during the period identified by the Trust Mrs W's records had been accessed in excess of 26,000 times, and returned the names of 201 staff who had accessed the demographics section of the records where the patient's address would have been visible. This was narrowed to 131 staff, although the criteria which the Trust used for this narrowing were not recorded in the contemporaneous documents produced to the Review (including the final Information Report, which simply refers to *further analysis*). I was not able, despite having interviewed those involved, to establish the criteria adopted to reduce the number of staff from 201 to 131. The team investigating the incident wished then to *by a process of elimination identify a group of people that will need further follow up for the reason of their access to the patient's electronic records.*

18. On 28 January 2019, an email was sent to the 131 staff members identified to ask for their reason for accessing the records. This is described in the Information Report as the Trust seeking to *verify legitimate access*. Unsurprisingly, we were told that there would be a legitimate reason for *all* medical staff engaged in a patient's care to access their records, save for if a medical professional accessed the records significantly after the patient's death and was unable to explain why there was a need to do so at that time.

19. The vast majority of the responses from staff aligned with this: they had obvious clinical reasons to access the records. There was a degree of incredulity among some medical staff at the Trust's request that they explain why they had accessed the notes of a patient under their care.

20. We were told that two names stood out from the list of 131 as having potentially illegitimately accessed the records. One had accessed the record significantly after Mrs W's death. However, this individual later provided an explanation that was accepted by all in the process to be legitimate. The other was a medical secretary, who subsequently provided the explanation that she might have been asked to access the records to obtain information for a clinician, naming two by way of example. As this was subsequently disputed by both clinicians,

she became a suspect in her own right as well as bringing the clinicians she had named into question as well.

21. The Information Report issued in March 2019 concluded that a *robust review of the Trust's IT systems to ascertain a staff link to the inappropriate access to the patient's demographic details* had not been able to conclusively identify the person responsible. However, it did identify a *cohort of staff names who did have access, **but the findings were inconclusive as these staff also had legitimate access to the patient's records***. In consequence the matter was passed to *the Trust's Human Resources Department for decision if any staff disciplinary action or further investigation is required.*

Findings: The initial response to the anonymous letter

Whilst it is acknowledged that the Trust were under an obligation to investigate the letter as evidence of a possible data breach, that was only was only one aspect of the matter. Another was why any of their employees would choose this device to raise a potential patient safety matter (at its heart the letter was advising the patient's widower to ask questions about his wife's care). That second question – about the quality of the patient's care - was in fact already the subject of a SIRI investigation and to be considered by the coroner but it appeared that the letter writer was not aware of those investigations already in hand. In the interim the Trust's efforts to identify the letter writer were controversial and fundamentally flawed.

22. The sending of an anonymous letter to a grieving widower was condemned by clinicians and managers alike. Whatever questions existed in the mind(s) of the letter writer(s) about the events referred to in the letter, no-one thought this was an appropriate way of raising such concerns.

23. However I agree with those attending the Medical Staff Committee meeting in September 2019 (see paragraph 87 below), who were concerned that the main issue should not have been the identity of the letter writer: We were told that *as a group of doctors it wasn't that we were that interested in who had written it, it was more why has somebody and nobody is interested in why somebody has written this letter.* The concerns set out in the anonymous letter were in fact ill-founded (since there is no suggestion that Dr A was personally at fault in the care of Mrs W). However, the fact that the writer had gone to such lengths to attempt - anonymously - to encourage Mr W to raise the appropriateness of the way in which the self-medicating incident had been dealt with suggested that the writer was not confident to raise their concerns more openly.

24. The CEO, DWC and COO have all stressed to me that they interpreted this letter as a malicious attempt to undermine colleagues, and that there was no

alternative explanation for the motivation behind it, because both the self-medicating incident and the issue of the arterial fluid error had been appropriately investigated and dealt with. Because it represented a potential data breach, was a breach of professional codes and ethics, and had seriously distressed the family of a deceased patient, they saw no alternative other than to identify who had written it. The CEO has told me that *it would be very difficult to further clarify the reasons for the malice, without identifying whose malice this was.*

25. Whilst I am not disputing that this was their sincerely held view, their interpretation discounts a second explanation for the motivation behind the anonymous letter, which in my view is the more likely one. Two events, both involving Dr A, are referenced in the letter: the self-medicating incident described in chapter 5, and the use of the incorrect arterial fluid in the treatment of the late Mrs W described above.

25.1. in the case of the **self-medicating incident**, whilst I have described (in chapter 6) my concerns about the handling of this incident when it first came to light, an MHPS investigation and disciplinary process had been followed. But it was rightly treated as a confidential staff matter, and therefore those among the Operating Theatres Staff (in whose name the letter was signed) who had heard about the incident may well have been unaware how it had been dealt with.

25.2. On the matter of the ***mistake with the fluid into the arterial drip in theatre***, some of the staff who heard about the incident may have been unaware of the comprehensive investigation into it conducted by a senior consultant anaesthetist, in which no blame was attached to Dr A in any respect. (Nor, later, did the coroner find this to have been an error for which Dr A was responsible.). They will almost certainly not have been aware of the Duty of Candour disclosure about the incident to the deceased patient's family.

26. It is therefore completely possible that the letter writer or writers were unaware of the actions taken in response to the two incidents and may genuinely have believed that there had been some kind of *cover up,* that needed to be exposed.

27. The letter should have presented the opportunity for further reflection. Given the strength of feeling it suggested, it would have been sensible to consider what other possible motive there might have been behind the letter apart from malice.

Whilst the anonymous letter will have caused clear distress to the patient's family, the decision to seek to identify the letter writer was impractical and unwise

28. I find that the Trust Executive's decision to seek to identify the letter writer, whilst the letter had clearly caused distress to Mrs W's family, was ill-advised, for two reasons:
    28.1. It was impractical: it would be, as one interviewee put it to us, *like looking for a needle in a bunch of needles*
    28.2. Whilst this was not a case of Speaking Up in the context of the Freedom to Speak Up policy - the concerns having been raised to a patient's family rather than anyone in an official NHS capacity - to seek to identify someone who had raised concerns about patient safety was not in the spirit of an open culture where staff are able to raise concerns freely. The nature of the investigation that was conducted could well be damaging to the open and transparent culture in relation to reporting patient safety concerns that all Trusts in the NHS should be seeking to nurture.

29. It would indeed appear – in the words of one interviewee, which reflected the views of others we interviewed - that *the organisation was hell bent on finding somebody to say you sent this ….don't worry everybody it is all this individual* and *not a wider issue when in fact we know …that there are much wider concerns held not just in the anaesthetic team….about the way in which cases previously have been handled.*

The initial investigation to uncover the letter-writer's identity through analysing access to electronic patient records was flawed and not fit for purpose.

30. There were fundamental problems with the initial part of the investigation, because it started off on a double mistaken premise: that the letter writer would have needed to access the electronic records in order to find Mr W's address, and that all of those who had accessed the electronic patient records could be identified. Thus, it was assumed, it would be possible to draw up a list of possible suspects from trawling through the digital records. However, as noted above, the trawl did not account for anyone who could have established Mr W's address from paper records and sticky address labels, nor did it take account of the open access terminals in theatres, where such data could be accessed using a generic login. We were told by one witness that *these are all intelligent people…. They wouldn't access it under their own login anyway.*

31. I concluded therefore that the investigative method pursued was flawed and not fit for purpose. Whilst the staff members directed to undertake it did so in good faith, we were told that *this isn't a scientific approach, and the team would have been aware that there were generic logins.* Further, another witness involved understood it was but one component of the investigation (albeit they were not aware what other steps might be in contemplation). In the event their presumption that other avenues were being explored was ill founded.

No objective or reasonable rationale has been supplied as to how the initial list 131 suspects was then narrowed down to seven. In the event, four of the seven individuals singled out for further investigation were those who had raised concerns relating to Dr A.

32. Following the IG investigation, many organisations in the NHS might have concluded they would not be able to identify the author of the anonymous letter. However, in this case, those directing the overall investigation – the COO and DWC- decided to take the investigation to the next stage.

33. It appears to have been recognised that it would not be practicable to investigate 131 individuals, especially as the vast majority had been directly involved in the care of Mrs W. There had to be a way of reducing the number.

34. We were told by one senior interviewee that the 131 names were *sieved at a high level.* The DWC told us that the criteria for deciding to investigate individuals further included those *amongst that 131, who would have known about Dr A.* This was confirmed in interviews with several of those involved in the investigation: people were picked out because they were believed by the executive team to have been aware of the self-medicating incident. This was despite the fact that, according to several of our interviewees, relatively few members of staff within anaesthetics and operating theatres would **not** have heard something about the self-medicating incident.

35. In August 2019, this approach was further confirmed in the criteria for selection of those to be investigated, as stated in a letter from the COO to the British Medical Association (BMA):
    35.1. *The Trust considered … had full knowledge of the issues referenced in the letter…*
    35.2. *Or the members of staff [who] appeared to have no valid reason to access the electronic file*
    35.3. *Or their name was provided by another individual as potential justification of why they had accessed the record.*

36. Ultimately seven names were identified for further investigation, of whom five were consultant anaesthetists, all of whom had provided verifiable and legitimate reasons for accessing the electronic patient notes. The consultants included two who had Spoken Up (Drs E and Dr C), the author of the original Datix on 22 March 2018 (Dr B), and a fourth who had earlier raised other concerns about Dr A in addition to being named by another suspect who said that she may have accessed the electronic notes at his request.

The next stages of the investigation

37. On 25 March 2019, the Trust's Deputy COO, was appointed by the COO to conduct the next stage of the investigation into the identity of the anonymous letter-writer. The Terms of Reference he was given provided that the *allegation* to be investigated was singular, that *an inappropriate letter was sent to patient W's husband*. The Terms of Reference also sets out the steps to be taken by the Case Investigator, including *in the absence of any admissions from witnesses, seeking their consent to provide fingerprints and samples of their handwriting.*

38. The Deputy COO did not have any experience of conducting or reviewing a forensic exercise, such as fingerprinting or handwriting analysis, and he was not given any training for the purposes of the investigation. He was however supported by a colleague from the DWC's HR team and I understand that the Trust took external legal advice on the investigation.

39. The Deputy COO was provided by the COO with the list of seven names for further investigation. However, he was unaware of the detail of the investigation process and did not know at the time that the majority of the individuals had already given legitimate reasons for having accessed Mrs W's electronic records. Nor was he made aware, in the case of two of the consultants on the list, that at the time the anonymous letter was posted in Peterborough, one was on compassionate leave overseas, and the other was unable to leave home as they were confined to bed following surgery.

40. The Deputy COO proceeded to conduct interviews in April and May 2019 with six of the staff members on the list. Dr C, who at this point was on extended sick leave, was not interviewed.

41. Dr C asked that her response to the email she had supplied in the context of the information governance investigation be used by the Deputy COO. This was that *I looked after Mrs W on Intensive Care and have documented entries on metavision there. I also met her husband and have noted that in the relatives' section on metavision*. Dr C had not accessed the patients' notes after 30 August 2018 and denied having sent the letter.

42. We have spoken with all of the staff members who were interviewed by the Deputy COO having accessed Mrs W's notes. All denied sending the anonymous letter. All except one were extremely upset and/or angry at the treatment they had received from the Trust in this process which they had found highly stressful. They considered that the allegations against them were baseless and that there was no fair cause to have raised them. Comments made to us included:

    42.1. *I've been very injured by this awful process*

42.2. *I thought they were going to fit me up…. they decided they were going to get someone and …make an example of someone…I put the house on the market*

42.3. *It just felt like a kangaroo court*

42.4. *I felt that if I didn't take part in these meetings that the conclusion would be 'she is an easy person to pin this on'.*

43. Throughout the interview process, the COO was provided with informal updates and she was made aware that the interviewees were hurt by and angry about the process and allegations they were facing.

Fingerprinting and handwriting analysis

44. As noted above, the Terms of Reference for the investigation into the anonymous letter specified that fingerprinting and handwriting samples were to be used to identify the writer if none of those under suspicion confessed.

45. Unbeknownst to Dr C and her BMA representative was that the DWC had in January 2019, whilst the initial investigations were being undertaken, sent a single sample of handwriting for analysis. The DWC told us that she noticed that the envelope containing the anonymous letter had handwriting similar to that on an envelope which had contained the petition initiated by Dr C about junior doctor payments in July 2018, seven months previously (further discussed in chapter 7). The DWC had kept this envelope. The notes of the Day 2 Catch Up meeting (of the team carrying out the initial investigation) on 31 January 2019 record that this envelope, along with a photograph of the envelope sent to Mr W, had been sent to a handwriting expert engaged by the Trust, with an estimated turnaround time of 2-3 weeks.

46. The DWC told us that she did not know who had written the envelope which contained the petition, and that she was *not pointing the finger at* [Dr C]. She had simply come across the envelope in her office and believed the writing on it was similar to that on the envelope addressed to Mr W, which is why she thought it would be helpful to have it analysed by an expert.

47. On 14 February 2019 the Trust received a letter from the handwriting expert who had reviewed the two envelopes. He noted that his analysis was *very restricted due to the limited amount of handwriting available for comparison* (NB: the writing on the petition envelope consisted only of two words i.e. the DWC's name), but despite this he found there was *moderate evidence to show that the same person is responsible* for the handwriting on both envelopes.

48. However, in the attachments to his letter, the handwriting expert explained that he used a scale of opinion adopted by most forensic document laboratories in the UK: *moderate' evidence is 4th out of 5th on this scale, with 'conclusive evidence' – 1st on the scale – offering the highest level of assurance.* He goes on to say, in describing the range of opinions he uses (which is the scale of opinion agreed by the Forensic Science Service in the UK) that *moderate evidence starts at the point where inconclusive is not sustainable, because there are factors that indicate more one way than another, but does satisfy the requirement of the Civil Court, meeting the burden of the balance of probabilities…there is not enough material to support a definite conclusion or …there are some indications of similarity or dissimilarity but not enough to identify conclusively or exclusively.*

49. There then followed email correspondence among the Trust investigation team about the possibility of sending a larger amount of handwriting and asking for an *upgrade* in order to have a *higher-level analysis to give a greater level of assurance.* Notwithstanding the DWC's statement to us (paragraph 46 above) that she did not know whose handwriting was on the envelope that had contained the petition, she then obtained a scan of Dr C's handwriting and asked that it be sent to the handwriting expert.

50. In an email to the COO dated 15 February 2019 which I have seen, the Governance Manager raised concerns about this:
    50.1. The sample of handwriting contained too much personal information and to send it off might (in the view of the Trust's IG Lead) be a *breach of personal data.* But also,
    50.2. he warned that sending a sample of handwriting from just one person, *if this becomes nasty…. could reflect badly on the Trust* and that instead *samples should be sent from all people identified*…. *this would then at a later date look like we are not just singling out any one individual*.

51. In the event, that second handwriting sample was not sent off at that point. The Trust decided not to rely on the first piece of analysis, and no more handwriting samples were sent for analysis until the end of August 2019, once all those in the group of seven apart from Dr C had been interviewed by the Deputy COO.

52. During the interviews in April and May 2019, the Deputy COO asked the participants (one of whom had by this stage left the Trust's employment) if they would agree to being fingerprinted and provide samples of their handwriting. This request was followed up in a letter. The Deputy COO told us that the responses ranged from unhappy to reluctantly compliant. Where individuals refused, the Deputy COO repeated the request.

53. Ultimately, all refused to provide fingerprints, save for one consultant. (The subsequent analysis showed that the fingerprints on the envelope did not belong to that consultant).

54. Those who had refused their consent received a letter from the COO in early August 2019 seeking their *rationale*. They were advised that the purpose of seeking reasons for refusing to provide consent was to enable the Trust to complete a Data Protection Risk Impact Assessment, because of the Trust's *duty to identify and mitigate against risks that might arise in relation to the rights and freedoms of data subjects*. They were also warned that *any refusal to provide a rationale and/or inadequate rationale could have a relevance to the fact-finding investigation and any further investigations… it could be evidence which implicates you as being involved in the writing of the letter.* The COO thus made clear that the Trust was willing to draw an adverse inference from a refusal to share biometric data.

55. The BMA responded on Dr C's behalf on 9 August 2019, objecting to the Trust's approach and noting that the tone of the letter was intimidating and designed to cause distress. It stated that the request/expectation [was] *highly controversial ...which goes well beyond what an employer can reasonably expect of an employee as part of a fact-finding* [exercise] *...this is not a criminal investigation.* They did however go on to confirm that Dr C would agree to a sample of her handwriting being used.

56. A similar letter was sent on this date by the BMA on behalf of other consultants who had refused or rescinded their consent to fingerprinting.

57. The two consultants who in the meantime had stressed that they could not have posted the letter in Peterborough on 15 October, one having been overseas and the other immobilised post-operatively, received letters on 12 August 2019 advising them that they would no longer be required to be involved in the investigation.

58. In response to the BMA letter of 9 August 2019, the COO replied on 16 August, accepting that the use of finger printing and handwriting analysis was unusual in an employment context but that the Trust had *no other options in terms of gathering evidence during the investigation*. It also confirmed the three criteria for including individuals in the group of seven for further investigation (see paragraph 35 above).

59. The Trust subsequently sent samples of handwriting for analysis by their handwriting expert for Dr C, Dr D, Dr E, Dr B and the member of staff who had retired. Dr D's and Dr B's handwriting was included despite their having been advised they were no longer part of the investigation. It is not clear what

happened regarding the handwriting of the remaining sixth suspect: he was later advised that his results had not come back but despite that the Trust had concluded he had not written the letter.

60. The request for fingerprints was eventually dropped by the Trust, following an internal backlash. I have seen no record of this decision, but it had been made by early October 2019 when the Chair of the Trust and CEO attended a meeting of the Medical Staff Committee (see paragraph 87).

Outcome of the investigation into the anonymous letter

61. The investigation report into the anonymous letter was produced by the Deputy COO on 16 September 2019 (the Letter Report). It concluded that there was no evidence to suggest that the anonymous letter was sent by any of the six staff members he had interviewed, save for one interviewee. As noted above, he had not interviewed Dr C.

62. In relation to the one interviewee still under suspicion the Deputy COO concluded that she did **not** have a legitimate reason for accessing Mrs W's notes, because the individuals she had cited as having possibly asked her to access the records on their behalf did not recall this. Nonetheless, the Deputy COO went on to conclude that there was evidence to suggest that the anonymous letter was not sent by her, because the handwriting analysis produced a result that it was *more likely than not* that she was not the sender.

63. In relation to another initial suspect the Deputy COO concluded that there was *no evidence to suggest* that he sent the letter. However – whilst I agree with that conclusion - insufficient evidence is provided in the Letter Report to support it. Additionally, his handwriting does not appear to have been submitted for analysis: there is a note (apparently a placeholder) in the Letter Report which states *need to be able to confirm the handwriting position*. No explanation was provided of the inconsistent treatment of this individual compared to other staff.

64. Dr C was on sick leave while the interviews for the investigation were taking place, and the Letter Report recorded that it had not been possible to interview her. However, she had replied to the email sent in January 2019 as part of the initial information governance investigation asking her reason for accessing Mrs W's records. As noted above, she had explained that she had accessed the records because she looked after Mrs W on the ICU and for reasons relating to speaking with Mrs W's family. This was is in line with the explanation offered by the other clinical interviewees in both the information governance investigation and the anonymous letter investigation.

65. The Deputy COO's report concluded that ***having reviewed what information is available and the advice of the handwriting expert….*** *there is evidence to suggest the letter received by [Mr W] was sent by* Dr C. It noted that she had accessed the patient records and had *prior knowledge of the allegations as described in the letter.* The handwriting expert's report states he had found a *significant number of similarities… whilst these similarities are limited, they demonstrate some unique characteristics and therefore, where they appear together on the same specimen handwriting, it would indicate that it would be more likely than not that the same person is responsible for the handwriting on… the envelope.*

66. The Deputy COO stated that Dr C was *the only individual for whom [there is] evidence to suggest she sent the letter*. However, he stressed to us that he was careful not to *provide any weight to that evidence or to say this is irrefutable evidence* in relation to Dr C. He considered that there would be more information to be provided. Critically, the Letter Report did not state that Dr C **was** the author of the anonymous letter. However, it did identify her, and only her out of the group of six, as a possible sender.

Findings: the next stage of the investigation

The investigation adopted an intimidating process that distressed and damaged individual staff members

67. As the conclusion to the investigation was delivered much later in the year than the interviews, the allegation that each staff member sent the anonymous letter hung over the suspect staff members' heads for over half a year. I received evidence that this delay amplified their distress and anger. The conduct of the investigation had a profoundly stressful and disturbing impact on the seven individuals who had been pursued. From their interviews with us, I was left in no doubt that all but one remained hurt and upset over a year later and did not feel that the apologies given later by the CEO were sufficient.

68. There were a number of aspects of the investigation that were intimidating to those subjected to it: in particular I find that the letter was sent to the six individuals asking them for their rationale for not consenting to provide biometric data in order to avoid the inference that they had in fact written the letter was intimidating.

69. This provoked the BMA representatives of at least two of the doctors to raise objections, in a letter dated 9 August 2019, at this *heavy-handed approach,* which had caused *significant distress*. In her response dated 16 August 2019, the COO stated that *the recent letter…was not designed to cause distress* and

had been intended as *an explanation of the next steps…and the potential repercussions for non-engagement in the investigation.* She agreed to *carefully consider the tone and content of future communications.*

The sending of one sample of handwriting for analysis six months earlier than samples from other staff under suspicion was a highly irregular step for which no credible explanation has been given. One inference is that Dr C was being unfairly targeted

70. Several interviewees told us, independently of each other and in the strictest confidence, about the DWC's decision to send a single sample of handwriting for analysis in January 2019 and believed it suggested that that there was an assumption that the anonymous letter had been sent by Dr C. The fact that this sample was sent so early on in the investigation process – weeks before even the initial IG investigation had been completed, and six months before the Data Protection Impact Assessment checklist was completed – was a surprise to me. No information about this was included in the documentation initially supplied to me by the Trust. It was only when, in an attempt to understand the initial investigation process, I requested copies of all email correspondence about it between those involved, that I found the evidence that this initial sample had been sent.

71. I noted in paragraph 49 above that we were told it was not certain that it was Dr C's handwriting on the envelope in question. However, on learning that that envelope did not contain a sufficiently big sample of handwriting, the DWC immediately identified a sample of Dr C's handwriting (and no one else's) and proposed that it too be sent to the handwriting expert for analysis – until objections were raised in an email we have seen from within the team which expressly warns that they could be targeting a single individual. That leads me to conclude that the decision by the DWC to send a single sample of handwriting, was highly irregular and a matter of grave concern.

72. Overall, I have concluded that the forensic investigation led by the COO and DWC was highly flawed. No explanation has been provided as to the objective basis for reducing the initial 131 suspects to a shortlist of 7, nor for the decision to pursue an investigation underpinned by an IG analysis disregarding the many ways the address could have been obtained without leaving a digital footprint. The conclusions drawn were not robust for the reasons set out above.

73. Although the Deputy COO had before him a conclusion reached on the balance of probabilities by the handwriting expert, there were obvious flaws in the process leading to that conclusion. I consider those flaws to be material and to have undermined the robustness of the analysis, and the use to which it has been put by the Trust. Namely:

73.1. The COO and DWC elected to send five samples of handwriting for analysis. These were from individuals the Trust already suspected (as set out above, without neutral valid reason). The universe of individuals who had accessed Mrs W's records was far larger (201). As noted above (paragraph 65), the conclusion on Dr C's handwriting was that there was only *moderate evidence* that she wrote the anonymous letter envelope. There were three levels of conclusion that would have provided **stronger** evidence, described in the Range of Opinions as Conclusive Evidence (the strongest, with no doubts), Very Strong Evidence (satisfying the criminal burden of proof without the need for corroboration), and Strong Evidence (which would satisfy the requirement of a Civil Court and is, according to the handwriting expert, *equivalent to the term 'probable'…I cannot completely exclude the possibility that another person was responsible)*.

73.2. That there was only Moderate Evidence that Dr C was said to have written the anonymous letter envelope, means that it is quite possible that **other** staff members within that 201 number would, had their handwriting samples been analysed, be determined to be similar to the writing on the envelope of the anonymous letter, on the balance of probabilities. It is important to make this point because both the CEO and COO have stressed that the handwriting expert concluded that it was *more likely than not* that Dr C wrote the letter; but this ignores the context in which there are three higher standards of likelihood and that this was the lowest possible level of evidence.

73.3. There is no evidence that the Trust sent one of the suspect's handwriting for analysis. The Report stated *need to be able to confirm handwriting position* (yet, despite this inconsistent process, concluded that there was *no evidence* to suggest the anonymous letter was sent by that suspect). This further reduced the cohort size, and in particular took out a staff member whose explanation for access to the records – as it happens - was weaker than Dr C's.

74. For the reasons set out above, there was an insufficient evidential basis to pursue Dr C in this way. I conclude that it was wrong to proceed to include the allegation that she had written the letter in the MHPS disciplinary investigation which by that time was already underway.

The allegation that Dr C sent the anonymous letter becomes a disciplinary matter

75. By the time the investigation was completed, a disciplinary investigation under the MHPS process for NHS doctors had been launched against Dr C in March 2019, details of which are considered further in chapter 11. Notwithstanding the flaws in the investigative process the Letter Report was used by the Trust to add an allegation that Dr C had written the anonymous letter. On 24 September 2019, the COO wrote to Dr C's BMA representative and stated that

following the *fact-finding investigation*, a *further concern has been added to the Terms of Reference in the MHPS process*.

76. On 25 September 2019 Dr C requested disclosure of the Trust's handwriting report, and when this was initially refused, she requested the reference sample and comparative samples of handwriting so that she could commission her own analysis by an independent expert. She denied writing the anonymous letter and wrote that she felt *absolutely persecuted.*

77. Responding on 3 October 2019, the COO stated that the Trust was in a *highly unusual position* which accounted for the *highly unusual request from an employer* to fingerprint its employees; she goes on to say that as Dr C had already indicated she would be unwilling to consent to fingerprinting, *it is not my intention to pursue this further unless you wish to.* She attached a copy of the handwriting expert's report, in confidence.

78. Dr C then proceeded to commission her own expert report from an independent forensic scientist who is an approved member of the UK Register of Expert Witnesses. He asked Dr C to produce a number of different samples of her handwriting. On the basis of his analysis, he produced an unqualified opinion: that [Dr C] *was not the author of the writing on the envelope.*

79. Dr C forwarded the report, which was dated 5 October 2019, to the Trust and to the External Investigator (ExIn2) who by this point had been appointed to carry out the formal MHPS investigation into her conduct (see chapter 11 for further details. The Terms of Reference for this MHPS investigation included the allegation that Dr C sent the letter to Mr W. ExIn2 noted the *clear conflict of opinion between the two expert reports* but nevertheless went on to conclude in his final investigation report that *there was evidence that would appear to offer reasonable support upon which a reasonable belief in the allegation could be sustained.* In support of this conclusion, he referred to:
    79.1. The fact that *access …to the relevant patient data and address was limited and included* [Dr C].
    79.2. [Dr C's] unwavering *and undeterred pursuit of the (Dr A) issue despite GMC and other reassurances….*
    79.3. Dr C' s *persisting and unwavering view that* [the MD] *got it wrong.*
    79.4. Her suggestion that [the MD] had *softened the facts chimed with the suggestion of concealment* in the anonymous letter.
    79.5. Limited access to the instructions that Dr C's expert witness had been given
    79.6. The fact that he relied on new handwriting samples, and this was not a *true blind test.*
    79.7. The lack of objectivity in Dr C's instruction of her expert.

Findings: the outcome of the investigation

The conclusion that Dr C wrote the letter was not robust. It was based on a flawed internal investigation, and at least in part based on her having Spoken Up.

