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Thesis submitted in partial fulfilment of the requirements of the Degree of Doctor of Philosophy.

What do stories tell us about whistleblowing conflict in the NHS in England and its resolution?

Statement of Originality

I, Clive Lampard, confirm that the research included within this thesis is my own work or that where it has been carried out in collaboration with, or supported by others, that this is duly acknowledged below and my contribution indicated. Previously published material is also acknowledged below.

I attest that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge break any UK law, infringe any third party's copyright or other intellectual property right, or contain any confidential material.

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Signature: Clive Lampard

Date: 22nd December 2022.

Details of collaboration and publications: none.

Acknowledgements

First, I must convey my sincere gratitude to the participants in this study, who have given generously of their time and themselves to share their often difficult experiences. I am deeply grateful to you for your willingness to take part in this study and for your invaluable contributions.

I would like to thank my supervisors Dr Debbie De Girolamo and Dr Ruth Fletcher for their knowledge, intelligence, expertise, ideas, guidance, good humour and patience over the course of this project. You have both taught me a huge amount over this period and I hugely appreciate it.

I am bound to say a particular and heartfelt thank you to Dr De Girolamo - Debbie - as my principal supervisor. Thank you Debbie for your unwavering commitment to the project and for encouraging me and believing in me. You have been so supportive and generous with your time, your guidance, your expertise, your patience and positivity, especially in these final months. You have truly seen this through and made it happen, and I can never thank you enough for that.

I also want to say a massive thank you to my immediate family for their patience and understanding over such a long period. You have all lived with this in different ways for as long as I have and especially over the last few months. Hopefully, now, I'll be able to (a) see you more, and (b) talk about something else.

I would also like to thank my brother Duncan for being a sounding board and second opinion about the whole research experience. It has been invaluable to have someone alongside who is also living the highs and lows. I hope very much to reciprocate.

Most of all I want to thank my lovely and long-suffering wife Julia who has had to live with me and bear witness to my agonies, wobbles, failings and frustrations for the seven plus years of this project. I realise it has had its challenges and I can never thank you enough Julia for your patience and tolerance, particularly in the final weeks and months. I had no real idea what I - we, as it turned out - were taking on and I cannot say how much I appreciate your love and support in seeing it through.

Abstract

This thesis examines NHS whistleblowing as conflict from the perspective of story and narrative theory to seek insights about the underlying nature of whistleblowing conflict. It aims to contribute to more informed interventions for the resolution of the conflict and more efficient outcomes.

Publicly available data suggest that whistleblowers in the NHS in England suffer retaliation causing personal suffering and damage to their careers and career prospects. Cases tend to end in damaging and unsatisfactory litigation and there seem to be few acceptable real-world alternatives to those outcomes.

To understand more about the nature of NHS whistleblowing conflict the study draws upon in-depth in-person narrative-based interviews with 21 participants grouped into three constituencies of whistleblowers, NHS managers and independent third parties in order to seek multiple, and group, narrative perspectives. Ancillary data was obtained from over 100 NHS Foundation Trusts by means of freedom of information requests made under the Freedom of Information Act 2000 (“the FOIA”).

Whistleblowing is analysed as conflict, viewed through a model of dispute emergence, framed around two core aspects of whistleblowing, the wrongdoing and the whistleblower. Participant and FOIA data is then analysed from a perspective of storytelling and narrative theory.

The study concludes from this analysis that certain aspects of whistleblowing conflict may be insufficiently recognised and greater attention should be paid to them in order to promote or to design improved or different interventions for the benefit of all parties. These aspects include the need for interventions to take greater account of wrongdoing, and its subjective nature, in seeking resolution of whistleblowing conflict; also, the need to address more deliberately the emotional and psychological aspects of the conflict perhaps through narrative approaches given, as the study argues, the embedded nature of stories and storytelling in the NHS whistleblowing setting.

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Chapter 1

Introduction

What do stories tell us about whistleblowing conflict in the NHS in England and its resolution?

1. Introduction

It is difficult to overstate the importance of whistleblowing and why it matters. It is a means by which society is protected from certain organisations unable or unwilling to address malpractice or wrongdoing which, because it happens inside the organisation, may be visible to organisational insiders but not to those outside it, such as members of the public or indeed regulators. Whistleblowing has far-reaching consequences as the single most important process by which governments and organisations, including the NHS which is the focus of this study, are kept accountable to the societies they serve. [1] It is also one of the means by which organisations can police themselves, working as a mechanism for internal risk management or business governance. [2] This is the case for all organisations whether public or private and regardless of sector and

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[1] See David Lewis, A.J.Brown and Richard Moberly, 'Whistleblowing, its importance and the state of the research' in A.J. Brown, David Lewis, Richard Moberly and Wim Vandekerckhove (Eds), *International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham, 2014) (hereinafter *The International Handbook*) at p.1. This is an important source of literature for this study, described by Terry Morehead Dworkin as providing "the world's most comprehensive and authoritative guide to whistleblowing research to date" at p.xx.

[2] See Wim Vandekerckhove, A.J.Brown and Eva Tsahuridu, 'Managerial responsiveness to whistleblowing: Expanding the research horizon' in *The International Handbook* (hereinafter 'Managerial responsiveness to whistleblowing') at p.299.

is an underlying reason for legislation that protects and compensates whistleblowers. [3] It can be a matter of public interest when an organisation is unwilling to listen to employees who raise concerns or to do something about it when concerns are raised, whether in financial services, healthcare, national security, or any other field. However, it remains the case today that there is no specific statutory duty imposed on organisations to investigate whistleblowing concerns of wrongdoing. [4]

The National Health Service in England ("the NHS") has its own history of whistleblowing and various reports have directly or indirectly addressed it, including the reports by Dame Janet Smith connected to the Shipman Inquiry, and the report by Robert Francis QC following the public inquiry into the Mid Staffordshire NHS Foundation Trust (hereinafter the Mid Staffordshire Inquiry). [5] The revelations of the Mid Staffordshire Inquiry increased pressure for an enquiry specifically into whistleblowing in the NHS and in 2014 Sir Robert Francis QC undertook the Freedom to Speak Up Review which lead to the publication on 11 February 2015 of the *Freedom to*

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[3] See Jeremy Lewis, John Bowers QC, Martin Fodder and Jack Mitchell, *Whistleblowing Law and Practice* (Fourth Edition, OUP, 2022) (hereinafter *Whistleblowing Law and Practice*) at pp.3/4 Introduction. Also, to the extent this study refers to or describes the operation of English law I have relied on *Whistleblowing Law and Practice* as the leading textbook on whistleblowing law in England.

[4] See *Whistleblowing Law and Practice* Introduction at p.3ff. Also, the term wrongdoing is a catch-all term for malpractice of any kind which I discuss in further detail below.

[5] See *The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (HC 947, 6 February 2013) by Sir Robert Francis QC (hereinafter *The Mid-Staffordshire Report*). Reports such as the *Mid-Staffordshire Report* can tell an important story of the inability of staff to speak out but represent experiences within particularly egregious settings where there may be multiple factors at play. For a more recent example of a major systemic failure see the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust Final Report published on 30 March 2022 at assets.publishing.service.gov.uk.Ockendon-Report-print-ready-pdf (hereinafter *the Ockendon Report*). See Appendix headed "Hearing the voices of staff" at p.178 of the Ockendon Report which shows that nursing staff were scared even to take part in an anonymised survey.

Speak Up Report. [6] The report related solely to whistleblowing in the NHS in England and contains substantial data from numerous perspectives within the NHS. The Review found that there was a serious and entrenched problem within the NHS, that serious concerns were not addressed and that NHS organisations responded to whistleblowing by punishing or disciplining whistleblowers rather than working effectively to address the wrongdoing. [7] The *Freedom To Speak Up Report* also observed that NHS workers were reluctant to speak up for two key reasons: there was fear of the repercussions for their career and for them individually, and there was a widespread belief that nothing would be done about the wrongdoing. [8]

In legislative, policy and professional terms some changes have occurred since the publication of the *Freedom To Speak Up Report*, including the establishment of the Freedom To Speak Up national and local guardian system. [9] However, there is a sense that little has changed: recent reports into substantial failings of maternity care at Shrewsbury and Telford Hospital NHS Trust and East Kent University

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[6] See the Freedom To Speak Up Report by Sir Robert Francis QC relating specifically to whistleblowing in the NHS: see www.freedomtospeakup.org.uk/the-report (hereinafter the *Freedom to Speak Up Report)*.

[7] See the *Freedom To Speak Up Report,* Cover Letter to the Secretary of State for Health, Jeremy Hunt MP.

[8] Ibid.

[9] The *Freedom To Speak Up Report* recommended establishing an "Independent National Officer" now known as the National Freedom To Speak Up Guardian (hereinafter "the National Guardian") office (hereinafter "the National Guardian's Office") which would head up a nationwide system of local Freedom To Speak Up Guardians at each NHS Trust in England (hereinafter "Local Guardians"). This regime was set up from October 2016 and is now well-established. The essential role of Local Guardians is to "act as an independent and impartial source of advice to staff" with access to anyone within the organisation including the CEO, or outside the organisation, to ensure that the focus remains on the safety issue and appropriate case-handling, including no retaliation for speaking up. See the *Freedom To Speak Up Report* at paragraph 60-63, and Principle 15 at pp.18/19. I refer to Local Guardians at various points within this study particularly in connection with Freedom of Information data in Chapter 4.

Hospitals NHS Foundation Trust, both published in 2022, have shown that staff in NHS hospitals remain as concerned about the consequences of whistleblowing in 2022 as they were in 2014. [10] Even as recently as 2 December 2022 NHS whistleblowers are again in the news regarding a "climate of fear" at University Hospitals Birmingham NHS Foundation Trust. [11] The NHS, self-evidently as an organisation which cares for people when they are at their most vulnerable, is an organisation in which the ability to call out wrongdoing is fundamentally important and central to the capacity of the organisation to deliver its service and to learn from its mistakes. [12]

The *Freedom To Speak Up Report* also provides evidence of the depth and breadth of the suffering and hardship endured by whistleblowers in the NHS, speaking of "truly shocking" stories following a remarkable repeat pattern of retaliation against them by

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[10] See Appendix headed "Hearing the voices of staff" at p.178 of the Ockendon Report which shows that nursing staff were scared even to take part in an anonymised survey. Also, see *Reading The Signals, Maternity and Neonatal Services in East Kent - the Report of the Independent Investigation* relating to East Kent Hospitals University NHS Foundation Trust (hereinafter *The East Kent Hospitals Report*).

[11] See 'Climate of fear putting patients at risk, say doctors' by David Grossman and William McLennan BBC News Online, 2 December 2022 at bbc.co.uk.

[12] Learning from its mistakes has been an enduring narrative in reports related to NHS failings over some years. See Department of Health, *Learning from Bristol, The Report of the Public Enquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995* (CM 5207(1) 2001) by Professor Sir Ian Kennedy (hereinafter *The Kennedy Report*) and Department of Health, *Learning from Bristol: The Department of Health's Response to the Report of the Public Enquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995* (CM 5363 2002) at www.gov.uk/government/uploads/273320/5363.pdf. Other examples include: Don Berwick, National Advisory Group on the Safety of Patients in England, *A Promise to learn - a commitment to act,* August 2013, including the Letters at Annex B, which emphasise the critical importance of learning. More recently, see: "Savid Javid pledges NHS leadership changes after review finds bullying' in which the NHS Chief Executive Amanda Pritchard said "the NHS is a learning organisation" - BBC News Website 8 June 2022.

their employers. [13] There is a body of evidence too that whistleblowers were being silenced by the use of confidentiality or non-disclosure agreements and compromise payments were being made. [14] Whistleblowers' careers were being damaged or destroyed and vital experience and knowledge being lost; it was recognised in the *Freedom To Speak Up Report* that because of the monopolistic nature of the NHS whistleblowers were for all practical purposes being informally blacklisted and unable to find work in the NHS. [15] Although legal recourse was available in principle through the whistleblower protections in the Public Interest Disclosure Act 1998 ("PIDA"), the statutory framework for whistleblowers in England and Wales which is designed to compensate whistleblowers for the detriment or damage inflicted upon them as a result of raising a wrongdoing concern, whistleblowers were invariably substantially disadvantaged. They usually faced well-resourced NHS Trusts who engaged experienced lawyers in prohibitively expensive litigation. Broadly, whistleblowers found themselves with few if any good options and typically faced a bleak future.

This study begins by arguing that it remains the case that it is not safe to be a whistleblower in the NHS today. As I will say,

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[13] The *Freedom to Speak Up Report* received substantial data (over 650 individual contributions, a research survey and meetings/seminars with over 200 participants) which revealed appalling whistleblower experiences and the toll they took on individual whistleblowers.

[14] Confidential settlements were known to be entered into prior to that report: almost 600 compromise agreements were entered into in the 3 year period up to 2011 under which £14.7 million was paid out "most of which included gagging clauses to silence whistleblowers" - *Telegraph Online* (26 March 2013). See also: Nick Kituno and Hayley Kirton, 'Trusts spending £1m+ a year on settlement deals with gagging clauses despite a crackdown on these conditions in recent years' (Health Service Journal Online 1 November 2021 accessible at https://www.hsj.co.uk.).

[15] See the *Freedom To Speak Up Report* at section 7.3 (Support in Getting Back to Work). This potential discrimination against NHS whistleblowers has been partially addressed at least at a legislative change to PIDA in 2015 by the insertion of a new s.49B into PIDA - discussed further below.

whistleblowing places whistleblowers in a position of conflict with their employer and with those around them in the workplace and that this specific conflict tends to lead to inefficient and unsatisfactory outcomes for whistleblowers, for NHS organisations and also for managers and colleagues affected by the whistleblowing. This study explores the nature of the whistleblowing conflict at the ground level and what that might reveal about how it might better be resolved.

2. Whistleblowing in the NHS in England: What happens in the real world [16]

Whistleblowing in NHS institutions almost always occurs within (and stays within) the NHS workplace. [17] It typically occurs when a healthcare professional, perhaps a junior doctor, a nurse or a midwife, raises a concern usually, but not necessarily, about malpractice or wrongdoing related to patient safety. [18] The concern would be voiced to a third party such as a line manager (the recipient of the whistleblower's concern) rather than directly to the colleague (the wrongdoer) about whom the concern is raised (if it

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[16] Concepts mentioned in this summary are defined or explained throughout this study at different points where their meaning is not a plain English meaning. For example, the concepts of "patient safety" and "wrongdoing" are both discussed in section 4 below. Note that there are no definitions in PIDA or English law generally of the terms "whistleblower" or "whistleblowing". The purpose of this short summary is to provide a non-technical overview in plain language so that readers have an understanding at the outset of how cases tend to develop. That said, it is important to emphasise that cases differ enormously and are often complex and fact-specific.

[17] The overall numbers of whistleblowing reports made to external NHS regulators is extremely small when compared to the number of whistleblowing reports made internally - see the discussion and data at *Whistleblowing Law and Practice* at p.887. These figures compare reports made to regulators to reports made internally to Local Guardians and may not be comparing like with like, as I discuss below in Chapter 6.

[18] Although concerns are sometimes raised anonymously, whistleblowing would usually be understood as not being anonymous. When they raise concerns, whistleblowers often do not realise they may be whistleblowers and are unlikely to have significant knowledge of PIDA.

was raised directly the act would not be whistleblowing as I discuss later). Usually the concern is raised with the expectation that action will follow to address it. At this stage the NHS Trust may investigate the wrongdoing and act upon it, or it may decide not to, instead retaliating against and victimising the whistleblower in varying ways, causing the whistleblower detriment and which, over time, may result in her dismissal. This period can last months or even years and the whistleblower's personal and professional life usually suffers, perhaps severely.

The whistleblower may seek legal advice, often a considerable time after having raised her concern, and may eventually bring a claim under PIDA for damages arising from the detriment she has suffered and/or her dismissal (they are not mutually exclusive). PIDA claims can be complex and challenging and even if she is successful and recovers damages there is little prospect of her being reinstated to her job, where dismissal has occurred. [19] Many NHS whistleblowers have found it difficult if not impossible to return to work within the NHS, and some have made allegations of blacklisting and discrimination against them. [20] In these circumstances, it is unlikely that the NHS Trust will take any action to address the wrongdoing. The whistleblowing process may not end in dismissal of the whistleblower but her detrimental treatment by managers and colleagues against the whistleblower takes its toll and adversely affects her mental and physical health, leading to resignation or early retirement. The experience is likely to be traumatic for all whistleblowers but for those with limited personal and financial

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[19] Many whistleblowers would prefer compensation to reinstatement owing to the hostility they might encounter in the workplace. See *Whistleblowing Law and Practice* at paragraph 12.07.

[20] See *Whistleblowing Law and Practice* for commentary and details of the legislative change at paragraph at p.891.

support from family and friends it can be particularly so. While the *Freedom to Speak Up Report* mentions mediation as a possible method for resolving difficult individual or team relationships in the workplace, mediation does not appear to be widely or effectively used as a way to protect the whistleblower from retaliation nor to reverse or arrest detrimental treatment.

I suggest the above summary provides an outline of the likely shape of a whistleblowing case, based on the substantial data provided by the *Freedom To Speak Up Report.* I will now discuss the real-world problem from the point of view of a whistleblower, focusing on the conflict that arises between whistleblower and the NHS organisation and certain factors relevant to it.

3. The Real World Problem

The real world problem can be put like this: that in the NHS in England, if a worker raises a concern about wrongdoing, it will place her in a position of conflict with the organisation and probably also with the wrongdoer and other colleagues; she is likely to suffer retaliation, detriment and possibly dismissal as a result and there are no pathways, legal or otherwise to satisfactory or positive outcomes either for the whistleblower, the NHS organisation or for other colleagues affected by the whistleblowing.

For me, there appear to be many possible contributory factors at work. Two major factors are, first, the nature of the NHS workplace itself, and secondly failings in patient care. Both appear contextual but also potentially causal at the same time, in the sense that

everyday behaviours in the workplace (often under extreme stress) may contribute to poor care or serious error, and poor practices may prompt whistleblowing and therefore conflict. [21] The NHS workplace is the legal and behavioural setting for almost all NHS whistleblowing and so is an important contextual factor for this study.

A further factor is case-handling by NHS organisations. The Freedom to Speak Up Review received evidence suggesting that when whistleblowing occurs, cases often become bogged down for months or even years in protracted bureaucracy and legal proceedings, suggesting that the NHS system does not have the know-how or systems in place to handle cases more effectively. [22]

I touch on these three factors below.

NHS workplaces, particularly large acute hospitals, can be seen as organisationally, bureaucratically, socially, politically, legally and emotionally very complex. [23] The NHS publishes substantial volumes of performance and other data about its services and individual NHS Trusts are subject to forensic scrutiny by umbrella

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[21] This can be inferred from the interview data collated for this study and from the NHS-related research discussed in Chapter 2 below: for example see Rachael Pope, 'The NHS: Sticking Fingers in Its Ears, Humming Loudly' J.Bus.Ethics, Published Online 25 September 2015 DOI 10.1007/s10551-015-2861-4 at (hereinafter 'The NHS: Sticking Fingers in Its Ears').

[22] See the *Freedom To Speak Up Report* section 3 (Evidence from contributors).

[23] See Oliver Quick, *Regulating Patient Safety: The End of Professional Dominance?* (CUP, 2017) (hereinafter *Regulating Patient Safety*) p.29ff.

bodies and regulators. [24] At the same time, each NHS Trust or NHS Foundation Trust has its own legal status which implies extensive legislation affecting the Trust itself rather than healthcare professionals individually. [25] The Trust's medical and other healthcare professionals are also separately subject to layers of professional regulation. [26]

Although NHS Trusts vary enormously as to catchment populations, services provided and other factors, the NHS workplace in which whistleblowing occurs sits within a broadly consistent legal and regulatory environment. Despite this, it appears as though organisational responses to whistleblowers are far from consistent. In Chapter 2 of this study, I draw upon some recent studies of behaviour in NHS organisations to provide a sense of the often difficult realities for staff in some NHS Trusts. My objective in doing so is to illustrate the behavioural climate for whistleblowers in the NHS workplace and how it is experienced by staff at all levels in

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[24] To mention only two: Monitor is the statutory NHS body which authorises, monitors and regulates NHS Foundation Trusts; NHS England is the umbrella body which sets the strategic priorities and direction for the NHS in England. The Care Quality Commission (the "CQC") is the primary regulator for Health and Social Care in England including substantial numbers of acute hospitals and care homes. As for public demand for its services: the NHS website at www.nhs.uk receives over 50 million visits per month. See also Andrew Gregory and Niamh McIntyre, 'Number of People on NHS waiting lists at record high: Figures show 6.2m people waiting for routine hospital treatment with A&E and Ambulance waits also soaring', The Guardian Online 14 April 2022.

[25] On terminology generally, NHS organisations are statutory bodies known either as "Trusts" (first established on 1 April 1991 by the National Health Service and Community Care Act 1990) or "Foundation Trusts" which have greater financial and clinical autonomy (first established by the Health and Social Care (Community Health Standards) Act 2003). Each Trust/Foundation Trust is a separate statutory body distinct from the National Health Service itself and from the umbrella bodies and regulators mentioned above.

[26] See *Regulating Patient Safety* for a sense of the complexity surrounding the regulation of the medical profession.

order to locate the stories told by all participant groups in a real-world context. [27]

The second contextual factor is the question of failings in patient care. The NHS harms substantial numbers of patients every year through medical error and negligence resulting in significant numbers of so-called avoidable deaths - as many as 150 deaths per week according to one estimate. [28] The Public Administration Select Committee report *Investigating Clinical Incidents in the NHS* put the figure at 12,000 avoidable deaths per year (over 230 per week). [29] *Investigating Clinical Incidents* estimated that the NHS carries a liability for clinical negligence (as at 2015) of £26.1 billion pointing to the long-term and enduring nature of sub-standard clinical care. [30] Various public enquiry reports and governmental responses have over a number of years contributed to creating a narrative of the NHS as a learning rather than a blaming organisation. [31] This narrative of learning implies listening to whistleblowers who raise concerns; instead, it has been interpreted as an aspect of

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[27] See section 2 of Chapter 2. I discuss various empirical and other studies which provide valuable behavioural context. For a less academic up to date perspective of the challenges and failings of the NHS see Jeremy Hunt [the former Secretary of State for Health 2012-2018], *Zero: Eliminating unnecessary deaths in a post-pandemic NHS* (Swift Press, London, 2022).

[28] See the Draft Health Service Safety Investigations Bill, September 2017, Cm 9497, Foreword, in which the figure given for avoidable deaths is "150 deaths each week" a figure supported by Helen Hogan et al., 'Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis', BMJ, 14 July 2015 at p.351. The estimate given in the *Mid-Staffordshire Report* was of between 400 and 1200 avoidable deaths over a four-year period. However, the measurement of "avoidable" deaths is itself complex: see the Office for National Statistics Quality and Methodology Information about Avoidable Deaths in the UK (at ons.gov.uk).

[29] *Investigating Clinical Incidents in the NHS* can be found at HC 2014-15, HC886 (hereinafter *Investigating Clinical Incidents*).

[30] Ibid.

[31] See section 1 above. Also, the NHS Chief Executive Amanda Pritchard recently said "the NHS is a learning organisation" - BBC News Website 8 June 2022.

investigatory systems rather than of improved handling of whistleblowing cases. [32]

Turning to case-handling, it is apparent from the *Freedom to Speak Up Report* that NHS organisations lack the skills and systems to handle complex whistleblowing cases. [33] Whilst handling whistleblowing incidents poorly is perhaps not a direct cause of the real-world problem, it arguably contributes to aggravating and prolonging the conflict. Francis comments that long-running unresolved cases may have better outcomes if they were handled well "from the outset". [34] One Trust CEO said "an open and honest conversation around a table might have saved years of legal proceedings, investigations, and anguish for many people, as well as huge cost". [35] Cases are complex and hard to interpret. As Francis states: "in some cases I received a number of irreconcilable versions of events". [36] To add to the complexity, legal advisers who are often involved in the whistleblowing conflict can also contribute to the escalation of conflict. [37]

The challenge is captured by the *Freedom To Speak Up Report* with the following description of the whistleblowing conflict: "cases are

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[32] For example, establishing a "safe space" for investigations of serious incidents, intended to create a learning rather than a blaming environment.See the Draft Health Service Safety Investigations Bill, September 2017, Cm 9497, Foreword. For background policy papers related to the establishment of the HSIB, see: Department of Health, *Providing a 'safe space' in healthcare safety investigations, Consultation,* (October 2016), and Department of Health, *Providing a 'safe space' in healthcare safety investigations; Summary of consultation responses and next steps,* (April 2017) both of which are available at assets.publishing.service.gov.uk.

[33] See the *Freedom To Speak Up Report* sections 6.1 and 6.2 at pp.118-122.

[34] Ibid at p.118.

[35] Ibid.

[36] Ibid.

[37] Ibid.

often not straightforward and can involve complex and long-standing professional and inter-personal difficulties between clinical colleagues. Cases can become a morass of claim and counter-claim with a toxic mixture of grievance and disciplinary activity where positions become quickly entrenched. Even if there is desire to resolve the issue, in many cases organisations may not have the expertise to do so." [38]

The *Freedom To Speak Up Report* suggests early intervention in whistleblowing conflict would help to minimise or contain it and although views of contributors to the review were mixed, mediation is seen as one way of ameliorating difficult ongoing relationships between colleagues in the workplace, although not as a method of ADR for settling whistleblowing litigation between the Trust and the whistleblower. [39] Mediation (and "reconciliation and ADR" in the words of the report) and mediation-related skills are therefore promoted in a general sense by the *Freedom To Speak Up Report* as a means of improving ways of addressing internal friction and for "handling concerns". [40] The report also explicitly promotes the use of experienced, skilled mediators. [41] Although this study is not about process, it is plain that the *Freedom To Speak Up Report* sees a potential role for dispute resolution methods as a way of addressing internal fall-out from whistleblowing - hence its relevance for this study. [42]

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[38] Ibid, at p.73.

[39] Ibid at section 6.6 at pp.133-134.

[40] Ibid at p.135.

[41] Ibid.

[42] See Hilary's case in Chapter 5 in particular.

Although there are many factors to consider in this complex real-world problem for me the three discussed above illustrate that the problem sits within in a complicated fabric of interconnected issues which appears to obscure elements of the whistleblowing conflict and thereby impede the ability of parties to respond to the conflict in ways which point to effective resolution outcomes.

In the following section I consider various relevant concepts and terminology relevant to NHS whistleblowing, including the potential meanings of the terms conflict and resolution, within NHS whistleblowing settings. Because of its importance providing the legal framework for whistleblowing in England I also outline the main provisions of PIDA, under which a whistleblower may bring action against her NHS employer (or a colleague personally) for detriment or dismissal suffered as a result of her whistleblowing. [43]

4. Whistleblowing in the NHS: Terminology, Definitions and the Public Interest Disclosure Act 1998 ("PIDA")

I begin this section with a research definition of whistleblowing necessary to ground this study.

4.1 Research definition of whistleblowing

A widely used research definition of whistleblowing in the field of general whistleblowing literature is that established by Near and Miceli:

[43] Any action for dismissal will be against the employer only.

"The disclosure by organization members (former or current) of illegal, immoral or illegitimate practices under the control of their employers, to persons or organizations that may be able to effect action." [44]

This definition, which in this study I will refer to as "the Research Definition", is internationally recognised and used by researchers. It is not restricted by jurisdiction or sector and has been adopted for a vast range of studies since it was first proposed in 1985. The definition encapsulates the essence of whistleblowing as a process composed of a number of steps. Morehead Dworkin describes the steps as follows: "noticing the wrongdoing, deciding to act, getting some managerial response to the evidence of wrongdoing, and dealing with actual or potential retaliation against the whistleblower". [45] Although the definition anticipates that the whistleblower may decide to report the incident to an external body, research shows that the vast majority of whistleblowing takes place inside the organisation. [46] This is a significant feature of whistleblowing.

As I discuss below, there are distinctions to be made between the broad conception of whistleblowing captured by the Research Definition and whistleblowing as it is found within the NHS in England. NHS whistleblowing formally subsists within the narrow

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[44] This definition was proposed by Janet Near and Marcia Miceli in 1985: see Near, J.P. and Miceli, M.P. 'Organizational Dissidence: the Case of Whistle-Blowing', Journal of Business Ethics (February 1985) 4(1):1-16, page 4. As Terry Morehead Dworkin states: "The definition of whistleblowing developed by Professors Miceli and Near three decades ago has become the standard one used by most researchers." See *International Handbook,* Foreword, p. xx.

[45] See Terry Morehead Dworkin, *The International Handbook,* Foreword at p.xx.

[46] "Research has now consistently shown (at least in the developed world) that before people blow the whistle outside their organisation, they almost always try to raise their concern internally", Wim Vandekerckhove, A.J.Brown and Eva Tsahurida, 'Managerial responsiveness to whistleblowing' at p.299.

legal framework of PIDA and within a specific workplace environment. This framework infers many legal and other factors which are not anticipated by the Research Definition, as I discuss below.

However, before discussing PIDA I will first touch on other relevant terminology for this study.

4.2. Terminology

The short real-world description of whistleblowing in section 2 above uses four terms which require further brief comment: patient safety, recipient, wrongdoing and wrongdoer. Patient safety is a widely-used term which although it may appear beguilingly simple is in fact extremely complex in practice with very broad boundaries. [47] It could apply to almost any aspect of patient care, whether clinically direct or indirect, which might result in harm to patients. [48] For this study it has relevance to the concept of wrongdoing, in that a failing in patient care may be perceived as wrongdoing in the eyes of a whistleblower, particularly where it is clearly observable or persistent poor practice. [49]

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[47] For a discussion of "The problem of patient safety" see Oliver Quick, *Regulating Patient Safety* at p.145. Quick describes how medical errors can become normalised and medical professionals engage in "vocabularies of realism" about risk and harm (also at p.145).

[48] The word *safety* is an elastic term without closely defined limits or boundaries which can encompass a vast range of healthcare-related activity including not only the work of health professionals but also "the design of buildings, the manufacture of drugs and devices, the effect of policy and management and the effect of resource allocation decisions…and even appropriately to the work of cleaners and porters". See *Regulating Patient Safety* at p.29.

[49] This is because endangering the health or safety of any person is a "relevant failure" under PIDA. I explain this below.

Wrongdoing can be equated with the “illegal, immoral or illegitimate practices” of the Research Definition above but, given the complexities of modern medical practice and the broad scope of patient safety, whether in practice a particular treatment is harmful to patients may not be clear-cut. Also, as I discuss in Chapter 2, whistleblowing research suggests that wrongdoing is a subjective matter, and cannot necessarily be ascertained or understood as purely factual or objective in nature. Wrongdoing is, however, a central feature of whistleblowing and is used as a major element in this study by which to frame discussions of whistleblowing conflict in Chapter 2 below.

The terms wrongdoer and recipient identify actors within whistleblowing settings. The wrongdoer is the colleague about whom the whistleblower speaks up and who she believes is engaging in wrongdoing. This again is fraught with complication and blurred boundaries as wrongdoing, as suggested, may not be clear-cut and although committed by the wrongdoer may in fact be known about by others who are thereby implicated (and who may be aggrieved as a result). Recipients are those who typically receive the disclosures of wrongdoing from the whistleblower, such as front line managers. There are likely to be a number of recipients in a complex NHS hierarchy meaning that decisions about responses to the whistleblower can also be complex. Because of their significance in the context of the organisation’s response to the whistleblowing, I consider recipients at greater length in Chapter 2 below.

I will now describe briefly the outline provisions of PIDA. These matter, because regardless of whether the whistleblower ultimately pursues legal proceedings under PIDA the conflict itself plays out in

PIDA's shadow because PIDA provides the only legal recourse available to the whistleblower for the detriment or dismissal inflicted on her as a result of whistleblowing.

4.3. The Public Interest Disclosure Act 1998 (as amended) ("PIDA") [50]

As mentioned, PIDA is the statute that creates a legal framework for whistleblowing in England, Scotland and Wales. It offers to whistleblowers a protected avenue through which to make their whistleblowing disclosures. Whistleblowers must make their disclosures in accordance with the tiered requirements described below in order to preserve their right to compensation in the event they suffer detriment or dismissal. The statute strongly incentivises whistleblowers to disclose first to their employers (the easiest tier to comply with) and therefore the vast majority do so. [51]

PIDA creates a regime of three tiers (or thresholds) applicable to disclosures by whistleblowers. Whistleblowers must adhere to the requirements of each tier (when making their disclosures about

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[50] PIDA is the originating statute for whistleblowing law in England, Scotland and Wales and operated by incorporating sections into the Employment Rights Act 1996 (as amended) (hereinafter "ERA"). References to PIDA or sections of PIDA are references to sections as so incorporated into ERA. In this section references to statute or statutory protection are therefore also references to PIDA as incorporated into ERA. Also, PIDA was amended by the Enterprise and Regulatory Reform Act 2013 ("ERRA") which removed the original "good faith" requirement for disclosures, introduced a "public interest" requirement and made employers vicariously liable for detriment inflicted by co-workers - see *Whistleblowing Law and Practice* at paragraph 1.29 (Reforms). A new section 49B was also added to PIDA by the Small Business, Enterprise and Employment Act 2015 conferring power to make regulations to protect NHS whistleblower job applicants specifically from discrimination from blacklisting. The Employment Rights Act 1996 (NHS Recruitment - Protected Disclosure) Regulations 2018 were made on 2 May 2018 and provide that no applicant is to be subjected to discrimination because they appear to have made a protected disclosure.

[51] Pursuing a claim under PIDA does not preclude a whistleblower from bringing a claim for harassment under other legislation eg the Protection From Harassment Act 1997 or discrimination or equality legislation, although such claims are beyond the scope of this study.

wrongdoing) in order to preserve their rights to damages if they suffer detriment or dismissal as a result of making the disclosures. [52] The tiered system is designed to encourage whistleblowers to disclose internally to the organisation before disclosing externally. If a whistleblower only ever discloses internally to the organisation, she will only have to comply with the first tier requirements to preserve her right to claim damages. Only if she discloses outside the organisation will the second and third tier requirements become relevant. The requirements of each tier become increasingly demanding to satisfy.

The first tier requirements apply where the whistleblower discloses to her employer and are the most straightforward to comply with. [53] The second tier requirements apply when disclosing to specified regulatory bodies (such as the CQC, known as prescribed persons) and, in addition to the tier 1 requirements, require that the whistleblower must reasonably believe that the disclosures are true. [54] The third tier requirements apply when disclosure is made to the wider public for example to an MP, the police or the media. This third tier requires the whistleblower to comply with the tier 1 and tier 2 requirements, and also to show that, in all the circumstances, it was reasonable to make the disclosure and that it was not for personal gain.

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[52] Damages is the likely remedy in the vast majority of cases. Reinstatement or re-engagement could be ordered by the Employment Tribunal in appropriate unfair dismissal cases but such remedies are rarely exercised - see *Whistleblowing Law and Practice* at paragraph 12.07ff.

[53] To comply with tier 1 requirements the whistleblower must reasonably believe (1) that the information disclosed tends to show a "relevant failure" (defined as any one or more of 6 heads: criminal acts, a breach of law, a miscarriage of justice, a danger to the health or safety of any person, damage to the environment or the deliberate concealment of information about any of the first five grounds) and (2) that the disclosure is in the public interest ("tier 1 requirements").

[54] The "tier 2 requirement".

Further, in tier 3 cases the whistleblower must also show a reasonable belief that she would have been victimised or that her evidence would have been concealed had she first disclosed to her employer (this assumes she did not) or that she had in fact previously raised the matter with her employer but no action had been taken. [55] As this implies, there are circumstances in which, where the whistleblower reasonably believes she would have been victimised or that her evidence would have been concealed, she can bypass internal disclosure and disclose externally. However, establishing her reasonable belief that her employer would have acted in these ways might prove challenging, so disclosing externally (without disclosing internally first) can represent a high-risk strategy for the whistleblower. [56]

The tiered requirements of PIDA represent an intricate and complex statutory scheme, the full detail of which is beyond the scope of this study. [57] I suggest that the wider points are these: that the vast majority of whistleblowing occurs internally to organisations, so navigating the complexities of tiers 2 and 3 is not relevant for most whistleblowers; further, because of the complexity of PIDA (of which this is only one aspect) it can be extremely difficult for whistleblowers to pursue a claim without legal representation. Also, many whistleblowers do not realise they are whistleblowing when they raise their concern, meaning that they do so without an appreciation of the requirements of the relevant tier. This can mean

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[55] These are the "tier 3 requirements".

[56] See the discussion of these requirements at *Whistleblowing Law and Practice* at paragraphs 6.103 - 6.115.

[57] For a detailed account of the statutory scheme of PIDA and the requirements of each tier, see *Whistleblowing Law and Practice* at chapter 6, pp.216ff.

that they do not satisfy the tier requirements, which they might otherwise have done so had they known the tier requirements at the time (for example, because of a lack of clear evidence, or information, about the concern).

As well as being made in accordance with the applicable tier requirements, disclosures must convey information, and so be more than mere unsubstantiated allegations. If the disclosures meet the various statutory requirements they are then known as "protected disclosures". The whistleblower must then show that the protected disclosures were the principal reason for her dismissal, or were a material or significant factor in the detriment she suffered. [58] This element of causation is heavily evidence-dependent and can often be difficult to prove. [59]

PIDA has many complexities and it can be difficult for whistleblowers to comply with its requirements particularly when they are unaware of its detailed tiered requirements. It is likely for instance that disclosures may be made by workers within organisations which would fall within the scope of the Research Definition but which would not qualify in the real world as protected disclosures meaning that any damages claim under PIDA would fail. In this study, to be clear, when I refer to "whistleblowing" in a generic sense it can be taken to refer to the Research Definition. Unless I distinguish between them, however, I will use the terms "PIDA whistleblowing" or "formal whistleblowing" to refer to whistleblowing within the PIDA framework discussed above. As I discuss in

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[58] See *Whistleblowing Law and Practice* at chapter 9 (The Right Not to Suffer Detriment) and and chapter 11 (Unfair Dismissal for Making a Protected Disclosure).

[59] The question of causation can be very challenging for whistleblowers. Tactically NHS Trusts will allege alternative narratives with reasons why a whistleblower was dismissed or suffered detriment - so-called "reason shopping".

Chapter 4 in the context of the Freedom of Information research conducted for this study, it appears that NHS Trusts may have different interpretations of whistleblowing as distinct from other concerns which may not amount to whistleblowing at all.
PIDA frames whistleblowing law as a group of employment rights (usually a claim in damages) which arise when the whistleblower suffers detriment or dismissal caused by the whistleblowing. In practice therefore, the PIDA claim is concerned with pleadings and evidence related to the detriment or dismissal. It is not in any sense an investigation about the wrongdoing. While a PIDA claim may hold the NHS employer to account in damages for the detriment or dismissal, it does not therefore hold them to account for the wrongdoing (nor their failure to address it). [60] PIDA is enforceable only through adjudication in the employment tribunal, although legal proceedings can be settled, like any other form of litigation. As I will show, however, it appears that settlement of PIDA claims in NHS whistleblowing cases is very unusual.

There is significant dissatisfaction with how PIDA fails to protect whistleblowers, fails to hold organisations and co-workers accountable for their actions, and fails to address wrongdoing or public-interest failings. [61] Reform may not be imminent, but seems increasingly likely. [62] At the time of writing (late 2022) three

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[60] See the critique of PIDA in *Protecting Whistleblowers in the UK.* This is a recognised organisational strategy: see also C.Fred Alford, *Whistleblowers and Organizational Power* (Cornell University Press, Ithaca and London, 2001) (hereinafter *Whistleblowers, Broken Lives and Organizational Power)* at p.32.

[61] See Blueprint for Free Speech/Thomson Reuters Foundation, *Protecting Whistleblowers in the UK: A New Blueprint* (2016) (hereinafter "*Protecting Whistleblowers in the UK")* for a commentary on PIDA's failings.

[62] See *Whistleblowing Law and Practice* Introduction at p.1ff. See also, *Protecting Whistleblowers in the UK,* and Jeanette Ashton, '15 years of whistleblowing protection under the Public Interest Disclosure Act 1998: are we still shooting the messenger?' [2015] Industrial Law Journal 29.

competing draft PIDA reform bills are before parliament. [63] The attempts at reform also point to a sense that better approaches are needed to address whistleblowing conflict and its repercussions. I suggest that improved understandings of the elements of the whistleblowing conflict are required before such approaches can be advanced. This study aims to address the need for improved understandings of the whistleblowing conflict.

I will now discuss the meaning of conflict, and whistleblowing conflict, in this study.

4.4 Whistleblowing conflict and its meaning within this study

Conflict within this study

Even within the NHS workplace conflict is ubiquitous and can emerge from many and varied sources. [64] One practising mediator who has undertaken NHS mediations defines conflict as occurring

[63] Campaigning to improve statutory protection of whistleblowers has been supported by the All Party Parliamentary Group on whistleblowing (lead by Baroness Kramer) in recent years. The three competing bills mentioned above all contemplate a new statutory body to be known either as the Office of the Whistleblower in one case or the Whistleblowing Commission/Commissioner in the other two, all with significant new powers. The draft bills contemplate other significant changes to PIDA such as additional proposals to prevent victimisation by colleagues. The draft bill sponsored by Baroness Kramer and the APPG for whistleblowing is being resisted by a number of parties including Protect (formerly Public Concern At Work) the whistleblowing charity: see 'New whistleblowing bill must not become law' by Sybille Raphael, Legal Director of Protect, The Law Society Gazette 29 July 2022 at p.22. The two further competing bills are sponsored respectively by Protect and by Dr Philipa Whitford MP. All 3 are compared in an online article by Protect see: "Unpacked: The 3 bids to transform whistleblowing law PIDA' dated 27 August 2022 and updated 28 September 2022 at protect-advice.org.uk.See *Whistleblowing Law and Practice* at paragraph 1.51ff for comment on the three reform proposals.

[64] See for example, the Circle of Conflict model proposed by Christopher Moore which identifies values, relationships, data (eg information/misinformation), interests and structures (including eg imbalances of power) as five major categories of potential conflict: Christopher W. Moore, *The Mediation Process: Practical Strategies for Resolving Conflict* (John Wiley & Sons, Inc, San Francisco, Second Edition, 1996).

when one person or group perceives that another is preventing him or her from achieving his or her needs or from expressing values or beliefs. [65] Brown and Marriott cite a range of broad-based definitions such as a "state of opposition or hostilities" or "disagreements between two or more parties which cause tension for the individuals concerned". [66] Conflict should also be seen as a subjective personal perception which is experienced emotionally and psychologically and which is capable of having a devastating and traumatising effect on individuals. [67] Palmer and Roberts see conflict not only as a broader concept than dispute, but also possibly a longer-lasting concept, which has resonance with whistleblowing conflict which can leave a long-term legacy. [68]

Although I acknowledge that conflict can have a positive function and generate learning and improvement when I refer to it in this study, it is generally as an adverse or negative experience for the parties involved. [69]

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[65] See David Liddle, *Managing Conflict, A Practical Guide to Resolution in the Workplace,* (Kogan Page Limited, London, 2017) at p.21.

[66] See Henry Brown and Arthur Marriott, *ADR: Principles and Practice* (Sweet and Maxwell, London, 2011) (hereinafter *ADR, Principles and Practice*).

[67] For a psychology-based description of the experience of conflict see Robert A. Baruch Bush and Joseph Folger, *The Promise of Mediation* (Josey-Bass, San Francisco, 2005) (hereinafter *The Promise of Mediation*) at p.49.

[68] See Michael Palmer and Simon Roberts, *Dispute Processes, ADR and the Primary Forms of Decision-Making* (Third Edition, 2020, Cambridge University Press) (hereinafter *Dispute Processes*) at p.104.

[69] See for example the discussion by Carrie Menkel-Meadow, 'The Mothers and Fathers of Invention: The Intellectual Founders of ADR', 16 Ohio St. J. On Disp. Resol. 1-37 (2000) at p.6 in which she cites Morton Deutsch as developing a taxonomy of different kinds of conflict, which suggest variability in how cases are handled. Transformative mediation as proposed by Bush and Folger is advanced on the basis that conflict can lead to personal growth ("empowerment and recognition") - see *The Promise of Mediation.* Social psychologists also propose models of conflict based on eg perceptions or relations of the parties and the way they perceive the world - see the discussion of narrative mediation advanced by Winslade and Monk in Chapter 3 below.

Conflict in NHS whistleblowing settings is a form of workplace conflict but is complicated by the wrongdoing raised by the whistleblower.

As discussed, almost all NHS whistleblowing occurs physically and legally within the NHS workplace and the conflict that arises from the act of whistleblowing should be seen as originating in the workplace and initially therefore, ostensibly, an employment matter between employer and employee. One obvious consequence is that the contractual employment context will apply, such as the worker's employment contract, the NHS standard terms and conditions, the NHS constitution, and applicable staff policies such as the whistleblowing policy. [70] However, although this context will include a Trust whistleblowing policy which should establish a procedure for internal investigation and resolution (such as a decision by the CEO of the Trust about the concern) I suggest that whether such procedure can contain the conflict that ripples out from the act of whistleblowing is uncertain and circumstance-dependent. [71]

It is in this typical workplace context that whistleblowing research often highlights two core aspects of whistleblowing: the wrongdoing on the one hand and the whistleblower on the other. Vandekerckhove and colleagues explain that research has tended to apply crude categorisations, such as "address" [the wrongdoing] or "retaliate" [against the whistleblower] as representing the binary choice faced by recipients when presented with whistleblowing disclosures. [72] They argue that the preferred way to look at these

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[70] See *Whistleblowing Law and Practice* at paragraphs 21.18 - 21.19 at p.886.

[71] Whistleblowing policies will usually be available on Trust websites. For example see The Heart of England NHS Foundation Trust policy at http://sharepoint/policies.

[72] See 'Managerial responsiveness to whistleblowing' at p.298.

aspects is not as a binary choice but as elements of whistleblowing settings which are wholly independent of one another. [73] Both aspects have relevance to the whistleblowing setting and therefore potentially to understandings of conflict in that setting. I therefore propose to frame the study by approaching these two dimensions as distinct from one another and analysing them as such. The purpose of this approach is to establish whether and how the wrongdoing and the whistleblower are distinct aspects of the overall whistleblowing conflict, and whether and how they may be interconnected and what the implications might be for whistleblowing conflict and its resolution.

To analyse these two aspects of whistleblowing conflict I propose to apply a form of dispute emergence theory, which I discuss briefly below, and in more detail in Chapter 2.

4.5 Dispute emergence theory

The dispute emergence theory I will apply for this purpose is the form proposed by Felstiner, Abel and Sarat in their seminal work, 'The Emergence and Transformation of Disputes: Naming, Blaming, Claiming…' (hereinafter "The Felstiner Model"). [74] Felstiner, Abel and Sarat argue that an initial perception of injury can transform into a

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[73] Vandekerckhove, Brown and Tsahuridu suggest that the "address" or "retaliate" responses can be seen as a dichotomy, being two opposite or totally different parts of a whole, where the whole was "managerial response" - see 'Managerial responsiveness to whistleblowing' at p. 301.

[74] This is the theoretical approach of "naming, blaming and claiming" proposed by William L.F. Felstiner, Richard L. Abel and Austin Sarat, in 'The Emergence and Transformation of Disputes: Naming, Blaming, Claiming…' Law and Society Review, 15:3/4 (1980/1981) p.631 (hereinafter 'The Emergence and Transformation of Disputes').

dispute over a series of identifiable steps. [75] To illustrate, the conventional model of NHS whistleblowing described above suggests that wrongdoing is sidelined and does not form part of the conflict; by contrast, the conflict becomes focused on the whistleblower, eventually evolving into a PIDA claim. Applying dispute emergence theory to the two dimensions, the wrongdoing and the whistleblower, may assist in testing the conventional view (namely, that the conflict rests on the whistleblower only) and may perhaps reveal connections between the two dimensions which might inform thinking about the nature of the conflict and its resolution. This is further explored in Chapter 2.

I now discuss what I mean in this study by the resolution of whistleblowing conflict.

4.6 Resolution

Whistleblowing conflict can imply a very wide range of differences between individuals, between groups, or teams, and differences of view with the employer organisation, but the conventional NHS model of whistleblowing suggests that the only dispute which arises from this messy reality is a PIDA claim by the whistleblower (usually adjudicated by an employment tribunal). Whilst a PIDA outcome may end the formal litigation it rarely resolves the broader conflict that has engulfed the whistleblower and those around her, such as conflict involving the the wrongdoer, addressing the wrongdoing, nor will it have addressed other consequences arising from the

[75] I discuss The Emergence and Transformation of Disputes in detail in Chapter 2 below as a way of structuring my analysis of the two dimensions of wrongdoing and the whistleblower as aspects of the overall whistleblowing conflict.

whistleblowing such as team dysfunction. In this sense therefore the adjudication of the employment tribunal has not addressed the wider conflict. [76]

As indicated, this study is using a framework of the wrongdoing and the whistleblower to assist in analysing the nature of whistleblowing conflict. This framework also has relevance to the meaning of resolution in this context. Perry suggests a concept of resolution which anticipates the "closure" (the ending) of the dispute under a number of scenarios, one of which is that the wrongdoing does not in fact stop. [77] Perry's conception of resolution therefore asks whether the wrongdoing conflict, as well as the whistleblower conflict, must be addressed for resolution of whistleblowing to take place. For me, in principle, the answer is that it should, but the following analysis of the two dimensions of conflict and how they inter-relate will inform a more detailed discussion. [78]

To summarise, resolution should apply in principle to both wrongdoing conflict (including potentially how the wrongdoer is treated and dealing with the wrongdoing itself, for example) and the whistleblower conflict and should take account of any interconnectedness between them. It must have regard to real-world

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[76] A similar point is made by David Lewis in 'Resolving Whistleblowing Disputes in the Public Interest: Is Tribunal Adjudication the Best that Can be Offered?' [2013] Industrial Law Journal 35 (hereinafter 'Resolving Whistleblowing Disputes in the Public Interest').

[77] See J L Perry, *The consequences of speaking out: Processes of hostility and issue resolution involving federal whistleblowers,* paper presented at the Academy of Management, Las Vegas (1992, August). The principle is that if it is clear that conflict comes about in connection with the wrongdoing dimension then that conflict should be addressed as part of the overall resolution.

[78] There are many complexities here. For example, to what extent is it practical and desirable that a whistleblower should "have a say" in how the wrongdoing is addressed or the wrongdoer treated. See for example the early intervention scheme at Annex 6 of the written submissions by Patients First to the Freedom To Speak Up Review (hereinafter *Patients First Submission*) (no longer accessible online) which suggests significant involvement of the whistleblower.

realities so that any resolution proposals are seen as credible and feasible. It may also be construed as including the submerged emotional and psychological aspects of conflict, having regard to the concern that ongoing dysfunctional relationships can endanger patient safety. [79] This study seeks to enable effective resolution of whistleblowing conflict through its findings about the nature of the conflict and the stories of those who are party to, or witness, the conflict. This is explained further in the following section.

5. The Research Problem

The real-world problem articulated above assumes that improved outcomes from NHS whistleblowing conflict are highly desirable and are not impossible. Addressing that question requires consideration of a range of issues. These include, I suggest, what is meant by whistleblowing conflict and resolution of that conflict in NHS settings.

NHS whistleblowing occurs within NHS workplaces, so a contextual understanding of those workplaces is also essential to understand behaviours that may be contributing to the conflict generated by whistleblowing. The Research Definition speaks of the "immoral or illegitimate practices" (the wrongdoing, discussed above) as an essential component of whistleblowing which resonates with patient-safety and hence is of public-interest. In the NHS context, PIDA is a complex and developed field of English employment law dealing with whistleblower claims, but PIDA claims against NHS Trusts are enormously challenging and risky for claimants as noted

[79] For discussion of submerged issues in conflict and interventions generally see *ADR: Principles and Practice* at pp.7-10.

above with little opportunity to settle claims through alternative dispute resolution means, particularly given the confidential nature of many alternative processes which may be objected to for different reasons by both employer and whistleblower. [80]

These observations suggest some of the multiple issues which have a bearing on the research problem, illustrating the complex nature of the whistleblowing conflict within the NHS context requiring choices to be made as to how best to approach the research question. Additionally, the NHS context adds further obstacles where NHS whistleblowing can be seen as deliberately obscured from public view by NHS organisations with robust and detailed data hard to access. [81] Whistleblowing research is seen by Miceli, Near and Morehead Dworkin as presenting challenges and can be a "trade off between relevance and rigour" adding that "nowhere is this truer than in research on whistleblowing"; whistleblowers, they say, are

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[80] For example, the NHS could be accused in the press of covering up bad news; the whistleblower may claim she is being pressured into silence. I discuss these aspects in detail in Chapter 5 onwards.

[81] There is no central repository of NHS data relating to formal whistleblowing or its outcomes. Local Guardians generally publish annual reports about their activities, including some outcomes, but observe confidentiality and anonymity. The National Guardian publishes some limited data related to speaking up but it has significant limitations. One dataset is the Freedom to Speak Up Index now published annually by the NGO. It is based on NHS staff survey data in response to 4 general questions related to speaking up. The Index ranks NHS Trusts according to changes in staff views about how safe or otherwise it is to speak up and compares Trust rankings to their CQC rankings thereby giving a generalised survey-based picture of how Trusts are improving their speaking up culture. The 2021 report is available on the National Guardian website at www.nationalguardian.org.uk. and was published on 27 May 2021. The Index does not provide any concrete data about whistleblowing outcomes. Another dataset is the Local Guardian annual reports which can appear confusing as they often do not distinguish between formal whistleblowing and other concerns which are not whistleblowing. My understanding is that these reports would not include HR matters such as normal grievances but a very high proportion of issues seem to relate to inter-personal relationships. I discuss the FOI Data referred to below in Chapter 6.

"the best hope for identifying the organisation's wrongdoing". [82] Also, historically much whistleblowing research has focused primarily on the whistleblower and it can be difficult to juxtapose views of opposing or different constituencies such as whistleblowers, managers and third parties to reveal how whistleblowing is experienced. [83]

Accordingly, my key decision to address the research challenges was to conduct empirical research which so far as possible takes account of the views of all parties who might be engaged with or proximate to NHS whistleblowing conflict, to generate a sense of all possible perspectives and to hear the stories told by all the parties. Because of the importance of storytelling to whistleblowers I also decided to adopt aspects of story theory as an approach to the interview data and discuss this below. [84] The problem, as I understand it, was first and foremost one of researching the experiences of the participants to understand how they view the whistleblowing conflict, but also how they view counter-parties to the conflict. Hearing and analysing the stories they told was my starting point for responding to the research problem as I saw it.

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[82] See Marcia P. Miceli, Janet P. Near and Terry Morehead Dworkin *Whistle-Blowing in Organizations,* (Routledge, New York and London, 2008) (hereinafter *Whistle-blowing in Organizations)* at p.31. Also: "Studying real-life whistleblowing is hard due to several factors. It is a sensitive topic, so gaining entry into organisations and ensuring participants that their anonymity will be kept can be challenging" - see Brita Bjorkelo and Hege Hoivik Bye, 'On the appropriateness of research design: Intended and actual whistleblowing' in *The International Handbook* at p.133.

[83] See David Lewis, *A J* Brown and Richard Moberly, 'Whistleblowing, its importance and the state of the research' in *The International Handbook* at p.1 (hereinafter 'Whistleblowing, its importance and the state of the research').

[84] The experience of hearing whistleblowers tell their stories was a personal experience discussed below. Alford explains the vital role of stories to whistleblowers in his empirical study, see C. Fred Alford, *Whistleblowers, Broken Lives and Organizational Power* (Cornell University Press, Ithaca and London, 2001) (hereinafter *Whistleblowers, Broken Lives and Organizational Power).*

I now discuss how the study has been designed to address the research problem.

6. Study Design and Methodology

As explained above, the key decision in response to the research problem has been to conduct empirical research by way of interviews with a spectrum of participants representing constituencies of the key actors. [85] My main objective was to hear and collate the authentic experiences from all perspectives (so far as practicable) and, in effect, let the stories told by each group interact with those of the other groups. Because of the conflict-based approach discussed above and so as to frame the voices of the participant groups in a conflict-based orientation to one another, I decided to structure participants in groups which broadly mirror the three points of view within NHS whistleblowing conflict, namely (1) whistleblower, (2) NHS managers and (3) independent third parties. [86]

It seemed to me that there was value in enabling aligned or allied participants (that is, the whistleblower group, the NHS group etc) to

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[85] Blenkinsopp et al in a review of whistleblowing literature emphasised that compared to other sectors there is very limited empirical whistleblowing research conducted in healthcare: see 'Whistleblowing over patient safety and care quality: a review of the literature' in Journal of Health Organisation and Management, 33 (6) pp. 737-756 (hereinafter 'Whistleblowing over patient safety and care quality').

[86] In more detail these groups broke down as follows: (1) whistleblowers and their natural allies, including 4 whistleblowers, a retired union representative, 2 claimant solicitors, 3 barristers (2 of whom represent NHS Trusts as well as whistleblowers) and an officer in a whistleblower support organisation; (2) a retired NHS manager, 3 former NHS consultants, an NHS solicitor, and an NHS barrister, and (3) independent third parties such as a mediator, a CQC regulator, a psychoanalyst who works with whistleblowers, a third party solicitor and an officer in the National Guardian's Office.

develop their own distinct group narrative. Participants were not aware of this approach, so each told their own story without regard to any other participant. The group narrative would, I hoped, reveal patterns and insights which would provide a greater granularity and depth of the narrative than treating aligned actors as unrelated. I believed it would also help to frame the dialogue between the three group narratives and to allow the idea of conflict to permeate and influence the shape and impact of the study.

In Chapter 4 (Design and Methodology) I explain how 21 participants were recruited by means of a snowballing approach, but that given the risks and uncertainties I decided to seek former rather than current NHS participants. [87] Loosely-structured interviews were conducted between September 2019 and May 2020 and were digitally recorded and transcribed by a professional transcription service provider, generating a total of over 37 hours of recordings. [88]

I also decided to seek additional NHS data by means of requests made under the Freedom of Information Act 2000 (the "FOIA") ("FOI Requests") from NHS Foundation Trusts in England in order to seek

[87] This was a major concern for me. Accessing current NHS managers required both QMUL ERC ethical approval and Healthcare Research Authority (HRA) ethical approval. The HRA process was time-consuming and applied Trust by Trust so would have to be replicated multiple times without any certainty as to the availability of willing participants. Once HRA approval was given I would have to approach each individual Trust to seek participants, again with no certainty of cooperation. The sensitivity and confidentiality of whistleblowing cases also suggested it could be difficult even with HRA approvals to recruit staff willing to speak openly about whistleblowing cases.

[88] In retrospect I was fortunate to complete all but 2 interviews in-person prior to the Covid 19 lockdown which began on 24 March 2020. Had that not been the case I believe there would have been no realistic prospect of conducting interviews in-person or otherwise with current NHS staff after the lockdown began owing to intense pressures on the service. The 2 which followed lockdown were conducted by telephone.

an up to date statistical context for the study. [89] The data obtained through the FOIA statutory process (" the FOI Data") is presented in Chapter 6.

I now briefly expand my comments relating to Story theory, an important aspect of the study for reasons discussed above, before finally considering the limitations and impacts of this Study.

7. Story theory [90]

As suggested above, stories are a prominent feature of whistleblowing and their stories are at the centre of their experiences for most whistleblowers. [91] Stories and narratives are also prominent within conflict and conflict resolution literatures. [92] There is no single all-encompassing theory of storytelling. Instead, stories, storytelling and narrative permeate through literatures and practices in various fields, including medicine, therapy, conflict resolution and law. [93]

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[89] Statistical data about numbers of formal whistleblowing cases, and how they are resolved is not published by the NHS (although see my comments above relating to the Local Guardian system). The standard form of FOI request is attached as the Appendix to this study.

[90] This choice of theoretical approach was prompted by experience working alongside whistleblowers to prepare submissions to the Freedom to Speak Up Review in 2014. I discuss this experience and its potential for bias under "Limitations" below.

[91] See generally *Whistleblowers, Broken Lives and Organizational Power.*

[92] I discuss storytelling within forms of narrative mediation in Chapter 3. Dispute emergence theory and the story model (in studies of juror decision-making) are also discussed in Chapters 2 and 3 respectively. The storying process is visible in the ways that disputes emerge but also offer potential for resolution in the mediation setting.

[93] In Chapter 3, I discuss terminology including the concepts of "story" and "narrative" and how each word tends to be used within relevant literature.

The aspects of story theory I draw upon are first, the significance of subjectivity, perception and perspective, and of the epistemological principle that all views are views from somewhere. [94] Questions of perspective, point of view, subjectivity and bias, for me, are central to narrative differences between whistleblower and manager/ recipient with NHS whistleblowing settings. [95] Secondly, I draw upon the role of narrative and stories in forms of mediation, which can be seen as a forum for conflict-related storytelling within a resolution-orientated process and, so, appropriate for this study. For this reason, I consider the work of Winslade and Monk in relation to narrative mediation and Sara Cobb (and to a lesser extent Janet Rifkin) in relation to storytelling and narrative within mediation. [96] Within the narrative mediation models discussed the authors present different approaches but each suggests that through active intervention by the third party intervenor and collaboration between the parties, the parties can develop alternate stories in which they may find common ground or at least common understandings, providing prospects for progressive dialogue. [97]

I will now discuss some limitations and uncertainties inherent in this study before then considering its potential impact.

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[94] Derived from epistemological feminist scholars such as Sandra Harding and Donna Haraway but highly relevant to Critical Race Theory also discussed in Chapter 3 .

[95] This is recognised within whistleblowing literature. See for example Richard Moberly, ' "To persons or organizations that may be able to effect action": Whistleblowing recipients' in *The International Handbook* (hereinafter 'Whistleblowing recipients') at p.288: "the perceptions of recipients and whistleblowers differ dramatically which can lead to problems in the whistleblowing process".

[96] See John Winslade and Gerald Monk, *Narrative Mediation: A New Approach to Conflict Resolution* (Jossey-Bass, San Francisco, 2000) (hereinafter *Narrative Mediation*). Also, see Sara Cobb, 'Dialogue and the Practice of Law and Spiritual Values: Creating Sacred Space: Toward a Second-Generation Dispute Resolution Practice' (2001) 28 Fordham Urban Law Journal, 1029 (hereinafter 'Creating Sacred Space').

[97] See the discussion of narrative mediation approaches in Chapter 3.

8. Limitations and Uncertainties of this Research and its potential Impact

Limitations and Uncertainties

The impact of the design of this study is to some extent dependent on its interview data. This dependency is evident in two areas particularly: the first is the make-up of the participant body including the participants within each participant grouping and the second is the nature of the FOI Data. I will discuss these areas below. I will also comment briefly about my own personal experiences working with whistleblowers.

The participant body comprised 21 individual interviewees all of whom I approached using a classic snowballing method. [98] The snowballing approach influenced the make-up of the overall group in two particular ways: one was age and seniority of participants generally and the other was in the prevalence of lawyer participants (9 were either solicitors or barristers, although one of the solicitors was non-practising, being now a full-time practising mediator). [99] These factors inevitably shaped the participant groups. I would argue, however, that the career seniority and substantial experience of almost all participants lends their data authority and make a very

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[98] See Anna Bryson and Sean McConville, *The Routledge Guide to Interviewing,* (Routledge, London, 2014) at p.58.

[99] Both aspects were influenced by my career stage and background. I am a solicitor who qualified in 1985. My initial whistleblower connections were made through a long-time family friend (a whistleblower) and the legal connections snowballed from the whistleblower connections. However, being a qualified solicitor and many years experience of navigating legal relationships with solicitors and barristers may have been helpful in the snowballing process.

positive contribution to the study. Conversely, however, I recognise that the data does not reflect the experiences of more junior or younger participants. [100]

Regarding the participation of the lawyer interviewees, I suggest the lawyer participants also have a valuable contribution to make. Whatever their perspectives, lawyers are likely to be repeat players in an environment where many managers and whistleblowers are not, meaning that lawyer participants have a depth and breadth of experience that lends their contributions credibility and weight; I also suggest that it gives their data greater value as it is to some degree more representative. [101] Lawyers will have visibility on and understand the legal aspects of PIDA claims and other legal processes such as mediation and can attest to the legal realities. They are (where they are claimant lawyers) to some degree removed from the emotional suffering of their whistleblower clients and - although often compassionate and reflective - tend to offer a more detached tone to the group narrative. On the other hand, lawyer participants do not experience first hand the encounters within the NHS workplace which constitute the whistleblowing process itself and which appear to generate conflict or the perception of injury.

The participant make-up was also affected by the difficulty of accessing current NHS staff, which I touch on above. Of the former

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[100] To my knowledge there is no research specifically about the age and experience of NHS whistleblowers. However, it was evident from the work I helped with in connection with the Patients First Submission to the Freedom To Speak Up Review that NHS whistleblowers are generally more experienced (the forms provided by the whistleblowers included brief details of roles/seniority/years of experience). I comment further below on my personal experiences relevant to this project.

[101] As mentioned, the repeat-player role carries with it some evidential or "expert" weight, so that when a claimant lawyer sees repeat NHS behaviours by numerous NHS Trusts, it has meaning. In the interests of balance, the same might also be said when an NHS lawyer claims that whistleblower cases tend to be complicated by performance or other HR issues relating to the whistleblower.

NHS participants I recruited, four were either career managers or had significant management responsibilities (and all had substantial wider experience) but I was disappointed on two occasions when my invitations to participate were declined by two excellent candidates (former senior NHS managers) which left me with a slight sense (but fully acknowledging my own biases and preconceptions) that perhaps there may be some senior NHS managers who would prefer not to revisit difficult and stressful experiences.