80. As noted above, I have concluded that the investigation into the anonymous letter was so flawed as to render its conclusion insufficient to justify the addition of allegations in relation to it. Regarding the conclusion in the draft MHPS report that Dr C was the author of the letter, I conclude that:
    80.1. it was based on an unsound and flawed internal investigation.
    80.2. aside from the handwriting analysis, which did not provide conclusive or strong evidence, the other reasons leading the investigator to conclude that it was reasonable to believe Dr C was guilty of writing the letter were circumstantial at best and based on the concerns about which she had spoken up; and
    80.3. three of ExIn2's conclusions in the draft MHPS report related to Dr C's continued Speaking Up about the self-medication incident. Thus, the potential victimisation of Dr C for having Spoken Up was continued in the context of a formal disciplinary investigation.

All the evidence presented to me suggests that Dr C did not write the anonymous letter

81. I am not required to determine who sent the anonymous letter. In common with multiple interviewees, I do not consider that to be a feasible task. However, I note that evidence has been presented to me in the course of this Review that materially indicates that it was **not** Dr C who was its author. As the Trust has not followed a valid or fair process to charge Dr C with sending the letter, this is particularly significant.

82. First, Dr C was open in raising her complaints to senior members of the Trust. She did not shrink from these challenges, and it is inconsistent with this to seek anonymity.

83. Second, an assumption was made that Dr C accessed Mrs W's patient records in order to find her home address. However, the spreadsheet compiled by those who undertook the IG investigation referred to above notes that she did not look at the notes after Mrs W's death. The suggestion that she noted down the address after counselling Mrs W's relatives shortly before Mrs W's death at the end of August 2018, in order to use it to send an anonymous letter more than six weeks later, on 15 October 2018, is implausible.

84. Third, it does not cohere with the timeline of events:
    84.1. Dr C was off work with stress in September and October 2018 and whilst on sick leave would not have had access to the records in the period running up to the date upon which the letter was sent; and
    84.2. She was, however, engaging with the SID and the DC (as I have set out in chapter 8). On all witnesses' accounts, these discussions were very positive. Accordingly, at the time of the despatch of the letter to Mr W, Dr C considered that two NEDs were positively responding to her concerns and that she was being listened to (the fallout in terms of the commissioning of a report from ExIn1 had not yet occurred). There was therefore no motive to go outside of this formal, constructive channel (direct to the Board) by writing an anonymous letter to a deceased patient's family.

85. Finally, there has never been a suggestion that Dr C has acted inappropriately with a patient or a patient's family. Everyone we interviewed who had knowledge of her practice agreed that she is an excellent clinician. It is inconsistent with this that she would seek to send what is obviously a very distressing letter to a grieving family (with whom she had spoken, as she noted in the records around the time of Mrs W's death).

Wider reaction from the staff at the Trust

86. As the Trust pursued its attempts to identify who had sent the anonymous letter, the traumatic effect their investigatory style and approach was having on members of staff affected became evident.

87. The Medical Staff Committee (MSC) met monthly. Its agenda was divided into routine business and reserved business. The convention was that the MD attended the first part of the meeting discussing routine business and then left.

88. At the meeting on 10 September 2019 the agenda followed that usual pattern. When the MD left the meeting, Dr E then stated that she wanted to tell the meeting about her experience of the investigation which was seeking to identify the author of the anonymous letter.

89. Dr E told the meeting that: *My grave concerns are about the culture that appears to exist within the senior leadership team and the Trust. …A specific patient safety incident occurred about 18 months ago. I raised my concerns through all the correct channels, including CD, MD, CEO and then NED. Subsequent to this, a patient's family received an anonymous communication, outlining the same patient concern. The trust has chosen to investigate this communication by looking at those who accessed the patient's notes and correlating these with those who had knowledge of the incident, which by*

definition, included a group of consultants who had raised concerns. As a result, this group has been singled out and have been communicated with, by senior executive members of the Trust, in a way that has been described by the BMA, the MDU and the MPS, as 'highly controversial' and 'unprecedented' in terms of the tone of letters which have been intimidating, and have implied that the refusal to give biometric data (including fingerprints) implies being involved in the anonymous communication. I think this goes well beyond what one would expect from an employer, particularly an employer which prides itself on its culture of 'speaking up'.

90. According to the minutes of the meeting *numerous other consultants related episodes where they had felt similar things ranging from being ignored to outright bullying. Most consultants admitted that they had generally kept these episodes to themselves…There seemed to be a general feeling that raising concerns was not in fact encouraged by the executive team. Many people felt that speaking out would only cause trouble for themselves. There was a general perception that the executive team's default response was to be defensive and protect themselves and the trust's reputation…*

91. At the conclusion of the meeting, the MSC directed the MSC Chair to send a letter to the Chair of the Trust which was dated 10 September 2019 and read *At the Medical Staff Committee of 10 September 2019, grave concerns were raised by multiple departments in regard to the culture and behaviours within the executive body of the Trust, which have not seemed to endorse the Trust values of freedom to speak up on multiple occasions.*

92. The Chair of the Trust told us that she was advised informally that *there had been some very strong views put initially by a few individuals…. there was great agitation around it and of course the whole … issue around fingerprinting was pretty inflammatory ….and that's understandable*. She was not alone. We were told by several consultants that they approached the CEO and some members of the Trust Executive in an attempt to dissuade them from the chosen path of asking staff for their fingerprints and handwriting samples in a hunt for the anonymous letter writer: described to us as *totally bizarre and inexplicable.* This included the CDA and the Deputy MD who approached the MD in mid-2019 to make him aware that relations in the anaesthetic department were becoming fractured as a result of the approach the Trust leadership were taking to the anonymous letter investigation.

93. The Chair of the Trust responded to the MSC Chair's letter, to suggest that both she and the CEO attend the next MSC on 8 October 2019. The meeting was well-attended and, we were told, *well behaved.* There was discussion of the anonymous letter and whether it constituted a data protection issue and the extent to which it was an act of whistle blowing. The CEO in summing up from

his perspective was noted to have said he wanted to be seen as a *values driven and listening Chief Executive…..it doesn't mean the Executive Team always get it right,* and in discussion afterwards it was noted that the CEO appeared to have *developed a willingness to move forward,* and had shown a *reflective tone.* He also attended the November 2019 MSC meeting where we were told that *he assured the meeting that the issues had been picked up and were being addressed by the Board and the Executives…..we had been given a whole load of resources for freedom to speak up.*

94. We were told that, amongst other things, the MSC sought clarification from the Board members as to how they handled whistleblowing incidents and expressed the view that the first question should have been why the anonymous letter was written rather than who had written it. In response to a specific question posed by one of the attendees, as to who they should go to if they had concerns about the MD, the MD is recorded as responding *you go to the Chief Exec and if you have no confidence in the Chief Exec you go to the Chair*. I would observe that that is what Dr C, in writing to the Chair in July 2018, had done.

95. It was during this period – September/October 2019 – that the CQC inspection took place at the Trust. The CQC's report, published in January 2020, downgraded the overall Trust rating from Outstanding to Requires Improvement, noting in the *Well-led* domain that

95.1. Not all staff felt respected, supported and valued or felt that they could raise concerns without fear. Communication and collaboration to seek solutions had not always been effectively undertaken. An open culture was not always demonstrated.

95.2. The style of executive leadership did not represent or demonstrate an open and empowering culture. There was an evident disconnect between the executive team and several consultant specialties.

96. The Guardian newspaper published a story on 11 December 2019 which reported on the MSC's approach to the Chair of the Trust, and that the Trust had sought to finger-print its staff, in a threatening nature with a focus on apportioning blame. It also reported that *senior staff…have privately passed on serious concerns to the CQC* about the ability of staff to raise concerns about patient safety.

Findings: The decision to seek to use biometric data

The decision to use fingerprinting and handwriting analysis in an NHS hospital, in the context of an anonymous letter and where no crime has been committed, was highly unusual and without doubt extremely ill-judged

97. I have been unable to establish any precedent for the use of biometric data in a non-criminal investigation in the NHS, despite asking a number of our witnesses. I find that the decision to seek to use fingerprinting and handwriting analysis in an investigation to identify an anonymous letter writer, in the context of an NHS hospital, was ill-judged. It is astonishing that it was pursued over a period of time without apparently any suggestion or reflection on the part of those Executives directing the process that it might be inappropriate. I do not disagree at all with the CEO's own view expressed to us in September 2020 that there is *clear learning to be had.* He put it in *the context of the sheer awfulness of the letter* [to Mr W] *,…the data breach, the fact that there had been police involvement already and they had provided fingerprint samples, the ongoing coroner's proceedings…all meant that organisationally and personally we didn't give enough thought to the severity of what we were embarking on and the impact on staff…those directly involved have received a personal written apology for the stress and upset caused.* From interviews with several witnesses, however, I know that concerns were raised by various senior members of clinical staff directly to the CEO and other Directors whilst the Trust was still seeking biometric data, but despite that, the process ploughed on until September 2019.

Whilst the executive directors, the Chair, and one of the non-executive directors were aware of the proposed use of biometric data, other non-executive directors we interviewed did not learn of it until media reports started to appear in December 2019. Even then – and despite the reputational damage being done to the Trust – the Board did not discuss it because by then it related to a live disciplinary process.

98. The existence of a Unitary Board, with non-executive directors who are not operationally involved in the stressful day to day process of managing an NHS hospital, is intended to be a means of bringing different and wider perspectives to the table. Had there been a discussion around the Board table about the anonymous letter and the proposal to use biometric data as part of the investigation, it is possible that there might have been second thoughts. I have not been able to find any evidence of such data ever being used before by an NHS organisation as part of a non-criminal investigation and in this instance, it had a profoundly adverse effect on a number of individuals caught up in it.

99. Although the decision to use biometric data originated with the Directors leading the initial investigation, having been written into the investigation Terms of Reference in March 2019, it was clearly known about by other members of the Trust Executive at the latest by July 2019. However, it would appear that the only non-executive Board members briefed on it were the Chair, and a NED

who was asked to oversee both the anonymous letter investigation and the MHPS investigation in respect of Dr C. We were informed that the decision to pursue fingerprinting of Trust employees was not discussed by the full Board until it came to light in the national press in December 2019. Given the controversial nature of the investigatory techniques being pursued, I found this surprising. We were told that the anonymous letter investigation was being pursued in accordance with MHPS confidentiality – but there would have been no need to name any of the suspects at the start of the investigation, or before the investigation reached its conclusion in September 2019.

100. Even when the nature of the investigation was reported nationally, non-executive directors raising it at the Board meeting were told it could not be discussed in any detail because it was part of an MHPS investigation and therefore needed to be kept strictly confidential. In my view, this was not correct: whilst by that point the MHPS investigation in respect of Dr C was underway and the allegation that she had written the letter had been included, the appropriateness – or otherwise - of the investigatory technique could have been debated then. But it would have been far better, and more prudent, to have done so prior to embarking upon it.

10: The First External Investigation (ExIn1) Report

Initiation of the Investigation by ExIn1

1. As set out in chapter 8 Dr C Spoke Up to the DC and SID in October 2018. The DC decided having spoken to the CEO and DWC after the Private Board meeting on 2 November 2108 that the respective parties perspectives were so polarised that an independent investigation may be required and, after taking advice from the DWC, decided to commission an independent investigation into two matters which he did not consider he could resolve on the basis of discussions with the CEO, DWC and Dr C. These matters, as the DC informed Dr C in his letter to her of 7 November 2018, were:
   1.1. Dr C's concern about the CEO's and DWC's behaviour in the 31 July 2018 meeting (the first issue); and
   1.2. *the serious concerns which [the CEO and DWC] have expressed about your behaviour and working relationships* (the second issue - together, the two issues).

2. As noted in chapter 5, neither of the above issues related to the matters about which I found Dr C had been Speaking Up to the Chair of the Trust in her email dated 27 July 2018. Dr E and Dr C had both continued to raise concerns about the handling of the self-medicating incident: whilst these concerns overlapped, they were different in that, for example, Dr C had expressed concerns about whether the information given to Dr A's new employer had been softened, and she also pointed out that the GMC's advice would have been based on the information provided to them by the Trust. Dr E's specific concerns had formed the subject of the report to the 2 November 2018 Board meeting by the CEO and DWC (see chapter 8); beyond the assurances (about the information given to Dr A's new employer) given in those reports, however, it is not clear that all of Dr C's concerns as raised in her email to the Chair of the Trust were the subject of an objective investigation as required under the Trust's FTSU Policy.

3. The DC subsequently commissioned ExIn1 to conduct the investigation (the ExIn1 Investigation). He received a recommendation from the Trust's external solicitors on investigators he could appoint. Having made enquires the Trust's solicitors provided a name of an investigator they were able to recommend and had established was available. Having spoken with referees, the DC decided to appoint him.

4. The DC appears not to have been advised that any of the concerns raised in Dr C's email to the Chair of the Trust dated 27 July 2018 remained outstanding. Instead, the investigation he commissioned focused entirely upon the *issues* set out above at paragraphs 1.1. and 1.2. In relation to those *issues* he (and

the Terms of Reference he approved) provided no information about what the *serious concerns* were. Other than being supplied with a copy of the initial Terms of Reference Dr C was given no further details of what she was to be investigated for – other than possibly what had been raised with her in the meeting of 31 July 2018. In the event the investigation ranged over aspects of her alleged behaviour over a two-year period in a number of settings (some of them social) many of which were not raised with her in the meeting on 31 July 2018.

5. By contrast, the CEO and DWC knew the nature of the criticism they had to meet: their conduct of a meeting which had lasted just over two hours some three months before and in relation to which there was scant documentation and, other than them, one sole witness: Dr C herself.

Was the launch of the external investigation compliant with the Trust's FTSU Policy?

6. As set out in chapter 6, the Trust's FTSU Policy provides that no one should be *victimised* for Speaking Up. This includes victimisation in the form of taking or threatening to take performance management or disciplinary action in response to Speaking Up. Although it is theoretically permissible under the FTSU Policy to investigate whether someone has Spoken Up in bad faith, that is never the default position (both because of the high bar for bad faith to be established, and because of the inherent risk of victimisation in pursuing an allegation of bad faith). Any process to investigate bad faith and/or disciplinary or performance management must be addressed **separately from** and **subsequent to** the FTSU process.

7. In this regard, it is significant that the issue of Dr C's conduct was initially raised at the meeting on 31 July 2108 which had been convened in **response** to what I concluded was an exercise in Speaking Up. Some of the allegations about Dr C's conduct and the manner in which they were raised by the CEO and DWC, which questioned her motives in writing to the Chair were objected to by Dr C in the course of the meeting, and subsequently gave rise to her Speaking Up to the DC about the behaviour of the CEO and DWC at the meeting.

8. Further, at least one of the specific allegations raised by the CEO in relation to Dr C's behaviour was that she was potentially Speaking Up in bad faith. The record of his interview with ExIn1 notes that he stated that, in her email to the Chair of the Trust, Dr C had unfairly targeted the MD and the Executive Team; and there was *a perception that part of [Dr C's] motivations was to escalate concerns to the Board in a manner that causes* [the MD's] *competence and judgement to come into question and undermine him*. This was said to be the

case (in part) because she Spoke Up to criticise the MD's and the Executive's handling of the self-medicating incident to the Chair of the Trust (and in his view this criticism was unjustified)

9. Pursuing the *two issues* (the CEO's allegations about Dr C's behaviour – including that she may have written to the Chair of the Trust in bad faith and her allegation about the conduct of the 31 July 2018 meeting) in tandem in the ExIn1 Investigation was thus a significant error in the process. In this regard it is important, and fair, to note that, after consideration, the CEO and DWC had concluded that Dr C had not Spoken Up to the Chair of the Trust - but I do not accept that was a reasonable conclusion to have reached.

10. Dr C's concerns about the CEO and DWC effectively encompassed allegations that their behaviour in the 31 July 2018 meeting either constituted victimisation (in the sense that it arose in consequence of her having Spoken Up to the Chair) or was at the very least inappropriate and had the potential to be victimisation. Dr C had been led to believe the purpose of the 31 July 2018 meeting was to discuss the concerns she had expressed about the handling of the self-medicating incident. Thus, investigating or otherwise progressing the allegations about her prior conduct had the potential to be victimisation of Dr C for Speaking Up; and it also had the clear potential to encompass whether Dr C had Spoken Up in bad faith.

11. The DWC suggested to us that the external investigation was designed appropriately and that there was no intermingling (potential or actual) of the Speaking Up process within it, because the Speaking Up route was *exhausted* when Dr C received the 7 November 2018 letter from the DC. By that stage, the DWC considered the Trust had explained exactly what had gone on and Dr C could not take her allegations any further. I disagree with this assessment (see chapter 8). The issue is whether the Trust was, or risked, victimising Dr C through the ExIn1 investigation, for her previous exercises in Speaking Up. In my view that risk clearly existed.

12. In his report, ExIn1 noted that Dr C had been under a duty to raise her concerns (about the self-medicating incident) under the provisions of (the GMC's) Good Medical Practice. However, he also noted both that Dr C did not check the FTSU Policy before writing to the Chair of the Trust, and that the CEO had taken the view that she was not whistle blowing. On that basis, ExIn1 then concluded that in writing to the Chair of the Trust rather than to the FTSU NED champion, she was sidestepping FTSU processes, and went on to criticise her for making serious allegations without grounds. I have had the opportunity to look in more detail at the events leading up to the email to the Chair, and as I have already explained in chapter 6, notwithstanding the CEO's concerns about her in other respects, I consider that Dr C was raising concerns about lack of,

or poor, response to a reported patient safety incident. That incident clearly fell within the FTSU policy regardless of the policy not having been expressly cited in her email to the Trust Chair.

Was Dr C's complaint about the 31 July 2018 meeting classified by the Trust as a grievance?

13. ExIn1 was offered the opportunity to be interviewed by the Review Team. He declined the offer and instead opted to submit a brief statement.

14. From his report, it is possible that ExIn1 may have understood or concluded that Dr C was raising a grievance about the conduct of the meeting on 31 July 2018 and was therefore outside of the scope of the FTSU Policy. Indeed, the DWC told us she believed that Dr C was raising a grievance about the conduct of the 31 July meeting, not Speaking Up. Further, in March 2019, when the COO was appointed as case manager in the subsequent disciplinary process, she contacted the Practitioner Performance Advisory service (PPA) and, according to the PPA adviser's subsequent letter to her, informed them Dr C had submitted a *grievance under [the Trust's] local policy alleging bullying and harassment* against the CEO and DWC (I will discuss this in more detail in chapter 11). Normally, serious matters of personal grievance are required to be resolved under the Trust's Grievance Policy.

15. However, no evidence was presented to me that the Trust were acting in accordance with its Grievance Policy. First, there is no contemporaneous reference to the Grievance Policy (whether before or after the ExIn1 Report). Second, the Trust received external legal advice on the process around the ExIn1 Investigation. Had the ExInv1 investigation been a grievance investigation it would have been referred to as such and the Grievance Policy followed.

16. Dr C had not raised a "*grievance"*. As a long-standing consultant and a former Clinical Director, she would have known the procedure to do so, and that would not have required any reference to the non-executive lead for FTSU. Dr C had raised a complaint with the non-executive lead for FTSU (or at least the person stated in the FTSU policy at the time to be the non-executive lead) in part because she alleged it was inappropriate for the CEO and DWC to have conducted themselves as they did in the context of a meeting convened directly in response to Speaking Up (although her objection was wider than this). Even if Dr C's actions in writing to the Chair of the Trust had not been motivated by an intention to Speak Up under the Trust's policy (a conclusion the Trust was not entitled to reach without appropriate investigation), the conflict **was** related

to (as the DC, the CEO and DWC later accepted) an exercise in Speaking Up, and could not be neatly siphoned off from that broader context.

17. Accordingly, the design of the ExIn1 Investigation was misconceived from the outset. The conduct of the CEO and DWC about which Dr C complained arose in the context of a response to her Speaking Up and had the potential to be victimisation as defined in the Trust's FTSU Policy. It was then inappropriately intermingled with the alleged behaviour issues raised by the CEO in the course of the meeting. Whether it was so intended or not, those alleged behaviour issues were always potentially a precursor to a disciplinary process, including on matters relating to or overlapping with allegations of bad faith in Speaking Up. Therefore, the Trust connected the disciplinary process to the exercise in Speaking Up – in breach of the FTSU Policy, and in an act of potential victimisation.

18. Dr C did not protest contemporaneously that the FTSU Policy required that a Speaking Up process be kept distinct from a disciplinary or performance management action. Her evidence to us was that had there been an option not to proceed with the ExIn1 investigation she *absolutely wouldn't have done*. However, she did not think that she could object as she had been warned by the BMA that failure to cooperate with the ExInv1 Investigation could lead to disciplinary action.

Findings: the initiation of the ExIn1 investigation

The design of the ExIn1 investigation was unfairly balanced. The DWC and CEO understood the questions about their conduct that were to be investigated, which were limited to their actions in a two-hour meeting, where only they and Dr C were present and of which there is no record. However, in seeking to establish whether the CEO's concerns about Dr C were reasonable, it provided the opportunity for allegations about her behaviour going back over a two-year period to be detailed without the opportunity for investigation as to their veracity. Further ExIn1 later sought clarification of the Terms of Reference from the DC in consequence of which the scope of one of the allegations was widened, without Dr C being informed.

In my view the commissioning of the investigation breached FTSU Policy: in setting out to investigate Dr C's conduct, it inappropriately – and in an act of potential victimisation - connected the disciplinary process to Dr C's exercise in Speaking Up.

The Terms of Reference and Structure of the ExIn1 Investigation

19. The Terms of Reference for the ExIn1 Investigation are dated 22 November 2018. They contain more detail than does the DC's letter of 7 November 2018 summarising the two issues (see paragraph 1 above). I have not been provided with any evidence in relation to their formulation. The DC told us that he took advice from the Trust's external lawyers.

20. The Terms of Reference were: **Allegation 1:** Whether in the meeting on 31 July 2018, conducted by [the CEO], in the presence of [the DWC]:
    20.1. A written list of [Dr C's] professional behaviours was put on the table (which we refer to as the *list of issues*) and, if so, whether or not this was reasonable and/or justified or not.
    20.2. Unfounded allegations were levelled at [Dr C] about her conduct and, if so, whether or not this was reasonable and/or justified or not.
    20.3. [Dr C] was heavily pressured and, if so, whether or not this was reasonable and/or justified or not; and/or
    20.4. [Dr C] was extremely badly treated and/or treated in a way which belied the behavioural values of the Trust.

21. **Allegation 2:** Whether:
    21.1. [The CEO] and/or [DWC] had reasonable grounds to hold and conduct the meeting on 31 July 2018 in the way it was conducted; **and/or (stress added)**
    21.2. [The CEO] and/or [DWC] had reasonable grounds to have serious concerns about [Dr C]'s behaviour, including that [Dr C] was undermining the MD.

22. **Allegation 3**: Whether there are reasonable grounds to be concerned about the working relationships between [Dr C] and senior colleagues and, if so, what impact this may have had or be having.

23. Allegation 2 is extremely broad. Having been drafted in the alternative – using the term *and/or* - it could be upheld if:
    23.1. they had reasonable grounds to hold and conduct the meeting as they did, even if their concerns about Dr C's behaviour were not reasonable; and/or
    23.2. their serious concerns about Dr C's behaviour were reasonable but their decision to hold and conduct the meeting as they did was not reasonable.

24. Allegation 3, as drafted, did not identify the *senior colleagues* to which it referred. ExIn1 sought clarification from the DC in a meeting on 18 December 2018. In their subsequent email exchange ExIn1 noted *We discussed the scope of senior colleagues and in particular whether this extended to the CD and CLA. You confirmed that it did…*That the Trust's own investigator needed to seek clarification of the scope of his Terms of Reference provides eloquent confirmation that they were not clear. I was therefore surprised that, having sought and obtained that clarification neither ExIn1 nor the DC (who provided

it) felt it necessary to communicate that clarification to Dr C. She remained unaware of the scope of his investigation, which now encompassed her relationships with other senior members of the anaesthetic department.

25. This development was not foreseen by Dr C. Given that the CEO and DWC were senior colleagues and she had complained about the way they had arranged and then conducted the meeting of 31 July 2018 she, in my view reasonably, assumed that the third term of reference (or, as it was described, *allegation*) was intended to investigate her working relationships with them. This interpretation was further buttressed by the fact that the Terms of Reference only provided for three witnesses (the CEO, DWC and Dr C).

26. Two additional witnesses were, however, subsequently added at the request of the CEO. This request was made by the CEO to ExIn1 and put by ExIn1 to the DC on 20 December 2018 - approximately two weeks after the start of his investigation, and nine days after his one and only face-to-face interview with Dr C on 11 December 2018. The DC's note of this request to add additional witnesses and his decision in relation to it records: [ExIn1] *called me to agree two more interviews, both proposed by [the CEO]. One is* [the MD], *who is on the Executive and is at the heart of the broader issues involved and will need to have a view on the potential resolutions (if any); the second is* [a member of the anaesthetic department who was granted anonymity by the Trust] *who is apparently well aware of the situation and may have useful corroborative information to assist an understanding of whether [CEO] was justified in calling for the key meeting with* [Dr C].

27. The DC thus agreed to both requests, but no evidence was produced to me that Dr C was informed of the expansion of the number of interviewees. At the conclusion of ExIn1's interview with Dr C on 11 December 2018 he had asked Dr C *Do you think I should be interviewing anyone else other than yourself* ***and those listed in the Terms of Reference? If so, who?*** Dr C mentioned the name of her appraiser (not an anaesthetist) but did not pursue the request as she had spoken to him in confidence and was not sure whether him being interviewed might place him in a difficult position. She also told us that her *understanding was that it was purely a fact-finding exercise around what happened on the 31 July* - and her appraiser had played no part in the meeting on 31 July 2018 about which she was complaining.

28. As the anaesthetist granted anonymity had also played no part in the meeting on 31 July 2018 it would have been clear (had Dr C been informed of their involvement) that the term *senior colleagues* was being interpreted by the Trust more broadly than was necessarily apparent from the version of the Terms of Reference shared with her.

29. In the event the ExIn1 report went on to give an unchallenged account (unchallenged because comments critical of her – sometimes on the basis of hearsay evidence - were not put to Dr C) of Dr C's conduct – both professional and personal over a two-year period. The DC was asked by ExIn1 whether Dr C should be alerted to and given the opportunity to respond to the critical comments, but the DC decided that would be outwith the scope of the investigation he had commissioned. He believed – in line with Allegation 2 - that the investigation should only comment on the existence of reasonable grounds for the CEO's concerns about Dr C, and not on whether they were well-founded. He was also concerned not to inflame sensitivities within the Anaesthetic Department. However, whilst there would have been a possibility that Dr C might have been able to identify the colleague who was given anonymity, had the matters raised by them been put to her, the approach ExIn1 was directed to take was in my view unfair to Dr C.

30. We were able to interview a number of the primary witnesses to events referred to in ExIn1's report (albeit some eighteen months later) and having done so it was evident to me that their direct account of several of the matters he described was different to that which he was able to conclude on the basis of the accounts given by the CEO, DWC and MD and one anaesthetist (other than Dr C) out of a department of over 25 consultants.

31. The CEO informed us that he considered the ExIn1 Report *laid out the status* of a *catalogue of concerns* about Dr C, even if it was not a *perfect capture*. The DWC told us that no action was taken by the Trust on the basis of the ExIn1 investigation and that was why the Trust commissioned a different independent investigator to conduct a subsequent MHPS investigation which was more far-reaching. However, as I describe in Chapter 11, the allegations in the ExIn1 report were used as justification for launching a subsequent MHPS process.

32. A formal investigation does require a degree of rigour if it is to serve any useful purpose. Most importantly it has (wherever possible) to make an attempt at triangulation. However, because of the focus in the Terms of Reference on whether the CEO had 'reasonable grounds' for concern, the design of the investigation meant that no attempt at triangulation was made. A number of potentially direct witnesses to events that were to be the subject of findings in ExIn1's Report were not interviewed. Only two anaesthetists were interviewed one of whom was Dr C, and even in her case a number of the allegations upon which ExIn1 would later make findings were not put to her.

33. In my view, given ExIn1 was not asked to interview the primary witnesses, he was not able properly - or at all – to investigate Dr C's relationships with any senior colleagues other than the CEO, the DWC and/or the MD. Unfortunately, however, ExIn1 did go on to refer in his report to allegations from the one

anonymous interviewee as to what may have occurred on a number of occasions when that individual was not present. Accordingly, the investigation could not establish the *status* of any *concerns* in any way, to any legally recognised standard of proof.

34. I am strengthened in this view because the design of the Investigation meant that it was not to take into account the relevant evidence on each allegation (as I consider further below and in chapter 6). This is material to all three Allegations in the Terms of Reference, but particularly Allegation 3, which raised the possibility there had been a breakdown of relationships between Dr C and fellow anaesthetists.

Information in the Terms of Reference of the ExIn1 Investigation

35. Dr C was provided with the original Terms of Reference by the DC. She did not comment on or seek to amend them, nor did she question the process or ask for further detail. She did contact the BMA to seek its view on the investigation and was orally advised that if she did not comply with the process then that could be a disciplinary matter.

36. I have not sought to interview the BMA advisor (just as we did not for reasons of professional privilege seek to interview the Trust's advisors). It is for the Trust - and not the respondent doctor - to ensure Terms of Reference they issue are clear and capable of being addressed on the basis of the resources commissioned to discharge them. The Terms of Reference for ExIn1's failed to specify (1) what the alleged *serious concerns* were with Dr C's behaviour which were to be addressed in the Investigation; (2) the potential reasonable grounds for holding the 31 July 2018 meeting; (3) what the potential reasonable grounds were for concern about Dr C's relationship with senior colleagues; or (4) who those senior colleagues were. Furthermore, at no point during the ExIn1 investigation was this information provided to Dr C.

37. Contrary to the (significantly wider) interpretation of the scope of the Terms of Reference once the additional witnesses were added, Dr C's understanding was that the allegations in the version of the Terms of Reference shown to her (and upon the basis of which she sought advice) meant that her *conduct at [the meeting on 31 July 2018] was going to be questioned as: did [she] behave in a way that was reasonable? Because the implication at the subsequent meeting [on 2 August 2018] was that [she] hadn't*. She understood the reference to her relationships with *senior colleagues*, to be her senior colleagues in that context - i.e. the CEO and DWC, both of whom were the senior colleagues present at the 31 July 2018 meeting. Crucially, she told us

she did not understand the ExIn1 Investigation to relate to the set of matters listed on the CEO's list of issues at the 31 July 2018 meeting.

38. I note in this respect that Dr C was never supplied with a copy of the list of issues the CEO had prepared in advance of the 31 July 2018 meeting, whether at the 31 July 2018 meeting or otherwise. In the course of the meeting on 31 July 2018 she had managed to read part of the list from her position at the table, and challenged its relevance to the discussion which she thought had been arranged to address her patient safety concerns in the light of the handling of the self-medicating incident. Further, given the very limited cast list of interviewees (of which she was told) in my view it was entirely reasonable for her to have concluded that the investigation was to focus upon the meeting on 31 July 2018.

Findings: the design and Terms of Reference of the ExIn1 investigation

As has already been noted the DC had concluded, having spoken to the CEO, DWC and Dr C, that he could not comment further on Dr C's, the CEO's or the DWC's perspectives of the meeting on 31 July 2018. That was unsurprising given there were only three people in the room and no agreed record of the meeting. Given those circumstances, an external investigator would be in no better position to reach an objective conclusion into what had happened. However I accept the DC's view that it is difficult for an NHS Board Director to objectively conduct an investigation into a complaint raising concerns about fellow Board members, and that the involvement of an external investigator in such circumstances was a possible way forward.

In the event however – due largely to the increase in scope of the external investigation into Dr C's behaviour over a lengthy period, wholly unrelated to her Speaking Up to the Chair of the Trust – the ExIn1 report provided a means of listing further allegations against her from those interviewed.

The consequence of her not being told about the expansion of the Terms of Reference and the subsequent decision of the DC that the new allegations raised by the Consultant granted anonymity resulted need not be " put" to her resulted in Dr C being unaware of the scope and nature of ExIn1's investigation.

39. Based on my analysis in paragraphs 19-34 above, the asymmetric Terms of Reference and selection of interviewees provided to ExIn1 did not permit him to deal effectively with the allegations against Dr C – nor could it have done given the way the Terms of Reference were drafted. I conclude that the design and execution of the ExIn1 Investigation itself added nothing to the process of

resolving those issues. At its highest it can be said that the ExIn1 Report listed allegations against Dr C from the CEO, DWC and MD and an anaesthetic consultant granted anonymity by the Trust.

40. The DC and ExIn1 did not make Dr C aware of the scope of the ExIn1 investigation. ExIn1 has, reasonably in my view, pointed out that he read out the Terms of Reference at the beginning of his interview with her, that neither she nor her representative raised any questions or concerns about them, and that he expected the Trust to have made it clear to her what was being investigated. Even though she did not ask for greater detail, it was incumbent on the Trust as her employer to provide this information. The failure to do so meant that she was denied the opportunity to meaningfully address the concerns forming the basis of the investigation, and thus to mount a defence to them.

How the ExIn1 Investigation proceeded

41. The Terms of Reference stated that ExIn1 would *seek to interview the following in the first instance:* Dr C, the CEO and DWC. They added that ExIn1 was requested to speak with the DC to discuss whether it may be appropriate to interview other witnesses. The DC was made aware of requests for two further witnesses made by the CEO both of which were granted without reference to Dr C.

Dr C

42. Dr C was interviewed once by ExIn1, on 11 December 2018, with a brief clarificatory telephone call on 20 December. The interview lasted just over three hours (including a break part way through). She was not provided with any additional information about the investigation beforehand.

43. Dr C attended with her BMA Representative. The representative was present in a support capacity rather than as an advocate, and he was not permitted to speak during the interview.

44. Dr C was asked to provide her narrative. It is evident in the interview note which ExIn1 produced that she was not, in this interview or at any other subsequent point in the investigation, provided with an opportunity to comment on the further accounts given during the investigation by other witnesses (despite much of this being adverse to her) beyond the issues concerning her conduct that were raised at the meetings with the CEO and colleagues on 31 July 2019 and 2 August 2019. Nor was she supplied with a written account of the allegations made against her by other witnesses.

45. ExIn1 asked Dr C to suggest any potential witnesses for him to interview. As explained above, Dr C understood the scope of the investigation to be limited to fact finding as to the meeting of 31 July 2018. She was not informed any differently by ExIn1. Although ExIn1 did ask questions on matters which were on the list of issues produced by the CEO and partially read by Dr C in the course of the meeting on 31 July 2018, this did not alert her to the broader nature of the investigation being undertaken. Rather she presumed the questions were put because there was a dialogue (at times heated) at the meeting between herself and the CEO as to why those matters were being raised with her at all given she understood the meeting to be about her Speaking Up to the Chair of the Trust. Dr C did not understand the questions to point to any wider significance.

46. In the light of Dr C's understanding of the Terms of Reference she did not think that there would be other relevant witnesses to interview beyond the CEO and DWC (who were the other attendees at the 31 July 2018 meeting). When she learnt that the MD was also to be interviewed, she did not raise any objection, as he was clearly central to the questions she was raising about how the self-medicating incident had been dealt with. She was never told that one of her consultant colleagues was to be interviewed. Dr C told us that she did initially propose that the Deputy MD – her appraiser at that time - be interviewed but did not pursue that and he was not interviewed.

47. Dr C told us that had she understood the true (significantly wider) scope of the investigation, and particularly its focus on her broader conduct, then she would have put forward a list of people who were witnesses with first-hand accounts of the underlying events. She had no idea of the *tsunami* that was about to hit her based on the wide range of allegations put to ExIn1 and described in the Report.

48. The only point at which Dr C could have raised – but did not – a question as to the scope of the investigation ExIn1 may be undertaking was a comment he made towards the end of their meeting and captured on the final page of the note he prepared of her interview on 11 December 2018:
    48.1. I will be discussing with the Commissioning Manager the scope of "Senior Colleagues" and the extent to which this is intended to include senior colleagues in Anaesthetics. So, by way of preliminary question only, how are your working relationships with senior colleagues in Anaesthetics?
    48.2. The interview notes record Dr C as having said *Fine.*

49. It is clear from this exchange (and from his subsequent confirmation to me in his statement) that ExIn1 viewed the Terms of Reference of his investigation to be at best ambiguous.

50. Dr C did not seek any professional legal advice on the conduct of the investigation prior to or after her interview.

The CEO and DWC

51. The ExIn1 also interviewed the CEO and DWC. Their accounts were broadly consistent with each other.

52. The CEO was interviewed on three occasions – two of those interviews took place after the decision was made to interview the consultant anaesthetist to whom no reference had been made in the Terms of Reference. In addition, he prepared a five-page statement, a five-page chronology of key events, and his transcription of the note he had prepared in advance of the meeting with Dr C on 31 July 2018 and which Dr C had been able, in part, to read in the course of the meeting.

53. Because ExIn1 was asked to look into whether the CEO's concerns about Dr C were reasonably held, the drafting of the Report relies heavily upon the CEO's account to support its findings: the evidence presented included the CEO's allegations on over 20 matters. Three of these were related to Dr C's Speaking Up:
    53.1. The CEO stated that Dr C was making serious and wide-ranging allegations against Dr A, HR and the Trust, and this was contrary to her professional obligations (this related to the matters which I and the DC recognised as Speaking Up, but the CEO did not).
    53.2. He considered that Dr C was trying to prevent the Trust and the MD from having a fair hearing in that the *email to the Chair was another instance contributing to the perception that part of [Dr C's] motivations was to escalate concerns to the Board in a manner that causes [the MD's] competence and judgement to come into question and undermine him* (no details were supplied on other specific steps she was said to be taking in relation to the Board – as distinct from her actions in Speaking Up);
    53.3. As noted in paragraph 12 above, the CEO did not consider Dr C to be whistle blowing (on the basis that Dr C had not made reference to FTSU in her email to the Chair of the Trust on 27 July 2018 and the CEO had never seen any evidence that the suppression of issues she had alleged was occurring). However, as I have already set out (see chapter 7, paragraph 33), these are not the correct tests as to whether Dr C was a whistle blower under the FTSU Policy, and I do not agree with the CEO's view that she was not Speaking Up).

54. Other evidence from the CEO included his perspective on various matters which featured in his preparatory notes for the 31 July 2018 meeting, and which I have considered in detail in chapter 7.

55. The CEO also told ExIn1 that Dr C did not like the MD from the outset of his appointment and carried out *low level sniping* (this was not particularised). He considered it was widely known in the Trust that Dr C did not respect the MD clinically and had an *unhealthy focus* on him and was engaged in a wider campaign to discredit him. He stated that various members of the anaesthetic department (some named, some not) had told him that Dr C was out to get the MD. We note that the CEO named the Deputy MD (although he was not a member of the anaesthetic department) as one of these individuals; however, when we interviewed the Deputy MD in July 2020, his account was not consistent with the CEO's description of his position)

56. The CEO also stated that his trust and confidence in Dr C had gone, on the basis of matters which arose **after** the 31 July 2018 meeting, which I consider in paragraphs 64 - 76 below. In view of the decision of the DC referred to in paragraph 29 above much of the alleged inappropriate conduct was not put to Dr C who therefore had no opportunity to respond to it.

Further witnesses

57. The CEO told ExIn1 that the anaesthetist given anonymity *felt bullied* by Dr C. There is also evidence that they were upset with Dr C around the time of the ExIn1 investigation (in this regard I make **no** findings on the legitimacy of those feelings, but only note that was their subjective position). Clearly, had any of the concerns mandated management action then it should have been taken to determine the true position (separately from and unrelated to the ExIn1 Investigation process) so they could be properly tested with Dr C being informed about the concerns being raised and invited to respond to them.

58. In my view the undisclosed selection of a single consultant was not a representative one and is very likely to have skewed the presentation of sentiment in the department in relation to Dr C. There is a clear risk that the introduction of a new witness enabled separate, unparticularised interpersonal issues (and motivations) to enter the fray. At no stage was Dr C informed that the consultant had been added as a witness.

59. In response to a suggestion that the selection of witnesses may not have appeared fairly balanced (i.e. that there were four witnesses out of five who would be likely to raise arguments against Dr C), the DWC told us that she did not accept this, and further – quite reasonably - she did not consider that she had responsibility for taking action on this at the time, because she was a witness under investigation. Instead, she thought that it was the DC's responsibility. I note however that the DC was a NED and thus unlikely to be aware of the dynamics of the department. He told us that he had never previously met the consultant who had been introduced by the CEO as an additional witness.

60. The DC told us he was aware of the *potential perceived imbalance* with calling the MD as a witness, due to the small number of witnesses. However, he thought it was appropriate as the MD was one of *very small number of senior managers or executives* with relevant evidence to give. To the extent that was the case, it does not take into account the DC's contemporaneous note of one of the reasons for the MD's inclusion – which was that he would *need to have a view on potential resolutions (if any).*

61. The MD and the additional consultant did have relevant evidence to provide in relation to the broader underlying allegations. However, they were not the only clinicians (senior or not) at the Trust who would have had relevant evidence to provide – the allegations which the CEO discussed (as set out above in paragraph 53) involved many employees at the Trust, none of whose accounts were obtained to balance, confirm or challenge the credibility or reasonableness of the evidence taken from the CEO, DWC, MD or the consultant.

62. The MD gave evidence to ExIn1 of his view that:
    62.1. his relationship with Dr C had irretrievably broken down and that attempts to conciliate had also broken down. He did not think Dr C could ever have trust in the organisation, and that she would seize opportunities to *do down* the Trust; and
    62.2. He thought the relationship between Dr C, the CDA and the CLA was beyond repair.

63. A number of the interviews conducted as part of the ExIn1 investigation took place **after** the interview with Dr C on 11 December 2018: specifically the interview with the additional consultant granted anonymity, both of the interviews with the MD, as well as two of the three with the CEO. Reference was made in the CEO's interview and ExIn1's report to many aspects of Dr C's conduct that the CEO thought inappropriate, including matters post-dating the 31 July 2018 meeting. As with other new allegations, in line with the decision made by the DC about the limited scope of the investigation, these additional

examples of alleged inappropriate conduct were not put to Dr C who had no opportunity therefore to respond to them.

Trust and confidence

64. In his interview with ExIn1 on 4 December 2018, the CEO reported that the **Executive Team had** lost confidence with Dr C and that one NED's view was that they had a *terrorist in our midst*. The context suggests that the *terrorist* reference was to Dr C. The NED was not identified by (and possibly to) the ExIn1. This is extreme language in an employment context.. ExIn1 records that the CEO approved his transcripts after the interview; he did not make any correction to this evidence.

65. In a subsequent interview with ExIn1 on 10 January 2019 the CEO said that the Board had lost confidence in Dr C. However, when we interviewed him for the purposes of this Review the CEO told us he was not sure of the basis for him having told ExIn1 that the Board had lost confidence in Dr C, that there had been no Board discussion of it and that he had probably meant to refer to the Executive Team having lost confidence in Dr C.

66. I note that allegations of loss of trust and confidence are particularly serious because they may (if properly made) provide a basis for terminating a contract of employment. The investigation of whether there had been a loss of trust and confidence did not appear in the Terms of Reference, but there is repeated reference to issues of trust and confidence in the witness evidence presented to ExIn1.

67. The CEO told us that he personally, and possibly the Executive Team, had trust and confidence issues with Dr C. The DWC also told ExIn1 that confidence had been destroyed between her and Dr C. However, the CEO was clear in his evidence to ExIn1 (and to us) that at the time of the 31 July 2018 meeting he had **not** had trust and confidence issues with Dr C.

68. By the time the CEO was interviewed by ExIn1, in early January 2019, that position had clearly changed (although Dr C had been on stress-related sick leave for two of the intervening six months).

69. The only matters which he identified to me as arising after the 31 July 2018 meeting which had led him to lose trust and confidence in Dr C during that period was her alleged refusal to *engage with Quince House* and the Executive Team; and concerns he stated had been raised with him about *relationship issues in Anaesthetics*.

70. However, ExIn1's summary of the CEO's evidence to him in relation to his loss of trust and confidence after 31 July 2018 included the following further reasons:
    70.1. Dr C had resigned certain leadership roles after the 31 July meeting. However, I note that Dr C was not under any obligation to maintain leadership positions.
    70.2. Dr C had not engaged properly on the substance of the meeting on 31 July 2018 and only challenged the style of it. However, for the reasons set out previously, it was in my view reasonable for Dr C to challenge the CEO's approach in the meeting given he was seeking to challenge her motivation for Speaking Up to the Chair of the Trust and as she had not been informed by him of its true purpose and was unprepared for it.
    70.3. Dr C had continued to pursue and raise issues in relation to Dr A; she had *re-opened and escalated her concerns to the Board through [the DC],* despite having suggested the matter was closed. However, we note that an employee's decision to Speak Up should not be used to suggest there is an issue of trust or confidence. I consider that the CEO's evidence to ExIn1 suggests that he lost confidence in Dr C at least in part because of her Speaking Up;
    70.4. That the CEO suspected that Dr C had whistle-blown to the Care Quality Commission, or that the whistle-blower was Dr E (we note that there is statutory protection for whistleblowing, and that this would, again, be Speaking Up);
    70.5. The anaesthetic leadership had repeatedly conveyed [to the CEO] how Dr C and Dr E appeared to be seeking to undermine some of the department's key achievements (no evidence was produced as to this); Dr C and Dr E had repeatedly said that they did not accept the judgement of the clinical leadership in anaesthetics (no evidence was produced that either or both Dr C and Dr E did not accept the judgement of the clinical leadership of the anaesthetic department);
    70.6. Dr C had not raised clinical issues immediately, or with the right people or in the right way and this had been done in a way to undermine the MD. No detail was provided on this.
    70.7. that if Dr C did not recognise the Executive Team's authority then there could be no trust in her (however, the only example the CEO provided to ExIn1 of how Dr C allegedly did not recognise authority in fact related more to Dr E, and not to Dr C).
    70.8. that both Dr C and Dr E had a habit of raising complaints and then criticising the Executive Team's response (again, I note that some criticisms may be protected under the FTSU Policy, for the reasons I have set out elsewhere);
    70.9. that, going forward it *might* be the case that Dr C and Dr E use *every mistake* against the CDA and the CLA to undermine them professionally (we note that this is a suspicion which is forward-looking, rather than a statement of what Dr C had allegedly done – it therefore could not form the basis of an

allegation that trust and confidence **had** been destroyed. It also, in common with several matters raised, applied equally to Dr E); and

70.10. in relation to wider relationships, in his summary of his interview with the CEO on 4 December 2018, ExIn1 records that SD told him he had heard of further *snippets* and ongoing issues in the anaesthetics department and that some colleagues were concerned about Dr C's motives and behaviour. The detail provided was that an (identified) anaesthetic consultant felt bullied; various unnamed consultants had spoken informally to him about it; and that two other consultants had stated they had been *subject to a degree of pressure* from Dr C, although one of those may have arisen in relation to a disciplinary procedure.

71. In relation to this final point, concerning alleged disquiet about Dr C from other consultants, our investigation revealed that there was disquiet within the department for a variety of reasons: a phrase that had some currency was *divided and unhappy*, which was used by ExIn1 in his report to describe the evidence he had received, but also by the DC in his later letter to Dr C in which he said he would be recommending that the Trust executives *address the serious concerns about ..your conduct and working relationship with members of the Executive team…..*[and] *the divided and unhappy state of the Anaesthetics Department.* The interviews we conducted did not take place for another 18 months, in July 2020: during those discussions different anaesthetists gave differing accounts as to the reasons for that unhappiness – with some citing concerns about the behaviour of Executive Directors (e.g. the meeting about potential *fraud* mentioned in chapter 7). We were not told of any investigation to establish what was happening in the department in 2018-19 (or later) and who (if any one in particular) was to blame. Instead, any further investigation into this alleged matter was restricted to the ExtIn1 review; thus, the net effect of this was that it was targeted solely towards Dr C, and pursued alongside other, broader, allegations.

72. We were told that no staff member had raised a grievance against Dr C under the Grievance Policy.

73. In summary, the narrative given to ExIn1 to support an alleged loss of trust and confidence on the part of the CEO and /or the entire Executive Team consisted of a number of assertions which had not been put to Dr C in view of the limitations of the Terms of Reference and in the light of the decision of the DC referred to in paragraph 29 above. In addition, the CEO made reference to having been informed (directly or indirectly) of concerns of others, none of which had been raised with Dr C via the Grievance procedure (or by any other means). These matters will have provided further evidence of concerns held by the CEO. However, it is important to remember that these matters were raised with ExIn1 following on from concerns Dr C had raised under the FTSU Policy

about the Trust's response to the self-medicating incident, the Chair of the Trust's decision to pass her email to the CEO, and the CEO's and DWC's subsequent conduct of the meeting on 31 July 2018.

74. In relation to the assertion that Dr C refused/was refusing to engage with *Quince House* (the building in which the Executive team had their offices), I do not consider that there was a sufficient basis for this. I was not told of any instances of Dr C failing to follow appropriate management instructions. Her actions in the latter part of 2018 were relating to ensuring there was **oversight** of the Executive Team. That does not indicate a refusal to engage with them within her employment. Indeed, the evidence recorded in the ExIn1 Report included that Dr C had emailed the CEO on 14 August 2018 to say that she wanted to bring the episode (of conflict, following the 31 July 2018 meeting) to a close.

75. In her interview with ExIn1, Dr C stated that because she no longer had leadership roles she was no longer required to physically visit Quince House on a day to day basis; however, she gave examples of her willingness to engage with Quince House and the professional team there.

76. I do not consider that the threshold had been passed for trust and confidence to be called into doubt based on matters arising after July 2018 (which the CEO was clear at interview had been the reason he had come to that conclusion). Further, although it was the CEO's evidence that the Board had trust and confidence concerns with Dr C, he later confirmed to me that the Board had never articulated such concerns.

ExIn1's findings

77. ExIn1 made the following findings in his final Report.

78. In relation to Allegation 1:
    78.1. that the list of [the CEO's] issues was put on the table in the 31 July 2018 meeting but the purpose of doing so was to assist the CEO; the list was not presented to Dr C and this was *not unreasonable*. The only objection from Dr C to the list of issues was to the inclusion of EBAC, and not to there being a list on the table *per se*.
    78.2. that there was a reasonable basis for the CEO to raise concerns with Dr C about her behaviour.
    78.3. ExIn1 did not draw any clear conclusion as to whether, objectively, the CEO's and DWC's actions in the meeting of 31 July 2018 constituted pressuring Dr C. However, he found that the CEO and DWC were **subjectively** concerned with finding a *constructive outcome* [although to

what is not specified] and that emotion arose due to Dr C wanting *to pursue another agenda at the meeting*. This conclusion ignores the factual evidence of the purpose of the meeting as conveyed to Dr C – that it was to discuss her letter to the Chair of the Trust and that.

78.4. even if Dr C was pressured *that this was justified and reasonable* as the *concerns needed to be raised* and the CEO's and DWC's evidence *had been that that they were firm but fair in their approach*; and

78.5. Dr C was not treated badly by the Trust because the CEO and DWC were entitled to raise their concerns as they did.

79. In relation to Allegation 2:

79.1. that their *serious concerns* gave the CEO and DWC reasonable grounds for holding the meeting with Dr C and they had reasonable grounds to conduct the meeting in the planned manner.

79.2. that the CEO and DWC had reasonable grounds to have serious concerns about Dr C's behaviour *which merited further investigation*. *These include the Locum Rates Petition Concerns (probably the strongest), the Clinical Director Replacement Concern, the MHPS Process Concerns, the Annual Leave Concerns and the EBAC Concerns and the Unhealthy Focus and Undermining [the MD's] Concerns*.

79.3. that the *Party Statement Concern* (where Dr C had allegedly said at a party that she would seek to get the MD fired) did not relate to Dr C's conduct as it was not clear whether she had made such a statement, but nevertheless the CEO had reasonable grounds for a serious concern about perceptions of Dr C (ExIn1 did not elaborate on what these reasonable perceptions might be);

79.4. that other concerns listed on the list of issues *taken together* raised *potential serious concerns about [Dr C] taking a strong role in moves to enable the Department to self-govern*; and

79.5. these above matters *raise concerns of potential breaches of Good Medical Practice*.

80. In relation to Allegation 3:

80.1. that there were reasonable grounds to be concerned that relationships between Dr C, the CEO, MD and DWC had *broken down*.

80.2. the position was *likely to be the same with* the ECN and Deputy CEO (who had attended the 2 August 2018 meeting (see chapter 7), *but* the same *would need discussion with them* (neither of them was later interviewed);

80.3. the status of the Deputy MD's relationship with Dr C was not clear (the CEO having told ExIn1 that Dr C's relationship with the Deputy MD had also *probably* broken down; I note that this is not consistent with the Deputy MD's later evidence to us).

80.4. that the CEO, MD and DWC all have concerns that *there is a strong possibility* that Dr C would *behave inappropriately in the future*.

80.5. there are *reasonable grounds to have concerns on Dr C's relationships* with the CLA and the CDA - but Dr C and others would need to be interviewed to reach a conclusion that was *balanced*; and

80.6. that the poor relationships had a highly *negative impact on the Trust*.

81. ExIn1's recommendations then included that the Trust should:

81.1. consider whether to commence further processes in relation to the concerns about Dr C's conduct and the concerns on her working relationships with members of the Executive and senior members of the anaesthetics team.

81.2. consider whether the CDA should be interviewed.

81.3. ensure that the consultant [granted anonymity] be made aware of protections that they had against Dr C should they face reprisals for giving evidence.

81.4. review the FTSU Policy (although in which respects was not stated); and

81.5. train Non-Executives on the FTSU Policy (although in which respects was not stated).

Findings

The limitations placed on the ExIn1 investigation meant that there was no scope for triangulation of the concerns put to the investigator. It would have been fairer and more transparent if ExIn1 had been allowed to put matters raised about Dr C's conduct to her so that she could respond to them. But ExIn1 had not been asked to determine whether the allegations were true or not; simply to establish whether the CEO and DWC had reasonable grounds for concern about Dr C's conduct.

Given the asymmetric nature of the allegations in the Terms of Reference, and the lack of transparency and imbalance in the selection of witnesses in the ExIn1 investigation, the conclusions reached could not be used as a robust basis for any management action without further investigation. ExIn1 clearly caveats, in his Report, that further investigation would be needed, including interviews with the CDA and with Dr C herself.

87. The Trust management's view was represented by three Executive Directors plus one consultant of the CEO's choosing from a department of 25 + Consultants, whilst Dr C was the only witness interviewed on her behalf. There are several references in the final Report to the *weight of evidence* received – which inevitably led to findings against Dr C.

Some of the evidence submitted to ExIn1 was based on hearsay accounts which could not be triangulated because of the limited scope of the Terms of Reference

The Terms of Reference of the ExIn1 investigation failed to give notice of all the matters that would be explored

88. The written Terms of Reference failed to specify the particular allegations Dr C was under investigation for within Allegations 2 and 3. Those allegations were in fact numerous (as is clear from the details which the CEO provided to ExIn1 in the investigation). The allegations related to the previous two years of Dr C's employment.

89. In particular, there was no clarity about the meaning of the term *senior colleagues* in Allegation 3, where the investigation pursued a broader interpretation than Dr C's understanding that the matters being looked at were confined to the 31 July 2018 meeting.

90. As Dr C was unaware of the true scope of the ExIn1 investigation, she did not have a fair opportunity to propose a list of witnesses who could support her account of matters, as she was never in a position to determine what would be relevant. In contrast, the CEO and DWC were aware, and thus able to fully prepare for their interviews and able to provide uncontested evidence to the investigator (uncontested because their evidence was at no stage put to Dr C).