Turning to the FOI Data: in Chapter 4 I comment in greater detail about the FOI process and the data collected. The process is a statutory process and available to members of the public. [102] It lacks some certainty in the sense that it is the organisation that responds to set questions, interprets the questions subjectively, and can call upon qualifications and exceptions available under the FOIA all of which can affect the quality and quantity of reply data. In practice, the data received proved variable from one Trust to another and despite efforts to ensure clarity in the form of the FOI Request the data pointed to different interpretations of whistleblowing by Trusts apparently conflating formal whistleblowing with all concerns raised with the Local Guardian (only some of which might be formal whistleblowing). [103]

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[102] The process is prescribed by the FOIA.

[103] There appeared to be confusion about whether Trust replies about numbers of whistleblowing cases in fact included other concerns which on their own would not usually amount to whistleblowing, such as bullying. Data published by the National Guardian's Office ("NGO") shows that a substantial proportion (30%) of concerns raised with Local Guardians in the year ended 31 March 2021 included an element of bullying or harassment: see *The Year of the Pandemic: A Summary of Speaking Up to Freedom to Speak Up Guardians 1 April 2020 - 31 March 2021* published by the NGO in July 2021. Bullying could and often does affect groups or teams, not isolated individuals, and thereby potentially patients, and so could affect staff well-being and therefore patient safety. However, the perception of bullying is essentially subjective - see Lizzie Barmes, *Bullying and Behavioural Conflict at Work, The Duality of Individual Rights* (OUP, 2016)p.12ff. Bullying is unlikely to amount to a criminal offence, but is always potentially immoral or illegitimate. It will be circumstance-dependent but a complaint about bullying could, I suggest, amount to formal/PIDA whistleblowing in some cases.

Although the process delivered a substantial volume of data the interpretation of that data was challenging and my statistical findings are inevitably contingent on the assumptions which I describe in Chapters 4 and 6. [104] Overall, however, the FOI Data is valuable as it provides a different dimension of NHS voice and a sense of statistical context providing relevant data for the research question of this study. From a wider research perspective I would note that FOI requests have been used by some NHS researchers. [105]

One further qualification to this study relates to my experience working with NHS whistleblowers. That experience had a significant impact on me and was instrumental in my decision to embark on this study. I would say I have unavoidably been affected by their stories. My experience with NHS whistleblowers included working with a group of whistleblowers and lawyers in preparing a thematic review

[104] It has only been possible to use a fraction of the data obtained from the FOI process within the circumstances of the study. My approach to interpreting the data is described further in Chapter 4. Although uncertainty seems inevitable, the numerical findings eg about numbers of cases mediated or litigated are quite emphatic perhaps suggesting that a degree of distortion would not disrupt the overall picture painted by the findings.

[105] See Ashley Savage and Richard Hyde, 'Chapter 4: Whistleblowing in the time of Covid-19: findings from FOIA requests" being a draft chapter retrieved from the Middlesex University Research Repository related to the International Whistleblowing Research Network conference at Maynooth University in 2021. The researchers used FOI requests to compare the number of whistleblowing complaints raised between March and August 2020 with the same period in the previous year. They do not comment in detail about the use of FOI requests save to observe that FOI requests can only obtain basic, non-detailed information. My decision to use FOI requests as a research tool pre-dated the publication of this paper and was not influenced by it or by any other academic publication.

for submission to the Freedom To Speak Up Review in 2014. [106] The project entailed a review, as part of a small team of lawyers, of approximately 70 NHS whistleblower written accounts of their experiences. [107]

Given this experience, I have consciously attempted to guard against any pro-whistleblower researcher bias. As I explain further in Chapter 4, I have attempted to offset natural bias by using a structure which specifically aims to express perspectives other than those of the whistleblower group. I have also been mindful of the need to provide, so far as possible, balance and impartiality when interpreting and selecting data and to write in measured terms even when some stories might invite a more emotional response. The study was designed so far as practicable to incorporate such balance and impartiality. The steps taken in this regard are articulated in Chapter 4.

Impact

The real-world problem suggests that NHS whistleblowing conflict remains damaging and inefficient and that outcomes that are better for NHS organisations and staff, and therefore patients, remain

[106] The submission is defined above as the Patients First Submission but I have been unable to locate a copy on the internet (I hold a hard copy). The experience of working with NHS whistleblowers showed me something of the appalling suffering many of them endured and their extraordinary courage and resilience. It was very clear that from their experiences only whistleblowers really understand how whistleblowing works on the ground. It was also evident to me that whistleblowers are compelled to tell their stories and those stories can be extremely powerful. The prompt for this study was that I could not understand why there were not better solutions and outcomes for NHS whistleblowers; it was astonishing that the NHS was apparently willing to lose talented and experienced healthcare professionals who had spoken up in order to protect patients.

[107] Inevitably some of the accounts were very harrowing but formed the basis for the Patients First Submission and as far as I am aware it was the only submission of its type based as it was on substantial first hand evidence of a significant number of NHS whistleblowers.

elusive. It appears that (as participants put to me) little changes. By seeking to examine whistleblowing as conflict and to do so with the advantage of an unusual "360 degree" mix of participant points of view through the stories they tell themselves and others, I hope to offer an authentic sense of what actually happens in practice, and from this, to uncover the nature of the conflict, how it relates to wrongdoing, how it relates to the whistleblower and whether and how the two interconnect. The objective in so doing, using a story theory approach, is to identify areas of difference in how the group narratives view the conflict in order to best assess the potential for improving resolutions of these conflicts. The data may explain why alternative interventions (such as mediation) appear unattractive to all parties; it may also identify subjective as well as objective barriers to resolution; and, it is hoped, open a conversation between researchers as to ideas and preferences for resolution which have a chance of working in the real-world. [108]

Analysing what the participants say about the conflict and the related issues that matter to them will disclose the areas that are not being addressed by resolution methods now, and why that may be, and allow the study to identify them and suggest how those areas of difference might be thought about and addressed. For example, it seems to be accepted wisdom that the wrongdoing raised by a whistleblower is not dealt with and the conflict focuses on the person of the whistleblower, when the data tells us that the wrongdoing matters to the whistleblower and should be part of the dialogue.

[108] An ultimate long-term objective might be said to be contributing to NHS organisational change, such that it is safe for whistleblowers to speak up, with all the multiple benefits that might bring for patients and staff.

There may be a multitude of systemic and managerial and human reasons why the preference is to handle the wrongdoing without whistleblower involvement, but none of those reasons seem to take account of the emotional and psychological significance of the wrongdoing to the whistleblower and how approaching it differently might positively help in terms of handling and resolving the conflict.

The study is therefore about ensuring that human experiences of whistleblowing conflict, seen from all perspectives (which is what stories can reveal), are considered with a view to showing us the nature of the conflict and doing so with a view to lighting pathways towards ideas for positive interventions for the benefit of all parties, including NHS patients.

9. Thesis Overview

Having discussed the nature of the study in this chapter, Chapter 2 contains a review of literature relating to the behaviour of NHS managers towards staff who speak up about wrongdoing within the NHS and to recipients who receive whistleblowing disclosures, thus providing context for the conflict. Whistleblowing as conflict will then be explored, adopting the dispute emergence approach advocated by Felstiner, Abel and Sarat framed by two important dimensions of whistleblowing, the wrongdoing and the whistleblower. [109]

Narratives and stories appear to me to be central to whistleblowing conflict and so, in Chapter 3, I discuss two aspects of story theory

[109] I frame my approach to whistleblowing as conflict by considering each of these dimensions as distinct and analysing them each separately. The purpose is to understand whether and how they are distinct aspects of the overall conflict and whether and how they may be interconnected. I discuss this further below.

applied to my analysis of the interview data. These are, first, the power of the first person narrative, the role of subjectivity, perspective and point of view, and secondly approaches to narrative (or storytelling) mediation which may enable the development of a common alternative third story as a pathway towards resolution.

The study, as I explain in Chapter 4, is designed as an empirical study with interview data being collected from three groups who represent constituencies relevant to whistleblowing conflict: whistleblowers, NHS managers and third parties. [110] I also explain the FOIA-based data obtained from over 100 NHS Foundation Trusts relating to whistleblowing cases and their outcomes.

In Chapters 5, 6 and 7, I present and discuss the data of the three groups, the whistleblower group (Chapter 5), the NHS group (Chapter 6) and the third party group (Chapter 7). In each chapter, I analyse the data in the light of story theory for what the data reveals about whistleblowing conflict with the purpose of establishing a narrative for each group which will inform findings when considered together with and in relation to the other group narratives.

In my final chapter, Chapter 8 I discuss the data offered by the three groups, my findings from the previous chapter and present my conclusions in response to the research question.

I now turn to Chapter 2 (Literature review).

[110] The third party group includes participants such as a mediator, a psychoanalyst and a CQC regulator.

Chapter 2

Literature Review

1. Introduction

This study is concerned with understanding NHS whistleblowing as conflict through the stories told by its participants and it is this perspective which has shaped the research review in this chapter.

Whistleblowing originates in and overwhelmingly remains in the workplace. Studies now show convincingly that, at least in developed countries, over 90% of whistleblowing disclosures are made internally within the organisation, the majority of those being made to line managers, with fewer than 10% being made to persons external to the organisation. [111] Disclosures made to the media may make headlines but are a very small proportion of cases generally. [112] Recent data suggests this is also the case for NHS whistleblowing: in the NHS financial years 2017/18, 2018/19 and 2019/20 in aggregate the numbers of whistleblowing reports made to external healthcare regulators was extremely small (a total of 547) when compared with the number made internally within NHS

[111] See 'Whistleblowing, its importance and the state of the research' at p.20.

[112] Ibid. Unless indicated otherwise I am using the phrases "whistleblowing disclosures" (or just "disclosures") interchangeably with "whistleblower reports" (or just "reports") although I suggest the word report is most appropriately used when referring to disclosures being made to an external body. This follows the general language of legal whistleblowing commentary - see for example *Whistleblowing Law and Practice* pp.887-9 discussing NHS whistleblowing data. The term "protected disclosures" on the other hand is a term used within PIDA. A "protected disclosure" is a disclosure of information which meets various PIDA requirements as discussed in Chapter 1.

organisations to Local Guardians over the same period (a total of 35,530). [113]

The overwhelming prevalence of complaints to Local Guardians (including those which may amount to formal whistleblowing) within organisations underlies what appears to be a recognition amongst researchers that the research focus should shift away from the decision-making of the whistleblower (about whether to blow the whistle or remain silent) towards the internal response of the organisation and to the more societal question of how whistleblowing can be more successful in two important senses: that it is safe for employees to blow the whistle and that wrongdoing is addressed effectively. [114]

Research is therefore increasingly orientated towards the internal behaviours of organisations towards the whistleblower and this shift is reflected in this chapter in a number of ways. [115] There are two particular contextual factors related to the NHS as an organisation which I wish to address in this chapter: the first is the NHS as a workplace in which the study is situated, because this is where

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[113] See the discussion and data at *Whistleblowing Law and Practice* at p.887. The data shows that the whistleblowing reports made to the three regulators who received the largest volume of reports (The General Dental Council, The General Medical Council and the Nursing and Midwifery Council) was an aggregate of 547, while the reports to Local Guardians over the same period was 35,530. However, these figures compare what appear to be formal whistleblowing reports made to regulators to reports made internally to Local Guardians (explained in Chapter 1 above) and so may not be comparing like with like. This is because reports to Local Guardians appear to include many which are unlikely to amount to formal whistleblowing, as I discuss below. The low number of external reports is striking, however, although it is speculation as to why this is the case.

[114] See Wim Vandekerckhove, A.J.Brown, Richard Moberly and David Lewis, 'Strategic Issues in whistleblowing research' in *The International Handbook* (hereinafter called 'Strategic issues in whistleblowing research') at p.522.

[115] Ibid.

almost all NHS whistleblowing occurs. [116] In section 2 below, therefore, I discuss a number of empirical studies which consider behavioural responses by staff towards colleagues who speak up. The second contextual factor is the NHS recipient of whistleblowing disclosures. Recipients are usually the front line managers who are faced with the often complex task of how to respond to whistleblowing disclosures. As I will show, researchers consider recipients an under-researched group and a group whose perspectives of the whistleblowing can differ radically from those of the whistleblower. [117]

The real-world problem described in the previous chapter suggests that retaliation against NHS whistleblowers is a persistent and entrenched problem; rather than seeing the whistleblowing positively as drawing attention to harmful patient practices, the response is often to retaliate against the whistleblower. [118] Researchers consider that whistleblowing should be seen as pro-social organisational behaviour that is, behaviour of the whistleblower as an organisation member for the benefit of others within the organisation rather than a neutral act or an act intended to harm the organisation (hereinafter the "POB Model"). [119] The beneficiaries of the whistleblowing are not necessarily defined in the POB Model (although in NHS cases it is likely to be patients/their families and/or staff); however, the overriding point is that the whistleblower has identified wrongdoing

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[116] See the *Freedom To Speak Up Report*: over 650 contributions were made to the review body, of which 612 were from individuals - see p.52.

[117] See 'Whistleblowing recipients' at p.275

[118] See the *Freedom To Speak Up Report,* Cover Letter to the Secretary of State for Health.

[119] The pro-social organisational model or "POB Model" of whistleblower behaviour is discussed in *Whistle-blowing in Organizations* at pp.35/36. The POB Model evolved from social psychology into organisational contexts and is broadly defined as the behaviour of an organisational insider for the benefit of others within the organisation whilst acting within her organisational role.

and is taking responsibility by speaking up about it rather than being a passive bystander and in doing so seemingly acts for the benefit of others within the organisation.

This model suggests merit, or moral virtue, on the part of the whistleblower because she has spoken up about wrongdoing for the benefit of others but the retaliation by those around her (recipients, managers or colleagues) suggests they do not view it in this way. It also invites consideration of wrongdoing in this context, as the wrongdoing in practice will be the whistleblower's subjective perception of that wrongdoing; others may take another view as to whether the concern even amounts to wrongdoing. In some instances it may be clear-cut, factually true and serious. In other cases it may be far from that, and research suggests that views will differ. [120] With this in mind, I discuss perceptions of wrongdoing and whistleblowing as a POB Model in the context of recipients, in section 3 below.

In the previous chapter, I highlighted the research distinction between the wrongdoing and the whistleblower, both being core aspects of whistleblowing which are explicit in the Research Definition. [121] These two core aspects, or dimensions, of whistleblowing will be used to frame the analysis of whistleblowing as conflict that follows in section 4 below. Whistleblowing conflict is overwhelmingly set in the workplace and so arguably constitutes workplace conflict - but with a defining difference, namely, that it has arisen because the whistleblower has unilaterally raised a concern that has wider public-interest, legal, regulatory and reputational

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[120] See 'Whistleblowing recipients' at p.289.

[121] The wrongdoing being the "illegal, immoral or illegitimate" practices and the whistleblower being an "organization member".

implications and therefore more complex than a typical grievance between an employer and an employee. [122] In this significant way, any analysis of whistleblowing conflict cannot ignore the wrongdoing and its implications. The wrongdoing component of the whistleblowing conflict is an important focus for this study.

As stated in Chapter 1, I have employed the dispute emergence model developed by Felstiner Abel and Sarat (defined above as the "Felstiner Model") to conduct this analysis. I discuss and critique the Felstiner Model in section 4 below and then (in section 5 below) apply it to analyse the real-world understandings of the wrongdoing and the whistleblower. I draw on data from the *Freedom To Speak Up Report* and whistleblowing literature to ground this analysis of whistleblowing as conflict. [123]

2. Everyday medical encounters: how NHS staff react when colleagues raise concerns.

2.1 Introduction

The objective of this section is to provide context about how NHS staff behave towards colleagues who raise concerns. The studies considered here are specific to NHS workplaces and mostly based on empirical data, dealing with a variety of issues such as how staff

[122] See for example David Lewis, 'Is a public interest test for workplace whistleblowing in society's interest? [2015] International Journal of Law & Management 141; and also as to the inability of the employment tribunal to address all elements of whistleblowing conflict, see: 'Resolving Whistleblowing Disputes in the Public Interest'.

[123] For clarity, this analysis has not drawn upon or involved consideration of any participant data and does not therefore suggest any conclusions from that data. Also, further analysis follows in Chapters 5 to 8 inclusive whereby I consider the participant data using the storytelling lens in the light of this understanding of whistleblowing conflict to draw out findings and conclusions.

interact and communicate with one another when caring for patients, behavioural values and managing risks around patient care. [124] They provide an academically-grounded context showing the behaviours of staff towards colleagues who may raise concerns in their everyday interactions and therefore how NHS organisations respond to them. Reports published following major NHS scandals often find that adverse organisational culture is at the heart of the systemic failings and that culture change is necessary. [125]

These studies assume a wider view of how staff within NHS organisations behave with patients in mind generally rather than a narrower, specific, lens of how the organisations behave towards whistleblowers and so tend not to use the terminology of some whistleblowing studies (such as the terms recipients, or wrongdoing, discussed above). Some present themselves as studies of NHS culture (focused on the NHS as an organisation) and in others, the authors use the terminology of "negative behaviours" (focused on the human responses). [126] For purposes of this study, the term culture is referencing the broad nature and values of the NHS workplace rather than specific behaviours relevant to whistleblowing conflict.

This study, however, is about people, specifically how staff within NHS settings respond to whistleblowers, rather than the much

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[124] The studies are not of whistleblowing per se, but provide valuable context as to how staff behave towards those who may raise concerns in various NHS settings. The studies also provide context to the workplace environment within which the whistleblowing occurs; in other words the studies illuminate NHS culture in this regard.

[125] Examples would include *The Mid Staffordshire Report* and *the East Kent Hospitals Report.* It is also the single most prominent conclusion of the *Freedom To Speak Up Report:* see the Cover Letter to the Secretary of State for Health: "The overarching Principle is that every organisation needs to foster a culture of safety and learning in which all staff feel safe to raise a concern."

broader and more complex concept of organisational culture, which is beyond the scope of this study. NHS culture is relevant for the limited purpose of contextualising the organisational response to whistleblowing and whistleblowers. The study acknowledges that culture is a broad concept which in relation to the NHS alone implies a substantial literature. For example, Dixon-Woods and colleagues in a recent very substantial multi-method study see culture…"as a term that is widely used but notoriously escapes consensual definition". [127] NHS culture is often cited as relevant to patient safety and in need of change and as mentioned above tends to be associated with major failings in patient care. As Oliver Quick states: "Most studies and inquiries into patient safety have concluded by calling for cultural change" and the treatment of whistleblowers offers "powerful examples of this culture". [128]

There has been an ongoing narrative about the need for culture change built around various public enquiry reports about localised "toxic" cultures over a number of years which points to the complexity of the concept of NHS culture and entrenched nature of the challenges it presents. [129] As for the narrower phenomenon of negative behaviours, discussed in the literature below in relation to

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[127] For an example of a study of NHS culture, see Mary Dixon-Woods et al 'Culture and behaviour in the English National Health Service: overview of lessons from a large multi-method study', BMI Qual. Saf. 2014 23 106-115 (hereinafter 'Culture and behaviour in the English National Health Service') at p.107. For a study targeted at behaviours rather than culture, see Rachael 'The NHS: Sticking Fingers in Its Ears, Humming Loudly' which is discussed below.

[128] See *Regulating Patient Safety* at p.161.

[129] To illustrate this see: *The Kennedy Report* and *The Mid Staffordshire Report*; also, the *Report of the Morecambe Bay Investigation* by Bill Kirkup, March 2015 (related to maternity services) at assets.publishing.serrvice.gov.uk ; the *Freedom To Speak Up Report* in which Sir Robert Francis QC dedicated a whole section to NHS culture (Section 5, p.94ff) stating that there was "near universal agreement" that NHS culture was "the most important factor" affecting staff willingness to speak up. For a recent but also highly relevant report see also the *East Kent Hospitals Report* by Bill Kirkup who comments specifically about the signs that were missed over many years to effect change in the maternity unit at East Kent University NHS Foundation Trust.

organisational behaviours, Rachael Pope adopts the following definition: “Any behaviour that is disrespectful and undermines/ violates the value/dignity of an individual. It is behaviour that harms individuals and organisations” and includes “incivility, aggression, bullying, harassment or abuse”. [130] However egregious that conduct may be I suggest for the purposes of this study that - as Oliver Quick suggests above - negative behaviours towards whistleblowers (as shown by the studies discussed here) should be seen perhaps as an expression or example of NHS workplace culture and should not be conflated with the culture itself.

2.2 The Studies

Pope investigates negative behaviours across a large sample of NHS staff and organisations, looking at several aspects: bullying/ harassment, organisational silence, corruption/dishonesty and good news cultures which NHS organisations tend to promote. [131] Pope’s field work included 6 focus groups and 43 semi-structured interviews across a range of Trusts. [132] She finds the NHS to be systemically and institutionally “deaf” to those who speak up, bullying, defensive and dishonest; it can be wilfully blind to patient safety concerns and resists unpalatable information about patient care. [133] Pope is of the view that the NHS is a dysfunctional, perverse and troubled organisation, a coercive bureaucracy and

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[130] See‘The NHS: Sticking Fingers in Its Ears’ at p.2.

[131] Ibid.

[132] Focus group membership required substantial NHS experience, a broad spectrum of roles, including clinical and trade union representation and from a wide geographic area.

[133] See Margaret Heffernan, *Wilful Blindness, Why we ignore the obvious at our peril,* (Simon & Schuster, London, 2012).

under certain conditions even corrupt. [134] Further, she says that the NHS, as an organisation, embraces and promotes good news and covers up bad news; its behaviours have a detrimental and sometimes devastating effect on the wellbeing of staff and patients. [135] Although Pope's theoretical approach seeks to explain individual personal conduct through the exercise of moral agency, her findings are expressed as institutionalised and widespread organisational standards of behaviour and as such, relevant for this study. [136]

Pope found that fear within the workplace was a major driver of worker behaviours so staff were scared to speak out and, in her words, "truth-telling" and "ethical resistance" were unwelcome. [137] Another driver of behaviour was the preservation of the NHS image, or reputation, a higher priority even than patient safety. [138]

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[134] Pope adopted the theoretical approach of Selective Moral Disengagement to help explain how individuals in NHS workplaces can "behave harmfully and still live in peace with themselves". The theory was developed by Albert Bandura in: 'Selective moral disengagement in the exercise of moral agency', Journal of Moral Education' 31(2) 101-119 and in *Moral Disengagement, How People Do Harm and Live with Themselves,* (Macmillan Learning, New York, 2016) (hereinafter *Moral Disengagement*). Bandura sees individuals as moral agents who generally sanction and regulate their own conduct and can find ways to disconnect the self-regulating function so as to justify their conduct to themselves.

[135] 'The NHS: Sticking Fingers in Its Ears", at p.1.

[136] This blurs the line between individual behaviour and personal accountability. It was recognised in the *Freedom To Speak Up Report* that managers who victimise whistleblowers are almost never held accountable. See the *Freedom To Speak Up Report* at p.12, paragraph 35: "No-one ever appeared to be held to account for bullying". Co-workers can be held personally liable for causing detriment to a whistleblower: see *Whistleblowing Law and Practice* at Chapter 10 (Vicarious and Individual Liability).

[137] Pope adds: "The NHS does not appear to like 'truth-telling' or 'ethical resistance' in any form". See 'The NHS: Sticking Fingers in its Ears', at p.1.

[138] The protection of the NHS image, Pope states "seems to override all other considerations, including the needs of the patients or the staff". Protecting the image and self-esteem of some individuals was also "a dominant influence" - see 'The NHS: Sticking Fingers in its Ears' at p.1.
As for patient safety: according to Oliver Quick the concept of patient safety is "beguilingly simple, yet in reality is extremely complex". The focus of patient safety is on what Quick calls "the human dimension of everyday medical encounters involving healthcare professionals and patients". See *Regulating Patient Safety* at p.29.

Organisational behaviours such as these are destructive and harmful to staff and damaging and dangerous for patients. [139] Pope sees negative behaviours as normalised within the NHS and argues that it is for the NHS to re-model itself as a learning, honest and respectful organisation. [140]

The idea of an organisation being deaf to concerns and complaints is also seen in Jones' and Kelly's work. They use the term "deaf effect" to capture the phenomenon of organisations disregarding staff concerns and treating them in ways that silence them. [141] The authors consider the ways in which staff raise their concerns (including informal strategies that may not amount to formal whistleblowing) and argue that whistleblowing research has been too rigid or binary (for example, that staff choices are seen as black and white, so either they speak up and suffer the consequences or they remain silent). [142] Jones and Kelly challenge this; they argue that staff use other behaviours to find ways to address concerns which fall short of formal whistleblowing but which can be effective. [143] These behaviours include speaking directly to the wrongdoer (including through the use of humour and sarcasm for example) or perhaps reporting anonymously. [144] Staff are labelled as silent when in fact they are not silent, suggesting that they find ways to address

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[139] See 'The NHS: Sticking Fingers in Its Ears' Abstract at p.1.

[140] Ibid.

[141] See Aled Jones and Daniel Kelly, 'Deafening silence? Time to reconsider whether organisations are silent or deaf when things go wrong' BMJ Qual. Saf. 2014; 23: 709-713 (hereinafter 'Deafening silence?').

[142] See 'Deafening silence?' at p.709.

[143] Ibid at p.712: "The binary concepts of whistleblowing and silence…miss the important point that workplace concerns are raised in a multitude of different ways and contexts".

[144] 'Deafening silence?' at p.710.

wrongdoing, or the risk of speaking out about the wrongdoing, whilst minimising the risk of being seen as a whistleblower. [145]

In a further study (albeit in social care settings for elderly people rather than NHS settings) Jones and Kelly found that formal whistleblowing was recognised by staff as risky and therefore led to them generating their own informal channels. [146] These were typically in the form of verbal interventions such as conversations or reprimands through which to address concerns directly with colleagues rather than whistleblowing to a third party. [147] The authors also found an "overwhelming preference" among staff for verbal interventions rather than formally documenting concerns. [148]

Tarrant and colleagues conducted a substantial ethnographic study of how staff manage patient risk day to day in 19 intensive care units ("ICUs") in NHS hospital settings in England in 2017. They found that "low level social controls" were employed by staff to manage patient risk and minimise errors in the mundane interactions that take place between staff every day. [149] These low level social controls broadly reflected the kind of verbal interventions described by Jones and Kelly in their studies. [150] Tarrant and colleagues

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[145] Ibid. A similar finding is made by Tarrant and colleagues, cited below.

[146] See Aled Jones and Daniel Kelly, 'Whistle-blowing and workplace culture in older peoples' care: qualitative insights from the healthcare and social care workforce', Sociology of Health and Illness Vol 36 No 7 2014 pp. 986-1002 (hereinafter 'Whistle-blowing and workplace culture in older peoples' care'). The range of interventions appears considerable, from friendly banter to strong direct reprimands.

[147] See 'Whistle-blowing and workplace culture in older peoples' care' at p.996.

[148] Ibid.

[149] Carolyn Tarrant, Myles Leslie, Julian Bion, Mary Dixon-Woods, 'A qualitative study of speaking out about patient safety concerns in intensive care units', Social Science and Medicine 193 (2017) 8-15 (hereinafter 'A qualitative study of speaking out'). The study included 98 interviews and over 900 hours of ethnographic observation.

[150] See 'Deafening silence?' and 'Whistle-blowing and workplace culture in older peoples' care', above.

identified a spectrum of verbal interventions including challenges and sanctions such as “quiet words”, “humiliation” or “brutal reprimands” as well as pre-emptive interventions such as “gentle reminders, use of humour, and sharp words”. [151]

Dealing directly with colleagues in these ways appeared to alleviate or minimise the possibility of formal whistleblowing but one consequence identified by the authors was that concerns expressed informally (and usually undocumented) were effectively hidden from view. [152] By contrast, a concern (especially a formal whistleblowing concern) voiced to a third party such as a line manager or an HR officer would be visible in the sense of being documented and possibly logged by the organisation. [153] They conclude that the emphasis on formal reporting to the organisation (so, whistleblowing) as the solution to voicing patient safety concerns was simplistic in that it appeared to take no account of the day to day interactions directly between staff (which is not whistleblowing) but which is how staff manage patient risk in practice.

Accordingly, the authors argue that more sophisticated understandings of social controls between staff in the workplace is needed. [154] This finding has relevance to this study as it suggests that formal internal processes by which whistleblowing can occur are out of touch with everyday informal clinical practices in which

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[151] Ibid. See also “A qualitative study of speaking out’ at p.4 which found that staff also used “corrective interventions” based on greater knowledge or experience more in the nature of supervision than intervention.

[152] Ibid at pp.5-8.

[153] Local Guardians are required to record cases in accordance with guidance issued from time to time by the National Guardian’s Office and also provide data returns so that the National Guardian can publish annual returns posted on its website at https://nationalguardian.org.uk.

[154] See ‘A qualitative study of speaking out’ at Abstract p.1.

staff find ways to manage patient risk. It also infers that raising a formal concern through an organisational process may be seen as a departure from the usual way of doing things (ie directly between colleagues, rather than raising a concern with a manager) and creating a perception that the whistleblower has acted contrary to accepted norms of everyday interactions between staff.

Mannion and Davies in their desk-based study of the role of whistleblowing in the context of healthcare organisations argue that whistleblowing is often wrongly construed as separate and distinguishable from normal organisational functioning, when it should be seen as part of a broad spectrum of behaviours, formal and informal, within NHS organisations. They too see whistleblowing-related concepts (they refer to "voice and silence") as being all part of a connected whole sitting within the wider organisational setting of the NHS. [155] They conclude that whistleblowing can be part of an effort of making the NHS safer for patients but that will only happen if it becomes normalised as part of the wider organisational environment rather than "something somehow separate and different". [156]

The Mannion and Davies study is a short desk-based article and does not rely on empirical data; it does not consider whistleblowing as a form of conflict, nor does it use narrative approaches. Mannion and Davies take an organisation-based approach which considers organisational cultures of speaking and listening and argues that whistleblowing sits outside of organisational norms, recognised as

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[155] Russell Mannion and Huw Davies, 'Cultures of Silence and of Voice: The Role of Whistleblowing in Healthcare Organisations' IJHPM September 2015 at p.3 (hereinafter 'Cultures of Silence and of Voice').

[156] See 'Cultures of Silence and of Voice' at p.3.

distinct from them, perhaps framing the whistleblower as something of an outsider, someone who does not fit in. [157]

With this in mind, the authors suggest that everyday communications between clinical staff in caring for patients means that concerns may be raised and dealt with every day without being visible to managers, suggesting that staff may not be silent when they see wrongdoing. [158] That being so, they suggest that the raising and responding to concerns happens all the time and that improving systems of whistleblowing as a formal organisational process is not necessarily a "solution" (their word) to the concern that staff are not speaking up. This is not however the view taken by this study; this study is aimed at understanding the whistleblowing conflict that does occur and signposting potential approaches to address that conflict.

These studies point to a complex and messy reality about negative organisational behaviours where staff appear to use strategies across a range of more or less informal verbal interventions to exert low-level social control (Tarrant's term, discussed above) over one another for the purpose of correcting errors, maintaining care standards and protecting patients. These researchers see the conventional view that staff either speak up or remain silent as artificially binary and insufficiently sophisticated to reflect real-world practices in the NHS workplace. These practices of verbal

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[157] They describe whistleblowers as "individuals with (often) complex personal and professional idiosyncrasies" and whistleblowing as "fraught with rival interpretations" occurring in a "highly situated organisational context" - see 'Cultures of Silence and of Voice' at p.2.

[158] Many argue that staff are afraid to speak up. This is a theme of the *Ockendon Report* and the *East Kent Hospitals Report*, discussed above. The authors are suggesting that instead, staff are quietly dealing with concerns without managers necessarily being aware of it.

interventions can be seen as a response to the “deaf effect” of NHS organisations or, in other words, a counter-response to the organisation’s adverse reaction towards whistleblowing as described in their studies.

From a staff point of view, concerns which might constitute whistleblowing if reported formally are handled by other strategies in order to minimise the risks associated with formal whistleblowing. Yet these strategies are not without risk; bullying or perceptions of bullying can arise as it could be argued that the tougher verbal interventions between colleagues might be subjectively perceived as bullying, thereby muddying the water further as these interventions are ostensibly to protect patients by collaborative methods, not to generate conflict. [159] Further, from a patient safety point of view, the use of informal interventions and social controls in everyday encounters may infer uncertainties about clinical standards and how care is actually delivered because concerns are not raised and dealt with. [160] However, as I argued in Chapter 1, it is far from certain that

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[159] The more robust interactions could be construed subjectively as bullying having regard to the subjective self-labelling method mentioned by Lizzie Barmes - see *Bullying and Behavioural Conflict at Work* at p.15: “Self-labelling” is a subjective understanding of bullying which “classes people as bullied when others would not regard them as being so and leaves out those who put up uncomplainingly with harsh treatment”. Bullying is a recognised and entrenched problem in the NHS: 30.1% of all complaints to Local Guardians in the NHS in England in the year 1 April 2020 - 31 March 2021 included an element of bullying/harassment - a significantly higher proportion than those which include an element of patient safety (which is 18%). In the following year (1 April 2021-31 March 2022) these figures were both higher: 32.3% had an element of bullying/harassment and 19.1% included an element of patient safety. The overriding point is that even a well-intentioned verbal intervention can be subjectively perceived by the worker on the receiving end as bullying and potentially therefore as an injurious experience under the Felstiner Model discussed below.

[160] Tarrant et al express misgivings about the opaque and sometimes idiosyncratic nature of these interventions, meaning that patient care may not be delivered at a consistent quality - the point being that matters are dealt with by individual practitioners rather than being more widely aired. See ‘A qualitative study of speaking out’ at p.1.

in a typical case wrongdoing or malpractice will be addressed in any event. [161]

I now turn to research relating to recipients of whistleblowing disclosures.

3. Recipients

3.1 Why Recipients Matter

Recipients are typically internal organisation managers who receive whistleblowing disclosures about wrongdoing of some kind, often patient safety and for that reason are important actors within whistleblowing settings. [162] Recipients matter in this study because they hear and receive the whistleblowing concerns and are a critical element of how the organisation reacts: they are the organisational insiders - NHS employees - who receive the whistleblower's complaint, often in supervisory or management roles.[163] Also, as we

[161] See the discussion at section 1 of Chapter 1.

[162] The particular focus on recipients is because they represent the front line agency of the organisation and are thought to be under-researched thereby offering balance and relevance for the study. Whistleblowing research is increasingly focused on organisations, to understand the effectiveness of whistleblowing, so discussing recipients in particular aligns with that research objective. See 'Whistleblowing recipients' generally.

[163] Recipients in this study are typically NHS managers and in any given case there may be a number of recipients such as junior and more senior managers in the NHS hierarchy. The study data suggests that recipients are unlikely to be Human Resource (HR) executives as HR tends to be viewed with mistrust and likely to be associated with disciplinary matters rather than support for staff. Local Guardians however are likely to be recipients of whistleblowing (among other) concerns.

know, almost all whistleblowing occurs within workplaces meaning recipients are key actors. [164]

Recipients are also considered to be an under-researched group by comparison to whistleblowers in relation to their behaviour and their role in relation to the whistleblowing process which according to Moberly is surprising because of the "crucial and difficult" role they play. [165] Recipients, as the face and voice of the organisation, can work either to alleviate the wrongdoing or disregard it and retaliate against the whistleblower. [166] The real-world problem described in Chapter 1 above proposes that NHS managers or other recipients often retaliate against the whistleblower and do little to address the wrongdoing. [167]

Part of the complexity underlying recipient responses to whistleblowing disclosures involves an understanding of wrongdoing and the nature of the whistleblower's act of whistleblowing as the perception of what amounts to wrongdoing can differ significantly. I will now therefore discuss wrongdoing and also explore the assumption that whistleblowing is pro-social organisational behaviour as that too can be contested between the whistleblower

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[164] Whistleblowers who report to an external person or organisation, such as a regulator, are overwhelmingly likely to have reported internally first and often go outside the organisation only when internal avenues have been exhausted. See 'Whistleblowing recipients' at p.275. See also Kate Kenny, *Whistleblowing, Toward a New Theory* (Harvard University Press, Cambridge, Massachusetts, 2019) (hereinafter *Whistleblowing, Toward a New* Theory) at p.19.

[165] See 'Whistleblowing recipients' at p.273. Also, David Lewis and colleagues see recipient behaviour as more important from a public policy perspective than further study of whistleblower behaviour but state that research in the field is in its "relative infancy" - see 'Whistleblowing, its importance and the state of the research' at p.19.

[166] See 'Whistleblowing recipients' at p.273.

[167] The *Freedom To Speak Up Report* contains evidence based on numerous submissions from whistleblowers that recipient responses were retaliatory: [whistleblowers] "described a harrowing and isolating process with reprisals including counter allegations, disciplinary action and victimisation" at p.10.

and recipients. Both aspects can therefore be areas of difference between whistleblowers and those they report to.

3.2 Wrongdoing

The term *wrongdoing* is used by researchers as shorthand for the illegal, immoral or illegitimate practices mentioned in the Research Definition. [168] In NHS settings wrongdoing would usually denote a form of malpractice which could endanger patient-safety but could equally suggest financial or administrative malpractice. Researchers recognise that the breadth of the definition invites challenge as it is essentially a subjective judgement and could encompass an almost infinite range of possibilities: the use of the word "illegitimate" in particular invites the implication of a subjective values framework. [169] Skivenes and Trygstad point out that acts of wrongdoing can be highly subjective and the term represents a "well-known challenge in whistleblowing research". [170]

As law, PIDA introduces an element of objectivity in order for a whistleblower have the standing for a claim in damages: for whistleblowing disclosures to satisfy the statutory requirements of PIDA the whistleblower must show "a reasonable belief" that the information disclosed tends to show a "relevant failure" (such as a breach of a legal requirement or endangering the health and safety

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[168] The Research Definition refers to "illegal, immoral or illegitimate practices". Marit Skivenes and Sissel C. Trygstad see this phrase as problematic because of its breadth and discuss various more specific definitions which build on the Research Definition and their implications in 'Wrongdoing: Definitions, identification and categorizations' in *The International Handbook* at p.95 (hereinafter 'Wrongdoing: Definitions, identification and categorizations'). They see it as "obvious" that the breadth of the phrase means that wrongdoing will be subjective and contested - at p.96. See also *Whistle-blowing In Organizations* at p.4.

[169] See 'Wrongdoing: Definitions, identification and categorizations' at p.96.

[170] Ibid, at p.97.

of any person) and a “reasonable belief” that the disclosure is in the public interest. [171] Wrongdoing is not a word used within PIDA itself but in NHS settings it could be seen as the illegal, immoral or illegitimate practice (of the relevant physician or surgeon for example) which endangers the health of a patient (although the relevant practice could endanger the health of others, such as a member of staff) which has resulted in the relevant failure. [172]

Whether an act or practice of any kind is perceived as wrongdoing will I suggest inevitably be a matter of perspective for the actors involved in a whistleblowing incident influenced by multiple factors within the workplace. [173] For example, Jones and Kelly identify interpersonal relationships between nurses and line managers as playing an important part in the reporting of wrongdoing, for instance, that fear of repercussions by a manager may deter a nurse from speaking up about the wrongdoing she has witnessed. [174] The perceived seriousness of the wrongdoing can also differ as between managers and employees (who are not managers) and even between some employees and others according to Skivenes and Trygstad; even though the wrongdoing proposed in one of their studies was illegal, views were evenly divided within a large group of

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[171] Ibid at p.99.

[172] In practice, however, the language of the Research Definition would not be relevant to establishing the “relevant failure”. Under PIDA, for a disclosure to qualify for protection the whistleblower must show “a reasonable belief….that the disclosure tends to show…that the health or safety of any individual has been, is being, or is likely to be endangered” (s.43B ERA) so whether that belief could be established at the employment tribunal about the “illegal, immoral or illegitimate practice” in question would depend on the facts and circumstances.

[173] See ‘Wrongdoing: Definitions, identification and categorization’ at p.103.

[174] See Aled Jones and Daniel Kelly, ‘Whistle-blowing and workplace culture in older peoples’ care’ at p.988.

participants as to whether it was a serious concern for the organisation or not. [175]

In healthcare, assessments of poor practice or substandard care as a form wrongdoing may be technically complex and even highly specialised and well-informed medical opinions may differ. [176] Researchers recognise that wrongdoing is not therefore primarily a matter of objective knowledge or fact to be established by an impartial fact-finding investigation, but a subjective judgement made initially by the whistleblower. Those around the whistleblower, the wrongdoer, the recipients and colleagues, also then form judgements about the wrongdoing from their own perspectives, which will inevitably differ to some degree. Skivenes and Trygstad emphasise strongly the subjective and uncertain nature of wrongdoing and describe it as "a well-known challenge" for whistleblowing researchers. [177] The discussion above serves to reinforce the sense that the wrongdoing is inherently unstable and therefore almost by definition a site for differing perspectives, leading to conflict. [178]

3.3 Whistleblowing as pro-social organisational behaviour

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[175] See 'Wrongdoing: Definitions, identification and categorizations' at p.108.

[176] For a discussion of medical culture and differing views of patient safety see *Regulating Patient Safety* at p.145. Cultural norms within different Trusts (or even departments) may differ. Quick describes how medical errors can become normalised and medical professionals engage in "vocabularies of realism" about risk and harm (also *Regulating Patient Safety* at p.145). See also *Whistleblowing Law and Practice* at section 5 on p.166 which suggests that if the risk of harm appears trivial in practice that may raise a question as to whether the whistleblower's belief that there was danger to a patient's health was reasonable.

[177] See 'Wrongdoing: Definitions, identification and categorizations' at p.97.

[178] This discussion appears to support the suggestion below (prompted by the Felstiner Model) that the whistleblower's colleagues perceive the whistleblower's story about the wrongdoing as an injurious experience leading in some cases to a sense of grievance.

A second consideration relevant to the relationship between the recipient and the whistleblower is the conception of whistleblowing as pro-social organisational behaviour and therefore intended to be beneficial to others within the organisation. [179] The POB Model frames whistleblowing as an act of personal selflessness by the whistleblower which entails an uncertain evaluation of the wrongdoing (which we have seen to be highly subjective). Yet whistleblowing can be pro-social without being altruistic: a whistleblower may speak up for the benefit of others notwithstanding a mix of motives, which may be difficult to establish or infer. [180]

The POB Model can be seen as aligned with the public interest (in the sense that the whistleblowing may benefit a defined group of members of the public) which is also a relevant concept for PIDA protection. [181] However, the pro-social organisational nature of an act of whistleblowing may also be contested, as it entails a highly subjective evaluation of the wrongdoing (discussed above) and because recipients' perceptions of the whistleblower, her personal

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[179] The development of this model (hereinafter "the POB Model"), which had its origins in social psychology, particularly theories of bystander intervention, is discussed in *Whistle-blowing in Organizations* at pp.35/36. Also, see *Whistleblowing, Toward a New Theory* at p.19; and'Whistleblowing, its importance and the state of the research' at pp.5/6. Eileen Chubb, emphasises that whistleblowers are selfless: see *There is no ME in whistleblower* (Chipmunkapublishing, UK, 2020). Chubb is a well-known campaigner in health and social care. Alford however sees whistleblowers as narcissistic, introducing the concept of "narcissism moralised" in *Whistleblowers, Broken Lives and Organisational Power.*

[180] See *Whistle-Blowing In Organizations* at p.36. The authors add that financial reward (as a motivation for whistleblowing) does not undermine an individual's status as a whistleblower.

[181] See above. To satisfy PIDA requirements the whistleblowing disclosures must be capable of benefiting a definable group of members of the public. See the leading case on the PIDA public interest test: *(1) Chesterton Global Limited and (2) Verman v Nurmohamed (Public Concern at Work intervening)* [2017] EWCA Civ 979 [2017] I.R.L.R 837) and *Whistleblowing Law and Practice,* Chapter 5 (The Public Interest Test) at p.175. Also, see 'Whistleblowing, its importance and the state of the research' at pp.5/6.

qualities and her motives can override ideal responses towards the whistleblower and her actions. [182] Whistleblowing has always had its detractors, opposing voices who place organisational loyalty over speaking up and who see whistleblowing as initiating conflict: it is not seen as benefitting others, but as disloyal and damaging to the organisation. [183]

3.4 Recipient Responses

As between the whistleblower and the recipient, perspectives of both the wrongdoing and the alleged pro-social (and pro-organisation) act of whistleblowing may differ and both aspects are seen by researchers as subjective, and influenced by social and cultural factors which impact the way recipients and whistleblowers interact.

The reality of a whistleblowing incident for recipients is likely to be politically and emotionally complex. It is conceivable that managers are complicit in the wrongdoing but turn a blind eye. [184] Study data suggests that whistleblowers will receive a spectrum of reactions from different voices within the organisation, suggesting (as I argue below) that whistleblowing is likely to affect multiple parties. [185] This may depend on factors such as the status and credibility of the

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[182] See *Whistleblowing in Organizations* at p.39. See also section 4 below in which I discuss the role of attribution theory in the Felstiner Model.

[183] See 'Whistleblowing, its importance and the state of the research' at p.6 for a discussion of views that consider the loyalty of a worker to the organisation as more valuable and important than a worker's willingness to blow the whistle (which is seen as disloyal). James Roche, Chair of General Motors in 1971 equated whistleblowing with "industrial espionage" and attributes it with "creating conflict". Whether the act of whistleblowing initiates conflict by creating a perception of injury is a point discussed in sections 4 and 5 below.

[184] See Pope, 'The NHS: Sticking Fingers in its Ears' at p.1.

[185] See 'Whistleblowing recipients' at p.285.

whistleblower and the wrongdoer, and the seriousness of the wrongdoing and its longevity. [186] Moberly identifies other factors, such as hierarchy, which can be significant: junior managers can face a difficult process themselves when telling their senior line managers about a whistleblowing report being less well equipped and less able to address the wrongdoing. [187]

A further complication in construing organisational and recipient reactions is distinguishing between the reaction to the wrongdoing and the reaction to the whistleblower. Outcomes can be strongly influenced by recipient perceptions of each of these two core aspects of whistleblowing. [188] The recipient's subjective perception of the credibility of the whistleblower can affect the direction of whistleblowing cases and that credibility (or lack of credibility) has greater significance where the evidence of wrongdoing is very limited or non-existent. [189]

Recipient "misperceptions and misunderstandings" about the whistleblower, such as scepticism about her true motivations, or whether her concern is seen as genuine, will also influence the response of the organisation. [190] Recipients can struggle to distinguish between personnel grievances (which would usually be

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[186] See *Whistle-blowing in Organizations* chapters 4 and 5 for a discussion of these and other factors shown to have relevance to predictions of retaliation against the whistleblower (see chapter 4 at p.101) and ending the wrongdoing (see chapter 5 at p.131).

[187] See 'Whistleblowing recipients' at p.286. A junior NHS manager would be unlikely to have the experience or authority to react to concerns about a senior consultant, for example.

[188] See 'Whistleblowing recipients' at p.287: "the *perceptions* of the initial recipients [ie how they view the whistleblower] matter greatly to the outcome of the whistleblowing process".

[189] See 'Whistleblowing recipients' at p.287.

[190] Ibid at p.286.

handled by HR) and concerns with a patient safety component. [191] For example, it appears that there are misunderstandings of the distinction between an HR grievance and a whistleblowing complaint even amongst Local Guardians. [192] Recipient perceptions of the wrongdoing (rather than of the whistleblower) are also significant in dictating the direction of the organisation's reaction to the whistleblowing complaint. The recipient must form an initial judgement about whether the wrongdoing has occurred, which can be a difficult assessment particularly for an inexperienced manager with limited knowledge of clinical issues. [193] For example, research suggests that managers are also more likely to treat a whistleblower poorly when multiple reports of the whistleblowing are required through levels of a complex hierarchy. [194]

Some studies also suggest that recipients perceive only a minority of whistleblowing complaints to be valid. [195] Assessing the validity of the complaint can be challenging for managers and highly influential in how they respond and whether the wrongdoing has occurred can

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[191] Ibid at p.287 and p.296. See the statistics cited above about the number of concerns expressed to Local Guardians that contain an element of patient safety.

[192] The National Guardian's Office ("NGO") carries out case reviews and publishes reports on its website - see the case reviews at nationalguardian.org.uk. One review relating to complaints at Whittington Health NHS Trust (published on 21 April 2021) highlights significant discrepancies between the Trust's own whistleblowing policy and the national standard integrated policy approved by the NGO as to the meaning of whistleblowing. The NGO stated: "Finding Trust policies do not align with the national standard integrated policy *has been a theme in every case review to date*" (my italics). This is a worrying sign, that Trusts are either unable to reflect the national integrated policy accurately or are deliberately seeking to depart from it. One issue was that the definition of a "grievance" was inappropriate because "it would always channel cases that referred to an individual's own experience down the grievance route" - which appears to say that the Trust would always class the self-labelled *perception* of eg bullying as an HR grievance rather than assessing whether it might contain a patient-safety/public interest component. This sort of error would also affect the accuracy of the data reported to the NGO as to which Local Guardian cases included an element of patient-safety.

[193] See 'Whistleblowing recipients' at p.287.

[194] Ibid. The NHS is notoriously multi-layered and bureaucratic.

[195] See 'Whistleblowing recipients' at p.287 and footnote 8 on p.297.

be “in the eye of the beholder” that is, the recipient. [196] Recipients, senior managers and onlookers are not unbiased observers; they may have different views from those of the whistleblower and even vested interests in allowing the wrongdoing to continue. [197] Near and Miceli see attribution theory (discussed in section 4 below) as potentially relevant, explaining that the recipient may be over-influenced by the whistleblower’s personal or dispositional characteristics in assessing whether the complaint is genuine, suggesting a significant connection in the mind of the recipient between the wrongdoing on the one hand and the whistleblower on the other. [198]

The complex set of factors affecting the judgements made by recipients about both the wrongdoing and the whistleblower highlights the subjectivity and uncertainties inherent in their role and perhaps therefore the fragility of organisational responses. The subjective perception of the recipient in relation to both the wrongdoing and the whistleblower points to the potential for opposition or resistance to the whistleblower’s cause: if neither the wrongdoing nor the whistleblower are perceived as credible and the recipient is unconvinced as to the validity of the whistleblower’s complaint it creates space for conflict. Recognising the uncertainties

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[196] See *Whistle-blowing in Organizations* at pp.20/21. The authors call this aspect of the process the “Eye of the Beholder” problem ie the perception of the recipient in relation to the wrongdoing.

[197] See *Whistle-blowing in Organizations* at p288. In the case of Ian Paterson, a rogue breast surgeon, it was clear that his economic value to the Trust influenced senior managers notwithstanding that colleagues were raising concerns. See *Report of the Independent Enquiry into the Issues raised by Paterson (HC 31, at* assets.publishing.service.org.uk*)* opening statement at p.2 (hereinafter *the Paterson Report*).

[198] I discuss attribution theory further in section 4 below. It is seen as potentially relevant to dispute emergence theory: see Dan Coates and Steven Penrod, ‘Social Psychology and the Emergence of Disputes’, 15 LAW & Soc’y REV.655 (1980) (hereinafter ‘Social Psychology and the Emergence of Disputes’) at p.659ff.

and subjective perceptions of these two elements (the wrongdoing and the whistleblower) is important because (as I explain above) I am using these two dimensions to frame the analysis of whistleblowing conflict that follows below.

I will now discuss whistleblowing as conflict in the following section.

4. Whistleblowing as Conflict

In this section I situate whistleblowing within the dispute emergence theory of the Felstiner Model. [199]

Felstiner Abel and Sarat describe their model as a social process. Whistleblowing is also seen by researchers not as an isolated decision taken by the individual whistleblower but as a process with social, organisational and political characteristics. [200] It is the process (rather than the decision of the whistleblower, or her individual characteristics) which is now seen as central to the research agenda. [201] The process has been described as social in nature owing to the centrality of the interactions between the

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[199] See William L.F. Felstiner, Richard L. Abel and Austin Sarat, 'The Emergence and Transformation of Disputes' (defined above). The Felstiner Model is discussed by Michael Palmer and Simon Roberts in *Dispute Processes* at pp.101ff and looked at from a sociological and cultural perspective at pp.308-312. I also discuss the following commentaries: Jeffrey Fitzgerald and Richard Dickins, in 'Disputing in Legal and Nonlegal Contexts: Some Questions for Sociologists of Law', 15 LAW & Soc'y REV. 681 (1980) (hereinafter 'Disputing in Legal and Nonlegal Contexts'); also, Dan Coates and Steven Penrod, 'Social Psychology and the Emergence of Disputes'; and also Sally Bostock-Lloyd, 'Propensity to Sue in England and the United States of America: The Role of Attribution Processes - A Comment on Kritzer', 18 J.L. & Soc'y 428 (1991) (hereinafter 'A Comment on Kritzer').

[200] See 'Strategic issues in whistleblowing research' at p.522.

[201] Ibid.

numerous actors. [202] According to Kenny some researchers argue that the process is too complicated to model, given the multiple variables involved. [203] She says that, reduced to its essential elements the process includes an interaction between only two parties, the whistleblower and the recipient. [204] Real-world data suggests the interactions often engage multiple recipients, reinforcing the sense that the whistleblowing process is complex and requires numerous steps. [205]

The Felstiner Model describes the dispute emergence process as having a number of stages: first, an individual will have undergone an experience which she may or may not have perceived to be injurious to her and which, having *not* felt it to be injurious, subsequently perceives that it has become so. If this happens then a transformation will have occurred when the individual moves from not recognising that the experience has injured her to recognising that it has. [206] The term "transformation" has a specific meaning in this context, which is that a change of mind takes place in the injured individual - that is, the potential claimant - which arises out of that individual's perception, itself derived from social and cultural factors or structural or other circumstances affecting the population

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[202] See *Whistleblowing, Toward a New Theory* at p.19.

[203] Ibid.

[204] Ibid.

[205]Although Vandekerckhove, Brown and Tsahuridu describe the social interactions as being between the whistleblower and a single recipient (see 'Managerial responsiveness to whistleblowing' at p.315) Sir Robert Francis QC suggests multiple recipients are more likely in practice as the whistleblowing incident can affect other organisation members - see the *Freedom To Speak Up Report* at paragraph 3 on p.8, and at p.55. (which is a convoluted hand-drawn diagram summarising the complex experience of one whistleblower revealing multiple recipients contacted in the NHS hierarchy between November 2011 and November 2014).

[206] See 'The Emergence and Transformation of Disputes' at p.633. The example given is a nuclear leak that causes cancer in a local population: some do not initially recognise the personal injury but their views subsequently "transform" as they perceive that they have suffered injury.

at large such as “differences in class, education, work situation, social networks” between those who do not recognise the injury and those who do. [207] This stage of the process is identified as Naming.

The second stage, identified as Blaming, occurs when the perceived injurious experience is transformed into a grievance. [208] This happens when the injured individual attributes the injury to the fault of another person or entity. This is an explicitly subjective matter seen from the injured person’s perspective whereby she must feel wronged - aggrieved - and believe that some action might follow in response to the injury. [209] For blaming to occur, the grievance must be directed against a human person or social entity such as a government agency or an organisation but not against “no one in particular”. [210]

The third stage, identified as Claiming, occurs when the aggrieved person voices the grievance to the person or entity he believes is responsible and seeks redress of some kind. The claim is finally transformed into a dispute when it is rejected in whole or part by that person or entity. [211] Although the model does not prescribe the then direction of the dispute nor the forum for its resolution it does

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[207] Ibid at p.634. These factors appear to be the elements of the social process of dispute emergence. The authors acknowledge “conceptual and methodological difficulties” in studying transformation, most obviously in measuring the social variables that show why some individuals value/“disvalue” the same injury differently from others, or perceive the injury differently.

[208] Ibid at p.635

[209] However “politically or sociologically improbable such a response might be”: The Emergence and Transformation of Disputes at p.635.

[210] Ibid. So, an example would be a generalised feeling of grievance against society at large.

[211] Ibid at p.636: not necessarily by express words, delay or silence can constitute a rejection.

discuss the role of dispute resolution institutions such as courts and tribunals and how through the legal process they affect and shape the dispute. [212] The audience chosen by a grievant, such as a court, an administrative agency or a psychotherapist, will determine the rules which apply, such as the actors, the norms and the remedies which may apply to the claim. [213]

The process is described by Felstiner Abel and Sarat as subjective, unstable, reactive, complicated and incomplete and is personally experienced by means of the cognition, perception, emotions and psychology of each individual. [214] For example, transformations may take place when the feelings of the individual change about the seriousness of the injury or the culpability of the counter-party. The injured party may redefine her perception of her experience. The authors state that the human experience of the injured party is inevitably subject to biased thinking, cognitive error, ambiguous behaviour, faulty memory, conflicting objectives and other similar factors. [215] The personal experience of conflict can be profound and enduring and the authors see the process as incomplete. [216] Conflict is never truly forgotten and leaves its psychological and

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[212] See 'The Emergence and Transformation of Disputes' at pp. 647-649. The authors make a brief comparison between the court system and psychotherapy as ways of "handling conflict". The court system offers conventional adjudication, whereas psychotherapy addresses the state of mind of the disputants. Whereas the outcome of litigation will be an adjudication, the outcome of a psychotherapeutic intervention may be "a change in the client". I suggest this may have relevance to whistleblowing because of the traumatic effect of retaliation on the mental and emotional well-being of the whistleblower (see *Whistleblowing, Toward a New Theory* for numerous assertions of whistleblower suffering) but also because psychotherapy offers an approach to personal storytelling contrasted to litigation which is a forum in which stories are contested.

[213] See 'The Emergence and Transformation of Disputes' at p.642.

[214] Ibid at pp.637-639.

[215] Ibid at p.638.

[216] Bush and Folger describe the distressing experience of conflict from a social and cognitive psychology perspective - see *The Promise of Mediation* at p.48.

emotional mark on the individual, they say. [217] Evidence submitted to the *Freedom To Speak Up Report* appears to support this observation in relation to the experience of NHS whistleblowers. [218]

Felstiner Abel and Sarat see the parties to the conflict as both subjects and agents of transformation: through their interaction a party transforms the counter-party and in turn is transformed by that counter-party. [219] The identity and the number of parties is not fixed or prescribed by the Felstiner Model, leaving open the possibility of multiple parties to conflict. Neither is the model prescriptive of conflict settings, leaving open the possibility of disputes emerging in workplace settings. [220] Transformations from one stage to the next are influenced by personality and experience which are related to factors such as class, ethnicity and age. [221] The relationship between the parties is significant, including their working relationship relative to one another, their relative status and any historical animosity between them. [222] The parties are key in this process of dispute emergence in that they exercise transforming agency in relation to one another that can "have a major transformational role" in relation to the conflict. [223]

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[217] 'The Emergence and Transformation of Disputes' at p.639: "people never fully relegate disputes to the past, never completely let bygones be bygones…there is always a residuum of attitudes…and sensitivities that will consciously or unconsciously colour later conflict". This point is reflected in the account given by Damian in Chapter 7 in which he says whistleblowers often re-enact historical grievances when they blow the whistle.

[218] See the *Freedom To Speak Up Report* at paragraph 3.2.5 on p.54.

[219] See 'The Transformation and Emergence of Disputes' at p.639.

[220] Ibid.

[221] Ibid p.640

[222] Ibid.

[223] Ibid.

The Felstiner Model implies a chronological sequence in the three stages of transformation whereby a later stage is contingent on the previous stage: without naming, there can be no blaming, and without blaming there can be no claiming. Sally Lloyd-Bostock challenges this: she believes that the naming, blaming, claiming type of model (of which the Felstiner Model was one and the model suggested by Herbert Kritzer was another) confuses sequences of reasoning and logic on the one hand with actual events and causal sequences which form perceptions, decisions and actions on the other. [224] Researchers should not expect people to arrive at perceptions, judgements and decisions in a particular order; she argues that the process is more complex and disorderly than the Felstiner Model implies, so that attributions of fault or blame can occur *after* a decision has been made to bring a claim. [225] There is no one "all-purpose" attribution of cause or blame; she claims that psychological, social and cultural factors are constantly interacting throughout the process. [226] In particular, the "blaming" (the attribution of fault to another) can be influenced by knowledge that a claim (or potential claim) may exist. [227] Lloyd-Bostock questions the neat and tidy shift from one stage to the next, in favour of the messy realities she observed from her own empirical research. [228]

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[224] See, 'A Comment on Kritzer': "a significant body of literature about the emergence and evolution of disputes, is premised on a 'naming - blaming - claiming' type model [whereby] each stage is to some degree contingent on the one before and the model implies a time sequence'. Lloyd-Bostock is commenting specifically on a similar model advocated by Herbert Kritzer which he called the Developmental Theory of Litigation which was based on the Felstiner Model: see Herbert M. Kritzer, 'Propensity to Sue in England and the United States of America: Blaming and Claiming in Tort Cases', 18 J.L. & Soc'y, 400 (1991) at p.401.

[225] See 'A Comment on Kritzer ' at p.429.

[226] Ibid.

[227] Ibid. She adds: "Too much of what happens in practice does not sit easily in a model of this kind".

[228] Ibid at p.429.

Fitzgerald and Dickins argue that the Felstiner Model does not provide explanations as to why individuals behave as they do. [229] They suggest additional social and cultural factors to enhance the Felstiner Model (discussed below) but mainly advocate that social psychology can make a contribution because the dispute emergence model is reliant on changes in subjective perceptions and emotions which are contingent on psychological responses to external factors and events. [230] They identify and discuss social and cultural factors which they say improve the completeness and therefore plausibility of the naming blaming and claiming approach. [231] Cultural context (such as the workplace) is one of these, so that an event which might pass unnoticed in one context could lead to the perception of an injurious experience in another. [232] Another factor is the role of outsiders to the dispute: who they are and how they might affect the overall trajectory of the conflict through their interaction with and influence upon the parties. [233]

Coates and Penrod propose to integrate social psychological theory (rather than additional cultural and sociological factors) into the

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[229] See 'Disputing in Legal and Nonlegal Contexts' at p.684.

[230] Citing 'Social Psychology and the Emergence of Disputes' which I discuss below - see 'Disputing in Legal and Nonlegal Contexts' at p.693

[231] These are: (1) trigger events, (2) the role of third parties, (3) cultural context, and (4) personality type such as "authoritarian" or ""litigious" personalities - see 'Disputing in Legal and Nonlegal Contexts' at pp.685-686.

[232] As discussed in section 2 above, bullying can be a subjective perception (see Barmes' discussion of "self-labelling" cited above) and we know that bullying and harassment complaints comprise a substantial number of the total concerns reported to Local Guardians - see *Whistleblowing Law and Practice* at p.908 for a table of data for the period 2017-2021.

[233] Outsiders are grouped by the authors into four categories: Audience (such as colleagues/bystanders), Supporters (friends and family, social network), Agents (representatives such as lawyers, but with a range of roles) and Intervenors (any third party who might contribute in some way or another, or a mediator). See 'Disputing in Legal and Nonlegal Contexts' at pp.694-700.

Felstiner Model. [234] They argue that some perceive an act as injurious (when others do not) because they perceive the injury relative to other people rather than in absolute terms and it is this relative perspective that holds the potential for perceptions of injury. [235] Similarly, injury can be perceived when people feel they are being treated less well than others who are no more deserving than they are, based on their calculation of what they contribute to a relationship and what they receive in return. [236] Both aspects emphasise the individual psychological response, relative to others, which underpins the initial perception of injury. [237]

Coates and Penrod place emphasis on attribution theory, which holds that people prefer to find order and meaning in the world than not and thereby develop reasons for themselves as to why events happen and why people behave as they do. The attributions are the causes that people see as underlying why events happen and why

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[234] See 'Social Psychology and the Emergence of Disputes' at pp.655/6.

[235] This aspect of theory is called "relative deprivation"; see 'Social Psychology and the Emergence of Disputes' at p.657.

[236] This is a basic principle of "equity" theory: see 'Social Psychology and the Emergence of Disputes' at p.658. An example might be that an employee is happy with a pay rise in absolute terms until they realise they are paid less than colleagues on the same grade.

[237] This is only the first step of "naming" of course. The conflict which arises at this stage may go no further as the potential claimant may decide to take it no further. This so-called "avoidance" (of the conflict) is also discussed by Fitzgerald and Dickins at p.683. See also, Marc Galanter, 'Reading the Landscape of Disputes: What We Know and Don't Know (and Think We Know) about Our Allegedly Contentious and Litigious Society' 31 UCLA L. REV 4 (1983) at p15, "Exit and avoidance - withdrawal from a situation or relationship by moving, resigning, severing relations, etc - are common responses to many kinds of troubles". This assertion could apply to NHS staff who actively take steps to avoid speaking up. Some of the low-level social controls described in section 2 above could be seen as an example of conflict avoidance or perhaps a decision to engage in one form of (low-level) conflict in order to avoid one which has potentially far worse consequences (formal whistleblowing).

people behave as they do. [238] For example, two people exposed to the same set of circumstances, such as a patient and a doctor, (and assuming a lapse in care by the doctor) can form very different views about the underlying cause of that event. The cause attributed by the patient to that lapse in care is likely to influence any action the patient may take: the patient may blame the doctor and claim against him, or may not. [239] To illustrate this: it has been shown that an attribution by one party of intentional harm by the counter-party is likely to generate a greater desire to punish or react against the harm-doer than an attribution of unintentional harm. [240]

The authors also highlight the role of biased thinking, particularly " 'fundamental attribution error' " which is the tendency to over-attribute blame to individuals rather than to external or situational circumstances - a form of bias whereby people overestimate the importance of personal or "dispositional" factors. [241] In lay terms, people who perceive injury can be too quick to attribute the cause to another person's personal qualities rather than to situational or external circumstances. [242] So-called harm-doers (who are perceived as inflicting injury) can also make biased attributions: research has shown that harm-doers and bystanders often distort available information in order to convince themselves that victims of

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[238] See 'Social Psychology and the Emergence of Disputes' at p.659. Felstiner Abel and Sarat also identify attribution theory as relevant, particularly the "degree and quality of blame". Whether an individual naturally blames others more and themselves less or vice versa is an important factor. See 'The Emergence and Transformation of Disputes' at p.641.