Conclusions were reached based on allegations made by the CEO which were not presented to Dr C so that she could respond

91. The DC did not make Dr C aware of all of the evidence of the conduct concerns against her. The DC's reason for this was that the remit of the investigation was limited to considering whether the CEO had *reasonable grounds* for having held and raised his concerns (as set out in the Terms of Reference for the investigation), not to test the veracity or fault for any such concerns. The DC did not consider this to be an investigation into Dr C's conduct. Whilst this was technically the case, this meant Dr C did not have an opportunity to propose a list of witnesses who could support her account of matters. The CEO and DWC did provide evidence to the investigator on these issues. That evidence was not put to Dr C to contest, upon the instructions of the DC to the investigator in the course of a meeting between them on 23 January 2019, because they considered that Dr C would not have been able to comment on whether or not the concerns were held by the CEO or the DWC. They took the view that this was something that only the CEO or DWC or those who had reported concerns to them could address.

92. In particular, ExIn1 recorded that his investigation related to the **manner** in which Dr C raised her concerns, and therefore that he was not considering or making findings on the **substance** of her concerns raised in the course of 2018

or whether the investigation into the self-medicating incident was properly carried out. He noted the requirement in the FTSU Policy that those who Speak Up *must feel safe to raise a concern* i.e., cannot be victimised. However, he went on to conclude that she made *serious allegations without grounds*. He had had accepted the CEO's account on this point – without investigation as the self-medicating incident was outside his TOR.

Yet despite these defects, the ExIn1 report was used as a trigger to launch formal MHPS proceedings, with the potential for disciplinary action, against Dr C – who even then was not shown a complete copy of the report.

93. In relation to the underlying allegations of misbehaviour by Dr C addressed in the ExIn1 investigation, I have considered these separately and set out my findings in chapter 7. My conclusions are largely different: I have been in a position (especially as a result of contacts made with me via the confidential staff inbox) to interview a much wider range of witnesses than ExIn1 was able to, in order to obtain their direct evidence, including those with first-hand accounts of the events which formed the basis of the CEO's allegations.

94. The matter which we do find took place as alleged by the CEO on behalf of the Trust in the ExIn1 Report is that Dr C sent an ill judged and ill-tempered email to the MD in June 2017, in response to his failure to promptly organise a replacement for her as Clinical Director. As set out in chapter 7, this was an inappropriate email which in my view should have been managed – but was not - by the MD requiring an apology from Dr C at the time that it occurred.

95. However, by no means do I consider this matter sufficient to launch an independent MHPS investigation (potentially leading to a disciplinary process), or to found allegations that Dr C was orchestrating a campaign against the MD and/or the Trust Leadership. The matters the Trust combined with it in the ExIn1 Investigation do not alter that conclusion, for the reasons stated both in chapter 6 as well as in the present chapter.

The handover of the ExIn1 Report

96. The ExIn1 Report was finalised on 8 February 2019 and handed over to the DC, in his capacity as the NED who had commissioned the Investigation. I consider in chapter 11 how the Trust then considered and acted upon its content.

11: The Maintaining High Professional Standards (MHPS) Process

The Trust's consideration of the first external report (ExIn1 Report)

1. When the ExIn1 Report was received by the Trust, the only individuals who read it in full were the DC (as the commissioning NED), the Chair of the Trust and, later, as part of the Trust's triggering of an MHPS investigation in respect of Dr C, the COO.

2. On 19 February 2019, the DC wrote to Dr C, the CEO and DWC. He summarised ExIn1's findings and attached the table from the report listing the allegations and the investigator's views on each. He then recorded the recommendations he would make to the Board which were that:
   2.1. no further action be taken in relation to the concerns that Dr C had raised about the CEO and DWC; and
   2.2. *appropriate Trust management* consider how to *address the potentially serious concerns about [Dr C's] behaviours and about the working relationships between [Dr C] and senior colleagues*.

3. The DC offered to meet with Dr C to discuss the ExIn1 Report. He noted that it might be stressful for her and that she should let him know if she wished to be contacted by HR or if she wanted details of employee support.

4. Dr C subsequently met with the DC and SID on 1 March 2019, along with her BMA representative. The DC subsequently wrote to Dr C, on 7 March 2019, with his summary of the discussion and informing her that an appropriate Board member would be in touch to discuss next steps.

5. In his letter the DC:
   5.1. noted Dr C's disappointment that the summary of the ExIn1 Report supplied to her failed to acknowledge that the planned content of the 31 July 2018 meeting should have been signalled to her in advance and that she felt she had been *ambushed* or that there were *any shortfalls on the part of the CEO in the way the meeting …had been called or conducted*;
   5.2. noted that despite the above she had explained that she wished to avoid conflict and to normalise her working relationships with colleagues, and that this had already happened with the MD and the CDA. She had stated that because she did not want an *escalation* of the matters contained in the ExIn1 Report, she was willing to sign a letter of expectations or a behavioural plan in order to resolve the issue. She had stressed that, more

broadly, the anaesthetics department was in *a somewhat fragile and unhappy state* and that work would be needed to rectify that, but that she was willing to participate.

6. Dr C's recollection is that in the course of the meeting on 1 March 2019 the DC stated that he would recommend that the issue be resolved informally. She accepts that this point was not captured in his subsequent letter, although she did not notice that at the time. In a later letter to the COO, dated 29 March 2019, her BMA representative (who had also been at the meeting) repeats that the DC *actually stated to us that he would be recommending that the matter is dealt with informally*. The DC, on the other hand, recalls Dr C raising the issue of informal resolution, but not that he had provided any assurance in response. His recollection is that he did not have a strong view on it and did not consider that it was his role in the process to decide whether a behavioural agreement was appropriate.

7. On 11 March 2019, the DC wrote to the CEO copying in the Trust's lawyers, the Chair of the Trust, the DWC and the SID, to hand over responsibility for taking forward the recommendations of the ExIn1 Report. He summarised that the key issues were:
   7.1. serious concerns about the conduct of Dr C and her working relationship with members of the Executive team; and
   7.2. the divided and unhappy state of the anaesthetics department.

8. Despite having a role in deciding how to progress matters, the CEO did not have sight of the full ExIn1 Report until October 2019. He did discuss it but not *in detail* with the DC. The DWC told us she did not ask to see the ExIn1 Report in full. Like the CEO, she had seen those sections of the report relating to herself.

The decision to launch an MHPS process against Dr C

9. The CEO decided to appoint the COO as the case manager. The COO has a clinical background but (at that time at least) no HR experience.

10. The appointment of a case manager signalled that the CEO was approaching the matter under the Trust's MHPS process. However, the mere appointment of a case manager does not necessarily mean that the **formal** procedure under the MHPS policy will be invoked.

The MHPS Policy

11. The MHPS policy in force at the time (issued by the Trust in 2018) provides that the Trust must have in place procedures for handling *serious concerns about an individual's conduct and capability*. It defines serious capability concerns as when a *practitioner's actions have or may adversely affect patient care*. It does not provide express criteria as to what constitutes a serious concern about conduct. However, it mandates that the Trust's procedures should reflect the framework of the MHPS policy and *allow for informal resolution of less serious problems*.

12. Under the MHPS policy, a relevant serious concern should be registered with the CEO, who must then appoint a case manager. The CEO or MD must approach the Practitioner Performance Advice Service (PPA – formerly known as NCAS) about the matter. PPA will provide support and advice on how to handle it. At *any* stage of handling the case, the Trust must consider updating and involving PPA.

13. The MHPS policy mandates that after the case manager has discussed the matter with the PPA they *must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed*. When the formal route is selected, the Executive Medical Director (or case manager if different) will, after discussion between the CEO and the Director of Workforce and Communications, appoint an appropriately experienced or trained person as case investigator.

14. Alongside the case manager, the MHPS policy provides that the Chair of the Board must appoint a NED to oversee the case and ensure that momentum is maintained.

15. The MHPS policy notes that *the case investigator has a wide discretion on how the investigation is carried out but, in all cases, the purpose of the investigation is to ascertain facts in an unbiased manner*. It follows that the case investigator is required to exercise his or her discretion, free from apparent or actual bias.

16. The MHPS policy also contains requirements as to confidentiality so that the *Trust and its employees* must maintain confidentiality. These are clearly established to protect the practitioner under investigation.

The initial steps taken by the Trust

17. In accordance with the MHPS policy, on 13 March 2019, the Chair of the Trust appointed a NED (MHPS NED) to oversee the MHPS process.

18. MHPS NED was briefed in the course of a conference call on 19 March 2019 by the COO, DWC and the Trust's external lawyers. The MHPS NED was not provided with a set of papers in relation to the investigation nor with the ExIn1 Report. They understood, in the light of the briefing, their role to be one of oversight of the investigation and ensuring that it progressed in a timely fashion, and that they were not to become involved with issues of substance. The effect in this instance was that assurance that the process was being run correctly was entirely dependent on the case manager in charge of the case, over whom oversight should be exercised, self-certifying that they were proceeding appropriately.

19. MHPS NED made notes of the call on 19 March 2019 which record that there were a broad range of issues to be considered in Dr C's case, including undermining the Executive, divisive conduct and an *attempted coup* against the anaesthetic department's clinical leadership. The notes also record that Dr C had not been provided with the ExIn1 Report, and that this was on the basis of sensitive, confidential personal information within it.

20. MHPS NED also noted *It is important that* [Dr C] *is able to hear and understand the issues and provide a response should she wish to.*

21. MHPS NED's record of this call shows that the anonymous letter was also discussed, although it was noted not to be part of the MHPS process *at this stage*. MHPS NED was appointed to act as the NED overseeing the investigation of the Anonymous Letter as well. The Trust therefore treated the two matters as related from the outset, as the two were discussed and managed in tandem, overseen by the same NED. As set out in chapter 9, Dr C had also by this point become a suspect in the Anonymous Letter investigation, with PPA being informed by the MD on 11 March 2019 that five consultants, of whom she was one, had been identified for further investigation.

22. On 26 March 2019, the COO, MHPS NED and the CDA met with Dr C. The COO handed Dr C a letter, in which she summarised that the DC had recommended that consideration be given to *serious concerns about* Dr C's conduct and her working relationships with members of the Executive team, and *the divided and unhappy state of the Anaesthetics Department*. Insofar as these concerns relate to *conduct or capability,* the COO explained that these would fall within the MHPS policy; that she had been appointed as the case manager and would decide how to proceed, including whether formal MHPS processes should be invoked. Further, that MHPS NED had been appointed to oversee *any formal process* that did follow.

23. It is difficult to understand how one member of a team with over 25 consultants could be fairly held solely or largely accountable for the alleged *divided and*

unhappy state of the anaesthetic department. When, more than a year later, we interviewed several consultants in the anaesthetic department there was widespread agreement that the team were *divided and unhappy* but the reasons given for that were varied – and only one suggested that Dr C was wholly or mainly responsible for it with far more being clear that she was **not** responsible for it.

24. In the meeting on 26 March 2019 Dr C became upset at learning that she might be subject to an MHPS process. The COO offered her a referral to Occupational Health, but Dr C declined that at that stage.

25. On the same day, the COO spoke with PPA. The PPA adviser summarised their conversation in a letter to her dated 28 March 2019. The letter recorded that the COO told PPA that Dr C had submitted a *grievance under [the Trust's] local policy alleging bullying and harassment* against the CEO and DWC. Further, that an independent report had recommended that the Trust should consider managing the conduct and behavioural concerns it identified, and that Dr C was one individual identified as having accessed the clinical notes of the patient whose treatment was the subject of the Anonymous letter, *in relation to which preliminary enquires [were] being undertaken*.

26. On 29 March 2019 Dr C referred herself to Occupational Health and was signed off with work related stress.

27. The COO told us that she contacted PPA nine months later, in January 2020, to correct her reference to Dr C having submitted a *grievance*, informing them that the concerns Dr C raised about the conduct of the meeting on 31 July 2018 had been dealt with *in accordance with the principles of the grievance policy.* This may have been prompted by Dr C having contacted PPA herself in January 2020 and learning that they had been informed she had raised a grievance. She wrote to the COO on 20 January 2020, copying in the CEO, to challenge this and point out that she had spoken with the *Freedom to Speak Up NED*, attaching the notes of that meeting to her email. However, there is no record of the COO having, at any point, informed PPA that the DC (who had at the relevant time been named in the Trust's FTSU policy as having that role) had accepted that Dr C had in fact been Speaking Up.

28. PPA recommended that various steps be taken by the Trust. These included that if the COO had any health concerns regarding Dr C, she might wish to arrange an OH assessment, and that Dr C should be advised to seek independent advice.

The decision to invoke formal MHPS procedures

29. In her role as case manager, the COO had a significant decision to make: should Dr C be subject to a formal MHPS process, or should the issues identified in the ExIn1 report be addressed by informal means?

30. As already noted in paragraph 6, Dr C's BMA representative wrote to the COO on 29 March 2019. He asserted that at the 1 March 2019 meeting with the DC, the DC had stated his intention to recommend that the matter with Dr C be *dealt with informally*. The COO told us that she had never received a recommendation to that effect from the DC, and he had told her it had not been the *tenor* of the discussion in the meeting on 1 March 2019.

31. The COO told us at interview that in order to reach a decision as to whether to proceed with a formal MHPS investigation, she read through the witness statements of the consultants in the anaesthetics department annexed to the ExIn1 Report, mentioning two (other than Dr C) by name. In fact, as set out in chapter 10, only one anaesthetic consultant other than Dr C was interviewed, that consultant having been proposed by the CEO. At the time of interview, the COO was either unaware of the very limited anaesthetic input into the ExIn1's Report or had forgotten that the only source for the allegations against Dr C from within the anaesthetic department was a single consultant. The COO told us later that ExIn1 had made reference *to the fact he* [was] *constrained by time* from interviewing additional people. In deciding to advise that a formal MHPS process be triggered she had also considered:
    31.1. The potential seriousness of the allegations (multiple allegations of undermining and bullying colleagues) and broken working relationships.
    31.2. the range of the allegations…unacceptable behaviour towards the MD, ….and other members of the Executive; and
    31.3. the fact that informal intervention had already been attempted unsuccessfully by the CEO and DWC.

32. The other anaesthetic consultant interviewed did raise concerns about Dr C to ExIn1. However, these were made in an interview that took place a month after Dr C was interviewed and those allegations were not subsequently put to Dr C herself. Indeed, the only question in relation to her working relationship with senior colleagues that was put to Dr C in her single face-to-face interview with ExIn1 was the very brief and general question about her working relationships described in paragraph 46 of chapter 10.

33. As noted in chapter 10, in accordance with the scope of the investigation he had been asked to undertake, ExIn1 merely set out the allegations raised by the other consultant anaesthetist and did **not** establish that they were true on the balance of probabilities. These allegations were wider than those first raised by the CEO and DWC to Dr C on 31 July 2018 (when the allegations were

neither being managed under the MHPS policy nor considered to amount to a trust and confidence issue), and at least one – the *attempted coup* (see paragraphs 54 - 61 below) - related to matters involving others in the anaesthetics department as a whole and in relation to which Dr C was not the one most directly involved.

34. At her interview with us, the COO:
    34.1. told us she felt that the evidence in the ExIn1 Report was unfinished and that she needed to explore it further. I acknowledge and agree that ExIn1 in his report had advised the Trust to *consider whether to commence further processes in relation to the concerns about [Dr C's] conduct and the concerns on her working relationships.*
    34.2. She did not think that an informal [behaviour] agreement, (as proposed by Dr C in her meeting with the DC on 1 March 2019) would adequately address the *concerns that were starting to bubble up.* Asked what those concerns were, she identified them as those of the single other anaesthetist interviewed by ExIn1.
    34.3. suggested that ExIn1 had *hinted* that there was the potential for more information to emerge. She therefore wanted to use the formal MHPS process to *explore that in more depth*; and
    34.4. mentioned a further concern, namely that Dr C had continued to raise issues about the Trust response to the self-medicating incident: part of the problem was the *repeated escalation* by Dr C of her concerns about the Trust's handling of the self-medicating incident.

35. The COO discussed the commencement of an MHPS process with the DWC. The CEO recalls that he was then advised by the COO and DWC that the case required formal investigation.

36. The CEO told us that he did not put up any resistance to initiating a formal process because of his understanding of the concerns held by the anaesthetist he had nominated for interview by ExIn1; the evidence supplied to ExIn1 by his colleagues and himself, including concerns raised with him by other colleagues who were not interviewed by ExIn1; divisions in the department relating back to the issue of alleged fraud (see chapter 7 paragraph e); and the *tension in Anaesthetics*. He told us he was aware by this time of the anonymous letter which *was targeted at an anaesthetist in what we knew to be a divided and troubled team, which made it all the more important not to ignore serious concerns about members of the team*. He also told us that he was seriously concerned and thought it important that the concerns be investigated in order to demonstrate their validity.

37. The CEO told us that he did not know that the anaesthetist that he had put forward to be interviewed by the ExIn1 was hostile to Dr C. Yet he certainly did

know that there was a level of conflict between Dr C and them, as he stated that from his perspective at the time that [they were] *deeply upset about how [they] had been treated by colleagues* (which he appeared to have understood included Dr C).

38. The DWC could not recall whether she was aware of the proposed de-escalation and behaviour agreement raised by Dr C in her meeting with the DC on 1 March 2019 and referred to in the DC's letter of 7 March 2019. She did however recall speaking with the DC, the COO and CEO about the decision to proceed down the formal MHPS route.

39. The DWC told us she thought proceeding down a formal MHPS route was justified on the basis that *matters had got to a point where there was genuine concern about [Dr C]… her relationships in Anaesthetics and with Senior Management* and that, in her view, it was important that these were *thoroughly investigated*. Similarly, to the COO (see paragraph 34 above) she thought that *the issues had been serious when we tried to deal with them informally [through the 31 July 2018 meeting] and although that had not worked…something had to be done*. We were not offered any evidence that anything had materially changed from when she and the CEO had tried to *nip things in the bud* with Dr C in the meeting on 31 July 2018. She told us that the offer to de-escalate (on the part of Dr C) *only happened once the ExIn1 report found no basis for her allegations of bullying*, and so she was sceptical about the proposal.

40. The DWC said that when making the decision to pursue a formal MHPS investigation, she and her colleagues had become aware of the anonymous letter, which she saw as clearly targeted at Dr A and potentially at the MD, and she believed it *raised the stakes in relation to our concerns about the anaesthetics team*, making it important not to *brush the issues with [Dr C] under the carpet.*

41. The COO decided to trigger the MHPS process and wrote accordingly to Dr C on the 26 March 2019. A brief exchange of emails confirms that she was supported in this by the CEO and DWC (although, as set out above, they appear not to have been supplied with a copy of ExIn1's full Report in the light of which the COO made her decision). However, there is no documented record of the agreed reasons for making the decision to launch a formal investigation.

Findings: launching the formal MHPS process

It was not reasonable to trigger a formal investigation under the provisions of MHPS without exploring the possibility of a behaviour agreement (which had been volunteered by Dr C) or other informal options.

42. In reaching her decision, I consider that the COO paid insufficient regard to the fact that Dr C had offered an informal route and to enter into a behaviour agreement. The issue at this stage for the COO, on behalf of the Trust, was what was an appropriate resolution. The Trust's MHPS policy expressly refers to the possibility of informal resolution. As Dr C had expressed a willingness to put issues behind her and enter into a behaviour agreement, in my view this should have been explored.

43. I consider that the DWC and CEO (both consulted by the COO before she made the decision to launch a formal process) also gave insufficient consideration to resolving matters informally, before supporting the COO's decision to trigger an MHPS investigation.

44. The CEO subsequently confirmed to us he was aware of Dr C's proposal as to an informal resolution (by her offer to sign a behaviour agreement) and was also aware of a similar stance adopted by Dr C on 14 August 2018 when she emailed him saying that she wished to *bring the recent episode to a close as a protracted period of disharmony is not in the interests of the executive team, medical staff or, ultimately, the patients*.

45. I note that the CEO and DWC had handled the meeting with Dr C on 31 July 2018 as they had because they wanted to try to address their concerns in an informal way – *nipping things in the bud.* However, as previously noted, I do not agree that the 31 July 2018 meeting could be described as informal. Both the CEO and DWC told us that, in the weeks following that meeting, they approached some of Dr C's colleagues to try to resolve matters informally and to *hold out the olive branch.* Dr C was however on sick leave from early September, and I have not been told about any further attempts to manage the concerns about Dr C's conduct informally in any other way. A behaviour agreement would have offered a possible way forward.

46. The only source of new (or, more accurately, continued) push-back from Dr C following the 31 July 2018 meeting had been in relation to her Speaking Up and the Trust's handling of this. She was entitled to act as she did in this respect, under her contract of employment, her professional Code as articulated in the GMC's *Duties of a Doctor,* and the FTSU policy. What the COO described as *repeated escalation* of this matter is not a valid basis for action because it is directly in response to Dr C's Speaking Up, and therefore, in the terms of the Trust's FTSU policy, would *victimise* Dr C for Speaking Up.

47. There is no obligation for Trust management to take an informal approach under MHPS before embarking on a formal investigation, and the COO, as Case Manager, had understood from her colleagues that Dr C had rejected

previous attempts at informal resolution. But a formal MHPS procedure is relatively lengthy and more complex than pursuing the informal route, making significant demands on the Trust and on the doctor concerned, and without doubt exposing the Trust to additional costs. Strictly speaking its only advantage – from the employer's perspective – is that if found proved it may justify a fair dismissal. In my view - unless dismissal was being seriously contemplated as an outcome - it would have been wise to have at least explored Dr C's offer to enter into a behaviour agreement, without or before embarking on a formal MHPS investigation. There was no valid basis for concluding that she would fail to comply with an informal resolution which she had herself volunteered.

48. Unfortunately, the CEO, DWC and COO did not formally document the basis on which they made the decision to trigger a formal MHPS investigation save for a brief email exchange between the Case Manager and the CEO in which the latter noted his agreement

49. There is no formal requirement to document the reasons for making a decision to pursue a formal MHPS investigation. But whether or not there is any formal policy on this matter, the potential impact on Dr C of the investigation required those administering it to act fairly and transparently at all times. Beyond a brief exchange of emails between the COO, DWC and CEO, there is no record of their considerations. It would have been better practice to document their rationale. Had this been recorded, the reasons for the decision would have been clear, was would the factors the executive directors took into consideration in reaching their conclusion that this major step was justified.

It was unreasonable and unfair to use anonymised concerns about the anaesthetic department as part justification for a disciplinary investigation into a single individual

50. In referring to the *divisions* and *tensions in Anaesthetics* (paragraph 36 above) as a justification for preferring a formal MHPS process, the executive directors responsible failed to recognise that they appeared to be authorising an investigation in part to specifically look into Dr C's responsibility for some or all of the concerns in what was said to be a *divided and unhappy department* in the context of an MHPS process – which, it should be clearly stated, had the potential to end her employment.

There was no evidence to implicate Dr C in writing the Anonymous Letter, and it should have been irrelevant in the decision to pursue a formal MHPS process

51. That the Trust had become aware, two months previously, of the anonymous letter (as mentioned by both the CEO and DWC) should have been irrelevant to the decision about pursuing a formal MHPS process in relation to Dr C. Whilst it referenced the self-medicating incident about which she had Spoken Up, the investigation of the anonymous letter was still underway, and there was no evidence that it had any connection to her (see chapter 9).

The use of a formal MHPS process to explore the potential for further problems to become evident is inappropriate.

52. The suggestion (see paragraph 34 above) that the formal MHPS process be used to *explore in more depth* the potential for more information to emerge, is in my view inappropriate. It is illegitimate to rely in part on entirely unstated concerns (the seriousness of which is obviously impossible to ascertain) to launch a formal MHPS investigation. In saying this I acknowledge that ExIn1 had recommended that further investigation was needed. But it would have been better practice, before embarking on a formal MHPS investigation, to have undertaken further internal analysis to ascertain whether there were any grounds for further concerns to be considered.

The MHPS Investigation - The Terms of Reference

53. The Terms of Reference for the MHPS Investigation set out a number of allegations that Dr C had, since at least 2017, sought to undermine the MD and the senior leaders or Executive Team at the Trust in relation to a number of matters that had been considered by ExIn1 (and which have been have briefly considered elsewhere in this report) including:
    53.1. the process to seek a replacement for Dr C as Clinical Director (see chapter 7 of this report).
    53.2. *leading a disproportionate and unreasonably hostile response* to the MD's investigation into annual leave and the number of clinical sessions delivered by the consultant anaesthetists (see chapter 7).
    53.3. leading the production of an anonymous petition about pay rates for junior doctors (see chapter 7).
    53.4. undermining the MD's clinical competence including questioning a colleague in the Emergency Department (see chapter 7); and
    53.5. making various derogatory remarks about the MD and also about the Executive, including referring to the latter as *Quince House*, saying that she would not engage with Quince House, and circulating a WhatsApp message to a small group of colleagues in August 2018 stating *Honestly, the only thing cheering me up right now is making Quince House suffer.*

New allegation: The alleged *attempted coup* in December 2018

54. The Terms of Reference for the MHPS investigation also included an allegation, made by the anonymous consultant in her interview with the ExIn1 (and supported by the MD), that Dr C led an *attempted coup* against the clinical leadership team for anaesthetics, by leading a plan by a group of anaesthetic consultants to ask the leadership team (appointed by the Trust) to resign. It has not been considered earlier in this report, as it is not said to have occurred until December 2018. The view appears to have been that Dr C was unhappy with the leadership of the CDA and CLA, and that she was *masterminding* a plan to install a leadership team which was more favourable to her.

55. The Review received clear evidence that a number of consultant anaesthetists (although not all) were unhappy at the style of management and particular decisions being taken by the CDA and CLA, albeit there was a recognition amongst many of their colleagues that their challenges were significant, and they were no doubt doing their best in difficult circumstances.

56. These concerns, and underlying tension between the leadership team and some of the other consultants, came to a head at a heated meeting in December 2018, where it appears that those criticised shouted at attendees in response. I consider that Dr C did share the concerns of other colleagues in attendance, and that she did contribute to the debate. However, we have not received any credible evidence that she was leading or instigating the discussion or that she was the most vocal of the attendees.

57. The following day, a different consultant (Dr D - not Dr C) met with the CLA and put it to her that she should consider resigning from her position as she did not have the confidence of the department and she was putting her health at risk. She decided not to resign.

58. The MD told ExIn1 that he was fairly sure that Dr C had tried to orchestrate the *coup*. The MD's evidence consisted of hearsay accounts from various other consultants, who he said had informed him, specifically, that Dr C had tasked Dr D with telling the CLA that she did not have the confidence of the anaesthetics department. We interviewed Dr D, who was very clear that this was not what had happened – he had himself decided to speak to the CLA (whom he described as a friend) as he believed it might be in her interests to step down. He described the suggestion that Dr C had engineered his intervention as *nonsense*.

59. The other doctors to whom the MD referred were interviewed for the purposes of the ExIn2 Report. Although some offered support for the view that, generally, Dr C did not consider the CLA to be doing a good job, they did not offer any specific evidence to support the allegation that Dr C had led a *coup* or

spearheaded the resignation request. The CLA said that she could not say for sure whether Dr C led a leadership challenge but was suspicious because Dr C had been taking notes in the course of the departmental meeting which preceded it. I would observe it is not uncommon to take notes in a departmental meeting.

60. Insofar as the alleged *coup* was an allegation raised against Dr C what had the potential to become a formal disciplinary context, it could have also been raised against every other individual who expressed a view that the leadership team were not performing well. That it was not is inconsistent and unfair.

61. I do not consider that there is any credible evidence that Dr C led a *coup* against the leadership team in 2018. In my view, any consultant (or indeed more junior colleagues) should be entitled to raise concerns with their departmental leadership and for such concerns to result in disciplinary action is extremely surprising.

Further new allegations

62. Later (as I explain further below) additional allegations were added to the Terms of Reference as follows:
    - *62.1.* that Dr C wrote the anonymous letter to [Mr W], *which amounted to a data breach contrary to the Data Protection act 2018 and the General Data Protection Regulation 2016/679 and/or the Trust's policies and procedures; was otherwise inappropriate by being misleading or incorrect; and/or seeking to undermine the Trust's own investigations and responses to its duty of candour; and/or seeking to cause harm to the reputation of a colleague and the Trust; and/or risking causing* [Mr W] *further unnecessary distress;*
    - *62.2.* that Dr C disclosed confidential patient and staff data to the Sunday Times; and that
    - 62.3. Dr C sought to inappropriately discuss/influence and/or undermine the investigation and/or used incentive, pressure and/or intimidation to do so.