[239] This follows a dyadic non-medical example in 'Social Psychology and the Emergence of Disputes' at p.659.

[240] Ibid at p.662 and which in itself connects with real-world experience.

[241] Ibid at p.664. That is, the personal qualities of the individual to whom fault is attributed.

[242] Ibid at p.664.

adverse events have some responsibility for those events. [243] Such attributional biases appear to offer interesting perspectives for analysing whistleblowing conflict and how the parties to it behave; there are other biases however - such as the over-inclination to blame one's-self which infers that in some cases blaming will never occur, so that conflict does not escalate. [244]

In viewing dispute emergence as a complex social process with human experience central to the transformation from one stage to the next and taking account of criticisms of the model, the Felstiner Model appears to me to offer an appropriate conceptual framework for a consideration of whistleblowing as conflict. I discuss the reasons why below.

First, the Felstiner Model emphasises a broad range of plausible and recognisable social and cultural factors, emphasises the importance of individual psychology and emotion and highlights the instability, subjectivity, reactivity and complexity of the process which taken together provide a credible portrayal of human experience. [245] Similarly relevant are social factors such as relative status, the nature of a relationship, the workplace, and any history of conflict are considered, as are external factors that can influence and shape the way disputes emerge. The model avoids rigid or artificial triggers for transformation from one stage of the model to the next and embraces the idea that uncertainty and instability are inherent qualities in the human experience of conflict. Lloyd-Bostock

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[243] Ibid. And thereby only have themselves to blame. This view of whistleblowers was mentioned in a number of participant accounts obtained for this study.

[244] 'Social Psychology and the Emergence of Disputes' at p.665.

[245] Felstiner Abel and Sarat state for example that "transformations may be nothing more than changes in feelings, and feelings may change repeatedly".

anchors models such as the Felstiner Model to real-world experience by arguing that logical reasoning is trumped by empirical observation, so that blaming may in fact follow on from knowing that a claim exists, rather than necessarily preceding it. [246] For me, this is a reasonable criticism, based as it was on empirical observation, as it allows for the irrationality or illogicality of human experience without undermining the naming blaming and claiming type of model in a material way.

Further, the addition of social-psychological theory advocated by Fitzgerald and Dickins and Coates and Penrod also appears to strengthen the Felstiner Model by contributing established theoretical explanations for certain behaviours and thereby enriching the theoretical bases for the model. For example, attribution theory, which can explain over-emphasis on personal qualities rather than circumstantial factors and which has also been cited in whistleblowing studies as explaining responses to whistleblowers. [247] Also, relative deprivation (relative value of an outcome is more important to an individual than the absolute value), equity (mentioned above), and perceived control (to be effective, people must see themselves as having control over outcomes) also contribute potential and credible explanations of why disputants behave as they do. [248]

While the critiques of the Felstiner Model proposed by the authors discussed above suggest areas where the model can be further

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[246] As discussed above - see 'Propensity to Sue in England' at p.429.

[247] As proposed by Coates and Penrod. Attribution theory has been cited in whistleblowing studies since 1992 - see 'Whistleblowing recipients' at p.287. Also, 'Social Psychology and the Emergence of Disputes' at p.659 (Attribution Theory).

[248] See 'Social Psychology and the Emergence of Disputes' at pp.656-659.

developed, particularly in terms of social psychology theory, they do not undermine or weaken its essential approach, namely, that dispute emergence is a complex process with human experience and perceptions at its heart. The critiques offered by these authors assist in theoretical understandings of why potential claimants may move from one stage of transformation to another, and also introduce additional factors for consideration, which for me add to the comprehensiveness and plausibility of the Felstiner Model. For example, while Felstiner, Abel and Sarat identify certain agents outside the dispute itself who influence it (such as lawyers), Fitzgerald and Dickins develop this, suggesting a typology of outsider roles (they see at least four: audience, supporter, agent and intervenor) each of which can exert influence on the trajectory of a dispute, in ways they discuss. This addition appears to broaden out the Felstiner Model, adding I suggest to its scope and reach.
For these reasons, and taking account of the criticisms discussed above, the Felstiner Model offers a robust framework for a consideration of whistleblowing conflict. It is orientated to human psychology, emotion and experience and cognisant of the role of subjectivity, perception, instability and uncertainties which appear relevant in whistleblowing contexts. It is also applicable to workplace and multi-party settings.

I now turn to the nature of whistleblowing conflict.

5. Wrongdoing Conflict, Whistleblower Conflict and Dispute Emergence

In this section I will discuss two core aspects of whistleblowing, that is the wrongdoing and the whistleblower, as conflict in light of the Felstiner Model and use them in order to frame my analysis of whistleblowing conflict. I begin by setting out real-world evidence about these two aspects.

5.1 Real-world descriptions of the conflict related to the Wrongdoing aspect and the Whistleblower aspect [249]

(a) The Wrongdoing [250]

In the executive summary of the *Freedom To Speak Up Report* Sir Robert Francis QC said this:

"There is….a remarkable consistency in the pattern of reactions described by staff who have told of bad experiences. Whistleblowers have provided convincing evidence that they raised serious concerns which were not only rejected but *were met with a response which focused on disciplinary action against them rather than any effective attempt to address the issue they raised*". [251]

"There are many reasons why people may feel reluctant to speak up in any industry. For example, they may be concerned they will be seen as disloyal, a "snitch" or a troublemaker. *Two particular factors stood out from the evidence we gathered: fear of the repercussions*

[249] In Chapter 1 I set out a short summary entitled Whistleblowing in the NHS in England and described the real-world problem this study seeks to address. I drew on *The Freedom To Speak Up Report, the Mid Staffordshire Report* and other reports and government responses in providing data and evidence to support those discussions and the descriptions given here also draw on those materials. These discussions do not draw upon participant data collated for this study.

[250] The meaning of wrongdoing is discussed above.

[251] At paragraph 6 on p.8.

that speaking up would have for an individual and for their career; and the futility of raising a concern because nothing would be done about it". [252]

These findings are supported by contributor evidence within the *Freedom To Speak Up Report* itself (Chapter 3 in particular) but also by the empirical studies of NHS workplace behaviours discussed in section 2 of this chapter. [253] They suggest a pattern of behaviour regarding the wrongdoing that contradicts policy statements that the NHS is a learning, not a blaming, organisation. [254] The whistleblower's dilemma is stated clearly here. There are two disincentives to speaking up: first that the whistleblower will suffer repercussions and, second, that little or nothing will be done about the wrongdoing. The *Freedom To Speak Up Report* provided evidence that serious incidents were not being reported and investigated (paragraph 3.2.11), middle managers particularly seemed ill-equipped to deal with wrongdoing concerns, there was closing of ranks, deliberate manipulation of circumstances and people, investigations turned against whistleblowers, (paragraph 3.2.38), falsifying records (paragraph 3.2.12) and tampering of evidence of wrongdoing by managers (paragraph 3.2.48). [255]

(b) The Whistleblower

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[252] At paragraph 7 on p.9.

[253] See section 2 above, particularly Rachael Pope, 'The NHS: Sticking Fingers in its Ears'.

[254] Discussed in Chapter 1.

[255] It is notable that the weight of evidence from contributors in Chapter 3 of the *Freedom To Speak Up Report* related to how whistleblowers were bullied and victimised for speaking out and not about the failure to take action in connection with the concerns raised. There are also some contributors whose concerns were addressed but it is clear that these are a minority: "The vast majority of experiences described were negative" (paragraph 3.2.4).

The quotations above are equally applicable in relation to the whistleblower: speaking up is likely to elicit retaliation, disciplinary action and victimisation. The following is also from the executive summary of the *Freedom To Speak Up Report*:

"I have heard shocking accounts of the way some people have been treated when they have been brave enough to speak up. I witnessed at first hand their distress and the strain on them and their families. I heard about the pressures it can place on other members of a team, on managers, and in some cases the person about whom a concern is raised. Though rare, I was told of suicidal thoughts and even suicide attempts. The genuine pain and distress felt by contributors was every bit as serious as the suffering I witnessed by patients and families who gave evidence to the Mid Staffordshire inquiries." [256]

The *Freedom To Speak Up Report* also contains multiple indications of retaliation, personal suffering, obfuscation, depression, financial hardship, NHS blacklisting, false allegations, ostracisation, psychological and physical harm, severe anxiety and long term harm and personal suffering. [257] Some employers by contrast referred to a "false perception" that "raising concerns always resulted in being victimised" and a number were "adamant this was not the case" (paragraph 3.4.18). [258]

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[256] *Freedom To Speak Up Report* at p.8.

[257] See Section 3.2, pp.53-64 of the report in particular, which contains multiple accounts, using these terms.

[258] However, the overwhelming evidence pointed to the "serious issue" highlighted by Sir Robert Francis QC in the Cover Letter to the Secretary of State for Health which accompanied the *Freedom To Speak Up Report.*

These brief extracts from the *Freedom To Speak Up Report* provide clear findings by the review body lead by Sir Robert Francis QC of how NHS institutions respond to whistleblowing by - apparently - not addressing wrongdoing, and retaliating against the whistleblower. They are intended to provide a basis for the following discussions of each aspect, and how the Felstiner Model can assist in understandings of each aspect as conflict. To structure the discussion I will include comment on the parties to each potential conflict, consider where the perception of injury may arise, and then how the conflict, or dispute, may develop in each case. I begin by discussing wrongdoing as conflict.

5.2 Discussion: the Wrongdoing Conflict

From the perspective of the wrongdoing there could be a number of parties affected by a whistleblowing complaint: the whistleblower, the wrongdoer, the recipient and colleagues/co-workers. [259] Sir Robert Francis QC (now KC) seems deliberately to identify all of these parties when describing those affected by the whistleblowing. [260] The act of whistleblowing appears to put multiple parties under pressure including other team members (colleagues), more than one recipient (managers), and the wrongdoer. All of these members of staff are potentially affected by the act of whistleblowing, with the whistleblower at the centre.

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[259] Co-workers may also be complicit with the wrongdoing, either actively involved in malpractice or knowing of it and remaining silent. This may be a factor in the perception of injury (the co-worker having been "found out").

[260] "I heard about the pressures it can place on other members of a team, on managers, and in some cases the person about whom a concern is raised." *Freedom To Speak Up Report* at p.8.

The Felstiner, Abel and Sarat analysis begins with the perception of an injurious experience by a potential claimant. The model is non-prescriptive as to who inflicts the injury, or how, or what it consists of. It is the perception of injury that matters, not its objective existence or material nature. In relation to whistleblowing, we assume the whistleblower has observed and is concerned about the wrongdoing, but beyond that we do not know the circumstances of any case, the history of the relationship with the wrongdoer, nor anything at all about the parties or the social and cultural conditions that pertain to them. The actor with agency is the whistleblower. She raises her concern and creates the conditions whereby other parties are affected by it; the inference from the *Freedom To Speak Up Report* is that all parties can be emotionally and psychologically affected, as a result of the whistleblowing, perhaps seriously. [261]

In the absence of other actions or agency of any other party, there is a reasonable inference to be made that some of the wrongdoer, the recipients/managers and the whistleblower's colleagues perceive an injurious experience to themselves, inflicted by the whistleblowing. [262] One other possibility - but the two inferences are not mutually exclusive - is the converse. The whistleblower, knowing of the wrongdoing, has perceived it as injurious; this seems less plausible as the wrongdoing is unlikely to affect the whistleblower at a personal or individual level, although knowledge of it may require her

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[261] This is evident from the quotations from the *Freedom To Speak Up Report* set out above.

[262] For the wrongdoer it may be perceived as a direct personal attack. For recipients or colleagues the whistleblowing may be perceived as criticism, or a sense that the whistleblower is exercising moral authority over them. The *Freedom To Speak Up Report* does not include any significant material as to why recipients or colleagues may feel aggrieved. There are nuanced possibilities of emotion, ego, perception as to why colleagues may be angry or upset, described above as part of the Felstiner Model. For instance, attribution theory may suggest that recipients may over-react to the whistleblower's personal qualities rather than the situational circumstances

to compromise her values or integrity by remaining silent. Other possibilities may exist, as we know nothing of the clinical and emotional conditions or relationships within the department or the team that might have contributed to the whistleblowing. [263] Immediately, however, the act of whistleblowing, by affecting multiple parties, infers complexity. Numerous colleagues may perceive injury, but equally the whistleblower may do so. If multiple colleagues perceive the act of whistleblowing as injurious, then it implies numerous potential claimants with potential grievances against the whistleblower. [264] Some colleagues may be sympathetic, implying that they do not perceive themselves to experience injury; the fact that some will and some will not points to the subjectivity and individualism advanced by the Felstiner Model.

In any event, the analysis suggests a complex matrix of potential conflict between multiple parties on the one hand and the perhaps now isolated whistleblower on the other. At this early stage the whistleblowing may have prompted visible consequences, such as investigations or other management interventions, and the perception of injury (if any, on the part of the wrongdoer, recipients or colleagues) is not yet being expressed. However, I suggest the existence of the potential grievances inflicted on the wrongdoer, recipients and colleagues and arising out of the initial act of whistleblowing should be seen as a reasonable inference framing this stage of the whistleblowing process.

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[263] The Felstiner Model does not make any assumptions about the detailed conditions or circumstances in any particular case, so how and why a party perceives the experience of injury will be a matter of the social, cultural and social psychological factors affecting that individual .

[264] As Francis suggests above, whistleblowers can be regarded as disloyal, or "snitches" or "troublemakers" regardless of the merit of their concern.

We know from the *Freedom To Speak Up Report* that a consequence of whistleblowing is that frequently little or nothing is done to correct the wrongdoing and that instead managers focus on disciplinary or other retaliation against the whistleblower. [265] The Research Definition tells us that the whistleblower speaks out to a person able to effect action but here we know that action is not always taken. [266] The failure to act in itself might create a perception of injury on the part of the whistleblower: her narrative is that she has done the right thing, yet nothing has been done to address the wrongdoing as she perceives it and as a result of which patients are still being harmed. This may be compounded by the wrongdoer and some colleagues ostracising or victimising the whistleblower, adding to a complex web of perceptions of injuries inflicted by a number of parties. Uncertainty exists, but at this stage, as circumstances become more complex, there may be a blurring as to whether the beginnings of retaliation relate primarily to the wrongdoing or to the whistleblower herself. For example, attribution theory suggests that colleagues may give disproportionately more weight to the dispositional qualities of the whistleblower and disproportionately less on situational circumstances. [267] In any event, agency is now being exercised by parties other than the whistleblower. To the extent that agency is directed towards the whistleblower by way of retaliation it must carry the possibility of the perception by her of injury - or, perhaps more likely, multiple perceptions of injury as a result of numerous acts of retaliation.

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[265] See the *Freedom To Speak Up Report* paragraphs quoted at section 5.1 above. Individual contributors were also quoted in section 3 of the report (Evidence of Contributors) stating that whistleblowers were aggrieved that nothing was done about the concern they raised.

[266] Ibid.

[267] See 'Social Psychology and the Emergence of Disputes' at p.664.

Taking the possible claims that could arise against the whistleblower: the wrongdoer is likely to perceive the whistleblowing as a direct attack against his professional competence and reputation, so animosity towards the whistleblower may follow. [268] In some conditions the wrongdoer might consider an action for defamation, but such a claim is technical and challenging. [269] In practice, the wrongdoer might retaliate in a formal way by making an internal complaint against the whistleblower or a complaint to a professional body, or bringing a grievance against the whistleblower, if any are viable options. [270]

For recipients such as managers, and to an extent colleagues such as team members, the perception of injury might derive from a sense of the whistleblower being disloyal to the organisation or the team, or damaging a colleague's or a team's reputation. Pope's empirical study suggests that organisational or personal reputation can override all other considerations, even patient care. [271] Recipients may also perceive whistleblowing as a direct challenge to the authority vested in them by the NHS employer which may generate negative emotions towards the whistleblower and may be seen as

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[268] "What may be regarded on one side as whistleblowing may in some cases be seen from the perspective of those on the receiving end as an attack on their reputation" - *Whistleblowing Law and Practice* at p.859.

[269] For example, under the Defamation Act 2013 a claimant must be able to show serious harm (or the likelihood of serious harm) to his reputation in order to sustain a defamation claim. See *Whistleblowing Law and Practice* at p.860.

[270] Retaliation can take many forms, some of them apparently spurious, and action against whistleblowers can be fabricated and unjustified. For example, paragraph 3.2.25 of the *Freedom To Speak Up Report* states: "We heard that whistleblowers could be subjected to performance management or referral to their professional regulator rather than an investigation of their concerns". The participant data also shows that NHS Trusts will develop an alternative narrative of events as a way of undermine the whistleblower's allegations of wrongdoing - see Chapter 5.

[271] See 'The NHS: Sticking Fingers in its Ears', p.1.

transgressive of organisational norms or values. [272] So potential claims felt by recipients and co-workers may be transformed into grievances or even claims against the whistleblower, if the social conditions described in the Felstiner Model enable that.

It is not clear, however, how any such claims might be legitimately pursued against the whistleblower through formal or legal channels. The whistleblower is unlikely to have breached law or regulation by blowing the whistle. As a healthcare professional the whistleblower is required to disclose concerns and is in compliance with the NHS constitution, and standard terms and conditions applicable to staff and various duties as a healthcare professional. [273] This discussion suggests therefore that grievances or claims by the wrongdoer, recipients/managers and colleagues may exist within the minds and perceptions of those individuals but lack a legal basis on which they might be pursued. These parties may feel injured or aggrieved by the act of whistleblowing, yet the whistleblower has acted as she should have acted in order to comply with the requirements of her employment and her professional body. [274] Accordingly, it may be difficult for these parties to sustain a justifiable claim or grievance against the whistleblower purely based on the whistleblowing, which may in turn add to the frustration of those around the whistleblower, and hostility towards her.

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[272] Ibid. Quick describes “a norm of non-criticism” of colleagues - see *Regulating Patient Safety* at p.146.

[273] For a summary of the requirements of the NHS Constitution and NHS standard terms and conditions of employment see *Whistleblowing Law and Practice* at paragraphs 21.15 - 21.19 at pp.886/887. Doctors, nurses and midwives are all subject to a duty to speak up, according to their professional codes of conduct issued respectively by the General Medical Council for Doctors and the Nursing and Midwifery Council for nurses and midwives: see *Whistleblowing Law and Practice* at paragraphs 21.15, 21.16 and 21.17 at p.886.

[274] Ibid.

Turning to the possible claims of the whistleblower against the wrongdoer, the recipients and colleagues: the whistleblower might advocate that the wrongdoer, by continuing the malpractice or other wrongdoing, has prompted the whistleblowing and that the act of whistleblowing is pro-social organisational behaviour by the whistleblower (in the interest of patients) even where the whistleblower's motivations may not be wholly altruistic. [275] If the whistleblowing was received constructively by recipients and co-workers and action taken to address it (this scenario is possible, but not the focus of this study, which is the conflict which arises) there would be no obvious basis on which a whistleblower might perceive injury from either the recipient group or the co-worker group. It is when recipients and co-workers follow the scenario described in the *Freedom To Speak Up Report* (at section 5.1 above), and inflict some form of retaliation on the whistleblower, that the perception of that injury by the whistleblower becomes plausible.

Multiple acts of retaliation by multiple parties can create a complex matrix of perceptions of injury for the whistleblower with a theoretical prospect at least of multiple grievances arising against all or some of the wrongdoer, managers and colleagues. Without knowledge of historical interactions we do not know if retaliation arises from unresolved animosity between the parties or other causes unrelated to the act of whistleblowing. Injuries may transform into grievances and ultimately into claims in some cases, presenting the whistleblower with unhappy and challenging dispute-related scenarios both against him and by him. In certain conditions

[275] The motivation for whistleblowing such as personal animosity or revenge should not detract from the objective relevance of the wrongdoing. See Peter Roberts, 'Motivations for whistleblowing: Personal, private and public interests' in *The International Handbook* at p.208.

which assume detriment and/or dismissal, these claims may also ground legal proceedings by the whistleblower under PIDA. [276]

The Felstiner Model suggests that conflict arising from the subject matter of the wrongdoing (so, arising directly from the whistleblower's act of whistleblowing) may give rise to perceptions of injury on the part of the wrongdoer (for the reasons discussed above) and the parties around the whistleblower, whether those having to address it (recipients/managers) or those looking on as bystanders (co-workers, team members). Depending on the circumstances, it is conceivable that the whistleblowing might be defamatory against the wrongdoer. The harm to the wrongdoer's reputation must be potentially serious for a claim to be feasible and any such claim is likely to be an unattractive, uncertain and expensive prospect for the wrongdoer. [277] As discussed, other pathways such as internal complaints or complaints (merited or not) to professional bodies by the wrongdoer against the whistleblower seem unlikely, but could be fabricated as an act of retaliation in some circumstances. [278] Recipients and co-workers have no obvious means of acting upon their perceptions of injury, grievance or claims but retaliation by those groups against the whistleblower could plausibly be positioned through their voicing their grievances against the whistleblower by invisible but impactful acts of bullying,

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[276] See the discussion of PIDA in Chapter 1 above.

[277] See *Whistleblowing Law and Practice* at Chapter 20 (Defamation) at p.859.

[278] None of these routes are attractive for a wrongdoer who feels aggrieved. For example, the GMC are now alert to managers using fitness to practice complaints as retaliation against whistleblowing doctors following a review by Sir Anthony Hooper in 2015. See *Whistleblowing Law and Practice* at paragraph 21.10 at p.884. The GMC recently reprimanded the Medical Director of University Hospitals Birmingham NHS FT for failing to indicate that a doctor had blown the whistle: see 'Climate of fear putting patients at risk, say doctors' by David Grossman and William McLennan BBC News Online, 2 December 2022 at bbc.co.uk.

intimidation or victimisation such that the retaliation can be seen as an explicit and tangible expression of claiming.

The causal connection from perceived injury (caused by the act of whistleblowing) to the initial retaliation against the whistleblower by affected parties (the wrongdoer, the recipients, the colleagues) seems to me to be credible when viewed through the Felstiner Model. I propose that, to this extent, it is reasonable to advocate that the resulting conflict is primarily about the wrongdoing rather than primarily about the whistleblower since it is the subject matter of the wrongdoing and its articulation that appears to create the initial perception of injury. Once the retaliation occurs by reason of the disclosure of the wrongdoing, causing detriment to the whistleblower, I suggest the pattern of the conflict changes. [279] It becomes harder to maintain the argument that the wrongdoing is paramount as the focus shifts to the whistleblower. I suggest that this change of focus, dictated by interactions on the ground, is the point at which it becomes clearer that a whistleblower conflict has been initiated. However, the Felstiner Model anticipates the uncertainties in such a setting and therefore, in real-world settings, this may be a very blurred boundary and highly circumstance-dependent, as I discuss in the next section below.

5.3 Discussion: the Whistleblower Conflict

The repeat pattern observed by Sir Robert Francis QC and detailed in the *Freedom To Speak Up Report* infers that a stream or strand of conflict emerges which is centred primarily on the whistleblower

[279] Circumstances will dictate how this might be perceived by the parties. It might be sudden, or much more gradual depending on how explicit or transparent the form of retaliation.

rather than the wrongdoing. [280] This may occur over a period and not at a single point in time. At this stage the pre-existing conflict arising out of the wrongdoing and the act of whistleblowing orientates towards the whistleblower and away from issues directly associated with the wrongdoing. The issue of the wrongdoing appears to be bypassed so that no meaningful attempt is made to rectify it, even where the concerns are considered to be serious by the whistleblower. [281] Whistleblowers tend to be excluded from any communication about the wrongdoing in these circumstances with their concerns having been rejected. [282]

An initial pattern of perceived injurious experiences seems to be established - as discussed in the preceding paragraphs. The pattern reported by Sir Robert Francis QC (in section 5.1 above) suggests a growing focus on the victimisation of the whistleblower by managers and to an extent by colleagues, undermining and isolating the whistleblower and rendering her professional life difficult, if not intolerable. [283] This pattern of behaviour (and conflict) may continue until the whistleblower leaves the employment of the NHS or is dismissed by the NHS and/or brings a PIDA claim against the NHS. Contributor evidence suggests false allegations and spurious counter-claims may be made against the whistleblower by managers, suggesting a continuum of repeat injuries are being inflicted on the whistleblower. [284] The Felstiner Model suggests this

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[280] This shift is evident in the sections of the *Freedom To Speak Up Report* quoted in section 5.1 above.

[281] See the *Freedom To Speak Up Report* at paragraph 6.

[282] See the *Freedom To Speak Up Report* at paragraph 3.2.11.

[283] The suffering of the whistleblower is very visible in the *Freedom To Speak Up Report* - see paragraph 3.2.5 on p.54 which speaks of “harrowing and isolating process” of blowing the whistle and the fear, depression and suicide of whistleblowers.

[284] Ibid at paragraph 3.2.5.

will generate a perception by the whistleblower of multiple injuries inflicted upon her by multiple parties and generating emotions of anger, frustration and distress for the whistleblower. The Felstiner Model does not insist that the established pattern will remain the same, nor that grievances will necessarily transform into claims. This will be a function of the numerous factors relevant to the model. For instance, it is possible that the perceptions felt by colleagues about the whistleblower may change if those colleagues learned new and relevant information about the wrongdoing or the wrongdoer. [285]

The pattern of cases observed in the *Freedom To Speak Up Report* suggests that once the focus of the conflict has shifted away from the wrongdoing and towards the whistleblower, the whistleblower is preoccupied with survival within the organisation in the face of retaliation from colleagues. The defensive actions of the whistleblower seem unlikely to inflict further perceptions of injury on those colleagues who are inflicting retaliation on her - if anything, the reverse is more likely. Again, although there are uncertainties about factors relevant to the conflict, I suggest therefore that it is likely to be primarily the act of whistleblowing that grounds a perception of injury on the part of these counter-parties. However, how and why colleagues perceive the act of whistleblowing as injurious will be discussed later in this study in the light of the participant stories. For now, the pattern observed in the *Freedom To Speak Up Report* sees the whistleblower as embattled and relatively powerless once the whistleblowing has occurred.

[285] See 'The Emergence and Transformation of Disputes' at p.639.

However, the real-world course of the conflict means that the most probable outcome will be that the whistleblower leaves the NHS and/or mounts a PIDA claim against the NHS (her only realistic option for recourse) thereby transforming her claim into a dispute as contemplated by the Felstiner Model. The counter-parties to the whistleblower conflict, now primarily the recipient/managers and some co-workers (possibly including the wrongdoer) and who have experienced injury caused by the whistleblower, may by this stage be voicing their claims against the whistleblower through their repeat acts of retaliation, typically bullying, harassment and other forms of victimisation such as (by way of example) imposing unworkable work schedules or anti-social hours of work on staff with childcare responsibilities, unfairly relocating a whistleblower to work in a different team, or at worst suspending the whistleblower from the workplace pending investigation. [286]

The Felstiner Model proposes that claiming occurs when the grievant voices her claim and asks for some remedy. [287] Yet the claimants here appear to be punishing the whistleblower rather than seeking a remedy as it is not clear what that remedy might be once grievances have arisen - unless perhaps retaliation could be seen as a self-help remedy of forcing the whistleblower from the workplace. [288] Whatever the claimant perceptions, however, I suggest that retaliation against the whistleblower sits uneasily with the third transformation articulated by the Felstiner Model. The retaliation appears to function as the voicing of a grievance, or claim, against the whistleblower, yet is not accompanied by a request for a remedy:

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[286] See *The Freedom To Speak Up Report* at paragraph 3.2.5.

[287] Ibid at p.635.

[288] Such exerted action by managers and/or colleagues could ground a PIDA claim depending on the circumstances.

that in one sense is not surprising because the whistleblower as a theoretical matter has acted in accordance with applicable employment and professional obligations and in the public interest - so it is difficult to see a rational basis (such as law or policy) on which grievances exist against her which would justify a remedy. What then remains appears to be a legacy of retaliation against the whistleblower without a defined objective, or remedy, and a hostile and dysfunctional work or team environment.

6. Conclusion

Viewing the wrongdoing and whistleblower aspects of whistleblowing from the perspective of the Felstiner Model has generated preliminary understandings of these two aspects, as conflict, which raise as well as answer questions.

The discussion above generally supports the proposition that the two dimensions are discernible as separate aspects of the overall whistleblowing conflict. The act of whistleblowing appears to initiate a specific conflict, although that is not to suggest that there are not pre-existing conditions that cause or contribute to it. The Felstiner Model accommodates that possibility; for example, if the whistleblower and the wrongdoer have a history of professional rivalry or personal animosity the model invites us to take account of that as causing a perception of injury, recalling the first stage of naming described by the Felstiner Model.

The act of whistleblowing appears to cause perceptions of an injurious experience in the various parties affected. I suggest those

parties are the wrongdoer, the recipients and colleagues/co-workers such as team members proximate to the whistleblower. For example, team members might be nurses or midwives in the same unit or department within the hospital.

As discussed, blowing the whistle is considered by researchers to constitute pro-social organisational behaviour by an organisational insider in the interests of patients or staff (also organisation insiders) and in accordance with employer and professional requirements. [289] Also, in principle, the act of whistleblowing is not targeted at an individual, but is targeted at stopping wrongdoing (although the wrongdoer may perceive himself as being personally targeted as the practitioner allegedly at fault). Counter-parties appear to perceive the whistleblowing as an injurious experience inflicted on them. The Felstiner Model sees this as the product of the social, cultural and personal factors affecting the individual as the perception of injury can be "any experience that is dis-valued by the person to whom it occurs". [290] Put simply, therefore, in the absence of other factors, it is the act of whistleblowing that has potential to injure those affected by it, but it is down to each individual as to how they perceive it.

The act of whistleblowing appears to affect multiple parties, suggesting that the resulting conflict may be complex, with many human interactions. It may isolate the whistleblower, who is in a position of conflict with many around her. Some colleagues, perhaps those who have not perceived injury, may offer their

[289] See *Whistleblowing Law and Practice* at pp.886/7 for commentary on the professional duties of NHS medical and nursing staff.

[290] See 'The Emergence and Transformation of Disputes' at p.634.

support, but this also implies colleagues in opposite to one another. These possibilities are accommodated by the Felstiner Model. [291]

The analysis suggests that initially the perception of injury relates to the wrongdoing, as managers and colleagues come to terms with the nature of the concern and how to respond. As noted above, the *Freedom To Speak Up Report* includes little evidence from whistleblowers or other contributors (to the Report) about this first stage of the whistleblowing process. There is uncertainty as to what the perception of injury is "about" (and under the Felstiner Model it will differ for each individual). External indications suggest there is an indeterminate period during which recipients are weighing their response (for example, do they "address" or "retaliate") when the wrongdoing is at the centre of those deliberations. [292] The whistleblower is inevitably a factor, but it appears at this stage, before retaliation has occurred, that there are no obvious indications that the direction of the conflict has yet orientated towards the whistleblower. At this stage it still appears to be directed towards the wrongdoing.

Over time, however, the conflict appears to coalesce around the person of the whistleblower as transformations to grievances (the second - blaming - stage of the Felstiner Model) take place amongst recipients and co-workers. The apparent focus on the whistleblower increases, perhaps quite dramatically, and the focus on the wrongdoing appears to decline which I suggest mirrors the absence of substantive evidence within the *Freedom To Speak Up Report* about how NHS organisations act in connection with the

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[291] Ibid at p.639.

[292] For a discussion of research related to this key decision of the recipient, see 'Whistleblowing recipients' at pp.283-5.

wrongdoing. It seems apparent that this next phase of the conflict, in which the employer victimises the whistleblower, often leading to the whistleblower's removal from the workplace is directed substantively at the whistleblower.

However, in terms of the Felstiner Model, the retaliation by managers and co-workers appears to function as the voicing of their grievances (the blaming or even claiming stage of the model) against the whistleblower directly to the whistleblower yet, unlike the model, is not accompanied by a request for a remedy. [293] In one sense this is not surprising, as on an objective analysis the whistleblower has acted rationally and in accordance with employer and professional duties so there is no obvious rational explanation why colleagues (with the exception perhaps of the wrongdoer) would perceive the whistleblowing as an injurious experience leading to a dispute. On that basis a request for a remedy appears difficult to justify. One possibility, suggested above, is that retaliation is in effect a self-help remedy: the rejection of the whistleblower from the workplace community. The Felstiner Model suggests that counter-parties experience transformations to the blaming and even the claiming stage arising out of the act of whistleblowing but it is far from clear how this growing sense of grievance is addressed in the real-world, if at all. [294]

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[293] "The third transformation occurs when someone with a grievance voices it to the person…believed to be responsible and asks for some remedy". See 'The Emergence and Transformation of Disputes' at p.635.

[294] Objectively: aside from a possible (but unlikely) defamation claim by an aggrieved wrongdoer, counter-parties will not enjoy legal recourse against the whistleblower, however they may feel about her. Conversely, we know that If the whistleblower suffers detriment or dismissal as a result of counter-party retaliation it may ground a PIDA claim - discussed in Chapter 1 above.

Although the Felstiner Model sheds light on the shape or anatomy of whistleblowing conflict there remain many uncertainties, which will be explored further when considering the data of the three participant groups in the following chapters. This analysis suggests that perceptions of injury arise apparently from the initial act of whistleblowing, that grievances follow, even claims, but that such grievances or claims may be caused by other factors and may not be objectively justified in relation to the wrongdoing. Further, in relation to the third stage of the Felstiner Model and subsequent emergence of a dispute, it seems apparent that pathways or interventions to address this complex multi-party picture do not presently exist.

Whistleblowing is fundamentally about people. This chapter considers two contextual factors both of relevance to the human dimensions of whistleblowing: the behaviours of staff in NHS workplaces, and the recipients of whistleblowing disclosures. The studies considered revealed many complexities and uncertainties related to how NHS workers interact in circumstances where concerns are raised, the meaning of wrongdoing, and the rival perceptions of people and events. The chapter then considers NHS whistleblowing as conflict, framed around two core aspects, the wrongdoing and the whistleblower, in light of the Felstiner Model. The conclusions set out above have raised a number of questions, including for example whether the act of whistleblowing creates a perception of injury in multiple colleagues, and whether retaliation by those colleagues against the whistleblower functions so as to voice a grievance with no other pathway. Perhaps the retaliation functions, as I suggest, as a self-help remedy to eject the whistleblower from her workplace community.

In Chapter 3 below I discuss storytelling and narrative theory as the lens through which I have explored the participant and group stories. I also use the storytelling lens to consider the FOI Data which, as I will show, also provides broader NHS narratives about whistleblowing conflict and its resolution.

Chapter 3

Story Theory

1. Introduction

NHS whistleblowing is a setting in which stories representing different viewpoints are a central feature. The preferred public narrative of the NHS is typically one of good news but that narrative collides with the "truly shocking" stories told by some whistleblowers and with recent scandals such as those at The Shrewsbury and Telford Hospital NHS Trust and the East Kent Hospitals University NHS Foundation Trust. [295] For reasons I discuss below, story or narrative theory, provides a natural theoretical perspective for a consideration of whistleblowing conflict and its resolution owing to its alignment with the prevalence of these stories within whistleblowing settings.

Stories, storytelling, and narrative are subjects and concepts of almost limitless application across an enormous range of academic and professional disciplines including literature, medicine,

[295] See the *Freedom To Speak Up Report*, Cover Letter to the Secretary of State p.4 onwards for comment about the "shocking stories" offered by NHS whistleblowers. I discuss the terminology of storytelling and narrative below; however, Rachael Pope and other scholars identify the phenomenon of the "NHS good news story" - see 'The NHS: Sticking Fingers in its Ears'. The public clapping for NHS staff during the Covid 19 pandemic was perhaps a reflection of this phenomenon. Lastly, the scandal of failing maternity services at Shrewsbury and Telford gave rise to the report by senior midwife Donna Ockendon published in March 2022, see *The Ockendon Report* and also the *East Kent Hospitals Report* published in October 2022.

psychology, therapy, social science and law, to name just some. [296] Storytelling is a defining and ubiquitous human activity which transcends cultures, beliefs, media, time, place and circumstances. Stories "are the way we understand, experience, communicate and create meaning for ourselves, both as individuals and communities". [297] Stories are a prominent feature of NHS whistleblowing and for whistleblowers generally, as Alford makes plain, their stories are at the centre of their experiences and can define their futures. [298] As the *Freedom To Speak Up Report* evidenced, NHS whistleblower stories are often dramatic and painful to hear, and contain claims about behaviours of NHS colleagues which do not seem credible. [299] These stories of personal suffering contrast with careful NHS press releases which infer no culpability on the part of the hospital and emphasise commitment to patient care. [300] Opposing stories seem to

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[296] For a sense of the breadth of scholarship in the field of literature studies see H. Porter Abbott, *The Cambridge Introduction to Narrative* (Cambridge University Press, Second Edition, 2014): Chapter 2 discusses definitions of narrative. For examples in other fields see: within therapeutic medicine, for a historic summary of the development of narrative practices see John Launer, *Narrative-Based Practice in Health and Social Care, Conversations Inviting Change,* (Routledge, London and New York, Second Edition, 2018) (hereinafter *Narrative-Based Practice in Health and Social Care*) at p.2; within the social sciences see John Paley, 'Narrative Machinery', Chapter 1 in Yasmin Gunaratnam and David Oliviere (Eds), *Narrative and Stories in Healthcare, Illness, Dying and Bereavement*, (Oxford University Press, 2009) at p. 22; within cognitive psychology and decision-making, see Nancy Pennington and Reid Hastie, 'The story model for juror decision-making' in Reid Haste (ed), *Inside the Juror, The Psychology of Juror Decision Making* (Cambridge University Press, 1993) (hereinafter *Inside the Juror*); within law (the focus of this study) for an excellent short summary of the origins of narrative, or storytelling, and the "explosion" of narrative-related studies, see Nancy Levit, 'Reshaping the Narrative Debate' 34 Seattle University Law review 751 (2011) (hereinafter 'Reshaping the Narrative Debate'). I cite various other law-related studies below in the context of legal storytelling; within whistleblowing specifically see *Whistleblowers, Broken Lives and Organizational Power* for a well-known study with an emphasis on narrative meaning and structure.

[297] *Narrative-Based Practice in Health and Social Care* at p.1.

[298] See generally *Whistleblowers, Broken Lives and Organizational Power.*

[299] Such as falsification of documents and extreme cases of bullying - see the *Freedom To Speak Up Report* at Chapter 3, paragraph 3.2.25 (Retaliatory Action).

[300] See the *Freedom To Speak Up Report* at paragraph 3.4 (Employer contributions).

sit at the heart of the conflict between whistleblower and employer and must therefore have relevance to understanding it, and how it might be addressed. Further, stories and narratives are prominent within conflict and conflict resolution literatures suggesting an alignment between participant data and the theoretical approach to it. [301]

As a result, I propose aspects of story theory and narrative approaches situated within the fields of law (legal storytelling) and conflict resolution (models of narrative mediation) which for me resonate with NHS whistleblowing. While legal storytelling originally took the form mainly of scholarly articles written by feminist and ethnic minority law professors in US universities it placed storytelling and the power of personal stories at its centre, as a means of conveying first-hand experience of disadvantaged social groups. It demonstrated the significance of the world-view of the narrator in understanding the narrator's perspective and how she was seen, reinforcing the significance of subjectivity, perception and perspective in how we interpret events and interact with those around us. Legal stories, that is the stories told by the legal storytellers, may also reveal how treatment of the storyteller might contravene equality or other laws. This can also align it with the stories of whistleblowers who often seek change within an organisation and reform of laws and procedures. [302] In these senses legal storytelling appears an

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[301] As I discussed in Chapter 1 (Limitations and Uncertainties) I have personal experience working alongside whistleblowers and have heard and read many of their stories. That experience impressed on me the powerful role of stories for whistleblowers as a means of speaking out, of being heard and perhaps also of seeking justice or holding the NHS to account.

[302] See Richard Delgado, 'Storytelling For Oppositionists and Others: A Plea for Narrative' [1989] 87 Michigan Law Review 2411 (hereinafter 'A Plea for Narrative').

appropriate lens for studying the radically opposed perspectives apparent within NHS whistleblowing settings.

In coming to the storytelling lens, I decided also to turn to theories of storytelling in conflict resolution literature (in addition to those of legal storytelling), and more particularly, I draw upon forms of narrative mediation. I do so because narrative mediation locates storytelling within a resolution framework and enables us to understand the nature of the conflict and the relevance of the parties' stories both to the conflict and to approaches to its resolution. [303] They have relevance, situated as they are in a conflict framework, and therefore enrich the study. However, to re-iterate, the interest of this study is in the role of stories and what they show us about whistleblowing conflict and how it might be resolved. It is not about mediation as a form of resolution process for this conflict or as a process in its own right; rather, by looking at the data (which include material about the use of mediation in these settings - Hilary's story particularly) we can learn about the nature of the conflict, about why the conflict does, or does not, respond to mediation as a way of addressing it, and about barriers to resolution. The analysis can help to show ways in which more might be done to resolve whistleblowing conflict not least because of the embedded nature of stories and storytelling in the NHS whistleblowing setting.

In Chapter 2 I discuss dispute emergence theory and use it to as a way to view the wrongdoing conflict and the whistleblower conflict

[303] As I describe below, there are a number of storytelling, or narrative, models in legal writing and dispute resolution. I discuss two mediation models, narrative mediation advocated by Winslade and Monk in *Narrative Mediation* and a storytelling model of mediation advocated by Sara Cobb - see Sara Cobb, in Creating Sacred Space.

as I see it in the real world. Dispute emergence theory and story theory have certain elements in common (such as an emphasis on subjectivity, world view, and social and cultural factors) but each is playing a quite different role in this study: dispute emergence theory is used to analyse the wrongdoing and whistleblower conflicts and whether and how they evolve as formal disputes in order to understand more of overall nature of the whistleblowing conflict. Story theory will be used to analyse and evaluate the interview data having regard to the discussion in Chapter 2 about the two aspects of the whistleblowing conflict - the wrongdoing and the whistleblower. In broad terms, dispute emergence theory assists with generating a picture of the whistleblowing conflict, whilst story theory assists with its analysis through data interpretation and assists with the development of the resolution-related possibilities.

I will now discuss terminology relevant to storytelling.

2. Terminology

The terms *story* and *narrative* are used within the literatures of legal storytelling and narrative mediation. [304] In this section I discuss the use of the terms in these contexts in order to draw out their range of meanings and their use in this study.

In plain English usage, *story* is generally understood as having a broad and multi-faceted range of meanings. [305] In fiction, stories have been associated with a chronological "narrative of events" with an irreducible characteristic of making the reader or hearer want to know "what happens next". [306] Forster here uses the word "narrative" as meaning a series of events, so that a narrative can form part of a story, but a narrative only becomes a story if the element of

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[304] A helpful historic summary of legal storytelling is given by Nancy Levit in 'Reshaping the Narrative Debate' p.751ff. There is a wealth of legal storytelling literature and for important examples see Nancy Levit, 'Legal Storytelling: The Theory and The Practice - Reflective Writing Across The Curriculum' [2009] The Journal of the Legal Writing Institute 259 (hereinafter 'Reflective Writing Across the Curriculum'); Kathryn Abrams, 'Hearing the Call of Stories' [1991] 79 California Law Review 4 (hereinafter 'Hearing the Call of Stories'), and Carrie Menkel-Meadow 'The Power of Narrative In Empathetic Learning: Post-Modernism And The Stories of Law' [1992] UCLA Women's Law Journal 287 (hereinafter 'The Power of Narrative'); also, Richard Delgado and Jean Stefancic, *Critical Race Theory, An Introduction,* (New York, New York University Press, Third Edition, 2017) (hereinafter, *Critical Race Theory*). In the narrative mediation field see *Narrative Mediation;* Robert Rubinson, 'Client Counselling, Mediation, and Alternative Narratives of Dispute Resolution', 10 Clinical Law Review 833 (2004) (hereinafter 'Alternative Narratives of Dispute Resolution'), Sara Cobb and Janet Rifkin, 'Practice and Paradox: Deconstructing Neutrality in Mediation' 16 Law & Soc. Inquiry 35 (1991) (hereinafter 'Practice and Paradox'), Sara Cobb, 'Empowerment and Mediation: A Narrative Perspective' 9 Negot. J. 245 (1993) (hereinafter 'Empowerment and Mediation') and also Susan Douglas, 'Neutrality, Self-Determination, Fairness and Differing Models of Mediation', 19 James Cook University Law Review 19 (2012) (hereinafter 'Differing Models of Mediation')

[305] *Story* encompasses historical uses and iterative meanings. It is suggestive of English historical and chronicle accounts as well as fiction, oral accounts of actual events, first-person accounts of a person's life (autobiography), fictional events, a "plot" of different literary forms, poem, drama or novel; also the sense of an account which is amusing or entertaining, a theme for mirth, a "tall tale" ie an incredible account and as a euphemism for a lie or an untruth. *Storyteller* also attracts that potential meaning ie that someone who tells a story may not be - or perhaps is probably not - telling the truth. See *The Shorter Oxford English Dictionary (On Historical Principles)* (OUP, Third Edition Reprinted 1973) at p.2141.

[306] See E.M. Forster, *Aspects of the Novel* (First published 1927, Pelican Books, London, 1978) (hereinafter *Aspects of the Novel*) at p.42.

suspense, or "what happened next", is present. [307] The term *narrative* which in practice appears at times to be used interchangeably with the word *story* tends to attract a narrower and slightly different range of meanings. [308] According to Forster, therefore, writing in the 1920s specifically about the English novel, a story is a narrative which has the quality of suspense; without it, it is just a narrative which he defines as a series of events in chronological order. [309]

In legal storytelling, the authors (invariably scholars) tend to adopt the terminology of stories and storytelling with the legal stories themselves (often first-hand semi-autobiographical or fictional accounts) being described as a mix of tales, morality tales, parables, autobiography, counterstories or stories from below, frequently drawn from specific social, cultural or ethnic contexts.[310] The distinctions of meaning between story and narrative are not always apparent and in some contexts appear to be used interchangeably; for example, as

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[307] Forster puts it like this, by way of example: " 'The king died and then the queen died' is a story" because the element of suspense is present. If it read like this: " 'The king died and then the queen died of grief' " then it is not a story as there is no element of suspense. According to Forster both are narratives ie a series of events, but only the first can be a story. See *Aspects of the Novel* at p.87.

[308] See *The Shorter Oxford English Dictionary (On Historical Principles)* (OUP, Third Edition Reprinted 1973) at p.1385: *Narrative* is used to suggest factual or descriptive accounts such as the narrative part of a poem or play; it encompassed legal meaning too, as that part of a deed which relates the relevant background facts to understand the context. To *narrate* is to relate, recount or give an account of a matter.

[309] See *Aspects of the Novel* at p.87. It may be part of a "plot" (a plot may reveal causality between narrative events) but this further distinction is not important in this context.

[310] See *Critical Race Theory:* "counterstories" because they oppose the dominant narrative of the racial majority. For example, in her autobiographical essays Patricia Williams wrote of her heritage as the great-great-grand-daughter of a slave and a white Southern lawyer: see Patricia J. Williams *The Alchemy of Race and Rights, The Diary of a Law Professor* (Harvard University Press, 1991) (hereinafter *The Alchemy of Race and Rights*).

recently as 2017, Delgado and Stefancic use the phrase "Legal Storytelling and Narrative" without defining each of the terms separately yet elsewhere refer to "narrative analysis" (which is not defined) as a specific technique. [311] The legal storytellers appear to adopt a very wide range of terminology with sometimes subtle distinctions and some perhaps unavoidable overlap depending on the context or approach, in a very substantial body of work; the distinctions are not emphasised as being significant however and are secondary to the objective of conveying the lived experience of the academic authors through their stories and narratives.

Levit describes the debate in the (US) legal academy about narrative, or storytelling and argues that narrative is now the subject of a myriad of studies and that "people are telling stories all over the place" - suggesting that for descriptive purposes she is also not making a distinction between them. [312] She refers to stories as capturing the lived experience of the legal storytellers, suggesting that story has a proprietorial quality belonging uniquely to the teller, giving it greater human meaning rather than the more neutral or impersonal sense of the term narrative. [313] These legal stories affected the language of law and how it is used, orientated as they are to first person narratives which conveyed experience and insights and influencing many areas of professional practice such as dispute resolution fora, courts, training of adjudicators and legal education.

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[311] The definition was: "Using stories, parables, and first-person accounts to understand and analyse racial issues" - see *Critical Race Theory* at p.178.

[312] See 'Reshaping the Narrative Debate' at p.753.

[313] Ibid. Levit uses the term "Narrative" in her title, for example. Here, "narrative" is used as an adjective whereas a story is always told by someone (to whom it then belongs).

[314] Further, Levit uses legal storytelling to ground her assertion that with media-generated stories in the public domain it is not enough to rebut false stories with fact and analysis: what is needed is the creation of a new story to explain the new reality. [315]

Some researchers, however, appear to draw distinctions between stories and narratives in specific settings. For example, Robert Rubinson, in an article primarily about counselling clients examines the "narrative structures" of litigation and mediation, stating that each narrative "shapes, orders and controls" the dispute. [316] He sees each of litigation and mediation as having characteristic narrative processes (different from one another) which affect the stories told within each process: the narrative process takes on an impersonal systemic or structural quality, whereas stories that populate the process imply the human experience and emotion of the storyteller. [317] He subsequently refers to the "Story" of litigation and the "Story" of mediation (rather than using the term narrative) apparently because using a story to communicate his meaning to clients will be much more effective in gaining client attention than a narrative (even if in practice the content is not very different). Again, there appears to

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[314] Ibid. Legal storytelling was closely associated with critical legal theory, notably in the areas of feminism and race.

[315] See 'Reshaping the Narrative Debate' at p.764. Levit has used the history of legal storytelling as a contextual grounding for her assertion that in the public sphere a new story is required to modify or replace the old (and false or inaccurate) stories (in this case a media narrative about women returning to work after giving birth). This thinking may have application in connection with the NHS good news narrative which is significantly undermined by research studies (see Chapter 2) but remains the dominant narrative in the public sphere. However, Delgado and Stefancic challenge this idea, calling it an empathic fallacy: it is false to believe "that one can change a narrative by merely offering another, better one" - see *Critical Race Theory* at p.34.

[316] See 'Alternative Narratives of Dispute Resolution' at p.835.

[317] Ibid at p.836.

be a degree of fluidity about the use of the terms story and narrative which is influenced by the particular context in which each term is used.

Further, Rubinson discusses the "cognitive story model" of juror decision-making, a further model of story creation within the law. [318] In this model, jurors do not originate the story from their own first-hand conflict experiences (eliminating the complex emotional experience of personal conflict) but construct a storied version of events by imposing a "narrative story organization" onto evidence they hear at trial. [319] The term "narrative story organization" is coined by Pennington and Hastie, the originators of the model and describes a process made up of three types of knowledge and which merges the two concepts of story and narrative together, apparently seeking qualities and meanings from both concepts. [320] The cognitive story model therefore (and in contrast, say, to dispute emergence theory) describes a cognitive process based on conflict affecting others (typically the accused and the victim of crime respectively) rather than conflict experienced first-hand by the storyteller.

The narrative story organisation appears therefore to operate as a process of organising knowledge and experience to make sense of the actions of others in a particular setting (the criminal justice

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[318] See *Inside the Juror at p.192.*

[319] Ibid.

[320] See 'Alternative Narratives of Dispute Resolution' at p.838. The theory holds that the narrative story organisation is made up of (1) trial evidence, (2) personal knowledge/ experience of similar events, and (3) generic expectations of what makes up a complete story: see *Inside the Juror* at p.194. It does not put particular emphasis on subjectivity and perspective, however.

system). [321] However, Rubinson mentions this model primarily to show that it is (in his words) "the only way" that judges and jurors can do their jobs and again does not emphasise distinctions between narrative and storytelling. [322] Other fields, as well as dispute resolution or legal settings, also offer insights as to different usage where the research contexts vary greatly. [323]

Moving from legal storytelling, we see that story and narrative can have specific meanings when used within the field of narrative mediation: for Winslade and Monk, the process of creating a story is a natural human process within conflict settings. Derived from narrative therapy, the authors present a model of mediation (discussed further below) which adopts a particular and distinctive approach; that stories create meaning for us all and can be central to conflict and its resolution. In their model, stories tend to be the personal emotional stories of the parties involved in the conflict; narrative tends to be used for discussing impersonal aspects of the

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[321] See *Inside the Juror* at p.198.

[322] See 'Alternative Narratives of Dispute Resolution' at p.838.

[323] For instance in literary theory H. Porter Abbott sees the story in metaphorical terms as the *cargo* carried along by the *ship* of narrative (see Abbott H.P. *The Cambridge Introduction to Narrative,* (Cambridge University Press, Second Edition, 2014); a story must function teleogenically that is, it must be created or designed by the storyteller (who alone knows how it ends) to pursue the storyteller's purpose or objective (see Davies, L.J., *Resisting Novels: Ideology and Fiction*, (Methuen, London, 1987)). Some scholars see stories defined in this way as particularly significant for the first-hand accounts that people tell about their lives - such as legal stories - because storytellers may manipulate their material for complex or undisclosed purposes. First-hand accounts have been called "an extreme and ubiquitous exercise in selection and editing" by John Paley (in 'Narrative Machinery', Chapter 1 in Yasmin Gunaratnam and David Oliviere (Eds), *Narrative and Stories in Healthcare, Illness, Dying and Bereavement*, (Oxford University Press, 2009) at page 22) curated by the controlling mind of the storyteller. Paley adds that personal accounts reflect the "sifting..and contouring of experience" and are therefore always "contrived" to some extent whether consciously or not. Sociologist Ian Craib puts it in more pejorative terms, claiming that "all personal narratives *are to some degree bad faith narratives*" see Ian Craib, 'Narrative as bad faith', in M. Andrews, S.D. Slater, C. Squire and A. Treacher, (Eds) *Lines of Narrative: Psychosocial Perspectives* (Routledge, London, 2000) at page 67).

model, such as structure or analysis rather than the human and the emotional aspects. Equally, the authors do not formally define story and narrative, but it is notable that the vehicle for progress between the parties is “the development of an alternative story” (not an alternative narrative) which carries common ground. [324]

For Sara Cobb, as I discuss below, the personal story of each participant carries their perspective often as a victim of the actions of the counter-party and their moral frame that establishes their legitimacy and delegitimises the counter-party - the “moral of the story” is that they are the victim. [325] Narrative, for Cobb, also tends to represent the structural or less emotionally loaded aspects of the story and used when discussing her analysis of how mediation functions to disempower some parties; for example, when analysing the structural aspects of mediation, she refers to narrative (not story) structures. While stories carry the human and emotional content and in that sense do the heavy lifting within the mediation, other words are appropriate for unpacking the narrative mechanics of the mediation process. [326]

So, as discussed, although distinctions can be drawn between stories and narrative, the use of the relevant terminology appears to be highly context- and theory-dependent and is secondary to the arguments of the relevant scholars. [327] For me, the review above

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[324] See *Narrative Mediation* at p.156.

[325] See ‘Creating Sacred Space at p.1030.

[326] See ‘Creating Sacred Spaces’ at p.1021.

[327] I think fiction could be seen as an exception, because in literary criticism defining a story within the setting of the novel is a central point at least for E.M.Forster - see above.

shows that within legal storytelling and conflict resolution research there is no single overriding cohesive theory which relies on or promotes a bright distinction between story and narrative. I suggest it is for each author in the relevant context to draw out the meanings that matter in that setting and to define them clearly. In this study, I use the word *story* broadly, but not exclusively, to mean the personal first-hand accounts of participants and I will use the word *narrative* to refer to the broader account of themes and patterns of each group of participants. Story therefore attracts connotations of emotional force, human connection, personal meaning and a persuasive purpose; narrative suggests an account of events, the telling rather than the meaning, shape structure and form rather than emotion and experience. But the two are not mutually exclusive and may overlap in ways suggested above.

In Chapter 2, I discuss the Felstiner Model in relation to dispute emergence theory, focusing on the wrongdoing and whistleblower dimensions of conflict. Recalling that discussion, the theory suggests that whistleblowing cases do not follow a conventional dyadic form of dispute and tend to affect multiple parties. Disputes appear to enable and may even encourage ostensibly negative organisational behaviours such as seeking out or constructing alternative unjustified narratives of whistleblower culpability to harm the whistleblower or provoke litigation. Adherence by the NHS to good news narratives appears to impede the potential for learning and other dialogue-based forms of communication or resolution. These discussions suggest profound differences in how whistleblowing is viewed by whistleblowers, NHS managers and other counter-parties, and that

entrenched competing narratives exist which define the conflict and contribute to poor outcomes. [328]

These profound differences in the stories of these parties lead to the choice of two aspects of story theory that resonate for this study: perspective, perception, subjectivity and knowledge within legal stories (legal storytelling) and the role of narrative and storytelling within conflict resolution settings (models of narrative mediation). I will now explain and discuss these aspects of story theory and their relevance to whistleblowing conflict in the following section.

3. Story Theory: Legal Storytelling and Narrative Mediation

3.1 Legal Storytelling: Perspective, Perception, Subjectivity and Knowledge

(a) Introduction

Legal storytelling is a form of scholarship in which primarily US academics made the case for writing about the lived experience of outsider or subordinated groups to show that laws and legal principles did not treat all people equally. [329] Contributions from feminist and critical race theorists were published in major US law reviews. Their stories described experiences of discrimination and

[328] Mannion and Davies describe whistleblowers as "individuals with (often) complex personal and professional idiosyncrasies" and whistleblowing as "fraught with rival interpretations" occurring in a "highly situated organisational context" - see 'Cultures of Silence and of Voice' at p.2. See also the discussion of the *Freedom To Speak Up Report* at section 5.1 of Chapter 2 above.

[329] See 'Reshaping the Narrative Debate' at p.754.

prejudice affecting various social groups and articulated the need for change by revealing new perspectives showing that different social groups perceive the world very differently. [330] A critical response was to tell stories of human lived experience both to reveal one perspective and uncover another. [331]

Legal storytelling claims that uncovering the subjective perspective and perceptions of the dominant group reveals more clearly the truths told through the stories of oppressed groups. [332] Although this claim has been challenged, for me (as I discuss below), legal storytelling offers an approach which can help explain the subjectivity inherent in radically different stories which seems common in NHS whistleblowing cases. [333]

In addition to legal storytelling, but I suggest relevant to it, I also discuss the epistemological work of feminist scholars who advocate standpoint theory as a basis for how our individual knowledge and world view develops, but who also argue that greater objectivity can be achieved by acknowledging biases and distortions in thinking. [334] Their standpoint theory is relevant to legal storytelling; I discuss this work at paragraph (c) below, but begin first by discussing legal storytelling in paragraph (b).

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[330] Ibid.

[331] Ibid.

[332] Legal storytelling is closely associated with both feminism and race and critical race theory, so legal stories are usually written from the perspective of the minority or oppressed group. There is a broad but not equivalent analogy in the sense that the NHS represents a dominant entity and whistleblowers an oppressed group. See 'Reshaping the Narrative Debate'.

[333] See section (a) below.

[334] See section (b) below.

(b) Perspective, Perception, and Subjectivity

Legal storytelling signalled a novel shift in legal scholarship towards the use of stories and narrative. This shift was met by significant resistance from more traditional legal theorists who saw the telling of stories as an inappropriate methodology for legal texts because individual stories are highly subjective, they are not representative, they are unverifiable and may not therefore represent reliable data.[335] These objections to legal storytelling debated the perspective and perception, subjectivity and knowledge of the legal storytellers and for me highlight theoretical approaches which can assist in thinking about radically divergent subjective viewpoints.

The promise of legal storytelling theory appears to reside to some degree in the persuasiveness of the human story told first-hand in legal narrative form. Legal storytelling made a compelling case for change, perhaps about inequality and discrimination, through a personal story of human experience but set within a broad societal and legal context and in that sense suggests promise as an approach for this study. Whistleblowing stories are also personal stories of human experience, but as the real-world problem suggests, they tend to be pitted against rival competing narratives. They do not convince the parties to the conflict, notwithstanding their apparent human and emotional force. This, I suggest, is an important point of connection between legal storytelling theory and NHS whistleblowing because of

[335] Ibid. See for example Daniel A. Farber and Suzanna Sherry, 'Telling Stories out of School: An Essay on Legal Narratives', 45 Stan. L. Rev. 807 (1993) (hereinafter 'Telling Stories out of School'). I discuss this and other critiques below.

the emotional force of the first-hand accounts (of the whistleblowers) yet their apparent inability to convince counter-parties (such as NHS managers or their lawyers) of the credibility of their concerns about wrongdoing, or indeed their own credibility as whistleblowers.

As I argue in Chapter 2, the Felstiner Model suggests that complex multi-party conflict arises from an initial act of whistleblowing which is seen by the whistleblower (and researchers) as a pro-social act in the interests of patients but is perceived by those around the whistleblower as an injurious experience against them and the organisation, leading over time to grievances directed against the whistleblower. This infers a conflict landscape of an isolated whistleblower whose perspective is now alarmingly divergent from managers and co-workers.

Legal storytelling offers the opportunity to explore the perspectives of the actors to the whistleblowing conflict, particularly the whistleblower and the NHS employer whose views can be in direct opposition. For example, while whistleblower participants tell stories of having acted in accordance with their professional duties and in the interests of patients, NHS participants tell a story of deep scepticism about the whistleblower and her motivations. [336] These highly subjective perceptions of the act of whistleblowing and the whistleblower illustrate the divide between the parties and emphasise the relevance of a theoretical approach connected to how different parties perceive the same events and their interactions.

[336] One NHS lawyer participant (Catherine) said that whistleblowers "never come to the table clean" and that "there is always an alternative version of events". See Chapter 6.

(c) Knowledge

As discussed, opposing perspectives are commonly encountered in whistleblowing conflict and subjectivity in how recipients perceive whistleblowers and the act of whistleblowing is acknowledged in some whistleblowing research. [337] In this section I discuss subjectivity (by which I mean the subjective nature of perspectives and perceptions of people and events) in the context of the concepts of standpoint theory and positionality which point to ways to understand and view subjectivity in contradistinction to objectivity. I suggest this theory of knowledge accumulation through experience has potential relevance for understanding subjectivity and its consequences within both legal storytelling and whistleblowing conflict.

One starting point is the work of feminist writers Donna Haraway and Sandra Harding at least in so far as it applies to understanding the status and robustness of knowledge. Harding advocates standpoint epistemology (or more generally standpoint theory); an individual's perspectives are shaped by their social and political experiences and create a standpoint from which that individual views the world. In a research context standpoint theory represents "a way of gaining less false and distorted results of research" and strengthens research objectivity compared to research which is supposedly value-neutral,

[337] See 'Whistleblowing recipients' at p.287 .

building on the idea that the authentic voice of lived experience should be privileged over less authentic forms of knowledge. [338]

Haraway claims that all knowledge is situated in two senses, that it reflects the particular applicable social, cultural or political conditions in which it was produced and that it is contingent on the methods used to produce it. Further, such knowledge, gained by our human experience, is inevitably incomplete or partial because of the imperfect methods or imperfect conditions by which it came about yet informs our world view as individuals and our individual standpoint from which we see the world. [339] Each individual standpoint is inevitably therefore partial and subjective. Haraway's focus was to dispel the myth of scientific objectivity and this aspect of her work has broad research application in that all participant accounts are situated within that individual's life and cannot therefore be objective in a universal or scientific sense. For Haraway, being explicit about this in methodology and assumptions is likely to create more robust research findings.

Katherine Bartlett has further developed the discussion about the partiality and subjectivity of knowledge in an overtly feminist context. Writing in 2014, Bartlett takes a different approach by seeking to define objectivity, which she defines as follows: "the quality of

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[338] What Harding termed "Strong Objectivity" ie research is less distorted and more truthful when standpoint is acknowledged rather than sidelined by unsustainable claims of neutrality. See Sandra Harding, 'Rethinking Standpoint Epistemology: What is "Strong Objectivity"?' In Centennial Review 36, No 3 (1992). Also Sandra Harding, *Whose Science/Whose Knowledge?* (Cornell University Press, Ithaca, 1991).

[339] See Donna Haraway, 'Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective*',* 14 Feminist Stud. 575 (Fall 1988) cited by Katherine Bartlett in Katherine T. Bartlett, 'Objectivity: A Feminist Revisit', 66 Ala.L.Rev. 375 (2014), (hereinafter 'Objectivity: A Feminist Revisit') at p.390.

approaching decisions and truth claims without the influence of personal preference, self-interest, and emotion". [340] Objectivity, she says, refers generally to "the quality of distance or remove" but "its assumed value is not distance for its own sake, but rather the improved accuracy it produces". [341] Bartlett suggests the term *positionality* as a more relevant term as it requires reconceptualising truth as partial and situated but also highlighting biases in human thinking: it is for her "the most useful way of thinking about the enterprise of truth-seeking". [342]

Bartlett's advocacy of positionality has value to this study because it suggests a further approach to understanding and construing subjectivity of parties in whistleblowing scenarios. [343] Bartlett argues that if people set aside their self-interest they come to see what others would see if they too set aside their self-interest but, additionally, argues that our ability to reason and act rationally is also flawed. [344] So, our ability to think objectively is affected not only by our self-interest but also by prejudicial and biased thinking. Our brains "over-generalise, self-justify, prioritise present over future gain, affirm rather than test what we already believe and form beliefs

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[340] See 'Objectivity: A Feminist Revisit' at p.376.