63. The Terms of Reference stated that the case investigator should ascertain the facts *insofar as not already set out* and take reasonable steps to gather relevant information and facts, including (1) the ExIn1 Report and appendices; (2) interviewing the [21] witnesses listed (all of whom had been selected by the Trust) ; (3) any other witnesses suggested by interviewees to whom the COO agreed; and (4) any other relevant facts, evidence or information.

64. The case investigator was required to produce a written report and set out for each concern raised any relevant professional standards engaged and his

findings on them. This report was intended to enable the COO to decide whether there was a case of [mis]conduct by Dr C which should be put before an MHPS conduct panel, or for a variety of other actions to be considered (including restrictions on practice, OH referral, an exploration by [PPA] of any performance concerns, referral to the GMC, consideration by a capability panel, or no further action.

65. The COO sent the Terms of Reference to Dr C on or around 5 April 2019. Although Dr C was by then on stress-related sick leave, the COO did not check beforehand with OH whether it was appropriate to send them to her whilst on sick leave.

66. In his quarterly update meeting with the GMC's Employer Liaison Adviser (ELA) on 3 June 2019, the MD noted that the Trust had opened an MHPS investigation into a *consultant anaesthetist* who had *told a senior independent director at the trust that she could not work with the Trust Executive or Board*. He advised that the Trust was concerned that she would be u*nable to escalate patient safety concerns appropriately*, and that she was currently on sick leave. I note that this statement to the senior independent director cited above was made on a single occasion, during Dr C's confidential Speaking Up meeting with the DC and SID on 12 October 2018 (see chapter 8), when she stated that *she and some others now felt unable to engage with Quince House* and that in her reply to the SID's email enclosing the meeting note, she stated that *I just want to reiterate my main focus is to improve the handling of patient safety events and the approach to those who raise them*.

67. The MD is not however recorded by the ELA as mentioning the other concerns that formed the bulk of the matters to be investigated, namely those about the allegations of undermining of himself and other members of the Trust management team, and the alleged *coup*.

The MHPS Investigation: a chronology

The Trust's management of Dr C's sickness and the evolving Terms of Reference

68. The COO provided the Terms of Reference to an external investigator who was engaged to carry out the MHPS investigation. I refer to him throughout this report as ExIn2. During the period from April 2019 and the production of his report ten months later, there were numerous events, meetings, and exchanges of correspondence pertinent to this Review. As I think it important to give a full account in order to properly describe how the process was conducted, the main issues are covered in order by month, in the section below.

June-July 2019

69. At the COO's request, on 25 June 2019, Dr C was assessed by OH to determine her fitness to participate in the MHPS process. The OH Consultant advised that she was not well enough to attend an investigation meeting.

70. The COO requested a second OH assessment, which Dr C attended on 22 July 2019. It was undertaken by a different OH physician. In a report dated 13 August 2019, he also advised that whilst Dr C's psychological well-being was improving, she remained *vulnerable to relapse, which could be precipitated by stress.* Noting that her absence was due to work-related stress in respect of the two investigations pursued by the Trust, he stated that the least risk to her health was to postpone any meetings until she had returned to work from sick and annual leave.

August 2019

71. On 2 August 2019, the COO spoke with PPA about Dr C's case. The COO referred again to the October 2018 letter to Mr W, to which she had also referred in her first discussion with PPA in March 2019 (see paragraph 27 above). The COO explained that there had been an internal review and that Dr C had been identified as *one individual having accessed the patient record*, and that she had previously informed Dr C of *circumstances surrounding the anonymous letter* and that preliminary enquiries were being undertaken.

72. The COO did not add the Anonymous Letter allegation to the MHPS Terms of Reference at this time. However, the COO did discuss Dr C with PPA in the context of her being a **suspect** in relation to the despatch of the letter.

73. On the same call the COO went on to tell PPA that she wished to add an additional issue to the investigation. Namely, that an *unidentified* individual had spoken to the Sunday Times newspaper about the anonymous letter and provided the name of the patient's widower. She considered that this may be a data breach. Further, that the CEO had received second-hand information from a former colleague that that colleague had heard from another colleague at a car boot sale that Dr C and a further colleague were the sources for the Sunday Times article.

74. PPA wrote to the COO on 5 August 2019, and advised that if the Trust wished to proceed as stated on the call it should amend the Terms of Reference and send them to Dr C. It stated that the COO should ensure that Dr C *has*

appropriate pastoral support and should be advised to obtain independent professional advice.

75. On 16 August 2019, the COO wrote to Dr C, via her BMA Representative. She attached updated Terms of Reference. These contained the Sunday Times allegation, as set out at paragraph 72 above, despite this being on the basis of third hand information exchanged at a car boot sale.

September 2019

76. Dr C returned to work on 2 September 2019 on a phased return basis. She was still due to take some annual leave shortly thereafter. As noted above, the OH advice had been to wait until after Dr C's sick and annual leave was complete before progressing the MHPS process. Upon her return, other consultants raised with the COO whether Dr C was really well enough to be back at work.

77. On Dr C 's second day back at work, the COO approached her in a corridor. She suggested that they have a discussion off-site. Dr C told us she understood this to be an opportunity for an informal discussion of the kind which she had originally sought from the Trust. However, that was not the COO's intention, which was instead to seek Dr C's agreement to be interviewed by ExIn2 on an earlier date than that advised by OH. The two met in a nearby garden centre. Dr C told the COO that she wasn't ready to participate in the MHPS process as she was not well.

78. As noted in chapter 9 on 10 September 2019, the Chair of the Medical Staff Committee submitted a *Statement of Concern* on behalf of the Committee, expressing the *grave concerns* raised by *multiple departments in regard to the culture and behaviours within the executive* which had run contrary to the values of FTSU on *multiple occasions*. This Statement was produced as a result of the Trust's attempts to fingerprint and obtain handwriting samples from its employees, [including Dr C], as part of the Anonymous Letter Investigation. As I have set out in chapter 9, in this same period the BMA was corresponding with the Trust on behalf of each of the consultants under investigation objecting to the Trust's approach.

79. On 12 September 2019, the COO spoke with PPA about Dr C's case. The COO raised the issue of the anonymous letter with them for a third time, and that Dr C had *been identified as one individual having accessed the patient record and is part of the preliminary enquiries*. She explained that following handwriting analysis an expert had *concluded that the handwriting on the envelope was more likely than not to be* [Dr C]. Accordingly, the COO informed PPA that she wished to amend the Terms of Reference to include the anonymous letter issue.

80. The COO told us that it was at this stage that she decided to tell PPA about Dr C's suspected involvement in the anonymous letter as it was only then that the issue had moved into the MHPS process, and she *linked it* to the *others that [she] had [had] a conversation* with PPA about. However, I note that the anonymous letter had in fact been consistently raised by the COO with PPA since the outset of the MHPS process in March 2019.

81. The COO also noted during this conversation that the OH physician had advised that Dr C would not be well enough to be interviewed until the completion of her return-to-work programme in November 2019.

82. On 13 September 2019 PPA wrote to the COO to summarise the conversation. It recorded the above and noted that the Terms of Reference for the MHPS investigation could be amended by formally writing to Dr C given that she was not well enough to attend a meeting. The PPA adviser also recommended that the OH physician be asked to review their previous advice in relation to Dr C's attendance at investigation meetings, *in view of these new serious allegations*.

83. On 20 September 2019, the Occupational Health physician wrote again to the Trust management, copied to the COO, following his further consultation with Dr C on 9 September 2019. He advised once again that it was in the best interests of Dr C's health to delay her engagement in the MHPS process until after her phased return and annual leave was complete.

84. On 24 September 2019, the COO wrote to Dr C's BMA Representative to inform him that the Terms of Reference were being amended to include that the Trust *has now received evidence which suggests that* the Anonymous Letter was written by Dr C. A copy of the updated Terms of Reference was attached.

85. Following a telephone call to OH when OH suggested she should write to them formally, the COO wrote to OH on 24 September 2019 to ask what the risks to Dr C's wellbeing would be of meeting earlier than originally planned (i.e. before the end of her sickness absence and annual leave). This was said to be necessitated in light of a *recent development* which was *very serious*.

86. On 25 September 2019, Dr C emailed the COO, copying in the CEO. She wrote that she did not write the [anonymous] letter and felt absolutely *persecuted*. She felt she had been pursued aggressively by the Trust for months. She asked that the Trust release the handwriting samples so that she could commission her own expert analysis. She set out that the only *crime* she was guilty of was Speaking Up and that the Terms of Reference contained protected disclosures she had raised (relating to patient safety investigations and the manner in which a patient's relative had been spoken to) which the Trust had still not adequately

looked into. She *plead[ed] with [the COO] to stop this victimisation before irreversible damage* – was done to both her and the Trust.

87. It was evident from the content of the email that Dr C was still raising and maintaining her attempt to Speak Up and that she was under a great deal of stress.

October 2019

88. On 2 October 2019, the COO received a further Occupational Health Report in response to her request to review their advice about delaying investigation meetings until after Dr C's annual leave. The Occupational Health physician noted that he had previously advised that delaying Dr C's participation in meetings represented the least risk; and that whilst her health had improved in recent weeks, *she remains vulnerable to an increase in psychological symptoms,* and that this *could occur in response to stress*. He assessed that there was a higher risk to Dr C's health of engaging in MHPS processes before her annual leave and phased return had been completed, than by delaying until after that time, and referred to a risk of *deterioration in her mental health*. The letter notes that the phased return to work process that was being followed was appropriate, and he would advise further after Dr C's next clinic visit on 22 November 2019.

89. Despite this clear statement from the Occupational Health physician, on 16 October 2019, the COO wrote to Dr C, via her BMA representative. She set out that although the *suggestion* from the Occupational Health physician was to wait to carry out the investigation interview with Dr C, her own view was that *the risks of further delay are likely to be detrimental to the investigation, to the organisation and potentially to [Dr C].*

90. The COO's letter invited Dr C to a meeting on 23 October 2019 and informed her of her right to bring a representative for support. She continued that if Dr C was unable to attend on that date, she should specify which of three alternatives over the following week would be suitable. The COO explained to us that she took this decision as she wanted to reach a conclusion in the MHPS investigation.

91. The BMA responded on Dr C's behalf on 18 October 2019 noting that they were *…naturally disappointed at the Trust's decision to go against Occupational Health advice with regard to the timing of Dr C 's investigation*. They went on to propose, by way of compromise, that the meeting be split into two, with one meeting prior to the date that OH had indicated she would be fit enough to attend for interview and a second after Dr C had a further OH assessment on

22 November 2019. Taking into account other diary clashes they proposed the first interview be on 4, 5 or 6 November 2019.

92. On 24 October 2019, the COO wrote to Dr C via her BMA Representative. She queried why the meetings needed to be split. The following day, Dr C's BMA Representative responded that the reason was because the BMA did not think that Dr C was *resilient enough to be able to go through the entire investigation in one date* even with breaks. He confirmed that she would attend a meeting on 13 November 2019 (one of the dates proposed by the COO) and requested that the second date be after Dr C had been seen again by Occupational Health.

93. Also, on 24 October 2019, the COO spoke with PPA about Dr C's case. The content of the call was summarised in a letter from PPA on 25 October 2019. PPA recorded that the COO had noted that she had received advice from the OH physician that Dr C was not well enough to be interviewed, but that the Trust had asked this advice to be reviewed and in her view the response from the OH physician did not provide a *substantiated rationale* to delay the interview. PPA recorded that the COO told them that the Trust had taken legal advice and were proposing dates at the beginning of November 2019.

94. In the course of the call with PPA on 24 October 2019 the COO informed the adviser that the MD had written to her to raise an additional concern, that Dr C had spoken with him to attempt to influence the outcome of the investigation, and that *other individuals* had raised this concern informally. Further, another senior clinician had informed the COO that they had felt *intimidated and threatened* by Dr C who had attempted to influence the individual and interfere with the process. In the light of these reports the COO and PPA discussed the possible exclusion of Dr C from the workplace on the basis that she was obstructing an investigation. PPA recommended that the COO meet with Dr C to hear her side of the story and to remind her that her conduct should be in line with professional guidelines.

95. Despite the OH advice given three weeks previously about the risks to Dr C's mental health of attending MHPS-related interviews before she was fit to do so, the COO wrote to Dr C, via her BMA Representative, on 25 October 2019, stating that Dr C was *required to attend* a meeting on 29 October 2019 to consider concerns that she had been discussing the MHPS process with colleagues and that there was a risk her *continued presence in the workplace would* hinder the Investigation. The COO told us that she *was meeting with her [about] her behaviour and speaking to witnesses, and that wasn't in conflict* with the OH advice.

96. Dr C did attend the 29 October 2019 meeting as she had been required to do. The COO informed her that she was alleged to have discussed the MHPS

Investigation with the MD, the Deputy MD and the CDA, and that this would be added to the investigation. Dr C stated that she had not initiated any conversations with witnesses about the investigation, but that *people have seen me upset*. The notes of the meeting record that she stated that the conversation with the MD had been during a course she was running; they had agreed that it was good for people to see them working collaboratively; and that the MD had initiated the conversation and used words such as *healing* and *moving forward*; it had been a positive conversation. Dr C gave her absolute assurance that she would not speak with anyone. She became tearful and said that she hated to think she had upset anyone. The COO ended the meeting by accepting Dr C's undertaking not to communicate about the investigation, and Dr C reiterated that she was supportive of the clinical leadership of the anaesthetics department.

97. The COO decided not to exclude Dr C from the workplace on the basis of the assurances she received from Dr C in this meeting.

October 2019: Dr C raises further concerns

98. Following on from her email dated 25 September 2019 saying, inter alia, she felt unfairly targeted (see paragraph 86), Dr C continued to raise concerns about how the MHPS Investigation was being conducted.

99. On 23 October 2019, Dr C approached the SID to raise her concerns about the MHPS investigation. The SID made a detailed note of these but told her that he had no direct knowledge of the process which was being overseen by the MHPS NED. He subsequently sent an email to the MHPS NED on 20 December 2019 attaching an email from Dr C setting out her concerns. Dr C had told the SID that the MHPS investigation was disproportionate and without grounds, and that she *was being penalised for blowing the whistle*. The SID asked the MHPS NED whether these points had been taken into account by ExIn2. The MHPS NED raised this with the COO who responded the investigation was progressing and was reasonable.

100. Dr C sent an email on 25 October 2019 to the MHPS NED in which she detailed her view that the allegations she faced flowed from her having *Spoken Up* by sending her initial email to the Chair of the Trust dated 27 July 2018 and that she felt she was being *persecuted*. In relation to the investigation into the despatch of the anonymous letter she noted that four of the suspects were consultants (including her) who had been *brave enough* to *Speak Up*.

101. On 31 October 2019, the MHPS NED met with Dr C. Dr C made the MHPS NED aware that she thought she had been Speaking Up. The MHPS NED discussed this with the COO and reached the view that the issues were separate as the MHPS investigation related to different matters and was required to go through matters with a *fresh lens*.

102. Dr C raised a concern about being able to call witnesses. The MHPS NED responded that they would ensure that the COO had Dr C's proposed list of witnesses and why they should be interviewed. Dr C became tearful and set out that she felt picked on and unfairly dealt with. Following the meeting, the MHPS NED spoke with the COO about the witnesses list and the COO informed the MHPS NED that she already had this list.

Witnesses

103. ExIn2 interviewed the list of witnesses provided by the Trust in the Terms of Reference. He completed these interviews whilst Dr C was on sick leave.

104. In a letter to Dr C on 3 October 2019, the COO referred to Dr C having mentioned other potential witnesses to be interviewed by ExIn2, so that she could consider adding them in to the investigation. Dr C proposed a list of witnesses setting out why she considered each had relevant evidence to provide on the Terms of Reference. The COO considered the list in conjunction with ExIn2, and also discussed the matter with the MHPS NED. In his final report, the ExIn2 referred to Dr C's request to add 19 witnesses and explained that he discussed this with the COO and they decided not to interview them all due to the *sizeable cross section of evidence* that had already been gathered*; the prolonged nature of this investigation; issues of relevance, proportionality and the impact of further delay*.

105. Ultimately, the COO and the ExIn2 decided to interview six further witnesses from Dr C's list of 19. He carried out these interviews by telephone, in contrast to his approach to the Trust's witnesses who had all been interviewed in person. The COO explained the decision to Dr C in a letter dated 9 January 2020.

November 2019

106. On 1 November 2019, in response to the BMA representative's *repeated request to split the meeting into two halves and for the second half to take place after* [Dr C's] *OH review on 22 November 2019,* the COO agreed that Dr C's interviews could be conducted over two days, but not to delay the second until after the OH review. She provided 11 and 13 November 2019 as dates. Dr C duly attended on both days, with her BMA Representative.

December 2019 – January 2020: Dr C raises further concerns

107. On 23 December 2019, Dr C wrote to the COO once more setting out her concerns about the MHPS Investigation. She copied this to a number of other recipients.

108. Dr C stated that the situation she was in had arisen *as a direct result* of her raising credible and concerning issues related to patient safety (i.e. Speaking Up), and that in her view the patient issues themselves had now got lost. She enclosed a copy of her email to the Chair of the Trust of 27 July 2018 and stated that there was no suggestion in the CEO's response that anything other than her concerns would be addressed in the meeting on 31 July 2018.

109. Dr C went on to explain her meeting with the DC and SID on 12 October 2018, what she had disclosed to them, and their responses. She explained that it was now clear that the commissioning of the ExIn1 investigation, which was a result of that conversation, *was not the correct course of action* and that the recent position of the Medical Staff Committee supported her. She noted her concern that ExIn1's *investigation, which claimed to be neutral, in every instance favoured the perspective of the Board members who were able to give a collective narrative of the meeting*. Dr C then disputed the conclusions reached by ExIn1.

110. The COO told us that she did not think anything Dr C raised in this email was valid. She discussed the letter with the DWC and responded on 9 January 2020. She set out that Dr C's letter had been passed to ExIn2 and would be referred to by him as far as was appropriate. However, she noted that ExIn2 was focusing on the Terms of Reference (drawn up by the Trust).

111. The COO also used this letter to respond to Dr C's correspondence in relation to witnesses. In particular, she stated that in her view the relevance of each of the 19 witnesses who Dr C had proposed was *not immediately apparent*, which was why she had asked ExIn2 to liaise with Dr C to understand the rationale for their inclusion.

112. Following this, the COO determined that for some proposed witnesses, the relevant issue which they might give evidence on was not in dispute. For others she determined that a short telephone interview would assist in deciding whether a more in-depth and in person interview was required. The COO did not explain which witnesses she considered fell into which category. She stated that if there were particular witnesses which Dr C felt had not been heard, she would *respond accordingly*.

The ExIn2 Report

113. ExIn2 delivered his report to the COO on 11 February 2020 (the ExIn2 Report).

114. I do not propose to detail his findings here, but in summary: The ExIn2 found *reasonable support* for the allegations that Dr C levelled unduly heavy criticism at the MD during and after the Clinical Directors' meeting in 2017 when the matter of her replacement as CD was raised. He also found reasonable grounds for believing that her actions in organising the petition about junior doctor pay rates were undermining of the MD.

115. In relation to the attempted *coup* in December 2018, ExIn2 acknowledged that whilst there was a *lack of direct evidence… there is evidence from several sources which would tend to support the comment and/or comments of a similar nature*.

116. In relation to the allegation about making statements such as that Dr C *was going to make it her life's work to get [the MD] sacked* or similar, ExIn2 acknowledged that whilst there was a *lack of direct evidence… there is evidence from several sources which would tend to support the comment and/or comments of a similar nature*.

117. He also found reasonable support for the allegations:
    117.1. about Dr C having made remarks questioning the MD's competence, including the instance (referred to in chapter 7) about her conversation with the doctor in the Emergency Department, despite *conflicting evidence* from the only witness (the doctor to whom Dr C had spoken);
    117.2. for Dr C broadcasting criticism of the MD's clinical decision making in relation to two clinical cases without stating her grounds for them; and
    117.3. the allegation that Dr C had made unfair criticisms of the MD in mid-2018 to senior colleagues and/or others by characterising his management of concerns about a consultant anaesthetist colleague [Dr A] as inadequate, *weak, conflicted or incompetent.*

118. In relation to the meeting in January 2018, where Dr C was alleged to have led a *disproportionate and unreasonably hostile response to a legitimate investigation led by [the MD] into concerns about a variation in the number of clinical sessions delivered by colleagues,* (see chapter 7) ExIn2 noted that *several witnesses did not support the suggestion*, but that *several witnesses* said that Dr C *stood out* , and that the latter evidence *may offer support for the allegation*.

119. The ExIn2 found support for the allegations that Dr C had sought to undermine senior leaders or the Trust Executive by referring to the Executive as *Quince House* stating that she would not engage with them and being critical of their decisions. However, he did not reach any factual or evaluative findings on this allegation, except in relation to a WhatsApp message sent by Dr C to a small group of colleagues on 4 August 2018.

120. In relation to the allegation that Dr C was the author of the anonymous letter to Mr W, ExIn2 determined that there was a *clear conflict of opinion between the two expert [handwriting] reports,* but that in any event the *evidence would appear to offer reasonable support upon which a reasonable belief in the allegation could be sustained*.

121. He found insufficient evidence to support the allegation that Dr C had disclosed confidential information to the Sunday Times.

122. Finally, he found that despite a *clear conflict of evidence* there were reasonable grounds to sustain the allegation that during *the investigation process, [Dr C] sought to inappropriately discuss/influence and/or undermine the investigation and/or used incentive, pressure and/or intimidation to do so.*

Findings: THE MHPS PROCESS IN RELATION TO DR C

123. I have addressed most of the underlying matters which ExIn2 investigated in the earlier chapters of this report, and, in the case of the *coup*, in paragraph 54 above. From the evidence I have received, I have drawn different, mainly opposite, conclusions to ExIn2. I do not set those findings out again here, save that I provide some further consideration of the finding in relation to the anonymous letter below.

I have serious concerns about the validity and appropriateness of this MHPS process. The decision to launch formal disciplinary proceedings was made on the basis of the ExIn1 report, which had been undertaken as a result of Dr C Speaking Up; if pursued to the disciplinary stage it would therefore have amounted to victimisation of Dr C in terms of the Trust's FTSU policy. Because of the design of its Terms of Reference, the report contained a number of unsubstantiated allegations made by those whose conduct was also under scrutiny.

124. I have already concluded in this chapter that insufficient consideration (indeed we were not told of any) was given to the possibility that an informal approach could be taken to deal with the concerns the Trust management held about Dr C's conduct. But more fundamentally:

125. The decision to launch an MHPS investigation was based on the outcome of the ExIn1 report, which, as I have outlined in chapter 10, was in part based on a set of largely unsubstantiated allegations made by other witnesses (the CEO and DWC – whose conduct was itself the subject of the ExIn1 investigation). Many of these were not put to Dr C so that she could respond.

126. I note, however, the COO had not been involved in these matters prior to being appointed Case Manager for the MHPS investigation, and believed it was reasonable for her to rely on the report as a basis for further action.

127. More importantly, the ExIn1 report was ostensibly commissioned in the light of Dr C's concerns about the conduct of the CEO and DWC towards her in the context of her Speaking Up about the handling of the self-medication incident – which itself was arguably not properly addressed in line with the Trust's FTSU policy due to their not having recognised that she was Speaking Up about her genuinely held concerns. As I have noted in chapter 10, the Terms of Reference set for the ExIn1 investigation inappropriately mingled the Speaking Up with alleged conduct issues. Thus, the launch of the MHPS disciplinary investigation against Dr C arose directly as a result of her Speaking Up and if it had been pursued through to a formal disciplinary stage, would have amounted, however unintentionally, to victimisation.

128. In this section, I will address a number of issues about the handling of the ExIn2 investigation and report, in order to assess the efficacy and overall fairness of the Trust's MHPS process and, within that, the robustness of the Investigation.

The selection of witnesses was unfair and unbalanced

129. Several problems arise in relation to the approach to the witnesses in the ExIn2 Investigation.

130. Only six of the 19 witnesses identified as relevant by Dr C were interviewed by ExIn2. Those not interviewed included:
    130.1. The Chair of the Trust. Dr C believed the MHPS process flowed directly from her attempt to Speak Up to the Chair of the Trust. The Chair had relevant evidence to give.
    130.2. The ODPs who observed the self-medicating incident. The Trust raised an allegation that Dr C was making *unfair* criticisms of the MD's investigation of the self-medicating incident and the ODPs (who had not been interviewed at the time) had relevant evidence as to the scale and scope of the investigation initially undertaken by the MD prior to his and the DWC's conclusion that Dr A could immediately return to unrestricted duties. As already noted, (see chapter 6), the GMC ELA had asked the MD to update

him on the Dr A case after he had spoken with the ODP[s] involved, but this was not done. I agree with the GMC ELA that the ODP[s] were relevant witnesses.

130.3. Dr C listed other clinicians who in her view had evidence to provide, giving details of the relevant events in respect of each witness.

131. The COO understandably endeavoured to take a reasonable and proportionate view of the witnesses to be interviewed and discussed the matter with ExIn2. She considered that, because the Trust already had other witnesses giving an account of those events, it was not proportionate to include more. However, that failed to take into account or properly consider that Dr C's witnesses might say **different** things than those witnesses selected by the Trust and upon whom the Trust was relying. Dr C was a highly experienced and senior anaesthetist who found herself in serious difficulty in relation to her employment. I therefore concluded that the COO, as Case Manager should have erred on the side of allowed her to properly set out her defence. The MHPS process would proceed on the basis of the factual findings from this investigation. Accordingly, the evidential basis had to be sound and the Trust was under a duty to Dr C to afford her a fair opportunity to adduce evidence.

132. In contrast, all of the witnesses selected by the Trust were interviewed. I consider that it was not reasonable to refuse to interview all save six of the 19 proposed by Dr C, for a number of reasons.

133. First, the decision about witnesses failed to have regard to the fact that Dr C was facing what could become a disciplinary investigation with potentially career-ending consequences for her. In these circumstances, she had a right to raise a defence, and such defence extended to the evidence gathered as part of this investigation. There was no question of a third, even larger investigation taking place later when she could otherwise vindicate herself. Accordingly, it would have been wiser had the default position been that Dr C could bring evidence before the investigator unless it was obviously irrelevant. The evidence she proposed did not, on any reasonable view, fall into that category.

134. Second, not only did the COO fail to adopt this approach, but those witnesses proposed by Dr C who were interviewed were interviewed by telephone only. In the context of all the other witnesses having been interviewed face to face this raises an issue as to an appearance of not taking the witnesses proposed by Dr C witnesses seriously – potentially an appearance of bias.

135. Third, in the final Report, ExIn2 listed three individuals whom he had interviewed but, in his opinion, did not have relevant evidence to give. He did not include their evidence in the annexes to the report, and therefore the

relevance of what they said could not be independently verified by the Trust or Dr C.

Undue pressure was put on Dr C to agree to be interviewed earlier than Occupational Health advised. This was unjustified and inappropriate, and paid inadequate regard to Dr C's welfare.

136. I have set out above the COO's actions in relation to moving the interview with Dr C forward, and seeking her out on her second day back at work after a nearly five-month period of stress-related sick leave, in an attempt to persuade her to agree to be interviewed earlier than the Trust's own OH advice thought appropriate.

137. I do not agree that the seriousness of the new issue – that of the anonymous letter - mandated increased expedition in the MHPS process. Whilst it was undoubtedly very serious, the allegation was by now a historical matter (the anonymous letter having been sent in October 2018 and reported to the Trust in December 2018) and there was no suggestion of any repetition. Thus, there was no increased urgency which justified arranging to interview Dr C contrary to the Trust's own OH advice, nearly a year later.