[341] Ibid.

[342] This theory stresses that all knowledge is partial and socially constructed: any claim to objectivity is the "product of a limited set of experiences and perspectives". Positionality recognises that what passes for objective truth tends to reflect the interests of those with the power to define what is objective but does not assume that any other single perspective is truer than any other. Positionality accords with the view that "truth claims are always from a certain perspective and always specific to the methods and conditions that produced them" - see 'Objectivity: A Feminist Revisit' at pp.337-384.

[343] I have mentioned other theoretical approaches that help to explain subjectivity, such as attribution theory (see Chapter 2).

[344] See 'Objectivity: A Feminist Revisit' at p.376.

according to the groups with which we identify." [345] Bartlett's formulation of positionality builds on the standpoint theory of Harding and Haraway and, by seeking to define objectivity, enables us to critique subjectivity. It recognises that experience underpins the knowledge and world view of the individual (a tenet of legal storytelling) but also allows it to be questioned, which for me is an important tool for thinking about how to understand the conflict that arises out of two (or multiple) opposing subjective views in whistleblowing settings.

Having discussed the elements of legal storytelling, I turn to the stories of the legal storytellers.

(d) Legal Storytelling

The stories told by the legal storytellers usually take the form of a first person narrative by a woman or person of colour often (but not always) based on actual events illustrating how the law or law-related social process (such as a job interview, or a retail transaction) or a member of a dominant group engages with or operates upon them as a woman or a person of colour (or both). Stories were usually but not always published in major law journals. [346] In 1989 legal storytelling

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[345] Also, research shows that all people and all groups share the same tendency to digest data to confirm their own view of the world but the processes we rely on to be objective, having consciously set aside our self-interests, are also unreliable. See 'Objectivity: A Feminist Revisit' at p.327.

[346] Occasionally also in book form, most famously *The Alchemy of Race and Rights* by Patricia J. Williams, which formed the basis for the Reith Lectures, broadcast on BBC Radio in 1997. The "Benetton" story (Williams was excluded from a Benetton store in New York City, because she was black); also, 'The Death of the Profane', at p. 44, is sometimes cited as a "classic example of the genre" (see 'Telling Stories out of School' at p. 808).

was also the subject of a symposium in a major law review. [347] It is now an accepted analytical frame.

Kathryn Abrams describes legal storytelling as "feminist narrative scholarship" and as a "distinctive form of critical legal discourse". [348] Legal narrative scholars (Abrams argues) cannot rely on their personal stories *simply as stories*, however powerful, but must convince hearers, with normative or other proposals, that these perspectives can contribute to social or legal change. [349] Abrams raises questions about the storytelling method; for example, to be legitimate, must a legal story be based on actual events and must that be communicated to the reader. [350] The narrator's voice can be distinctive and highly persuasive in a "first person agony narrative" of real events. [351] An example might be an insider perspective (which could be a whistleblower) which may convince a reader of the moral value or weight of the narrative content by the authenticity of the authorial - the narrator's - voice. Abrams also suggests that the uncorroborated perspective offered by a one-off story may be "perilously unsystematic"; in any event it is not statistically significant. [352] She urges narrative scholars to offer reflective and

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[347] See Symposium: 'Legal Storytelling', 87 Mich L. Rev. 2073 (1989). See *Critical Race Theory,* Chapter III for a summary of the development of legal storytelling scholarship.

[348] Kathryn Abrams, 'Hearing the Call of Stories' at p.971.

[349] Ibid.

[350] An important example of legal storytelling apparently based on real events is *The Alchemy of Race and Rights.* By contrast, one well known series of articles by Richard Delgado is wholly fictional: the 'Rodrigo Chronicles'. These are fictional stories in the form of a conversation between the narrator, Delgado, and his alter ego, Rodrigo Crenshaw, said to be half brother of famous civil rights lawyer Geneva Crenshaw.

[351] See Susan Estrich, 'Rape' 95 Yale Law journal 1087 (1986) (hereinafter 'Rape').

[352] See 'Hearing the Call of Stories' at p.980.

self-aware accounts so as to be “alert to the dangers of transforming a partial experience into a prescriptive proposal” and to the risk of “unreflective partiality” potentially undermining the persuasive force of a story. [353]

In contrast to Abrams’ analysis, proponents of legal storytelling stress the psychological, emotional and educational power of stories, based on first person narrative accounts of social ethnic and cultural oppression. [354] The form frequently challenges dominant norms and narratives. [355] According to Richard Delgado, legal storytellers insist on “naming their own reality” and believe that “knowledge and ideas are powerful”. [356] Legal narrative, he adds, is a “powerful means for destroying mindsets”. [357] Perhaps one of legal storytelling’s strongest claims is for the moral and political authority derived from first-hand human experience: as Nancy Levit puts it, the emphasis on “identity, voice, perspectives of lived experiences offers more accurate representations of human conditions than legal doctrines can capture”. [358]

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[353] Ibid.

[354] Susan Estrich who “in a courageous and controversial move” (‘Hearing the Call of Stories’, p.983) wrote an early example of experiential narrative, in this case her own rape: see ‘Rape’.

[355] See for example Delgado, ‘A Plea for Narrative’; also Tina Grillo and Stephanie M. Wildman ‘Obscuring the Importance of Race: The Implications of Making Comparisons Between Racism and Sexism (or other–isms)’, 1991, Duke L.J. 397 (hereinafter: ‘Obscuring the Importance of Race’); Carrie Menkel-Meadow, ‘Excluded Voices: New Voices in the Legal Profession Making New Voices in the Law’, University of Miami Law Review (1987) 29 in which “middle to upper class white males” are considered “lawmakers” and “the rest of us are law receivers”.

[356] See Richard Delgado, ‘When a Story Is Just a Story: Does Voice Really Matter?, 76 Virginia Law Review 95 (1990), p.95

[357] Richard Delgado, ‘A Plea for Narrative’ at p.2413 tells a story about a black candidate for a law professorship at a major US law school and explores the perspectives that emerge and inferences that can be drawn from it.

[358] See‘Reflective Writing Across The Curriculum’.

Some challenge this, however, questioning how true legal stories are, in the sense of being based on actual factual experiences. They may be faithful records of events based on experiences in the material world, but might equally be selective re-interpretations after the event. Daniel Farber and Suzanna Sherry expressed concern about the accurate communication of the status of the story and its implications for legal storytelling as a form of scholarship. [359] Farber and Sherry see three significant distinctions between legal storytelling and traditional scholarship: first, the story or narrative element is included as a central feature while conventional legal analysis is de-emphasised; secondly, stories "from the bottom" (those told by women and people of colour) are valued more than other stories; and thirdly, aesthetics and emotion are emphasised but accuracy and typicality are not. [360] I suggest that by today's values these objections now appear primarily of historic significance.

Jane Baron's view is that the truth of a "what really happened" story (as she calls it) can be consistent with the truth of (as she puts it) the "many realities" stories, because the latter reflect different and

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[359] Farber and Sherry propose three statements about the perception of an event conveyed in a legal story: (1) If you have been watching, *this is what you would have seen*; (2) the situation may not have looked this way if you had been watching, *but this is how it felt to me*; (3) the situation didn't feel this way to me at the time, *but this is how it seems to me now*. The first statement is taken to be the customary test for the truth of a description of events and (the authors say) it would be dishonest to present statements that are only true under the second or third standards without an explicit disclaimer. They provide an example: "Saying 'if you had been there, especially if you were a male observer, you probably would not have seen anything that appeared to be violence, but I felt exactly as if he had slapped me", is entirely different from saying, 'he slapped me'". It is intellectual deception for an academic to take advantage of an audience that he knows will believe a story to be literally true unless told otherwise. See 'Telling Stories out of School' at p. 833.

[360] See 'Telling Stories out of School'. For a further critique, see also Randall L. Kennedy, 'Racial Critiques of Legal Academia', 102 Harv. L. Rev. 1745 (1989).

multiple “places to sit”. [361] It is possible for multiple truths (in the sense of the psychological, emotional experienced reality) to co-exist in relation to the same events - so that all truths and perspectives are equally valid. [362] As Kim Scheppele says: “the same event can be described in multiple ways, each true in the sense that it genuinely describes the experience of the storyteller”. [363]

Many of the objections voiced by critics of the legal storytelling movement might also be voiced by opponents of whistleblower stories: that whistleblower stories have inherent problems of reliability and validity, that they are personal, subjective and can be hard to verify, they can give a “one-sided emotionally painted view of a situation” and, lastly, they could be “incendiary”. [364] On the other side of the scale, it is now well recognised that people comprehend events and create meaning in narrative form and that the first-hand account of lived experience is a powerful story on its own terms. [365] The legal storytelling theory that a story offers a more accurate representation of the human condition than “legal doctrines” are able to capture is not now considered controversial. [366]

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[361] See ‘Resistance to Stories’ [1994] Southern California Law Review 255 at p. 283. Also, Jane B. Baron, ‘The Many Promises of Storytelling in Law’, 23 Rutgers L.J. 79 (1991) (book review). One participant used exactly this metaphor - see Geraldine’s account in Chapter 5 below.

[362] See *Narrative Mediation* at pp.44-47.

[363] Kim L. Scheppele, ‘Foreword: Telling Stories’, 87 Mich. L.R. 2073 (1989), p. 2085.

[364] See ‘Reshaping the Narrative Debate’ at p.754.

[365] This point applies equally in the context of narrative mediation as it does to legal narrative more widely. See *Narrative Mediation* at p.41. See generally, ‘The Power of Narrative’.

[366] See ‘Reflective Writing Across the Curriculum” at p.261.

Accordingly, one central challenge presented by whistleblowing conflict in the NHS is understanding the perceptions and perspectives of the actors: what are the actors experiencing that makes the conflict come about, and why it is that (usually) the whistleblower's story collides with the stories of those around her about both the wrongdoing and about the whistleblower herself. Legal storytelling advocates for the importance and persuasiveness of first-hand narratives that reveal the storyteller's point of view; I suggest that it is this deeper and clearer sense of perspective that offers an approach for this study which can help explain the subjective experiences expressed in participant stories, and therefore how and why they contribute to and shape the whistleblowing conflict.

3.2 Storytelling in conflict resolution: models of narrative mediation

(a) Introduction

Narrative mediation provides a dispute-resolution setting in which the stories of the disputants, and a narrative-based approach to the mediation, take centre stage. It fits well with the study for two main reasons: first, it assumes a narrative- (or story-) based approach and so aligns with the research question; second, it is a conflict resolution setting and so speaks to the conflict but is also orientated towards resolution and so speaks too to that aspect of the research question.

Mediation has multiple forms and multiple purposes but is a universally recognised alternative dispute resolution ("ADR") method

which at its heart enables disputing parties (generally) to consensually enter into dialogue, aided by an impartial third party of their choice without compromising any live legal proceedings. [367] Definitions and terminology will vary, but I suggest that the most common conventional form of mediation would be a civil/ commercial form which is also sometimes termed the problem-solving model of mediation. Strictly, problem-solving mediation refers to the problem-solving approach to negotiation developed by US scholars but widely used elsewhere, whereby the mediation facilitates "collaborative, integrative problem solving rather than adversarial, distributive bargaining" and can generate "win-win" outcomes. [368] Here, I will refer to the problem-solving approach within mediation as a catch-all term capable of applying to

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[367] For an exposition of mediation within the context of disputing and other processes generally, see Michael Palmer and Simon Roberts, *Dispute Processes,* notably chapter 7 (Mediation). Also, ADR*: Principles and Practice* Chapter 8 onwards, describing various forms and settings for mediation. I say "(generally)" because there may be circumstances in which parties are required by the Civil Procedure Rules in England and Wales (the CPR) or upon the recommendation or direction of the courts to consider mediation and can face costs sanctions if they unreasonably refuse to do so. Cases may be adjourned specifically to enable parties to mediate and this may be ordered by the court. For a consideration of the role of ADR in the English court system, and the mandatory nature of the various requirements, see A*DR: Principles and Practice,* Chapter 5, at p.75. Also, Bryan Clark, 'Mandatory Mediation in England and Wales: Much Ado about Nothing? (Amicus Curiae, Series 2, Vol.4, No 1, 143-159 (2022)) (hereinafter, 'Much Ado about Nothing?); and *Dispute Processes* at p.254 and p.259. Although ADR is not presently mandatory in the UK in the sense that parties can be literally forced to take part in a mediation process against their will, the Ministry of Justice in August 2022 began a consultation about mandatory mediation for defended claims in the small claims court. In whistleblowing cases in the Employment Tribunal the parties must certify that they have attended an ACAS telephone mediation process before proceeding with a claim. See also Susan Blake, Julie Browne and Stuart Sime, *The Jackson ADR Handbook* (OUP, 2014) (hereinafter *the Jackson ADR* Handbook) Part 2 for further comment on court-related ADR and sanctions for refusing to engage in the ADR process.

[368] See *The Promise of Mediation* at p.10; also, Roger Fisher and William Ury, *Getting to Yes: Negotiating Agreement Without Giving In* (Random House, London, 2011) (hereinafter *Getting to Yes*); also, Carrie Menkel-Meadow, 'The Many Ways of Mediation: The Transformation of Traditions, Ideologies, Paradigms, and Practices' Negotiation Journal, 1995, 11, 217-242. See also the comparison of these two negotiation theories in the context of ADR in *ADR: Principles and Practice* Chapter 4 at p.47ff. Winslade and Monk describe problem-solving mediation as "pervasive in the philosophy and practice of mediation" - see *Narrative Mediation* at p.31.

conventional civil or commercial mediation. [369] Problem-solving mediation proceeds on a number of assumptions, including that the conflict is generated by the needs and interests of the parties which are not being met, and that the mediator is an independent, impartial third party. [370] It is also based on the concept of voluntariness: the extent to which the parties engage in the process is consensual and there is no determinative outcome imposed upon the parties. [371]

Unless the parties and the mediator agree otherwise the mediation would typically be a confidential process in which all parties can give their perspective about the conflict - and thereby tell their story. [372] It is probably the case that most forms of mediation, including problem-solving mediation, in this sense will be a natural forum for storytelling about conflict, making story theory a natural lens through

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[369] The problem-solving approach (also known as an integrative approach) is a theory of negotiation, rather than an explicit mediation model or process. However, the interest-based problem-solving approach is naturally suited to mediation because it seeks joint and collaborative solutions with the parties working together for a suitable solution: see *ADR: Principles and Practice* Chapter 4 at pp.47ff, also *Dispute Processes* at chapters 6 (Negotiations) and 7 (Mediation). See also Carrie Menkel-Meadow, 'Toward Another View of Legal Negotiation: The Structure of Problem Solving' [1984] UCLA Law Review 754 (hereinafter 'Toward Another View of Legal Negotiation'), who advocates the need to look beyond stated positions to underlying needs or preferences which also aligns the problem-solving approach to mediation settings. Although it is impossible to measure, the problem-solving approach is ubiquitous: Winslade and Monk describe problem-solving mediation as "pervasive in the philosophy and practice of mediation" - again, see *Narrative Mediation* at p.31.

[370] See *Narrative Mediation* at pp.32-4.

[371] The consensual nature of problem-solving mediation is vitally important to its prospects of assisting the parties to a solution: see the *Jackson ADR Handbook* at paragraph 13.02. To the extent that parties are required by the courts to undertake mediation this principle may be seen by some as undermined even to the point where it might be considered as a violation of Article 6 of the European Convention on Human Rights (the ECHR) (the right to a fair trial by a tribunal established by law) - see the discussion at *'Much Ado about Nothing?'* at p.154; also *ADR: Principles and Practice* at pp.94/96.

[372] Although mediation can be defined without a requirement of confidentiality (see the Law Society definition at *ADR: Principles and Practice* at paragraph 8-007 on p.155) in practice it very probably will be: see *ADR: Principles and Practice* at paragraph 23-026. See also for example the CEDR standard form NHS mediation agreement (clause 4 (confidentiality)) found at https://www.cedr.com which may be appropriate for an NHS whistleblowing case.

which to consider that storytelling. Mediation of any form has the potential to enable one party to connect at a human level with a counter-party through the medium of storytelling.

However, unlike problem-solving mediation, forms of narrative mediation represent approaches which are either specifically structured around narrative-related assumptions or philosophy (such as the form promoted by Winslade and Monk) or which advocate narrative-based techniques or methodology as ways of analysing the conflict or the mediation process (this is the case with Sara Cobb).[373] So, although approaches differ, narrative mediation acknowledges that mediation is a natural forum for storytelling between conflicting parties and analyses the resolution process in narrative terms that harness the power of the parties' stories to seek out approaches to resolution. For Winslade and Monk, narrative mediation is based on wholly different assumptions from problem-solving mediation.[374] These are reasons why these theories of narrative mediation are of interest - the specific focus on narrative as an approach or form of analysis and a means of understanding, addressing and resolving the conflict which can be distinguished from, and offer alternatives to, the problem-solving approach - which resonates with this study and its focus on storytelling.

ADR is considered to be a preferred approach to workplace conflict in England and Wales for reasons of cost, informality and the ongoing nature of the employer/employee relationship and as a

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[373] Winslade and Monk say that "narrative practices in mediation are built more on entering into a philosophical position than on learning some techniques" - *Narrative Mediation* at p.32.

[374] Which is discussed further below - see *Narrative Mediation* Chapters 2 and 3.

policy preference is also enshrined in law in England and Wales. [375] Workplace ADR is usually described as conciliation, arbitration or mediation and negotiated rather than imposed solutions are seen as naturally preferable. [376] In England, much individual workplace mediation would typically be a conventional civil model, facilitative rather than evaluative and future-orientated because of the ongoing employment relationship; it would be confidential, based on the principle of the self-determination of the parties and the mediator would be expected to be neutral and impartial in judgement and conduct. [377] Acas, the Advisory, Conciliation and Arbitration Service (a statutory body which is impartial and independent of government since 1976) offers various ADR services to employers. [378]

However, as discussed, NHS whistleblowing conflict differs from a typical workplace dispute such as a grievance because of the disclosure of wrongdoing by the whistleblower which raises questions of patient safety and may affect many other parties. [379] This appears to give rise to problems in practice and as the *Freedom To Speak Up Report* suggests, mediation is not widely used in practice in whistleblowing cases. [380] Although whistleblowing

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[375] See *ADR Principles and Practice* at p.335ff for a short historic summary of law and practice of ADR in the workplace. ADR in the workplace in England is promoted largely through ACAS, an employment service independent of government. Michael Gibbons in *Better Dispute Resolution: A Review of employment dispute resolution in Great Britain* (Dept of Trade and Industry, 2007) argued for much greater use of mediation and simplification of the system.

[376] Discussed at *ADR: Principles and Practice* at p.339 for a discussion of these processes.

[377] See *ADR: Principles and Practice* at p.342ff. Also, for a practical guide see David Liddle, *Managing Conflict: A Practical Guide to Resolution in the Workplace* (Kogan Page Limited, London and New York, 2017) at p.179ff.

[378] See *ADR: Principles and Practice.* Acas act as mediator/conciliator in collective bargaining disputes as well as individual disputes.

[379] See the discussion in Chapter 2 above.

[380] See the *Freedom To Speak Up Report* at paragraph 6.6.

conflict appears typically more complex than a routine workplace grievance, this does not, for me, undermine the use of narrative mediation theory in this study; it means the complications caused by the wrongdoing aspect of the conflict need to be taken into account when considering resolution interventions. [381] In principle I suggest that narrative approaches are as applicable and relevant, as theory, to complex whistleblowing conflict as to a simpler workplace grievance. It would be wrong, for example, to see wrongdoing conflict as a matter of objective fact that requires investigation only - because there will be stories in the minds of the actors about the wrongdoing (and the whistleblower, and the wrongdoer) which may well have at least as much relevance to the conflict as objective fact.

As previously discussed, however, this study is not about mediation (or any other ADR method) as a process *per se*, but is about seeking a more in-depth understanding of whistleblowing as conflict and possible implications for its resolution. The study offers resolution-facing suggestions based on its findings but does not consider in detail or advocate possible forms of intervention or particular processes or process design. [382]

Narrative mediation, for me, represents a theoretical approach within a resolution-orientated setting which can enable new understandings of the human experiences and perspectives of the

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[381] Ibid at paragraphs 6.6.16/16. The wrongdoing in NHS cases, particularly serious and continuing wrongdoing, is likely to be a matter of public interest. This has two immediate consequences for the use of mediation: first, it is not trusted by staff as it is seen as an employer-sponsored process which is secretive and open to manipulation and so not appropriate for public-interest wrongdoing; second, if it is used to negotiate confidential financial settlements, then from an NHS perspective it can lead to adverse press coverage of "cover-ups": see the *Freedom To Speak Up Report,* section 6.6, at p.133.

[382] Chapter 8 includes suggestions for future research that take account of the findings of this study.

actors in whistleblowing conflict in a way that the problem-solving approach is not designed or intended to do. In this sense narrative mediation looks beyond problem-solving mediation in the workplace (the little-used practical alternative at present) for ways in which stories and storytelling methods can disrupt entrenched conflict narratives and create the space within those narratives to find new narrative possibilities not previously felt or seen by the actors.

The two narrative approaches to mediation I will now discuss are those advanced by John Winslade and Gerald Monk (hereinafter the Narrative Model) and Sara Cobb whose model has been described as a story-telling model (hereinafter the Story-telling Model). I will describe each in turn and thereafter conclude by drawing out for discussion the theoretical aspects of particular interest to NHS whistleblowing conflict discussed in Chapter 2.

(b) The Narrative Model

Winslade and Monk's model of narrative mediation (the Narrative Model) evolved from narrative therapy literature particularly the work of Michael White and David Epston. [383] The Narrative Model sits in a wider therapeutic jurisprudence outlined by Paquin and Harvey and which incorporates certain narrative principles. [384] The Narrative Model reflects these principles, in part: it questions the existence of

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[383] Their primary text is *Narrative Mediation*. The model drew on the work of Michael White and David Epston, see *Narrative Means to Therapeutic Ends* (W.W. Norton & Company, New York and London, 1990).

[384] Paquin and Harvey outline four narrative principles connected to conflict: storytelling is a fundamental form of human communication, different perspectives allow for competing narratives, dominant culture stories are given more weight than stories told by subservient cultures, and there are no such things as neutral objective values. See Gary Paquin and Linda Harvey, 'Therapeutic Jurisprudence, Transformative Mediation and Narrative Mediation: A Natural Connection' 3 Florida Coastal Law Journal 167 (2002) (hereinafter 'A Natural Connection').

objective fact, such that knowledge is a matter of viewpoint and perspective; stories are situated with the participant and reflect social and cultural identity; conflict is an inevitable by-product of differences between competing cultural norms. [385] Because of its therapeutic provenance working with indigenous and oppressed communities and its emphasis on social constructivism, this form of narrative mediation has a natural orientation to social justice.

Mediation between members of different social or cultural groups requires deconstruction by the parties of the stories they bring to the mediation so that underlying assumptions are revealed, allowing the parties to think afresh about the narrative of their relationship, and dispute. [386] The conflict can only be understood if the narratives or stories told are examined with care through a careful process of questioning and deconstruction which gradually uncovers the underlying assumptions revealing the entitlement (or privilege) of the dominant party. [387]

The deconstruction process is intended to unpack the "conflict-saturated story" (as Winslade and Monk describe it) and separate the parties from those stories and their perspectives, already established by earlier engagement with the mediator. [388] The deconstruction process, by shining a light on underlying assumptions, opens up the possibility of disrupting the parties'

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[385] Winslade and Monk worked extensively with socially deprived groups and this experience therefore influenced their development of the narrative model. See *Narrative Mediation* at p.39ff. Also, see the critique of the narrative model by Susan Douglas in 'Differing Models of Mediation'.

[386] See *Narrative Mediation* Chapter 4 (Entitlement).

[387] See *Narrative Mediation* at pp.43/44.

[388] See *Narrative Mediation* at p.72.

narratives about the conflict. [389] The parties, according to the theory, have been emphasising elements of plot, and characterisation of people in ways that fit their conflict narratives; the deconstruction stage of the mediation process will disturb that narrative and create the space and freedom for the parties to emphasise other aspects of the narrative, or characterise actors in different ways. [390] The deconstruction of the conflict-saturated story thereby enables the mediator to tease out the beginnings of a new preferred narrative. [391]

Understanding the conflict through a narrative lens such as that advanced by Winslade and Monk means the focus is on the storytelling itself, the stories told by each party, the perspectives from which they tell them, and the assumptions that underpin those perspectives. The focus is not on the problem, or the needs and interests of the parties, as it would be in problem-solving mediation. Further, unlike problem-solving mediation, the Narrative Model does not draw a bright dividing line between the mediation process and the content of the mediation. [392] Winslade and Monk see the dividing line between content and process as an artificial distinction: for them, within the Narrative Model, the relationships between mediator and the parties, the process of the mediation and the content issues (that is, the substantive areas of disagreement) are too closely connected to be considered as separable from one another. [393] These elements are in effect blended together by the in-depth storying process in which the telling, deconstructing and

[389] Ibid.

[390] Ibid.

[391] Ibid at pp.82ff.

[392] See *Narrative Mediation* at p.15.

[393] See *Narrative Mediation* at p.15 and

reconstructing of stories is both process and content. The stories themselves articulate and then resolve the relationship and the issues between the parties.

The Narrative Model has, as suggested above, its own narrative arc of three stages - broadly, engaging with the parties, deconstructing the conflict-saturated story, and constructing the alternative story. [394] It appears the mediator is by necessity heavily involved in all three stages of de-storying and re-storying, both enabling and actively part of the process at each stage. [395] There is a sense therefore in which this enabling (getting the parties to tell their stories and over time to co-create a new story along with the mediator) is indistinguishable from the stories themselves: the narrative work done by both parties and mediator is both process and content. [396] The problem-solving approach to mediation by contrast holds that the mediator must be neutral, impartial and has no authority to make decisions regarding the issues in dispute. [397]

Additional narrative mediation practises include externalising (and therefore depersonalising) the conflict so that the parties are not assuming and internalising blame but working collaboratively to address the now externalised conflict issue "as if it were an external object or person". [398] The parties and the mediator work together

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[394] See *Narrative Mediation* Chapter 3.

[395] The role of the mediator is significant in the Narrative Model because it is more interventionist in mediation content than the problem-solving mediator. According to Douglas, unlike problem-solving mediators, narrative mediators are "actively engaged in recreating the reality of experience for the parties" - see 'Differing Models of Mediation' at p.34. However, a detailed consideration of the mediator's role is beyond the scope of this study.

[396] Ibid.

[397] See for example the Law Society Code of Practice for civil and commercial mediation: *ADR: Principles and Practice,* at p.155.

[398] Ibid at p.6.

against the externalised conflict to co-author a new story. [399] For Christopher Harper, the technique of deconstruction enables the parties to generate new meanings to the stories which ameliorate or replace the intractable conflict arising from existing meanings. [400]

The Narrative Model describes what was at the time a new and innovative and self-contained model of mediation which drew on new ways of approaching conflict in direct contradistinction to the dominant problem-solving model. It offers possibilities within whistleblowing because of this - stories and subjective perspectives sit at the heart of NHS whistleblowing and invite closer attention through narrative-based approaches because of that. I now turn to the Story-telling Model advocated primarily by Sara Cobb which offers another mediation model with stories and storytelling at its centre.

(c) The Storytelling Mediation model

Another mediation model which relies heavily on narrative theory is advocated by Sara Cobb. For Cobb, stories are at the heart of conflict and should be recognised as part of the resolution process. She explicates the story-telling model of mediation (defined earlier as the Story-telling Model) through examinations of empowerment, neutrality and participation in the mediation process: stories, or narratives, are part of the discourse of the mediation, that is, “the discursive structures in which conflicts are constructed and

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[399] See Toran Hansen, ‘The Narrative Approach to Mediation’ 4 Pepperdine Dispute Resolution Law Journal 297 (2004) at p.307.

[400] See Christopher Harper, ‘Mediator as Peacemaker: The Case for Activist Transformative-Narrative Mediation’, Journal of Dispute Resolution 595 (2006).

transformed". [401] The aim of the mediation therefore is the transformation of the parties' conflict narratives to enable them to work towards a further narrative that can accommodate elements of each party's position and provide a basis for resolution. [402]

For Cobb, the narrative structures and processes within mediation provide a theoretical basis for examining the political processes in mediation, that is, the ways in which some stories are promoted over other stories by virtue of the mediation process or the mediator's decisions. [403] One example, discussed below, is the finding by Cobb that the first story told in a mediation can be disproportionately influential in shaping and framing any agreement reached by the parties; the first story might therefore be seen as the dominant story and subsequent stories seen as subservient to it. [404] This ordering of the parties' respective narratives can operate to undermine these subservient stories and prevent their transformation (or perhaps negotiation) into a new mediated story. [405]

Cobb adds that stories and the discourse (that is, the speech and dialogue that generates the stories within mediation settings) can have direct consequences in the real world, which is why the way in which narrative structures operate within mediation affects peoples lives and therefore matters. As she puts it: "in mediation sessions, as in other social contexts, the story world constitutes the material world by generating descriptions that have consequences in the

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[401] See'Practice and Paradox' at p.51.

[402] See 'Differing Models of Mediation' at p.35.

[403] See 'Practice and Paradox' at p.36ff.

[404] See Practice and Paradox at p.51.

[405] Ibid.

material world". [406] An example given by Cobb is a mediation story told by the driver of a school bus who felt she was harassed by a schoolboy and had to call the police; as a result the boy was not allowed to take the bus and court proceedings were continued against him in case he found other ways to harass the driver. For Cobb, the story told by the driver within the mediation had a real-world consequence in the sense that the schoolboy's life and future were directly affected by it. Cobb's point is that how narratives are handled within mediations can have direct consequences for people's lives: they are not just stories. [407]

How stories are formed within Cobb's Storytelling Model is dictated (in part) by the positions (by which Cobb means the moral and political stance within discourse) of the speakers (for the purpose of this study) within the mediation. [408] The positioning of the parties is a narrative choice by each storyteller which determines how the storyteller is portrayed within it (often as a victim of the counter-party as Cobb sees it) but which also determines the counter-party as responsible for the conflict. [409] Some stories become dominant over other stories (owing to the hegemonic social process within the mediation discourse) by labelling and construing those other stories as morally less, or mad or crazy - thereby legitimising themselves in contrast as good and true. [410]

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[406] Ibid at p.52.

[407] Ibid.

[408] Ibid. The word "position" is used by Cobb as the position taken "within discourse" in speech or dialogue - but see 'Practice and Paradox' at footnote 63 on p.52 for further comment.

[409] See Practice and Paradox at p.57. Also, Sara Cobb,'Creating Sacred Space'.

[410] See 'Creating Sacred Space'.

I suggest this has a particular resonance in whistleblowing cases, where organisations position the whistleblower as transgressive and psychologically disturbed - thereby, as Alford puts it, transforming the issue from one of principle into one of the whistleblower's "private disobedience and psychological disturbance". [411] For Cobb, this can also happen in mediation when one party never tells its own story; instead it refutes or denies the story told by the other but unwittingly contributes to the delegitimisation of its own story by arguing on the ground set out by the other. [412] I suggest this point has significance in NHS whistleblowing conflict: the *Freedom To Speak Up Report* suggests that NHS organisations develop a narrative (in opposition to the whistleblower's narrative of the wrongdoing) which the whistleblower must then refute and deny and thereby unwittingly delegitimises the whistleblower's story of the wrongdoing by responding to the narrative established by the NHS employer. [413]

Further, Cobb sees narrative structures and dynamics as affecting, or regulating, the transformation of stories as they can reduce the participation of parties in the mediation, thereby disempowering them. [414] As mentioned, Cobb found that of a sample of 30 community mediations, in approximately 75% of cases the agreement reached was framed by the first story told in the mediation - so that the initial narrative became the dominant narrative and thus dictated the substance of the settlement agreement. [415] She argues that such structures are built into

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[411] See *Whistleblowers, Broken Lives and Organizational Power at p.32.*

[412] Ibid at p.53.

[413] See the *Freedom To Speak Up Report* at paragraph 6.

[414] See 'Empowerment and Mediation'.

[415]Ibid.

mediation processes generally and can prevent relevant conflict narratives from being disrupted, thereby inhibiting the emergence of new narratives. Further, the process in mediation of "turn-taking" when telling stories also maintains negative tit-for-tat styles of communication and has a similar effect; parties are unable to construct alternative stories and positive positions for themselves. [416] Such structures and processes, because of their effects within a mediation setting, may inhibit participation by the parties, making it less likely that alternative narratives will emerge on which to base a resolution of the conflict. [417]

Cobb (together with Janet Rifkin) argues that problem-solving mediation, for reasons such as those discussed above, is highly political and through its narrative structures and processes operates to disempower some participants. [418] Mediators, they argue, are under-trained in understanding the narrative structures and processes and consequences of the discourse at work; and the mediation risks legitimising a dominant story and delegitimising the subservient story. [419] Cobb calls for mediation practises that are more reflective of principles of social justice, including mediators who actively facilitate positive positions for all disputants to eliminate adversarial patterns within the mediation, building a "common discursive framework" from which to reach agreement. [420] Other practises include "circularising" stories to create interdependence between disputants and their stories, and between disputants, to construct a "conjoined" story which contains

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[416] Ibid at p.252/3. Also, see 'Practice and Paradox'.