138. Although the Trust was required to conclude an MHPS process with reasonable expedition, this is not an overriding requirement. The Trust was also under a duty to consider the welfare of Dr C. The clear assessment from OH on Dr C's welfare was – as clearly spelt out in three separate letters sent to the COO between July and October - that proceeding to interview her on an expedited schedule ahead of the conclusion of her sickness and annual leave was a **greater risk** than not doing so. The COO took the view that it was more important to proceed. She told us that she was concerned about Dr C discussing the MHPS case with colleagues and causing *potential patient safety concerns due to tensions with the anaesthetic department.* I do not however agree that there was a reasonable basis for going against the advice that had been given. Moreover, the dogged pursuit of the objective of bringing forward the interview date – including through several letters as well as the above impromptu and ill-timed meeting with Dr C – added to the pressure on Dr C and her representatives, to the extent that they offered the compromise of an earlier – albeit split – meeting than had been recommended by OH. We conclude that the COO's approach was foreseeably detrimental to Dr C.

139. In this regard, I note NHSI Chair Baroness Harding's 2019 guidance from the Amin Abdullah case. The Trust was aware of this contemporaneously and should have acted in accordance with it. It is extremely important to proceed with care during a disciplinary process to avoid psychological harm or distress

to a member of staff. We conclude that the COO as Case Manager did not take the requisite care in her approach towards Dr C.

140. Aside from the impact of the Trust's approach on Dr C, it also carried risks to the robustness of the investigation. When a witness is not in a fit state to participate fully the best evidence is unlikely to be obtained from them.

141. ExIn2 caveated all of his findings with language that there were *reasonable grounds* to hold a particular conclusion, rather than that he had in fact reached that conclusion on the civil standard of proof (the balance of probabilities). He later told us in interview that this was simply his chosen method of expression and that the wording did reflect his belief that a number of the allegations had been upheld on the balance of probabilities.

142. In common with ExIn2's other conclusions, he did **not** find that Dr C *did,* on the balance of probabilities, write the anonymous letter. Instead, he concluded that there *is evidence that would appear to offer reasonable support upon which a reasonable belief in the allegation could be sustained*. I have reached the opposite view on this issue, for the reasons stated elsewhere. However, I address ExIn2's reasoning here in brief.

143. First, ExIn2 states that access to the patient's records was *limited* but included Dr C. I should be clear that ExIn2 will not have been aware of the details of the problematic anonymous letter investigation as set out in chapter 9. He will therefore not have been aware that in fact, there was **potential** access to these records by **all** staff who had access to an open terminal in the Theatre complex and **actual** access by least **131** staff members in the relevant period. That is not, by any stretch of the imagination, *limited*. As the PPA were later wrongly informed by the MD, ExIn2 may have understood (although he does not expressly say so) that there was no good reason for Dr C to access the records when she did. But she had legitimate clinical reasons for doing so – which she had already described to the Trust. After her involvement in the patient's care shortly before the patient died on 30 August 2018, there is no record of Dr C accessing the records again: the anonymous letter was not sent until six weeks after the patient's death.

144. Second, ExIn2 refers to Dr C's *unwavering* pursuit of the self-injection incident against Dr A despite reassurance, as well as an *unwavering* view that the MD had got it wrong and/or was *softening the facts* (to the GMC): this latter expression was said to *chime with the suggestion of concealment of facts within the letter*. However, simply because Dr C had some consistent concerns about the way the self-medicating incident had been dealt with by the MD did not, in my view, make it more likely that she would take the qualitatively very different step of contacting a patient's widower. That is all the more so as she **never at**

any point stated that she was concerned that Dr A had any culpability in relation to Mrs W's death.

145. There were other staff within the Trust at the time – and we have interviewed several of them - who held a similar view to Dr C on the Trust's approach to the self-medicating incident (none of whom were subject to an MHPS investigation). Indeed, as I have noted in chapter 9, the evidence indicates that Dr C did not write the letter. At the time the letter was sent to Mr W, Dr C was legitimately and openly pursuing channels of Speaking Up to the NEDs – the SID and DC (whom ExIn2 did not interview). Dr C had no reason (at that time) to consider that they would fail to respond to her concerns fully. Accordingly, as I concluded in chapter 9, her motivation was highly unlikely to be the disruption of that process by contacting a patient's family directly.

146. ExIn2 refers to his having had limited access to the instructions given to the handwriting expert commissioned by Dr C and expresses a concern about the objectivity of her expert's analysis. He draws the conclusion that he found the Trust's expert to be more reliable. But as noted above, he was unaware of the shortcomings of the anonymous letter investigation, and the fact that, as noted in chapter 9, it is significant that the sample presented to the Trust's handwriting expert did not make clear that the cohort of potential suspects was at least 131, and not 5.

147. Taking into account these factors, the handwriting analysis is in my view simply not a conclusive or a safe basis on which to conclude that Dr C sent the anonymous letter.

Next steps after the ExIn2 Report

148. Dr C was provided with a redacted copy of the ExIn2 Report on 26 February 2020 (which did not include the statements taken by ExIn2). The next step under the MHPS policy would have been for the COO to decide whether to progress the case to an MHPS Panel on the basis of the ExIn2 Report. However, the remainder of the MHPS process, including any decision on progression, was put on hold following the initiation of this Review in early 2020.

149. Almost a year later - and 21 months since the MHPS process was launched – we were advised that the Trust decided to drop the MHPS process.

12: Other Relevant Bodies

1. The Terms of Reference for the Review require me to *consider the appropriateness and impact of the actions taken in response to the issues raised by/ connected with the October letter* (NB referred to throughout this report as the anonymous letter) *by the Trust and other relevant bodies; and to produce advisory recommendations and learnings*

2. So far as *other relevant bodies are concerned,* I have interpreted the term *appropriateness and impact of the actions taken in response to the issues raised by/ connected with the October letter* to be referring to:
   2.1. the handling of the self-medicating incident (described in chapter 6).
   2.2. the Trust's decision to focus upon **who** had sent the anonymous letter (see chapter 9), rather than the – in my view more important - question of **why** it had been sent.
   2.3. the Trust's decision, in pursuit of the attempt to identify who had sent the Anonymous letter, to seek biometric data – handwriting samples and fingerprints – from members of staff; and
   2.4. the concerns raised externally about the approach to those who had Spoken Up about these issues.

3. We interviewed representatives of:
   - NHS England and NHS Improvement: Enquiries, Complaints and Whistleblowing (ECW).
   - NHS England and NHS Improvement: East of England (NHSEI).
   - The General Medical Council (GMC).
   - Practitioners Performance Advice (PPA) (formerly NCAS and now part of NHS Resolution); and
   - The Care Quality Commission (CQC).

4. All were generous with their time and willing to supply copies of relevant file and meeting notes and correspondence. I am grateful to them all for their openness and transparency.

NHS England and NHS Improvement: Enquiries Complaints and Whistleblowing (EWC)

5. The Enquiries Complaints and Whistleblowing team (ECW) receive and log complaints from those who consider themselves to be Speaking Up. ECW do not, themselves, investigate such concerns but they do signpost those who

contact them to relevant policies on Speaking Up and how to pursue a concern with their employer.

6. If, however ECW consider that any complaint raised with them might signal underlying problems with how the Trust is being governed they may contact the Trust for more information and /or refer the matter to another organisation such as the CQC or the relevant Regional Office.

7. Around the time of the events with which the Review were concerned EWC were contacted by three individuals who considered themselves to be Speaking Up or whistle blowing about the Trust, two of whom were clinicians. The third was raising an issue unrelated to this Review.

8. Detailed notes of telephone calls and correspondence with separate EWC officers record that the issues raised included:
   8.1. Patient safety concerns about the handling of the self-medicating incident
   8.2. the proposed use of biometric data (fingerprints and handwriting samples) in the investigation into the anonymous letter.
   8.3. that those upon whom suspicion had fallen in the anonymous letter investigation had been told that failure to provide consent to the use of biometric data could indicate they were the author of the anonymous letter; and
   8.4. that one of the doctors (who had) raised concerns to the Chair of the Trust about the self-medicating incident had been told that their conduct was undermining the Medical Director, and (was) now the subject of a disciplinary investigation.

9. One of the whistle blowers, when asked *What do you want us to do?* responded: *Talk to the CQC. Raise concerns with the Trust.*

10. One of ECW's case workers sought further information from each of the individuals who had contacted them. In the light of the concerns expressed, the Head of Advocacy and Learning (Head of Advocacy) of ECW wrote to the CEO on 17 September 2019, flagging his concern that the Trust may be *focusing on identifying the author of the* [Anonymous] *letter rather than investigating the potential patient safety issue and understanding the reasons why the author of the letter felt the need to raise their concerns anonymously in this way*. He advised the CEO that EWC had drawn the CQC's attention to this matter, and that the CQC would explore it in more detail during their imminent inspection.

11. The CEO responded on 27 September 2019. The CEO's letter was written from the Trust management's perspective, and included the following points:

11.1. Over the previous three years the *anaesthetics team had become increasingly and negatively polarised,* and that *one of the driving forces behind this polarisation has been a charismatic, senior consultant, Dr* [C], and that she and *her faction…have sought to self-regulate the team* and *to undermine the Medical Director and to ostracise or force the exit of individual colleagues who have fallen out of favour;*

11.2. The self-injecting incident had been fully and appropriately investigated, and the subsequent MHPS disciplinary process had been *subject to subsequent rigorous Board scrutiny* through a review which he had undertaken personally and a full report to a closed Board meeting.

11.3. He and the DWC had met with Dr C on 31 July 2018 to address their concerns about her behaviour informally, and that *she did not react well.* The letter does not mention that this meeting had been arranged immediately following Dr C's letter to the Chair of the Trust raising concerns about the handling of the self-medicating incident; and

11.4. An external investigation had been commissioned following Dr C raising concerns to two of the Trust's NEDs, which had found that the CEO's concerns about Dr C and the conduct of the meeting were *reasonable and justified.* An MHPS investigation was now in progress.

12. The CEO's letter went on to justify the Trust's actions in relation to the anonymous letter which up until that point had included seeking consent to take fingerprints from seven of the Trust's employees *who had accessed the* [patient's] *records without …a clear reason…or with a known agenda against Dr Y (namely Dr* [C] *and Dr* [E]*)* in relation to the despatch of the anonymous letter (although by late September 2019 the Trust had abandoned these attempts). The CEO noted that following the handwriting analysis conducted by the Trust, the terms of reference for the MHPS investigation into Dr C had been extended to include the issue of whether she had written the anonymous letter.

13. Following their exchange of emails, the CEO arranged to meet with the Head of Advocacy on 15 October 2019. That meeting was ultimately attended by the CEO, Chair of the Trust, COO, MD and the Trust's lawyers in addition to the NHSEI East of England Regional Medical Director (RMD) and a senior representative from the CQC.

14. After the meeting, the Head of Advocacy wrote to the CEO on 25 October 2019 noting that he had stated at the meeting that much of what the CEO had described *demonstrate*[d] *good practice.* He has clarified to us that by this he was referring to the support that the Trust had offered to Dr A, the involvement of the Trust's non-executive directors, as well as the seeking of legal advice and advice from PPA; and that he did **not** mean the use of fingerprinting and handwriting samples in the anonymous letter investigation.

15. The Head of Advocacy's email also stated that he was considering the feedback he would give to the individuals who had been in contact with EWC. The potential draft feedback in his letter included, with reference to the decision to seek fingerprints from staff (whilst noting that the trust was no longer pursuing this), that *while there is learning to be had from these matters, we do not consider that the approach the trust has taken to the investigation raises substantive governance concerns.*

16. Also in the same email to the CEO, the Head of Advocacy requested further information, including the Trust's November 2018 Board paper about the investigation into the self-medicating incident, and emphasised the importance of a *comprehensive action plan, to be ready for the conclusion of the current* [MHPS – Dr C] *investigation.* He told us that the latter plan was not produced to him.

17. The CQC had commenced their inspection of the Trust on 24 September 2019 and provided an update to ECW in relation to the evidence they were gathering. Against that background the Head of Advocacy's concerns escalated.

18. In December, the ECW received a copy of an internal Trust briefing which they read as indicating that the ECW had *backed* the Trust's investigatory approach in relation to the anonymous letter. They were clear that it did not accurately reflect their position.

Advisory Recommendations for Enquiries, Complaints and Whistleblowing (ECW)

19. ECW received the concerns of those who were attempting to Speak Up courteously, being explicit as to their role and that they could not, save in rare circumstances, undertake an investigation into those concerns.

20. As requested by one of the individuals who contacted them, ECW alerted both the Trust and the CQC to the concerns that had been raised and were diligent in following up with the Trust to secure the further information and documents that had been requested. It was particularly helpful that the CQC were made aware of the issues in advance of their inspection of the Trust in September.

21. There were considerable differences between the respective accounts of the events in question given by the whistle blowers and the Trust leadership. As a result, the ECW should perhaps have pursued those differences more actively with the Trust. However, one of the two principal whistle blowers only wanted to consent to their identity being revealed if it could not be avoided, and so I

accept ECW might have felt inhibited in pursuing the issues more actively in case that risked inadvertently identifying the employees who had contacted them.

22. Henceforth I recommend that:

22.1. ECW should make formal records of all meetings with NHS bodies convened to address possible Speaking Up concerns (there is no agreed record of the meeting on 15 October 2019 although it is possible that the Trust's solicitors made a note that was not agreed with ECW); and

22.2. ECW should ensure that any proposed communication referring to them must be agreed with them in advance. Had they done that on this occasion they would have had the opportunity to correct the account given by the Trust which they considered to be erroneous.

NHS England and NHS Improvement (East of England) NHSEI

23. In 2019 the Trust was rated as Outstanding by the CQC and in segment 1 of NHS Improvements' Single Oversight Framework. As such they attracted – indeed required – little scrutiny.

24. The Regional Director, East of England (RD) took up her post in April 2019, coming into the East of England region for the first time having most recently been the Chief Executive of Kingston NHS FT. She had not received any written handover in relation to the Trust on her appointment from the regional leads of either NHS England or NHS Improvement. She visited the Trust on 14 May 2019 as part of her induction. The RD has confirmed that she has no recollection of the proposal to seek fingerprints from some of the Trust's staff. Following a request from the Review the RD has confirmed her office has no contemporaneous briefing material or records of the visit – noting that this was her second month in post and her first visit to the Trust.

25. The following month representatives from the Regional Office [RO] attended an Oversight and Support Meeting with representatives from the Trust. In the course of that meeting reference was made to possible *whistleblowing* by a former consultant who had been dismissed by Trust. In view of the subject matter a second, private, meeting was held to discuss the matter. The case of the dismissed consultant was unrelated to matters considered by the Review and so I have not sought any information about it (from the Trust or the RO). I did however inquire whether, in that meeting or in the course of any subsequent follow up to it, the RO representatives have any record of being told about the possibility of the Trust seeking fingerprints or biometric data from Trust staff. The RO have confirmed they have no such records.

26. It was the Trust's decision in March 2019, through the terms of reference drawn up for the anonymous letter investigation, to seek to obtain biometric data from members of staff whom they suspected of having written the anonymous letter writer which later led to:
    26.1. Strong protests from their Medical Staff Committee, in September 2019 (see chapter 9).
    26.2. Adverse press coverage from December 2019 onwards (notably in the Guardian and the Sunday Times).
    26.3. Close scrutiny from the CQC.
    26.4. Significant distress to the staff involved; and, possibly,
    26.5. the commissioning of this Review.

27. NHSEI East of England were not briefed **in advance** of the decision to seek fingerprints in order to track down the author of the anonymous letter - nor was the Board consulted about the proposal to seek biometric data from members of their staff. Whilst some members of the Board (including the Chair, and the MHPS NED as well as a number of the executives, were made aware of the decision to seek biometric data I was startled to learn from two of the Trust's non-executive Directors that the first they learnt of it was when the Guardian broke the story in December 2019.

28. The failure to brief the unitary Board and/or the Regional Office at an earlier stage in the process was unfortunate not least because it meant they did not have the benefit that such discussion would have brought. Had they done so they might have been dissuaded from their intended course which proved extremely damaging to members of their staff and the Trust itself.

29. The Regional Medical Director East of England (RMD), also took up his post in April 2019 having previously been the National Director for Professional Leadership in NHS Improvement. Prior to joining the East of England Regional Office, he had had no previous dealings with the Trust and, in his initial few months in his new role was focusing his attention on supporting Trusts within the Region who were formally in Special Measures.

30. Whilst he may have previously met him in a group setting (in a meeting open to all Medical Directors in the East of England) the RMD's first one to one meeting with the MD was on 24 September 2019. The MD had not previously canvassed the RMD's views about the issues raised by or connected with the anonymous letter. By 24 September 2019, the Trust's investigation into the identity of the author of the anonymous letter had effectively concluded and they had abandoned their demand that their staff supply fingerprints (see chapter 9).

31. Also, in September 2019 the RMD was contacted by the Head of Advocacy and Learning (FTSU) at NHS Improvement in relation to concerns raised with him

by staff at the Trust. In October 2019 he attended the meeting (described in paragraph 13 above).

Advisory Recommendations and Learnings for the Regional Office of NHSEI

32. I concluded that whilst it was unfortunate that the Trust did not seek input from senior colleagues at the Regional Office there was no **requirement** upon them to do so.

33. It was unfortunate that a recent restructuring of NHSEI with the appointment of new senior leaders in the regional offices may possibly have meant that it was less likely that they would pick up relevant intelligence through informal networks than might otherwise have been the case.

34. I make no advisory recommendations in relation to the Regional Office.

General Medical Council (GMC)

35. The GMC work to protect patient safety and improve medical education across the UK. They do this in a variety of ways including by:
    35.1. providing help and guidance to Responsible Officers via their Employer Liaison Advisors (ELAs).
    35.2. receiving and investigating concerns about individual doctors' Fitness to Practise (FtP).
    35.3. operating a Confidential Helpline enabling registrants and members of the public to seek advice in relation to medical practice; and
    35.4. publishing guidance to the profession including *Duties of a Doctor.*

36. All of these GMC services were, at one time or another, utilised by those addressing or subject to the issues arising out the self-medicating incident.

37. The GMC's first involvement was via the Employer Liaison Service when the MD telephoned the Trust's designated ELA on 23 March 2018. This was soon after the MD had first learnt of the self-medicating incident and prior to him having interviewed Dr A about it.

38. I was shown the note of that call prepared by the ELA (and incorporated into an email by them and sent to the MD) on 27 March 2018 following a further call from the MD. It recorded that the MD had told the ELA:
    38.1. that the self-medicating incident had been observed by an ODP (Operating Department Practitioner) who had not been concerned by the incident. The MD had not interviewed either of the two ODPs who had

witnessed aspects of the self-medicating incident when he made that statement. The ELA asked him to do so when possible and report back to the ELA as any difference in their account might change the ELA's advice. The MD has confirmed that he did not speak to either of the ODP's or report back to the ELA on this point. We did interview one of the ODPs who told us she had been very concerned by the incident, suggesting alternative courses of action to the self-medicating doctor (Dr A). This account was supported by the written witness statements both ODPs had supplied to the Deputy Medical Director who undertook the MHPS investigation into the incident; and

38.2. that the Datix belatedly logging the self-medicating incident *may* [have been] *raised retrospectively in retaliation* as other anaesthetists considered Dr A to be a *bad egg* [who] *needed to be dealt with.*

39. The MD did not tell the ELA that at the time of the time of the self-medicating incident Dr A was responsible for an anaesthetised patient *on the table* having left the patient in the care of a more junior doctor in theatre when he had moved to the adjacent anaesthetic room to administer parecoxib and magnesium to himself via an intravenous cannula.

40. The ELA advised the MD that there was no basis for referral in the light of the account supplied. When we interviewed the ELA as part of this Review he told us his advice *might* have been different had he been made aware of the patient on the table, as the question of whether or not Dr A met the threshold for a Fitness to Practise referral was *a borderline one.*

41. In the course of the telephone call on 27 March 2018 the MD advised the ELA that [Dr A] had provided a *reflective statement* and that having met the doctor and reviewed matters with senior colleagues (the DWC and Deputy CEO) he had decided there were no grounds to exclude [Dr A] or restrict his practise.

42. In the interim Dr E, who had learnt about the self-medicating incident on 24 March 2018, had called the GMC Confidential Helpline to seek their advice. Dr E noted that whilst she was told the Helpline operator could not comment on specifics until a concern had been logged, it [was] often the case that it is appropriate to place a consultant on leave whilst an investigation into an event of [that] nature was investigated.

43. Whilst it is entirely possible that telephone advice might vary in the light of the information supplied by the caller it is noteworthy that two separate "arms" of the GMC appear to have given differing advice in relation to whether a self-medicating anaesthetist should possibly have been placed on leave whilst the circumstances surrounding his decision to self-medicate whilst on duty and responsible for a patient were investigated. Although Dr E promptly informed

the MD of what she had been told by the Helpline Operator it appears that did not lead him to reconsider the decision he had made on 23 March 2018 to permit Dr A to continue in unrestricted practice.

44. It is also noteworthy that the GMC did not have a system to link calls to the Helpline with calls about the same matters to the ELA service (or if they had such a system it did not operate in this instance).

45. In April 2018 Dr C wrote to the GMC to raise her concerns about the self-medicating incident. A third "arm" of the GMC – the Fitness to Practise team - considered her concerns and, on establishing that the ELA was aware of the matter, informed her that the concerns she had raised did *not meet* [their] *threshold for opening an investigation…*This was despite the fact that (as the GMC's letter notes) Dr C had informed them that the self-medicating incident had occurred *whilst* [Dr A] *was on call consultant for theatre, and with a patient anaesthetised that he was responsible for* [and] *despite requests not to by the ODP that he was working with..;* and the ELA having earlier concluded that this matter was *borderline* for an FtP referral at a point when he had not been aware that Dr A was at the time of the self-medicating incident responsible for a patient on the table nor that the ODP had asked him not to self-medicate.

Advisory Recommendations for the GMC

46. It is self-evident that it is a matter for the GMC to determine what advice it should give those who contact its Employer Liaison Service, Confidential Helpline and Fitness to Practise team. However, it is clear that, in this instance, the advice might not have been fully triangulated in consequence of which apparently conflicting advice was given to three separate registered medical practitioners seeking GMC advice and guidance. With a view to reducing the risk of that happening in the future I would recommend that the GMC give further thought to improving the triangulation (and thus robustness) of their advice.

Practitioners Performance Advice (PPA)

47. PPA – formerly NCAS – are part of NHS Resolution. PPA's role is to provide *impartial and expert advice to healthcare employers ...to support the local management and resolution of performance concerns relating to individual doctors ...*handling *up to 900 new cases each year* ...they are *not a decision-making body. In all cases any decisions about the ongoing management, employment or contractual status of a practitioner rests solely with the healthcare organisation….*

48. PPA were not contacted by the Trust in relation to the self-medicating incident or its aftermath at any point. There was no requirement upon the Trust to seek support from PPA but the decision not to do so was noteworthy given the approach they adopted in relation to Dr C about whom they contacted PPA on fifteen occasions between March 2019 and September 2020. All but one of those contacts were made by the COO, the exception being a call made by the MD (in the presence of the DWC) on 11 March 2019.

49. The MD's call to PPA on 11 March 2019 was a surprising one in that, according to the PPA advisor's letter to the MD following the call, he informed them of the anonymous letter; that the Trust had concluded that the allegations in the letter were *made maliciously and were found to be demonstrably false;* and that *as a result of its records review process the Trust* [had] *identified 7 members of staff (5 clinicians and 2 others) who had,* ***for no clear and obvious reason, accessed records*** *which contained information relevant to the allegations made in the* [October] *letter. …the Trust now intends to seek to interview the 7 staff members* [and] *during this process they may be asked to agree to being fingerprinted.*

50. In his letter dated 13 *March* 2019 the PPA advisor commented *I think it may be advisable for the Trust to seek legal advice as to whether or not it is justified ..in attempting to finger-print a group of its employees for actions which, if proven, may constitute gross misconduct , but which ….****have not been viewed by the Police as being illegal.***

51. The allegation that the clinicians had *for no clear and obvious reason* consulted the notes was untrue, as all of them were able to point to their involvement in the patient's clinical care save for one who could demonstrate they had consulted the notes to extract data required for a national audit. It was therefore surprising that the MD (and by implication the DWC who confirmed to us she had been with the MD when he made the call to PPA) had made such a surprising error in a telephone call of such significance.

52. The Trust did not initially disclose PPA's letter of 13 March 2019 to the Review team, but on its disclosure both the MD and DWC were asked why PPA had been misled. The MD informed us he had simply said what the DWC had asked him to say and that he had not known at the time the call was made that the clinicians had provided a justification for accessing the notes.

53. The DWC confirmed that she had known when the call was made that the clinicians (all consultants who were either involved in the patient's care or who, in one instance, had consulted the notes in relation to gathering data for a

National Audit programme) were able to demonstrate *clear and obvious* reasons for consulting the notes.

54. Neither the MD not the DWC sought to correct the misstatement of the fundamental premise for seeking fingerprints. The MD told us that was because – as noted above – he did not know it was wrong as he had no direct role in the investigation into the anonymous letter. The DWC did not correct it, she told us, as she had not received the letter from PPA which had been sent to the MD.

55. In relation to the second point raised by the PPA advisor (that the Trust should seek legal advice) I was told that the Trust had done so and understood the resulting advice to be to the effect that seeking fingerprints was a known investigatory technique. I did not ask to see, nor were we shown, the legal advice as it was of course covered by professional privilege, but I did ask PPA if they were aware of any previous instance of an NHS body seeking fingerprints from members of their staff. They were not.

56. All other calls to PPA from the Trust were initiated by the COO who was the case manager of the MHPS investigation into Dr C.

57. One of those calls contained another rather surprising error to the effect that Dr C had brought a grievance against the CEO and DWC following the 31 July 2018 meeting (see chapter 10). Dr C had not initiated a grievance against the CEO or DWC at any point. Rather, in October 2018 she had *Spoken Up* to the SID and the DC as they had acknowledged at the time. When, some months later Dr C obtained copies of the letters from PPA to the Trust she challenged the misrepresentation which was then partially corrected in that the COO then indicated to the PPA that the matter Dr C had raised with the SID and the DC had been treated **as though it was a grievance**.

58. Senior PPA advisors told us that they had to rely upon the accuracy of any information supplied to them by NHS bodies.

59. PPA subsequently conducted an internal review of their dealings with this matter.

60. When we spoke to senior representatives of the PPA they told us that their advice to the Trust would not have been materially affected had they been made aware that Dr C had not raised a grievance.

Advisory Recommendations and Learnings for Practitioner Performance Advice (PPA)

61. I considered whether to recommend that henceforth PPA should, as a matter of routine, copy any letters of advice addressed to an NHS employer to the practitioner who is the subject of that advice so that they can be assured they are being given an accurate account by the employer.

62. Having discussed this possible recommendation with PPA I was told that they did not think it would be appropriate as it may discourage some NHS employers from seeking advice. I accept that is a possible risk and so **do not propose to make that a formal recommendation here**, but I would suggest PPA give further consideration to adopting such an approach in the spirit of transparency.

63. PPA told us (and I saw evidence of it in their letters to the Trust) that they already encourage NHS employers to share the contents of their letters and routinely inform Trusts: *The [PPA]…encourages transparency in the management of cases, and advises that practitioners should be informed when their case has been discussed with [PPA] I am happy for you to share this letter with [the practitioner] if you consider it appropriate to do so. [The Practitioner] is also welcome to contact [PPA] for a confidential discussion regarding the case.* I do not know how often Trusts act upon this encouragement and would suggest that PPA might wish to explore that further with the NHS bodies who seek their advice.

64. I do however wish to make a recommendation to PPA that if they are informed the practitioner has made a disclosure under the provisions of Freedom to Speak Up – or may have done so – that the employers be advised as to the terms of the National Policy which is to encourage Speaking Up and assure those who do that they will not be the subject of disciplinary action for having done so.

The Care Quality Commission (CQC)

65. The CQC inspected the Trust between 24 September 2019 and 30 October 2019 and published their report on 30 January 2020. In consequence of that inspection their rating for the Trust was downgraded from Outstanding to Requires Improvement. Amongst their findings were:
    65.1. *Not all staff felt respected, supported and valued or felt they could raise concerns without fear.*
    65.2. *The style of executive leadership did not represent or demonstrate an open and empowering culture. There was an evident disconnect between the executive team and several consultant specialities.*

Advisory Recommendations and Learnings for the CQC

66. I have no recommendations to propose for the CQC.

13: Response to Terms of Reference

1. The Review followed widely reported events arising from an anonymous letter that was sent in October 2018 to the widower of a patient who had died at the West Suffolk NHS Foundation Trust (the Trust).

2. The purpose of the Review was twofold:
   2.1. To consider the appropriateness of the actions taken in response to the issues raised by/connected with the October letter by the Trust and other relevant bodies and
   2.2. To produce advisory recommendations and learnings

3. The Review did not consider the cause of death of the patient at the Trust referred to above which was the subject of a coroner's Inquest.

Issues considered by the Review

Issue 1: How the Trust responded to the concerns raised which led to the circumstances which formed the basis of the October letter

Background

4. In October 2018 an anonymous letter *(*the October letter) was written to the widower of a patient who had been admitted to the Trust's Intensive Care Unit (ICU) on 27 July 2018, having had emergency surgery. Post-operatively, an arterial line had been inserted in theatre, but instead of the intended normal saline the patient was given dextrose solution. The error was not spotted on the day of her admission to ICU, overnight or the following day. At 8pm on 28 July 2018 the error was identified and corrected. The patient remained in intensive care until her death on 30 August 2018.

5. The October letter was sent to the patient's widower on 15 October 2018. It read in part: *We think you should know that the consultant anaesthetist who made the mistake with the fluid into the arterial drip in theatre should never have been at work. He had injected himself with drugs before while in charge of a patient and it was all hushed up and he was at work like nothing at all had happened – but we all knew the truth. You need to ask questions about this doctor and what investigations had been had about him before. We think there is a big cover up. Operating Theatre Staff*

6. The patient's widower received this letter on 19 October 2018 and informed the coroner the same day. He then reported the receipt of the letter to the Suffolk Constabulary on 22 October 2018. He understood the police would liaise with the Trust, but they had not done so by the time he was contacted by the Trust's Deputy Chief Nurse and Head of Patient Safety (DCN) on 20 December 2018 to ask if he had any questions about the Serious Incident Report (that had been undertaken into his wife's care and been sent to him earlier in December 2018). The widower confirmed he had no questions in relation to the Serious Incident Report (which fully disclosed the fluid error) but did want to discuss the October Letter. The DCN sought his authority to obtain the letter from the Police and duly did so.

7. The sending of the October letter was declared a Serious Incident and an investigation launched into the Information Governance breach by the Trust (on the basis that to send the letter the author may have obtained the patient's address from her hospital records). Thereafter the Trust sought to identify its author. The staff we interviewed universally viewed the October letter as reprehensible.

8. The Trust reasonably deduced that the October letter referred to Dr A self-medicating whilst responsible for a patient on the table on 5 November 2017 (the self-medicating incident*),* and the Trust thereafter permitting him to remain on unrestricted duties after the incident was belatedly reported on 22 March 2018. Dr A had also been in theatre with the patient on 27 July 2018 when the wrong arterial line had been put up, although he was not responsible for that error.

9. The seminal event which appeared to have triggered the October letter was the self-medicating incident the investigation of which I found to be inadequate in that it appeared to show insufficient regard for patient safety, the wellbeing of the practitioner, the understandable anxieties of the other staff on duty with Dr A on that day, and the legitimate concerns of other anaesthetists about Dr A's potentially harmful actions.

The Trust's response to the self-medicating incident

10. I concluded there were key shortcomings in the Trust's response to the self-medicating incident. Specifically, the Medical Director (MD) and the Director of Workforce and Communications (DWC), decided Dr A could remain on full duties (including being on-call) immediately and that they neither needed to place him on special leave nor restrict his clinical duties in any way. This decision was made without **first**:

10.1. Speaking with the direct witnesses to the incident. Had they done so they would have learnt that Dr A had persisted in self-medicating himself despite being urged not to proceed and being offered practical alternatives.
10.2. Arranging for Dr A to be reviewed by Occupational Health (OH) to assess his current fitness to work.
10.3. Consulting the Clinical Director of Anaesthetics (CDA).
10.4. Seeking independent expert anaesthetic advice (given the MD (not himself an anaesthetist) had chosen not to obtain anaesthetic advice from the CDA)

11. The first of several senior consultant anaesthetists to raise concerns about the Trust's approach was the CDA, who emailed the MD and DWC on Friday 23 March 2018 (see chapter 6 paragraph 11 for the text of the email). He detailed the concerns he and others felt and asked if *[we] owe it to [Dr A] ...to allow a period of leave whilst all doubts are put to rest?* Neither the MD nor the DWC responded either to this or a subsequent email sent on Saturday 24 March 2018.

12. On 24 March 2018 the MD was telephoned by another senior anaesthetist (then the College Tutor) Dr E who informed him that she had spoken to the GMC Helpline that day on first learning of the incident. She had been told that *whilst they could not comment on the specifics* it was often the case that it was appropriate to place a colleague on leave whilst an investigation was undertaken. Dr E followed up her call to the MD with an email recounting that she had learnt of the incident that day on being told by Dr B that Dr A had returned to work on Friday 23 March 2018 having spoken to the MD and DWC. In her email to the two Directors she provided details of her telephone call to the GMC Helpline and noted *we are now in a position of knowingly having a colleague working in the department who has self- injected intravenous medication while on duty…*she noted that her *concern is that [Dr A] by his behaviour, is showing he needs support and that for reasons of patient safety, should not be working with patients until a decision can be made about his fitness to practice once an investigation is complete.* Dr E was then responsible for the out of hours consultant anaesthetic rota and also raised that Dr A was working in an out of hours capacity with no additional support or supervision in the workplace.

13. The MD and DWC failed to consider the significant and legitimate concerns expressed by other consultant anaesthetists as to the wellbeing of Dr A and the risk to patient safety posed by the self-medicating incident.

14. The Directors could and should have taken time to reconsider their decision to permit him to remain in unrestricted practice pending an OH review and investigation but did not do so. They preferred their assessment of the matter to that of senior consultants in the speciality and colleagues of Dr A, who

believed the Trust owed it to him and the Trust's patients to fully investigate this *red flag* event before permitting him to undertake unrestricted practice.

15. Findings related to the shortcomings in the Trust's response to the self-medicating incident are outlined in chapter 6 paragraphs 20 - 34.

How the Trust responded to the concerns raised about the self-medicating incident

16. In the days and months that followed several senior anaesthetists within the Trust raised their concerns about the decision reached by the MD and DWC (endorsed by the Deputy CEO) to permit Dr A to continue in unrestricted practice pending a full investigation citing concerns about Dr A's welfare and patient safety.

17. When the decision was maintained Dr C consulted the GMC who determined that the matter did not meet the threshold for a Fitness to Practise investigation.

18. Dr C then raised the matter with the Chair of the Trust who passed her email (marked *In Confidence*) to the CEO without having sought her permission first. The CEO and DWC did not view Dr C's email to the Chair as an exercise in *Speaking Up* but rather as an attempt to undermine the MD.

19. Having invited Dr C to meet with him and the DWC on 31 July 2018 to discuss her email to the Trust Chair, the CEO and DWC conducted what they intended to be an informal performance management meeting with Dr C on 31 July 2018, raising with her their concerns about a number of aspects of her behaviour, including her continuing to raise issues about the Trust's response to the self-medicating incident. They considered many of these issues to be evidence of attempts to undermine the MD.

20. Dr C – who had not been advised of their intention to raise issues about her conduct in a meeting which she reasonably understood to have been called to discuss her concerns about the Trust's response to the self-medicating incident - protested and the meeting quickly became adversarial. Dr C became very distressed. In the days that followed she resigned her position on a number of Trust Committees and her role as the Guardian of Safe Working. Shortly thereafter she went on a two-month period of stress related sick leave.

21. I saw no evidence that the Trust recognised that the concerns raised by Dr C in her email to the Chair of the Trust fell within their own Freedom to Speak Up policy (FTSU policy), which was modelled on the National policy dated April

2016. However, the concerns did. Both policies included, under the heading *What concerns can I raise?*

21.1. *lack of, or poor response to a reported patient safety incident.*

22. See chapter 6 for the narrative and paragraphs 53-58 for my findings about the way that the Trust responded to Speaking up in relation to patient safety concerns arising from the self-medicating incident.

23. Chapter 7 describes how Dr C was misled as to the purpose of, and agenda for, the meeting on 31 July 2018. This meeting set in train a cascade of adverse consequences and led to Dr C Speaking Up to two non-executive directors (which I considered in my response to the sixth term of reference).

Issue 2: How the Trust responded to the concerns raised in the October letter, and to those connected with it raised subsequently, with particular emphasis on the Trust's use of its speaking up arrangements.

24. On becoming aware of the October Letter in December 2018, the Trust should have first considered why any of its staff might choose to raise a concern about patient harm anonymously rather than through its own investigatory process or the Freedom to Speak Up procedure.

25. Had they focussed upon that question (rather seeking to identify the author) it would have assisted them to foster a culture where those who have what they believe to be a legitimate patient safety concern feel free to express it through an appropriate channel.

26. In relation to the treatment of the patient whose care was the subject of the October letter, the Trust had:

26.1. triggered a Serious Incident Requiring Investigation (SIRI) which reported on 21 November 2018,

26.2. discharged their duty of candour to the patient widower and

26.3. reported the death to the coroner.

27. It is entirely possible that the letter writer was not aware of these steps, and so genuinely believed they were raising legitimate patient safety concerns. The Trust could have responded to the discovery of the October Letter in an open and transparent way by engaging with operating theatre and anaesthetic department staff, in order to make it clear that the letter had not only been distressing to the patient's family and wrong in the allegations made within it, but unnecessary given the steps already taken to investigate the fluid incident and the fact that a coroner's inquest was pending which would independently

identify any shortcomings in the care the patient had received. That would also have been an opportunity to provide comprehensive information about the avenues open to any member of staff to raise any concerns about the safety of patient care.

28. Such an approach would hopefully have reassured the author(s) of the October letter, and quelled any ongoing speculation about Dr A.

29. Instead, the Trust paid scant regard to the questions as to why the letter may have been sent, choosing instead to deploy a flawed investigatory process to identify the author of the letter.

30. The style and approach of the investigation had a traumatic effect on affected members of staff, which was still evident when we interviewed them in July 2020. The Medical Staff Committee, on learning about the issue in September 2019, wrote to the Chair of the Trust, to express their concern about *the culture and behaviours within the executive body of the Trust, which have not seemed to endorse the Trust values of freedom to speak up on multiple occasions.*

31. The Trust's efforts to identify the author of the October letter are described in chapter 9 and my findings in relation to them in paragraphs 22-27.

Use of the Trust's Speaking Up arrangements

32. In this Report I consider three distinct occasions on which attempts were made to make use of the Trust's Speaking Up arrangements. Those were:
    32.1. Dr C's email dated 27 July 2018 addressed to the Chair of the Trust. This is discussed in chapter 6 and my findings in relation to it appear from paragraph 53.
    32.2. Dr C's telephone call on 1 October 2018 to the non-executive named in the Trust's policy as having responsibility for whistle blowing (albeit the policy was out of date, and he no longer occupied that role on the Board). This is discussed in chapter 8 and my findings in relation to it appear from paragraph 60.
    32.3. Dr E's email dated 3 October 2018 to the non-executive with responsibility for FTSU. This is discussed in chapter 8 and my findings in relation to it appear from paragraph 60.

Overview of the Trust's operation of Freedom to Speak Up in relation to the Dr A matter

33. In relation to the exercises in Speaking Up at paragraph 32 above, all were ultimately elevated to two non-executive directors. There was some lack of

clarity in the Trust's internal documents as to the precise position each held in relation to the FTSU policy during the period of their involvement but neither they, nor the Trust, took any point on that and for ease of comprehension I referred to them, respectively, as the Deputy Chair (DC) and Senior Independent Director (SID) .

34. Whilst I was impressed by the accessibility and conscientiousness of the DC and the SID in their efforts to understand and address the concerns of both Dr C and Dr E, it was highly regrettable that (as I found in chapter 8), in consequence of having Spoken Up, Dr C was the subject of an investigation undertaken by the first external investigator. That investigation ultimately led to the triggering of MHPS proceedings against her. I found the commissioning of an investigation (not into the matter about which she had Spoken Up but in relation to broader concerns about her conduct) to be inappropriate and to be contrary to the policy, which states: *If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result* (page 2).

35. The attempts to Speak Up did not lead to a comprehensive investigation of the concerns raised by the two consultants, but the matters raised by Dr E were considered by the Board, and in response to their Speaking Up some changes were made to Board governance arrangements which improved Board oversight to some degree. They are discussed in chapters 6 and 8.

Issue 3: The appropriateness and impact of the Trust seeking to identify the author of the October letter and the steps it took in doing so, including requesting relevant staff to produce fingerprinting and handwriting samples, and any advice/interactions the Trust sought from other relevant bodies

Appropriateness

36. There can be no doubt that the sending of the October letter to the widower of a recently deceased patient was wrong and wholly reprehensible. However, that does not mean that it was appropriate for the Trust to seek to identify the culprit.

37. The police determined that no criminal offence had been committed and were not actively investigating the matter. Identifying the author of an anonymous letter would in any circumstances be very difficult, but for an NHS Trust to choose to divert its resources and the time of executive members of the Board in an attempt to do so (in what was likely to prove a futile attempt) was disproportionate and, in the circumstances, inappropriate.

38. As noted in my response to the second Term of Reference above (see paragraphs 24-35) on learning of the receipt of the October Letter, the Trust should first have considered why one (or more) members of its staff had chosen to raise a concern about patient safety in this way, and what steps it should take to ascertain why they had not felt able to raise their concern directly with the Trust's well-established Patient Safety team and/or via FTSU.

39. I found no evidence that the question of **why** (as opposed to **who)** was considered by any of the decision makers at any point. I describe the appropriateness of the Trust's response in chapter 9 and our findings in relation to that response in paragraphs 22 - 36.

Impact

40. The impact of the Trust's actions was nothing short of disastrous.

41. The poorly designed process (which appeared not to envisage the ways in which the patient's address could have been obtained without traceable access to her electronic records) not only meant that it lacked credibility internally but also that any disciplinary action taken in the light of it was likely to be susceptible to robust and credible challenge.

42. Notwithstanding these inherent shortcomings (which could and should have been foreseen by those directing the process) the Trust subjected several members of staff to interviews which were perceived to be aggressive by the majority. This was reinforced by correspondence which several found extremely hostile. We interviewed all of those who were classed as suspects, and, with one exception, they remained (in my view quite legitimately) distressed and angry about the process eighteen months afterwards.

43. As staff became aware of the style and nature of the investigation, it had a detrimental effect on the atmosphere and culture of the organisation. The minutes of the Medical Staff Committee on 10 September 2019 made it plain that *most people felt that speaking out would only cause trouble for themselves…the executive team's default response was to be defensive and protect themselves and the trust's reputation* (this is more fully described in chapter 9 paragraphs 86-96 of this report).

44. My description of the investigation triggered in an attempt to identify the author[s] of the October letter appears in chapter 9 and my findings in relation to it in paragraphs 67-74.

The steps the Trust took

45. The Trust started from the proposition that they could identify the writer of the October letter by ascertaining who had accessed the patient's electronic notes to obtain their address.

46. This approach was flawed as it was predicated upon:
    46.1. an assumption that the address had been discovered by accessing the electronic notes; and
    46.2. that all of those who had accessed the electronic notes could be identified.

47. In relation to the first proposition, they overlooked the continuing maintenance of paper notes throughout the Trust (including in ICU where the patient had been treated for several weeks) which could have been accessed by employees without leaving any *digital footprint*.

48. In relation to the second proposition, they overlooked the existence of computer terminals in the theatre suite that anyone could access without the need to use their personal log in.

49. Accordingly, the methodology was unfit for purpose. I describe these matters more fully in chapter 9 and my findings are in paragraphs 22-36.

50. Matters were made much worse however by the approach the Trust took to its decision to narrow the field of suspects. The initial Information Governance (IG) analysis had identified 201 staff who had accessed the patient's notes leaving a digital footprint. That list of 201 was then reduced by an opaque process to a list of 131 staff.

51. All 131 were written to, to establish their reason for accessing the records. As a large number were clinicians who had been responsible for aspects of the patient's care, that did not, of itself, take matters much further. Having exhausted the tools available to them the Trust's IG staff then passed the investigation to the HR team.

52. At that point further criteria came to the fore. The numbers would be reduced by focusing upon those who:
    52.1. had for no clear or obvious reason accessed the records; and
    52.2. knew about the self-medicating incident.

53. In relation to the second criterion, a number of interviewees expressed the view that, at least within the anaesthetic team and in theatres, there would be relatively few members of staff who had not heard something about the self-

medicating incident. Nevertheless, the HR team proceeded (via a process that was not detailed in any document produced to me and which none of the Review's interviewees was able to explain) to narrow the field of 131 to 7. Five of this number were consultants who had been involved in the treatment of the patient in ICU or who had a declared reason for accessing their notes (one had accessed the notes to collect data for a National Audit).

54. Despite giving verifiable and legitimate reasons for accessing the notes, four of the consultants were retained as suspects (one of the original five was eliminated having agreed to supply their fingerprints).

55. Of those four, three had raised direct concerns about the self-medicating incident (Drs B, C and E) whilst a fourth had earlier raised other concerns about Dr A in addition to being named by another suspect who said they may have accessed the notes at their request. In the circumstances there was a clear and obvious risk that the majority of the *suspects* could argue they were being victimised for raising concerns about Dr A.

56. I set out our significant concerns about the process adopted by the Trust in chapter 9 and my findings in paragraphs 22-36.

Requesting relevant staff to produce fingerprinting and handwriting samples

57. For the reasons set out in the main body of this Report and above, I had strong doubts as to whether any of the staff identified for further investigation were *relevant* staff (in the sense that the Trust had appropriately asked them to submit to fingerprinting and handwriting analysis). Even if, however, one sets aside those doubts, the requests for fingerprints and handwriting samples for analysis was incendiary.

58. No evidence was produced to me that fingerprinting had previously been used in the NHS in a potential disciplinary investigation such as this where the Police had already confirmed that there was no evidence that a criminal act had been committed. Indeed no one to whom we spoke was aware of any case of fingerprints being sought in any non- criminal NHS investigation.

59. In the event, all bar one of those asked refused to submit to fingerprinting. The majority of the executive directors we interviewed indicated that they could not envisage ever taking such a step again. What is more surprising was that they had not realised before they embarked upon it the scale of the opposition they would face.

60. The requests for handwriting samples came into a different category. Whilst the *suspects* we interviewed were very unhappy about that as well, all eventually consented to supply a sample or authorised the Trust to identify a suitable sample from manuscript records already in their possession.

61. The suspects were not however aware that the DWC had (months before seeking anyone's consent) already arranged for one handwriting sample to be sent to the Trust's handwriting expert – a handwritten envelope the DWC found on her desk which she thought had contained a petition supporting increases in junior doctor pay (see chapter 9 paragraphs 44-60) and which she thought had handwriting similar to that on the envelope which contained the October letter. In the event this did not advance matters as the handwriting expert selected by the Trust indicated the sample was insufficient to permit analysis. The DWC then considered sending a single sample of Dr C's handwriting but accepted internal advice that to do so might *reflect badly upon the Trust.*

62. Over six months later, handwriting samples from five of the remaining suspects were sent to the same expert. The expert was not made aware that the potential group of suspects was larger than the five samples he had access to, by a factor of approximately twenty. The expert concluded that on the balance of probabilities, one suspect's handwriting sample was likely to be the same as in the October letter – an outcome which was the subject of challenge by an expert retained by that suspect.

63. My analysis of this process appears in chapter 9 and my findings from paragraph 60.

Any advice/interactions the Trust sought from other relevant bodies

64. The Review interviewed representatives of
- the Regional Office of NHSEI.
- the Office for Enquiries, Complaints and Whistle Blowing at NHSEI.
- the Practitioners Performance Advice (PPA) service at NHS Resolution
- the GMC and
- CQC

65. and established:
- 65.1. the Trust did not consult the Regional Office of NHSEI prior to launching their request for fingerprints and handwriting samples.
- 65.2. the Trust did not consult the Office for FTSU at NHSEI prior to launching their request for fingerprints and handwriting samples.
- 65.3. the Trust did not consult the GMC prior to launching their request for fingerprints

65.4. the Trust did not consult CQC prior to launching their request for fingerprints and handwriting samples

65.5. the Trust did consult the PPA service prior to launching their request for fingerprints and handwriting samples but materially misled them when it did so.

Issue 4: How the Trust handled allegations of bullying and undermining behaviour by members of staff, including the efficacy of its actions and whether best practice learnings have been sufficiently embedded as a result

66. Although this Term of Reference refer to bullying and undermining behaviour by *members of staff* the central allegation of bullying and undermining relevant to our Terms of Reference was that Dr C had attempted to bully and undermine the MD.

67. No evidence was produced to me that the MD ever lodged a grievance about Dr C's alleged conduct toward him. Nor was any disciplinary process initiated against her in respect of the alleged bullying/undermining behaviour until after she had exercised her right to Speak Up.

68. Whilst I did conclude that, on one occasion Dr C had written an intemperate and inappropriate email to the MD– made worse by her having copied it to a number of their colleagues – no action was taken about that email at the time (see chapter 7 paragraph b).

69. Many additional allegations of undermining behaviour were made in the terms of reference prepared for the second external investigator in relation to MHPS investigation into Dr C's conduct. These were that Dr C had sought to undermine the MD and members of the senior leadership or the Executive Team at the Trust collectively. I considered those allegations, and how they were handled, in chapter 11.

Allegations that Dr C bullied and /or undermined the MD

70. Dr C told us that the first time became aware that the CEO and DWC believed she had been undermining the MD was in the meeting on 31 July 2018. I was not told of any occasion when they had been raised with her prior to that.

71. I described the 31 July 2018 meeting at some length in chapter 7 and do not repeat that account here, save to note that Dr C was not warned that matters relating to her alleged conduct over previous months would be raised at that

meeting and nor was the list of alleged bullying and undermining behaviour produced to her in advance of the meeting or subsequently.

72. There had been a number of clashes between Dr C and the MD in the course of 2017 and 2018 which I described in chapter 7. In one instance I concluded Dr C had sent an intemperate email to the MD which undoubtedly upset him and made at least one colleague feel uncomfortable. The MD and/or the CEO and/or the DWC could and should have raised this and /or other instances which concerned them with Dr C at the time with a view to inviting her to apologise to him and thereafter moderating her language. That did not, however, happen.

73. Intemperate language toward a member of the Executive team could, in extreme circumstances, constitute bullying and/or undermining behaviour but the bar is a fairly high one. All NHS leaders should not only be tolerant of but welcome criticism as it can lead to reflection and, on occasion, change.

74. An investigation under the provisions of MHPS was launched against Dr C in which allegations that she had bullied, and undermined the MD featured. Those proceedings were stayed following the announcement of this Review and later, in 2021, withdrawn. Whilst they are referenced in the body of my report (as an essential part of the narrative) I will not address them here.

75. Following the second external investigation (the one commissioned in connection with the MHPS process) allegations were raised that Dr C was seeking to undermine other members of the senior leadership or Executive Team of the Trust collectively by:
    75.1. referring to them as *Quince House*; and
    75.2. circulating a WhatsApp message on 4 August 2018 to colleagues in which she stated *Honestly, the only thing cheering me up right now is making Quince House suffer (really suffer).*

76. As noted above because the MHPS process has now been withdrawn I will not seek to address those matters here (although they are covered in the main body of my Report: see chapter 11).

The *divided and unhappy* state of the anaesthetic department

77. Many of those we interviewed were of the view that the anaesthetic department was divided and unhappy – yet each witness attributed that to a range of causes and there was no overall consensus as to a singular or predominant cause.

78. Although I explored the possibility of bullying and undermining behaviour as being the cause of the *divided and unhappy state*, in the absence of any sufficient consensus as to cause or complaint as to conduct, I was not able to make any finding on the balance of probabilities in relation to this.

79. Therefore, in response to the questions posed in this Term of Reference I conclude that:
    79.1. The Trust handled the allegations of bullying and undermining of the MD by Dr C ineffectively and badly.
    79.2. The Trust handled allegations that Dr C undermined members of the senior leadership or Executive Team collectively inappropriately by proceeding with an MHPS process; and
    79.3. There was insufficient evidence that the *divided and unhappy* state of the anaesthetic team was due to undermining or bullying on the part of any identified individual. However, there was some evidence that the team was *divided and unhappy,* but the cause appeared to be multi factorial.

Best Practice Learnings

80. On the retirement of the DWC, the Trust appointed a new Executive Director of Workforce and Communications in May 2019. He took up his post in the Autumn of 2019 and in succeeding months made significant changes to the structure of the HR team and the approach to HR practice within the Trust. Whilst he is fortunate in not having had to address the collection of challenges faced by his predecessor it is evident that best practice learnings are being embedded and that the Trust should be better placed in the future.

81. I looked specifically at the Trust's current:
    - attitude toward mediation in contentious HR matters.
    - approach toward allegations of bullying and/or undermining.
    - attitude toward the taking of, and compliance with, Occupational Health advice.
    - understanding of the importance of separation of the investigation of FTSU concerns and performance management or disciplinary proceedings.
    - increased focus on the wellbeing of any member of staff who is the subject of disciplinary or performance management processes.
    - appreciation of the importance of potential challenge from the overseeing non-executive director in MHPS proceedings.
    - work toward improving the staff's confidence in its *Speak Up* culture an aspect of which was surveying Trust staff on *What Matters To You* and basing their staff engagement strategy on the themes that emerged from that consultation.

- continuing support for the *Better Working Lives* project led by the Trust's Deputy MD.
- approach toward the assembly and retention of documentation produced in the course of HR investigations.

and draft policies relating to:

- Managing Conduct and Expected Standards and
- Expected Standards

82. These changes are significant and substantive. If fully embraced and adopted at all levels within the Trust they will greatly lessen – and hopefully eliminate - the errors and missteps that bedevilled the Trust's approach to the matters which are the subject of this Review.

Issue 5: The effectiveness of how the Trust operated Maintaining High Professional Standards in the context of matters arising both prior to and from the October letter

DR A

83. In relation to the events and the period covered by these Terms of Reference the Trust pursued MHPS proceedings against, respectively, Drs A and C.

84. There was no hearing in the process, as Dr A indicated he wanted an agreed outcome, and the Trust accepted this proposal.

85. Whilst agreeing an outcome without the need for the matter to come to a hearing represented a saving in terms of Trust resources, it also meant that there was no opportunity for an independent panel to hear evidence from the witnesses nor, indeed, to form an independent view as to the seriousness or otherwise of Dr A's conduct.

86. It further meant that there was no scrutiny of the decision of the MD and DWC in clearing Dr A as being fit to remain on unrestricted duties, without speaking to any witnesses or taking formal written expert advice.

87. The CEO noted in paragraph 22 of his undated report to the Board (headed "Version 5"), which was considered by the Board at their meeting on 2 November 2018, that the DWC had wanted to issue Dr A with a Final Written Warning. Yet, after negotiation with Dr A's representative, she agreed to issue him with a First Written Warning coupled with a referral to OH (as recommended by the Deputy MD who undertook the MHPS Investigation).

88. These matters are described in chapter 5 of this Report at paragraphs 27 - 34.

89. The potential seriousness of the self-medicating incident should, in my opinion have resulted in this MHPS matter coming to a hearing. This would have ensured:
    89.1. that a Panel could determine the appropriate sanction; and
    89.2. proper scrutiny of the decisions made by the MD and DWC on 23 March 2018 which, if endorsed by the Panel, might have brought the continuing controversy to an end.

90. For these reasons I concluded that the Trust's operation of MHPS was not effective in this case.

Dr C

91. The allegations against Dr C were extensive and are comprehensively described in chapters 7 and 11 in the main body of my report. Given that the MHPS process was, ultimately, withdrawn by the Trust in its entirety, I do not list them here but having considered them during the Review process I concluded that they were ill-founded.

92. The MHPS proceedings against Dr A were processed by the Trust in a relatively straightforward manner: the events were admitted, and the Trust chose not to interview any of the four witnesses to the self-medicating incident.

93. Those against Dr C were far more complex and contentious and the process followed was also more complex and contentious.

94. That process was flawed – initially a number of the allegations were initially put to Dr C in the course of a meeting which had ostensibly been convened to respond to her having exercised her right to Speak Up about the Trust's handling of the self-medicating incident.

95. The FTSU policy is explicit that those who Speak Up will not be at risk of losing their job or suffering any form of reprisal as a result (page 2 of the Trust's policy) and that FTSU processes will be kept separate from any disciplinary or performance management action (page 8 of the policy).

96. The conduct complained of had not been the subject of any prior warnings or grievance processes.

97. In order to resolve many of the allegations, the process required an attempt to establish Dr C's motivation for challenging the MD. This approach risks

victimisation for Speaking Up and/or deterring staff from raising concerns to leadership.

98. The Trust relied upon an investigation undertaken by an external investigator arising from Dr C's attempts to Speak Up as the basis for many of the subsequent allegations which were relied upon in the MHPS process.

99. Dr C was not informed that the first external investigator received evidence of a witness whose allegations were not put to her.

100. The witness referred to above was given a guarantee of confidentiality/anonymity (I cannot be any more specific as if there was a document setting out the terms of that agreement it was not produced to me).

101. The second external investigator interviewed 25 witnesses nominated by the Trust. However, on the instructions of the Case Manager, only six of the 19 witnesses put forward by Dr C were interviewed – and those by telephone (as opposed to face to face which was how the witnesses nominated by the Trust were interviewed).

102. Whilst the COO told me she was endeavouring to take a reasonable and proportionate view of the witnesses to be interviewed, I concluded that there was a lack of balance in the Trust's approach to witnesses. The Trust failed to properly consider that Dr C's witnesses might say different things than those witnesses on whom the Trust was relying; and that as Dr C was under investigation, she should have been allowed to properly set out her defence.

103. The COO also disregarded clear Occupational Health advice and insisted on Dr C being interviewed despite being advised that she was not yet fit for interview.

104. The Trust (the MD on one occasion and the COO on the other) gave PPA incorrect information, whether intentionally or not, on two occasions in the course of the investigation, including alleging that:
    104.1. Dr C had accessed Mrs W's electronic patient notes without a legitimate reason: this was not true, and that
    104.2. She had raised a grievance about the handling of the meeting on 31 July 2018 by the CEO and DWC: in fact, she had Spoken Up about the use of a meeting, intended to discuss patient safety concerns, instead to raise with her concerns about her conduct over a two-year period.

105. For the reasons listed above I concluded the MHPS procedure in relation to Dr C lacked fairness, balance and compassion, and was not effective. I note that, fortunately, the MHPS case has now been dropped. However, having been

launched in March 2019 it was not dropped for 20 months, and was the cause of considerable anxiety and stress for Dr C causing her to take a, for her, unprecedented nine months' stress-related sickness absence.

Issue 6: The effectiveness of the Trust's Freedom to Speak Up arrangements, including the policies, processes, and individual responsibility of Board members according to the "Guidance for Boards "

The Effectiveness of the Trust's FTSU Policy

106. The Trust's FTSU policy replicated the National policy.

107. It had not been updated to reflect a change in the identity of the Board non-executive FTSU champion. In consequence of this, Dr C contacted the former FTSU champion. However, no point was taken by the Trust in relation to Dr C having approached the wrong person and the matter was addressed by both the former and current FTSU champion attending the initial meeting with her.

108. However, in practice, the policy was not effective when a disclosure (which is in substance Speaking Up under the policy) was not expressly labelled as a case of Speaking Up under the policy by the person raising it. This is for the reasons set out below in the 'processes' section.

The Effectiveness of the Trust's FTSU processes

109. We interviewed the FTSU Guardian, who had been in post when the matters dealt with in this report were in process. He had attended relevant training, participated in a regional FTSU reference group and was well-versed in the policy and the protection it afforded those who Spoke Up.

110. However, he was not aware of the matters that had arisen in relation to Dr C as at no point was he consulted by her or any of the Board members who became involved in it. I was assured that had this been reported to him, he would have logged it and ensured that the process set out in the policy was followed.

111. The Chair of the Trust to whom Dr C initially made her Speaking Up disclosure marking her email *In Confidence*, did not seek Dr C's permission prior to passing Dr C's confidential email to the CEO. She did not recognise, nor did she receive advice from her senior colleagues, that the email fell within the FTSU policy. That action was directly contrary to the policy which provides those making disclosures under it are entitled to retain their anonymity

112. Receipt of Dr C's email directly led to the CEO convening the meeting on 31 July 2018 and all that flowed from that which is described in chapter 7.

113. Just over two months later, Dr C tried to exercise her right to Speak Up once more, this time contacting the non-executive champion named in the policy. He recognised, and acknowledged, that Dr C was Speaking Up. He arranged to meet with her, together with the then Board FTSU champion, and conscientiously took up the concerns she was raising with the Chair of the Trust, CEO and DWC. This secured some acknowledgement, and correction, of flaws in the Board's governance arrangements.

114. However, having reached an impasse in relation to the differing accounts of what had happened in the meeting of 31 July 2018 he decided to commission an external investigator. The ensuing investigation undertaken by the first external investigator was not into the matters that Dr C had Spoken Up about to the Chair of the Trust, but instead the manner in which the CEO and DWC had conducted the meeting on 31 July 2018 and whether they were justified in raising issues in that meeting about Dr C's conduct.

115. One direct consequence was that the specific matters Dr C had spoken up about (relating to the Trust's handling of the self-medicating incident) were never investigated separately to the overlapping but different concerns raised by Dr E. Further, Dr C's exercise in Speaking Up became an investigation into her conduct.

116. That derailment was wholly contrary to the FTSU policy (particularly its requirement that no one is victimised for Speaking Up). Accordingly, I concluded that the Trust's FTSU processes were not effective at the material time.

Individual Responsibility of Board members according to the *Guidance for Boards*

117. Dr C first exercised her right to Speak Up in July 2018 and then did so again in October 2018.

118. Dr E exercised her right to Speak Up in October 2018.

119. NHS Improvement and the National Guardian for Freedom to Speak Up first issued the Guidance for Boards on FTSU in May 2018. The Guidance was updated and re-issued in July 2019.

The May 2018 Guidance for Boards

120. The 2018 Guidance listed the expectations of Boards including that:
   120.1. The Board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.
   120.2. The non-executive lead for FTSU [is] required to oversee speaking up concerns regarding Board members. Wherever they do take the lead they should inform the FTSP Guardian, confidentially, of the case... and seek their advice around process and record keeping.
   120.3. The non-executive director overseeing an investigation into a Board member should inform NHSI and the CQC who could provide advice.

121. In this case, the non-executive lead did not seek advice or support from the FTSU Guardian, NHSI or CQC on the approach to the Speaking Up by Dr C or Dr E, nor on the retention of the first external investigator, their terms of reference (or any other matter).

122. The DC has confirmed that he was not aware of the provision set out in 124.3 above that that, as Dr C had Spoken Up to raise concerns about the conduct of the Chair of the Trust, CEO and DCW, he should have informed the CQC and NHSI who would have provided advice. He did not therefore take that step. That omission was unfortunate as I think that either body might well have been able to prevent the, in my view, manifest errors that occurred and which I have described throughout this report.

123. For the reasons outlined in paragraph 125 above I concluded that the May 2018 Guidance was not complied with.

The July 2019 Guidance for Boards

124. By the time the 2019 Guidance was issued, Dr C's Speaking Up exercise was regarded by the Trust as having been dealt with and matters had progressed to the commencement of an MHPS process. It is, however, noteworthy that the 2019 Guidance was significantly strengthened compared to the 2018 version, and contained the following statement in its Introduction:
   124.1. *managers need to feel comfortable having their decisions and authority challenged: speaking up should be embraced.*

125. My investigation has revealed that, in relation to the matters described in this report, this was not the case at the Trust at the time in question.

Appendix 1: West Suffolk NHS Foundation Trust: Terms of Reference for independent rapid review

West Suffolk NHS Foundation
Trust Terms of reference for independent rapid review Introduction

The independent rapid review (the review) of issues at West Suffolk NHS Foundation Trust (the Trust) is commissioned by NHS Improvement at the request of the Department for Health and Social Care (DHSC).

The review will be undertaken by Christine Outram MBE (the Investigator) who will send their report to NHS Improvement once the review is finalised. NHS Improvement will then send the report to the DHSC.

These terms of reference for the review and the investigator's final report will be made publicly available. The individuals who have spoken up have had the opportunity to comment on these terms of reference.

Background

The review follows widely reported events arising from an anonymous letter that was sent in October 2018 to the relative of a patient who had died at the Trust.

Purpose of the review

The purpose of the review is twofold:
- to consider the appropriateness and impact of the actions taken in response to the issues raised by/connected with the October letter by the Trust and other relevant bodies; and
- to produce advisory recommendations and learnings.

The review will not consider the cause of death of the patient at the Trust referred to above which is the subject of ongoing coroner's legal proceedings.

Issues to be considered in the review

The review will consider the following issues:

1. How the Trust responded to the concerns raised which led to the circumstances which formed the basis of the October letter.

2. How the Trust responded to the concerns raised in the October letter, and to those connected with it raised subsequently, with particular emphasis on the Trust's use of its speaking up arrangements.

3. The appropriateness and impact of the Trust seeking to identify the author of the October letter and the steps it took in doing so, including requesting relevant staff to produce fingerprinting and handwriting samples, and any advice/interactions the Trust sought from other relevant bodies.

4. How the Trust handled allegations of bullying and undermining behaviour by members of staff, including the efficacy of its actions and whether best practice learnings have been sufficiently embedded as a result.

5. The effectiveness of how the Trust operated Maintaining High Professional Standards in the context of the matters arising both prior to and from the October letter.

6. The effectiveness of the Trust's Freedom to Speak Up arrangements, including policies, processes, and individual responsibility of Board members according to the "Guidance for Boards".

Recommendations and learnings

The review will provide appropriate advisory recommendations and learnings for the Trust as well as other relevant bodies arising from the identified issues.

NHS Improvement will also consider learnings for the wider NHS and cascade as appropriate.

Access to documents

The Trust and all relevant NHS and non-NHS organisations are expected to cooperate with this review to further the public interest, and to provide the investigator with access to all relevant information, whether oral or in written form.

Timeframe

The review will be undertaken with all due pace and the investigator will aim to complete the review by April 2020. NHS Improvement will share the final report with the Department of Health and Social Care prior to its publication.

Annex

Attached to these Terms of Reference is an Annex setting out various administrative and other matters pertaining to the review.

Annex

Confidentiality & Documentation

All materials provided to the Investigator and produced by the Investigator in carrying out this investigation, are the property of the Commissioning Managers (NHS Improvement) and will remain so.

The Investigator will ensure the safe and secure storage of documentation throughout the investigation and upon completion of the investigation will discuss with the Commissioning Managers secure disposal (both physically and electronically) or delivery up to them of the documentation received and produced during the investigation.

The Investigator will ensure that the investigation is conducted in strict confidence at all times.

Personal data in the investigator's report will be processed by NHS Improvement in accordance with its Privacy Notice (https://improvement.nhs.uk/privacy). NHS Improvement has determined that, given the importance of the issues identified above which form the focus of the review and the public interest in having an independent and robust investigation and report to address them, there are legitimate interests in the processing of personal data and identification by role of a small number of individuals in the report.

NHS Improvement expressly does not authorise the identification of any individuals in the report (other than those who are identified by their senior role).

If an individual requests anonymity the Commissioning Managers have agreed that this can be offered and maintained by the Investigator and NHS Improvement.

Investigator's Obligations

The Investigator will act fairly and without bias (including disclosing any potential conflicts of interest) and will make all reasonable enquiries before making a finding.

The Investigator will ensure that all individuals who are relevant to the investigation are given a reasonable opportunity to participate and provide information to the investigation.

The Investigator will ensure that each interviewee is advised that the evidence they provide in the investigation may be shared with other relevant individuals as part of any subsequent internal processes conducted by the Trust or any related relevant

external process and seek their consent for the information they provide to be shared for this purpose.

Appendix 2: West Suffolk Review – Abbreviated timeline of key events

YEAR	MONTH	DAY	
2017	NOVEMBER	5	Dr A administers magnesium and parecoxib to himself whilst on duty and acting as the responsible consultant for a patient "on the table" (the self-medicating incident).
2018	MARCH	19	Dr C emails MD about concerns held by ICU consultants about Dr A's approach to morbidity and mortality reviews in respect of patients treated in the ICU.
		22	The self-medicating incident was reported on the Datix system by Dr B.
		23	Datix reviewed by DCN and escalated to MD.
		23	MD called the GMC about the self-medicating incident and speaks with an ELA.
		23	MD and DWC telephone Dr B to discuss the Datix.
		23	MD and DWC meet with Dr A to discuss the Datix report.
		23	MD, DWC and Deputy CEO, meet and agree Dr A did not pose a risk to patient safety and could continue to undertake normal duties on Monday 26 March 2018.
		23	CDA emails MD and DWC setting out concerns about Dr A undertaking normal duties on 26 March 2018. Neither respond.
		24	Dr E learns of the self-medicating incident and telephones the GMC's Helpline and the MD– she emails a note of the call later that day to the MD and the DWC.
		24	CDA emails MD and DWC again. Neither respond.
		26	CDA telephones the MD's PA but is advised he cannot meet with MD till the following day (27 March).
		26	CDA meets with Dr A and asks him to undertake administrative work until such time he (CDA) could meet with MD.
		26	CDA called to a meeting with MD, DWC and Deputy CEO and advised that a decision had been made not to exclude (or restrict the duties of) Dr A.

YEAR	MONTH	DAY	
2018	MARCH	26	MD speaks to a consultant anaesthetist in a London Teaching Hospital Trust.
		26	MD emails Dr E advising appropriate processes were being followed.
		26	Drs E, C & F meet with the Deputy Director of HR to express significant concern around the Trust's handling of Dr A.
		27	MD contacts GMC.
		27	MD instigates an MHPS investigation into the Datix report, assigning himself as case manager and the Deputy MD as case investigator.
2018	MAY		Having decided to seek a consultant appointment in another Trust, Dr A arranges for MD to speak to his opposite number in that Trust about the self-medicating incident.
			Dr E and Dr C have an impromptu meeting with CEO and DWC about their concerns about Dr A.
			Dr C subsequently refers Dr A to the GMC in relation to the self-medicating incident.
2018	JUNE	7	Deputy MD delivers MHPS report on the self-medicating incident to MD.
		27	MD and DWC meet with Dr A and HCSA representative to discuss the outcome of the MHPS report and agree to administer a First Written Warning.
2018	JULY	25	GMC writes to Dr C advising that it would not launch a Fitness to Practice investigation into her referral of Dr A in relation to the self-medicating incident.
		27	Dr C emails GMC advising she is not satisfied with the local investigation being undertaken by the Trust and requests the GMC to reconsider.
		27	Dr C emails Trust Chair In Confidence setting out her concerns and requesting a meeting.
		27	Trust Chair forwards Dr C's email to CEO.
2018	JULY	31	CEO asks Dr C to meet with him and DWC about her email to Trust Chair. CEO, DWC and Dr C meet later the same day. In that meeting CEO raises concerns about Dr C's conduct and his belief she is seeking to undermine the MD. Dr C becomes distressed.

YEAR	MONTH	DAY	
		27	Mrs W admitted to ICU at 09:45 following surgery. Instead of the intended normal saline drip she is given a dextrose drip in theatre. The error was not identified until 20:00 on 28 July 2018. Dr A had anaesthetised Mrs W but a subsequent coroner's inquest did not criticise him for the fluid error.
August		1	Deputy CEO advises Dr C that the Executive believed Dr C had questioned the MD's 's clinical competence.
		2	Dr C requests meeting with CEO, DWC, DCN and MD to discuss allegations about her professional behaviour and specifically to deny having questioned the MD's 's clinical competence. Meeting convenes that day – attended by 5 Executive Directors, Dr C and the CDA. .
		4	Dr C emails CEO and DWC referring to the FTSU policy.
		13	CEO writes to Dr C about 31 July meeting advising he would be happy to meet again to discuss any concerns and acknowledging that she was unhappy about the conclusions for which he apologised.
		13	Dr E writes to MD to query what action had been taken with regard to the concerns she had raised, in accordance with GMC guidance about the self-medicating incident. .
		14	Dr C emails CEO saying that she wanted to bring the episode to a close… as a protracted period of disharmony was not in anyone's interests.
2018	AUGUST	24	Dr E writes to CDA outlining concerns about patient safety asking the CDA to raise with the clinical leadership team.
		28	CEO responds to Dr C reiterating offer to "catch up"
		30	Mrs W dies in the ICU.
2018	SEPTEMBER		Dr A joins a new Trust.
		3	Dr C is signed off with work-related stress.
		17	MD advises Dr E that he could not provide further detail about the handling of the self-medicating incident but there was no cause for concern.

YEAR	MONTH	DAY	
		26	Dr E writes to MD once more about her concerns in relation to the self-medicating incident. .
2018	OCTOBER	1	Dr C contacts the DC in his FTSU capacity.
		2	Dr E meets with MD re Dr A and the self-medicating incident.
		5	Dr E meets with CEO about her concerns around Dr A and the self-medicating incident.
		11	Dr E writes to CEO asking for a review of the process where concerns had not been given appropriate consideration by MD.
		12	Dr C meets with SID and DC to raise her concerns.
		15	CEO formally responds to Dr E's concerns.
		19	Mr W receives anonymous letter about his wife's care raising allegations about a "cover up" of the self-medicating incident.
		22	Mr JMW reports the anonymous letter to the Suffolk constabulary.
		23	SID and DC meet with Trust Chair to discuss the circumstances around Dr C's In Confidence email of 27 July 2018.
		26	Dr E meets with the NED with FTSU responsibility (SID) to discuss her concerns about the handling of the self-medicating incident.
		30	The DC contacts Dr C to update her on actions taken to date.
2018	NOVEMBER	2	Private meeting of the Board at which concerns raised by Dr E are discussed.
		2	Private meeting between DC, SID, Trust Chair, CEO and DWC to discuss Dr C's concerns.
		13	DC writes to Dr C summarising her concerns and the Trust's response.
		21	SIRI report into Mrs SJW's death issued
2018	NOVEMBER	22	An External Investigation (ExIn1) process is instigated by the DC into the concerns raised by Dr C. Terms of Reference formulated
		23	SID writes to Dr E to clarify actions arising from the Board meeting of 2 November.
2018	DECEMBER	11	ExIn1 interviews Dr C.
		13	SID meets with Dr E to discuss outcomes from Board meeting relating to her concerns.
			DCN contacts Mr W and learns he had received an anonymous letter in October

YEAR	MONTH	DAY	
			suggesting he should ask questions about his wife's care. (the anonymous letter).
		21	COO appointed as case manager to lead investigation into the anonymous letter. An Information Governance Investigation began to review who had accessed Mrs W's records.
2019	JANUARY	28	131 staff members asked their reasons for accessing Mrs W's records.
		31	A single sample of handwriting sent for analysis to see if it matched the handwriting of the address on the anonymous letter envelope. This later returned to the Trust as having insufficient text upon which to make a judgment.
2019	FEBRUARY	8	ExIn1 finalises report and passes to DC.
2019	MARCH		Report on the Information Governance Investigation produced.
			Trust decides to request biometric data (handwriting samples and fingerprints) from members of staff suspected of writing the anonymous letter.
			MHPS disciplinary investigation launched against Dr C.
		11	MD contacts PPA in relation to anonymous letter investigation
		25	Terms of reference for the investigation to identify the author of the anonymous letter produced, including the use of fingerprints and handwriting samples from members of staff under suspicion.
		25	COO appoints Deputy COO to conduct the next stage of the anonymous letter investigation.
2019	APRIL - MAY		Anonymous Letter Investigation Interviews.
2019	AUGUST		Handwriting samples of five suspects sent for analysis.
			COO writes to those refusing consent for fingerprinting to provide their rationale advises if they fail to give consent that they may be suspected of sending the anonymous letter.
2019	AUGUST	9	BMA responds to Trust re fingerprinting on behalf of the clinicians.

YEAR	MONTH	DAY	
		16	COO responds to BMA stating the Trust had no further options in terms of gathering evidence.
2019	SEPTEMBER	10	Dr E speaks to the Medical Staff Committee about her experience of speaking up, and the anon letter investigation. MSC writes to Trust Chair raising concerns about the 'culture and behaviours within the executive'.
		16	Deputy COO produces the Letter Report.
		17	NHSI Head of Advocacy writes to the Trust about concerns raised by whistle blowers in relation to the anonymous letter investigation.
		24	COO writes to Dr C's BMA representative advising there is evidence that Dr C had written the anonymous letter.
		24	CQC Inspection commences.
		25	Dr C requests disclosure of the Trust's handwriting report.
		27	CEO responds to letter from NHSEI Head of Advocacy.
			Trust abandons demands that the suspects in the anonymous letter in investigation submit to fingerprinting.
2019	OCTOBER		CQC Inspection continues.
		3	COO provides Dr C with the Trust's handwriting report
		5	Dr C provides an independent handwriting report to the Trust and ExIn2 who has been retained by the Trust to conduct an MHPS investigation into Dr C's conduct.
		8	CEO and Trust Chair attend MSC meeting.
		15	CEO and colleagues meet NHSEI Head of Advocacy.
		25	NHSI Head of Advocacy asks for further information
2019	DECEMBER	11	Guardian Newspaper publishes bullying story relating to the Trust
2020	JANUARY	30	CQC report published Trust rating moves from Outstanding to Requires Improvement.

Appendix 3: Terms of Reference – ExIn1 Report

Terms of Reference for Investigation

The following are Terms of Reference provided to [ExIn1] to act as Investigator on behalf of West Suffolk NHS Foundation Trust (the "Trust")

Background

1. [Dr C] is a senior consultant anaesthetist at the Trust. She has formerly been a Clinical Director at the Trust, the Trust's Guardian of Safe Working Hours and Chair of the Trust's Deteriorating Patient Group.

2. On 12 October 2018, [the DC]. Non-executive director and [SID], Senior Independent Director, met with [Dr C] to discuss serious concerns that [Dr C] wished to air. These included concerns about the handling of an investigation earlier in 2018 into an incident involving a colleague. [Dr C] had previously raised concerns about this issue in an email to the Chair dated 27 July 2018. The Chair had passed the email to the Chief Executive, [CEO].

3. [Dr C] alleged that she had been called to a meeting (later established as a meeting on 31 July 2018) in [the CEO's] office, at which [the DWC], the Director of Workforce and Communications was present. [Dr C] stated that a list of her professional behaviours was on the table and felt that "unfounded allegations were levelled at [her] about [her] conduct in this matter". Dr C stated that she felt extremely badly treated and "heavily pressurised" by [the CEO] in what she considered to have been a heated meeting. [Dr C] stated that this belied the espoused behavioural values of the Trust (which were listed on a poster in that same office). [Dr C] felt that the effect of this meeting and preceding events meant she was now "not able to engage with Quince House" (meaning the Trust's leadership team) and also expressed particular concerns about her relationship with the Medical Director.

4. [DC] sought [the CEO] and [DWC's] perspective on the meeting of 31 July 2018. They acknowledged that the meeting referred to may have been difficult for [Dr C]. However, they stated that their intent had not been to criticise the action of escalating concerns to the Chair but that their focus had been on alleged serious concerns about [Dr C's] working relationships with senior colleagues, principally concerns that [Dr C] was undermining the Medical Director.

5. [DC] and [SID] were able to look into and respond to most of the concerns raised by [Dr C] in the meeting of 12 October 2018. However, the two very different perspectives of the meeting on 31 July 2018, the allegations of unacceptable behaviours by [CEO] and [DWC] on one hand and [Dr C] on the other, and the broader mutual concerns about a breakdown in working relationships, require further investigation.

Matters to be investigated

6. The Investigator is requested to investigate the following matters:

6.1. Whether the meeting on 31 July 2018 conducted by [the CEO] in the presence of [DWC]:

6.1.1. A written list of [Dr C's] professional behaviours was put on the table and, if so, whether or not this was reasonable and/or justified or not;

6.1.2. Unfounded allegations were levelled at [Dr C] about her conduct and, if so, whether or not this was reasonable and/or justified or not;

6.1.3. [Dr C] was heavily pressured and, if so, whether or not this was reasonable and/or justified or not; and/or

6.1.4. [Dr C] was extremely badly treated and/or treated in a way which belied the behavioural values of the Trust.

6.2. Whether:

6.2.1. [CEO] and [DWC] had reasonable grounds to hold and conduct the meeting on 31 July 2018 in the way it was conducted; and/or

6.2.2. [CEO] and [DWC] had reasonable grounds to have serious concerns about [Dr C's] behaviour, including that [Dr C] was undermining the Medical Director.

6.3. Whether there are reasonable grounds to be concerned about the working relationships between [Dr C] and senior colleagues and, if so, what impact this may have or be having.

Role of the Case Investigator

7. The Case Investigator is requested to carry out the investigation in an unbiased way, collating information both which might support or rebut or mitigate the perspectives of [Dr C] or [the CEO] or [DWC]. In particular the Investigator will:

7.1. Collate any relevant documents in relation to the issues.

7.2. Conduct witness interviews and produce a record of all such interviews.

7.3. Establish the facts in relation to the matters to be investigated.

7.4. Liaise with [DC] regarding any amendments to these Terms of Reference.

7.5. Produce a written report, making findings of fact, giving the investigator's views on each of the above issues and providing recommendations, so as to assist the Trust to determine what steps to take next.

Witness Interviews

8. The Investigator will seek to interview the following in the first instance:

8.1. [Dr C]

8.2. [CEO]

8.3. [DWC]

9. The Investigator is requested to consider and discuss with [DC] which other witnesses it may be appropriate to interview, if any, having met with the above and taken account of their

representations on this issue. The Investigator may need to speak to some witnesses, particularly [Dr C and the CEO], more than once.

10. The Trust will assign an appropriate co-ordinator to the assist the Investigator to schedule meetings with the witnesses.

Timescales

11. The Investigator is asked to carry out the investigation as swiftly as possible and to report on the anticipated timescales to [DC]. The investigator should aim to complete a report by the end of January 2019.

[DC]
Non-Executive Director
22 November 2018

Appendix 4 – Acronyms

Acronym	
ACSA	Anaesthesia Clinical Services Accreditation
BMA	British Medical Association
CDA	Clinical Director of Anaesthetics
CEO	Chief Executive Officer
CD	Clinical Director
CLA	Clinical Lead Anaesthetics
COO	Chief Operating Officer
CQC	Care Quality Commission
DC	Deputy Chair
DCN	Deputy Chief Nurse
DWC	Director of Workforce and Communications
EBAC	Employer-Based Awards Committee
ECN	Executive Chief Nurse
ELA	Employment Liaison Adviser
EWC	Enquiries Complaints and Whistleblowing
ExIn	External Investigator
FtP	Fitness to Practice
FTSU	Freedom to Speak Up
GMC	General Medical Council
GOSW	Guardian of Safe Working
HR	Human Resources
ICNARC	Intensive Care National Audit and Research Centre
ICU	Intensive Care Unit
IG Investigation	Information Governance Investigation
IGM	Information Governance Manager
IV	Intravenous
MD	Medical Director
MDU	Medical Defence Union
MHPS	Maintaining High Professional Standards
MPS	Medical Protection Society
M&M	Morbidity and Mortality
MPIT	Medical Practice Information Transfer
MSC	Medical Staff Committee
NCAS	National Clinical Assessment Service
NED	Non-Executive Director
NHSEI	NHS England & NHS Improvement
ODP	Operating Department Practitioners
OH	Occupational Health
PPA	Practitioner Performance Advice service
SHO	Senior House Officer
SID	Senior Independent Director
SIRI	Serious Incident Requiring Investigation
The Trust	West Suffolk Hospital Foundation Trust
TOR	Terms of Reference