[417] Ibid.

[418] Ibid p.60.

[419] Ibid p.60-62.

[420] See 'Empowerment and Mediation' at p.254.

elements of both parties' positions. [421] By destabilising the existing narratives the mediator will open the narratives to transformation and elaboration, facilitating the possibility of rich and complex narratives for all disputants. [422]

Unlike Winslade and Monk's defined or self-contained Narrative Model, Cobb (and Rifkin, as cited) critique the problem-solving model using narrative theory. Cobb's particular focus is on the narrative structures within mediation and the way they operate to promote certain stories and delegitimise others, or position their storytellers so as to establish a moral order, or framework, within the mediation that frames the counter-party as morally "less" within the conflict. As with Winslade and Monk the mediator is a significant figure who in Cobb and Rifkin's reading should build expertise in narrative theory and methods in order to implement the methods she advocates skilfully and effectively.

I now discuss the Narrative Model and the Storytelling Model together.

(d) Stories and Narratives in mediation.

Although both mediation models discussed above draw upon theories connected with story-telling, or narrative, they take very different approaches.

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[421] Ibid at p.255.

[422] Ibid. The mediators have an active role in reshaping these discourses. They must guard against parties relaying a story that delegitimises or marginalises themselves, which can easily happen when a party is positioned negatively in the counter-party's story. See 'Practice and Paradox' at p.62.

The Narrative Model is a self-contained coherent mediation model established in contradistinction to the problem-solving model. [423] It assumes multiple stories within or influencing the mediation, such as those of supporting actors and background stories of human, cultural and social significance, as well as those of the disputing parties and the story of the mediation itself. [424] In this model, the deconstruction process opens up a space for alternative stories to take shape; the complexity is helpful as it generates possibilities for new narratives - it is not a search for the one true story. [425] The model uses the term "subjunctive mood" which opens up the thinking of the parties to the possibility that things can be different and that substantive change is possible: the parties are no longer confined or imprisoned by the conflict. [426]

The Storytelling Model of mediation is not presented as a self-contained mediation model, but I suggest defines itself by reference to (rather than rejecting) problem-solving mediation through its advocacy of narrative principles. This model sees the ultimate purpose of the mediation as transforming the parties' conflict narratives, but within appropriate and fairer narrative structures which are not presently represented within problem-solving mediation. [427] The narrative elements of these stories include the parties' perception of the problem and the role each party has played; each story portrays the storyteller as the victim of the actions of the counter-party so that the moral of the story is that the

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[423] The Storytelling Model is not a self-contained model, as I discuss below.

[424] See *Narrative Mediation* at p.53.

[425] Ibid.

[426] Ibid.

[427] See 'Differing Models of Mediation' p.35.

counter-party (not the storyteller) must change in some way. [428] This model sees narrative structures and narrative processes as instrumental in enabling dominant stories to colonise or silence subservient stories and so requiring material intervention from the mediator into the discourse and process of the mediation. Storytellers within the mediation discourse also tell their stories so as to position themselves positively within the narrative and position the counter-party as morally less, or "mad or crazy", which has particular resonance for whistleblowing. [429]

Neither the Narrative Model nor the Storytelling Model can be understood without briefly considering the role of the mediator. [430] It differs in each case, but can be readily distinguished from the conventional role of the mediator in problem-solving mediation. [431] It will be apparent that both models anticipate active - or even activist - mediator engagement with the conflict narratives as being essential for change to occur, whether through the deconstruction-reconstruction process of the Narrative Model or to require fairer, more balanced narrative structures within the Story-telling model. Unlike problem-solving mediation, both narrative mediation models discussed, to some degree, blur the distinction between mediation process and the content of the conflict.

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[428] Ibid at p.36. Also, see Sara Cobb,'Creating Sacred Space'.

[429] It is a recognised strategy for organisations to develop narratives which portray whistleblowers in this way - see *Whistleblowers, Broken Lives and Organizational Power* at p.32.

[430] While it is important to draw attention to the role of the mediator, I will not discuss this in any depth, nor touch on other mediation process-related aspects such as neutrality or impartiality which are substantial subjects in their own right and beyond the scope of this study.

[431] I mention this above - see paragraph (a).

As discussed, Winslade and Monk are explicit about it; the substantive role of the mediator in co-deconstructing and co-reconstructing party narratives is simultaneously about the content of the conflict and the process. [432] The alternative story that emerges from the deconstruction and reconstruction may also represent a path towards resolution, or provide a basis for it. [433] For Cobb, the mediator is also a co-creator of a third story, but, in doing so, must create a fairer mediation environment by addressing the distortions created by prejudicial narrative structures discussed above.[434]

I will now discuss my conclusions.

4. Conclusion: The potential of Story-based approaches to NHS whistleblowing conflict and its resolution

In Chapter 2 above I conclude that (at least at the outset of the whistleblowing process) the wrongdoing conflict and the whistleblower conflict are discernible from one another, that the act of whistleblowing appears to be perceived by managers and co-workers as an injurious experience, that multiple parties are affected

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[432] In the Narrative Model, the mediator must pursue an intricate narrative-based series of interactions with the parties in which his role is focused on their narratives, his relationship with them, the deconstruction and reconstruction of the stories. He knows that he is co-authoring the new story and that he has an active role. He is not focused on external process as a distinct concern.

[433] This points to a mediator role very different from that in problem-solving mediation.

[434] Cobb sees mediators as generally orientated to problem-solving mediation and largely unaware of the narrative structures and effects that she describes, and so education of and increasing awareness from mediators are required. Also, see 'A Natural Connection' at pp175-177; also 'The Narrative Approach to Mediation' at p.304.

and therefore drawn into the conflict, that retaliation towards the whistleblower appears to function as the voicing of a grievance (but cannot be supported by a request for a remedy), and that ultimately there are no pathways which allow appropriate expression of the various grievances, or claims, which appear to manifest themselves against the whistleblower.

These conclusions will be examined in the light of the aspects of story theory discussed in this chapter, when looking at the interview data in the following chapters. Legal storytelling and its mode of narrative analysis and emphasis on the storyteller's perspective, together with the forms of narrative mediation described above suggest that story-based approaches to the conflict-stories generated by NHS whistleblowing have a contribution to make in explicating whistleblowing conflict and therefore how approaches to resolution might be thought about. By way of conclusion to this chapter I discuss below certain aspects of the conclusions from Chapter 2 (alluded to in the preceding paragraph) to which story theory may provide particular potential for insights when considering the participant interview data.

NHS whistleblowing is a setting where stories matter and appear to be central to the conflict that arises. The whistleblower's story of wrongdoing can have an incendiary effect on those around the whistleblower and result in widespread harm - as the *Freedom To Speak Up Report* illustrates. [435]

It can also be inferred from the *Freedom To Speak Up Report* that in many NHS settings whistleblowers are treated badly and that

[435] See the discussion in Chapter 2.

dialogue, however structured, has little profile as a means of addressing the conflict. It is apparent both from the *Freedom To Speak Up Report* and other major reports that conventional forms of mediation do not have a significant role. [436] So, for me, structured narrative-based communication, or dialogue, involving key parties, in principle holds potential for better understandings of the perspectives of the actors. The narrative mediation models - and indeed legal storytelling - point to the emotional and psychological reality of the stories told in NHS whistleblowing settings and narrative approaches to the experiences of conflict have the potential to generate further insights. Narrative approaches may also resonate with healthcare professionals given the use and acceptance of narrative techniques in some forms of healthcare. [437]

One of the conclusions from the analysis in Chapter 2 is that recipients and colleagues perceive the whistleblower's original story about the wrongdoing as an injurious experience. This is significant because much of the conflict that follows appears from the Felstiner Model to flow from this perception of injury. The actors who have perceived injury (one of whom will very probably be the wrongdoer) will also have their own stories and perspectives about why the whistleblower's story of the wrongdoing has generated a sense of injury and these perspectives will not align with the whistleblowers perspective. To understand this emotional reality, these stories about feelings of injury should be heard and considered, as stories, to understand why these actors see the whistleblowing as they do,

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[436] See the commentary about mediation at section 6.6 of the *Freedom To Speak Up Report.* There is also no mention of mediation in, for instance, the East Kent Hospitals Report eg as a method of addressing dysfunctional teams or other similar conflict.

[437] Not least because narrative approaches are an established branch of medicine. See John Launer, *Narrative-Based Practice in Health and Social Care*. As Sara Cobb adds: "the story world constitutes the material world" - see 'Practice and Paradox' at p.52.

and why they perceive it as injurious. Narrative practices, such as the Narrative Model, derive from therapeutic origins, and deliberately seek to drill below the surface of the conflict to reveal the forces and assumptions at play. Narrative methods such as this have the potential to increase awareness of difference in world views, to increase understandings and perhaps to increase tolerance for often dramatically diverse perspectives.

The *Freedom To Speak Up Report* provides evidence for the narrative that the wrongdoing raised by the whistleblower is sidelined and is not addressed by the organisation, giving a sense that the wrongdoing disappears from view. This may not reflect action taken in the real world by the hospital management who may be taking steps to tackle the wrongdoing. Investigations may occur and steps may be taken, unknown to the whistleblower, but that off-stage activity does not mean that a narrative-based approach to the human conflict about the wrongdoing is of no benefit. [438] Although the wrongdoing conflict may at the outset be distinguishable from the whistleblower conflict, it can be inferred that the wrongdoing continues to matter to the whistleblower and so is likely to be a live issue in the conflict and a significant theme in her narrative. The stories of all of the actors affected may take account of the wrongdoing and so any narrative-based approach to the conflict and ideas about its resolution should not ignore the story about the

[438] A concern might be that any dialogue does not prejudice any investigation or regulatory action. This was debated in connection with the proposed Healthcare Safety Investigation Branch ("HSIB"). See Joint Committee on the Draft Health Service Safety Investigations Bill, *Draft Health Service Safety Investigations Bill: A new capability for investigating patient safety incidents,* Report of Session 2017-19, HL Paper 180, HC 1064, Published on 2 August 2018. The HSIB investigates serious care failings and provides a "safe space" to enable learning. The HSIB will become a fully independent body with additional powers in April 2023 pursuant to the Heath and Care Act 2022 and become known as the Health Services Safety Investigations Body. HSSIB maternity investigations will be conducted by a separate body known as the Maternity and Newborn Safety Investigations Special Health Authority.

wrongdoing. For me, ignoring this centrally important part of the overall story appears to be an omission in the analysis of whistleblowing conflict. [439]

An obvious feature of the organisational response to the whistleblower is retaliation against the whistleblower, arguably a punishment for her transgressive behaviour. [440] The Felstiner, Abel and Sarat analysis of this conduct is to view the retaliation as part and parcel of the transformation of a perceived injurious experience into a grievance, or claim, which the injured party feels can be voiced to the person who inflicted the injury; in the eyes of the organisation and the individuals who retaliate, this person is the whistleblower. Retaliatory acts not only speak of grievance but also of the freedom of those who inflict it on the whistleblower to act in this way. Retaliation is, I suggest, in itself unacceptable organisational behaviour (in theory those who retaliate might themselves be disciplined for their treatment of a colleague) and in severe cases could give rise to liability under PIDA. [441]

For me, therefore, this aspect of the conflict requires further examination and analysis; narrative principles can help here to explain why managers and colleagues feel and act this way keeping in mind that the whistleblower claims to speak out in the interests of patient safety. It is not controversial to say that retaliation against an employee by an employer or co-workers can be harmful to staff or

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[439] As discussed in Chapter 2, whistleblowing literature sees organisational responses and behaviours as a research priority. As well as the organisation's response to the whistleblower, the action taken by the organisation in relation to the wrongdoing appears to me to be a vital aspect of future research, given its relevance to the whistleblowing conflict.

[440] See the *Freedom To Speak Up Report* at paragraph 3.2.25 (Retaliatory Action).

[441] The employer or the employee who retaliates - or both - might attract liability for detriment under s.47B of ERA.

patients for many reasons and can create barriers to the resolution of the conflict.

Story theory has the potential to drill down into and unpack these (and other) aspects of the experiences of those involved in whistleblowing conflict to generate narratives of why, for instance, colleagues perceive injury from the whistleblower's pro-social organisational behaviour, or why they feel free to retaliate when doing so appears to lack a legitimate basis and to have risk attached. Explication of the whistleblowing conflict using narrative approaches is necessary to begin to determine how best to approach its resolution, to disclose barriers to resolution or reasons why it is challenging and thereby open up space to determine new or better approaches for resolution.

In the following chapter I describe the methodology and research design for this project.

Chapter 4

Research Design and Methodology

1. Introduction and Design Outline

In this Chapter, I will discuss the key design aspects of the study, the methodology of data collection and analysis and certain limitations of the methodology of the study. As an entry point, however, I discuss how the design of the study is intended to answer the research question and why I have made certain design choices.

The research question views the data about whistleblowing conflict through the lens of stories, or narratives, and the study does so by seeking the first-hand stories of participants. [442] In that sense theory fits with design enabling the data (the stories) to be collected through a narrative-based interview process. My objective was to design a study reflecting a 360-degree view of whistleblowing conflict: an all-round perspective, or multiple voices in the room, speaking individually and in groups, in a conflict-, or resolution-, orientated dialogue which so far as possible would capture reliable data. [443] This was a fundamental feature of the design of this study,

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[442] By hearing their accounts in person. As Alford explains, whistleblowers are preternaturally compelled to tell their stories owing to their traumatising experiences: see *Whistleblowers, Broken Lives and Organisational* at p.37.

[443] Capturing reliable data in whistleblowing studies is a challenge: see *Whistleblowing, Toward a New Theory* at p.221f. For a more general discussion about the validity and reliability of data see Lisa Webley, 'Qualitative Approaches to Empirical Legal Research' in *The Oxford Handbook of Empirical Legal Research* at p.935.

intended to reveal meanings by juxtaposing opposing narratives, moderated by a neutral third-party narrative. [444]

This project is a qualitative study based on empirical data derived from narrative-based interviews with 21 participants and on data derived from FOIA requests. Participants were recruited to represent the broadest practicable spectrum of actors and perspectives within the confines of the study. I propose three broad participant constituencies: (1) the whistleblowers, (2) the NHS, and (3) independent third parties. The intent was that the groups would broadly be in balance with one another, so that no one group dominated the internal dialogue within the study. Interviews were loosely structured: all participants were invited to tell their stories as they saw them, so the participant's narrative priorities drove the interview. [445]

Analysis of interview data was carried out using thematic content analysis underpinned by an interpretive coding exercise and presented separately (group by group) and together. [446] The themes that emerged were considered through the lens of certain aspects of story theory discussed in the previous chapter. The study design also included the collection and analysis of additional non-interview data by way of the FOI statutory process touched on in Chapter 1, and described below.

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[444] The "opposing" groups being the whistleblower group and the NHS group, and the moderating group being the third party group.

[445] This usually covered the conflict in detail, but if not, then I would steer participants to share experiences of attempts at resolution towards the end of the interview.

[446] Chapters 5, 6 and 7 present the data for the Whistleblower group, the NHS group and the Third Party group respectively. Chapter 8 sets out discussion and conclusions.

I will now provide a more detailed description of the data collection methodology.

2. The Methodology of Data Collection

2.1 Participants

A snowballing approach to recruiting participants appeared to be the most appropriate and practical in view of my experience in the field. This was particularly so as I had worked with and come to know a number of NHS whistleblowers from 2012 onwards. I was also an experienced solicitor and an accredited mediator, so had both whistleblower contacts and a professional network I was able to call upon to begin the snowballing process. There were though some difficulties encountered in the selection process of participants.

The NHS group represented the most challenging to recruit as accessing current NHS managers required both QMUL ERC ethical approval and Healthcare Research Authority (HRA) ethical approval. The HRA process is a time-consuming process and applied Trust by Trust so would have to be replicated multiple times with no certainty of obtaining approvals for the study nor as to the availability of willing participants (who would be facing a cold-call request for an interview to discuss what some might see as sensitive and confidential information). Given the uncertainties and the time-constraints of a doctoral project, a decision was therefore made to recruit former, rather than current, NHS staff. [447]

[447] This decision I believe, avoided a protracted delay. I was able to recruit suitable participants. It was a condition of QMUL ERC approval that I did not recruit current NHS staff as participants.

Although this decision was pragmatic, I was also sceptical (from my previous experience) that current NHS staff would be willing to speak openly without fear of repercussions. While ultimately a matter of judgement, there is recent evidence showing that this is a real world concern for NHS staff. [448] For example, in December 2022 whistleblowers publicly reported "a climate of fear" at a large NHS Foundation Trust. [449] It may be wrong, as a researcher, to assume all current NHS staff would feel inhibited from speaking openly but the fact that former NHS staff are not subject to similar pressures once they are outside the organisation may make them more able to speak openly with a researcher. I saw this as a significant consideration.

Another potential difficulty to data collection across all groups was the role of confidentiality in whistleblowing settings. Potential participants included parties to mediation, and any party to a mediation will be constrained to some extent by the terms of the mediation agreement as to what they may say or share outside of the mediation. [450] In practice, this did not prove to be a concern, as only one participant attended mediation and she was careful to comment primarily about the mediation experience in generalised terms, without divulging sensitive confidential information. Participant whistleblowers might also be constrained by non-

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[448] See for example the *Ockendon Report,* where nurses were too scared of retaliation even to take part in a confidential survey of staff views run by the enquiry body. Also, the *East Kent Hospitals Report* identified the inability of staff to speak up and escalate concerns as contributing to team failings. Failures of team working are discussed at pp.3 and 4 of the *East Kent Hospitals Report* and the evidence given by staff to the review body is set out in an Appendix at pp.71-126.

[449] See 'Climate of fear putting patients at risk, say doctors' by David Grossman and William McLennan BBC News Online, 2 December 2022 at bbc.co.uk.

[450] See for example the CEDR Model Mediation Agreement (2022 version) at https://www.cedr.com.

disclosure obligations in compromise or settlement agreements with NHS Trusts although none of the four whistleblower participants of this study had entered into a settlement agreement, so this aspect was not a concern in practice. [451]

In whistleblowing research access to the workplace may also have challenges, particularly in a high-profile organisation such as the NHS. As I argue in Chapter 1 access to empirical data in connection with whistleblower research is seen by researchers as inherently problematic. [452] My concern was that these challenges might lead to or imply a potential narrowing of the group of participants and had to be navigated as part of the snowballing process. [453] In the end that appeared not to be the case, and participants recruited included: whistleblowers, a retired union official, an executive within a whistleblower support organisation, external solicitors and barristers advising whistleblower claimants and/or NHS Trust respondents, former NHS managers, a Care Quality Commission ("CQC") inspector, a mental health professional, an officer in the National Freedom to Speak Up Guardian's Office and a professional mediator.

The three groupings, whistleblowers, NHS and third parties respectively, were generally clearly defined in the sense that participants fell naturally into a specific group with the exception of two of the barristers, who represent both NHS Trusts in some cases or whistleblowers in other cases. These two barristers - Alan and

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[451] Although these are not effective to prohibit the making of protected disclosures pursuant to s.43J (discussed above). For a discussion of confidentiality clauses see *Whistleblowing Law and Practice* at p.495 paragraph 14.124.

[452] See Chapter 1 Section 3 (The research problem).

[453] I discuss this further in Chapter 1 section 4 as a limitation to this study.

Jacob - have been notionally allocated equally between the whistleblower group and the NHS group because of their professional experience representing both whistleblowers or Trusts in whistleblowing proceedings and that allocation is reflected in the numbers of participants in the two relevant groups below. Their views have been taken into account in the discussions relating to both groups although their profiles and stories appear for convenience in Chapter 5 (the Whistleblower Story).

At the completion of the interview process on 8 February 2021 the three data groups were as follows:

Whistleblower group – 10 participants

- 4 whistleblowers
- A retired union official/academic representing NHS whistleblowers
- An executive of a whistleblower support organisation
- 2 solicitors - whistleblowers/claimants only
- 1 barrister - whistleblowers only
- 0.5 barrister – whistleblowers and NHS Trusts
- 0.5 barrister – whistleblowers and NHS Trusts

NHS Group - 7 participants

- A retired NHS manager
- 3 former NHS consultants

- A solicitor - who advises NHS Trusts only
- 1 barrister – NHS Trusts only
- 0.5 barrister – NHS Trusts and whistleblowers
- 0.5 barrister - NHS Trusts and whistleblowers

Third Party group - 5 participants

- A Care Quality Commission inspector
- A psychoanalyst
- An officer in the National Freedom to Speak Up Guardian's office
- An independent solicitor
- A professional mediator.

All participants have been anonymised in this study in accordance with the QMUL Ethics of Research Committee ("QMUL ERC") signed consent forms and all participants have relevant experience in connection with NHS whistleblowing within their field. Participants were without exception accomplished professionals in their field, whether medical, managerial or legal. All participants engaged positively in the interview process appearing to recognise the potential value of research in the field. Every participant provided written consent, signed and dated, in the form approved by the QMUL ERC.

QMUL ERC approval was granted on 2 May 2019. The first interview took place on 9 September 2019 and with one exception all

interviews had been conducted by 10 March 2020. [454] The final interview took place on 8 February 2021. [455] Eighteen interviews were face-to-face and three were by telephone.

2.2 The Interview Process

Before each interview I contacted the participant via email to invite them to participate in the study. With this email I provided the Participant Consent Form (to be handed to me duly completed, signed and dated before the interview started) and the project Information Sheet, both in the form submitted to and approved by the QMUL ERC. I invited questions from participants in relation to the project generally or in relation to any aspect that concerned them (I did not receive any concerns). The Information Sheet confirmed that participants would not be identifiable from the final thesis nor any other published material arising from the research (and would therefore remain anonymous) unless they advised that they were happy to be identified. Two participants emphasised the importance of anonymity because of their particular circumstances so I have been careful to ensure participant profiles and accounts are appropriately anonymised. This has included allocating participants names chosen at random, using generic rather than specific language or descriptions, omitting details or specific matters, or aspects of the story, that might identify a participant. Protecting participants in this way is essential to comply with the QMUL ERC consent requirements, and has required me as researcher to make judgements about such omissions and changes

[454] The first Covid pandemic lockdown took effect on 24 March 2020.

[455] The Covid pandemic prevented the interview from taking place between March 2020 and January 2021, when I approached the participant again.

to the stories, which I have done conscientiously, but without losing relevant data which comprise the essence of each of story.

Progress with participant interviews was tracked from inception by means of individual participant records populated with interview dates, locations, receipt and filing of consent forms, typing, editing and delivery of transcripts. I used two identical ZOOM HP1 digital audio recorders to record each interview. Recordings were converted from WAV to MP3 (a more compact format) and uploaded to an external professional transcription service, TypeOut, who proved highly professional and an invaluable time-saver. [456] Interview data therefore took the form both of a digital audio recording of the whole of each interview and the professionally typed transcript (which was then printed). I also took handwritten notes during interviews although these tended to be ideas, observations and aides memoire rather than detailed records, as I relied on the recordings for capturing substantive content.

Interviews were conducted in every case at the participant's preferred location, either their own office or barristers chambers, or a home or neutral office location. Interviews were without exception cordial and cooperative, although more or less formal depending on whether I knew the participant previously or not at all. Email exchanges to plan arrangements provided a sense of the person but in one instance

[456] All project costs have been self-funded. Transcriptions cost in excess of £3000.

proved slightly awkward. [457] I interviewed in London, Manchester, Stockport, Exeter twice (separate participants), Leicestershire and Suffolk.

As indicated, the interviews were narrative-orientated; once the participant was settled, consent form signed and recorders set up, I began by inviting her to tell her story as she would usually tell it. For the first six interviews I prepared prompts to discussion and shared these with participants prior to the interview. These prompts were based on a standard set of questions I had prepared, for consistency, but tailored to individual roles or circumstances in each case. I explained to participants that the prompts were not so as to structure the interview or influence the story as they would usually tell it and they could have regard to them or not as they found it helpful. However, it was soon evident that the prompts were not being used or referred to within these early interviews. As the pre-prepared prompts appeared superfluous I decided not to use them thereafter although I continued to prepare them for consistency and used them as an aide memoire.

My guiding principle during interviews was to be light touch to avoid disrupting narrative momentum. Each story created its own narrative pace and shape; some themes, and issues featured prominently and others less so or not at all. Each story developed its own plot, characterisation of those who were pro-storyteller and those who

[457] One participant suggested meeting in a coffee shop, which prompted me to express concern about confidentiality, loss of audio quality and the ability to talk openly - which she immediately accepted, suggesting then that we meet at her home. Our meeting ultimately was extremely valuable and interesting but curiously was also easily the most interrupted (by family conversations, stepping out of the room, activity in the kitchen and a poorly family member).

were anti-storyteller, tone and moral positioning, consciously or unconsciously selected by the storyteller.

One ethical consideration was the emotional well-being of the participants during interviews, particularly the whistleblowers, all of whom spoke of their suffering. Participants were invariably composed and pragmatic even whilst sharing accounts of patient (or their own) suffering, which could still shock me even though my past experience working with whistleblowers had prepared me for such stories. Some interviews were more emotional than others. As researcher I was careful to prepare myself mentally and emotionally for hearing difficult stories but was still taken unawares on occasion.[458]

Following the interviews, the digital recordings were uploaded to the TypeOut platform for typing, usually completed in less than 5 days. I reviewed the transcripts for errors and omissions, corrected these against the recording, and then emailed them to the participants for any comments in accordance with the QMUL ERC Information Sheet. I only received comments from one participant in connection with the wording of the transcript itself; the changes were added, and the amended transcript approved.

I will now discuss the FOI research process.

2.3 The Freedom of Information research process

[458] Familiarity with the experiences suffered by whistleblowers, and what they had seen, undoubtedly helped me during the interview process, although you can never fully prepare yourself. One participant had to stop the interview at one point when relaying his story but resumed very quickly.

Freedom of Information requests ("FOI Requests") are forms of enquiry which can be submitted to public authorities or other public bodies pursuant to the Freedom of Information Act 2000 (the "FOIA"). A member of the public can request any information recorded and held by a public body in any form, whether electronic or paper records, photographs, videos or other recordings; it does not include personal information. [459] Guidance - which I followed - suggests that requests should be as specific as possible and generalised requests should be avoided. [460] The relevant public body must provide the information requested by the FOI Request within 20 working days unless it claims an exemption, the most common being the excessive cost of collating the information. [461] Other specific statutory exemptions also apply pursuant to which the public body may decline to respond to the whole or part of a request. [462]

I decided to conduct the FOI research in order to obtain further data from the NHS and to add to the contemporaneity of the NHS data. [463] I also had two other objectives in seeking the data: first, to provide some statistical context for the study by generating numerical data about three core questions: (1) how many whistleblowing cases occur, (2) how many cases are satisfactorily

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[459] One's own personal information can be obtained by submitting a "subject access request" which is a separate process under the FOIA.

[460] See the guidance published by the Information Commissioner's Office (the "ICO") at https://www.ico.org.uk. The ICO is the regulator under the FOIA.

[461] For a Government department or the Armed Forces this figure was £600 (when the requests were submitted) and £450 for other bodies.

[462] These are set out in detail in Part II of the FOIA (Exempt Information) at Sections 21 to 44 inclusive. For example, information need not be provided where it might prejudice national security (s.24 FOIA) or defence (s.26 FOIA).

[463] This was also partly because I was by then clear that I would not be approaching current NHS staff. I submitted FOI Requests from 24 October 2019 onwards.

resolved, and (3) how are they resolved (eg by a form of mediation).[464] The second objective was more speculative, to see what information NHS Trusts held in their records about whistleblowers and case-handling, and more generally how they responded. While a number of the FOI Request questions were framed in terms of the resolution of whistleblowing cases (specifically mediation) the FOI Request could - it seemed to me - tell you something more about the Trust in terms of its openness and transparency, given the sensitivity of the subject matter of the request.

My decision to conduct research by the FOI method was entirely of my own volition, and not prompted by any academic study.[465]

FOI Requests were submitted to all 143 NHS Foundation Trusts in England between 24 October 2019 and 3 November 2019. I decided to submit requests to Foundation Trusts because even though they vary in many and complex ways, they are nonetheless comparable in their statutory origin and legal status and in that sense represent a consistent organisational form for research purposes.[466] Given the numbers involved and assuming a

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[464] The questions I refer to here are raised by Questions 3, 5.1-5.4 (inclusive) and 8 in the form of FOI Request in the Appendix below.

[465] I submitted FOI Requests from 24 October 2019 onwards, since when I have become aware (in December 2021) of an NHS-related article using this method: see Ashley Savage and Richard Hyde, 'Whistleblowing in the time of Covid-19: findings from FOIA requests' (selected papers from the International Whistleblowing Research Network conference at Maynooth University, 2021, Middlesex University Research Repository at https://eprints.mdx.ac.uk/34505/) (hereinafter 'Whistleblowing in the time of Covid-19').

[466] There are 4 types of Foundation Trusts: acute, mental health, ambulance and community. Of the 143 Foundation Trusts, 94 were Acute, 39 were Mental Health, 6 were community and 4 were Ambulance. Submitting FOI Requests to non-Foundation Trusts would have introduced a second category of organisational form and invited comparisons between the two forms which for this study I considered irrelevant and outside the scope of the project.

reasonable proportion of responses it appeared to me to suggest statistically a good sample size, appropriate for this study. [467]

The form of FOI Request related to the last three NHS financial years prior to its submission, namely, those ending 31 March 2017, 31 March 2018 and 31 March 2019. Each request was in the same form and was submitted in soft copy only online through the relevant Trust website or by email. All replies were received by email. Only one Trust (Tees Esk and Wear Valley NHS FT) declined to respond in any form to the request on the basis of excessive cost. 28 Trusts acknowledged the request but subsequently failed to provide a substantive reply. [468] In these cases I sent one email reminder following the original request but did not follow-up further. [469] 114 substantive replies were received in response to the FOI Requests between 19 November 2019 and 17 June 2020. [470]

If Trusts ultimately failed to reply or to apply exemptions I did not challenge that decision nor report a Trust to the Information Commissioner's Office. In order to maintain consistency of the data I examined, I decided against reviewing additional information sent by some Trusts (but not others) such as Local Guardian annual reports or policies which accompanied a reply. Replies in this sense were

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[467] 114 substantive replies were received which is fractionally below 80% of the 143 submitted.

[468] This is a breach of statutory duty under the FOIA 2000.

[469] Although Trusts could be reported to the Information Commissioner's Office for failure to comply it was clear to me by Jan/Feb 2020 that I was receiving a good proportion of substantive responses and I was increasingly conscious of not adding to NHS challenges during the Covid pandemic.

[470] Note the FOIA requirement mentioned above to reply within 20 working days. A number of Trusts emailed to explain that delay was caused by the pressures of the Covid pandemic.

inconsistent, as some Trusts included additional documentation and others did not, so practice was variable. My primary focus however was on the three core questions mentioned above to obtain a consistent dataset. [471]

In addition to the three core questions, the FOI Request also inquired about clinical incident recording, the use of mediators, governance structures to support whistleblowers and the use of non-disclosure agreements which were intended to provide further contextual information for each Trust. [472] When formulating the request I chose to use the word "whistleblowing" (particularly as in "whistleblowing cases" and "whistleblowing policy") so as to distinguish "formal" or "PIDA" whistleblowing from the broader concept of freedom to speak up which encompasses concerns which do not amount to formal whistleblowing. [473]

Although the Local Guardian regime was established following recommendations in the *Freedom To Speak Up Report* the Local Guardian role is not however restricted to formal whistleblowing; Local Guardians are there to assist with all concerns raised by workers which may in practice result in different interpretations of whistleblowing and therefore whistleblowing conflict. As discussed in Chapter 1, a Local Guardian can receive a wide range of concerns

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[471] The questions I refer to here relate to Questions 3, 5.1-5.4 (inclusive) and 8 in the FOI Request. However, I received a substantial volume of data including some Local Guardian annual reports which may present opportunities for future analytical work.

[472] See the FOI Request in the Appendix for the exact wording.

[473] Many Trusts appeared to interpret "whistleblowing" in the FOI Request as meaning all matters raised with the Local Guardian which as mentioned includes matters which are not formal whistleblowing: some concerns raised with the Local Guardians are formal whistleblowing and some are not.

from staff; for the purpose of this study, I suggest concerns may fall into one (or possibly two in some cases) of three categories: first, formal or PIDA whistleblowing; second, whistleblowing within the Research Definition (but which fall short of formal or PIDA whistleblowing); thirdly, concerns which however genuine or distressing are not whistleblowing at all. [474] These can be fine distinctions, suggesting it is unsurprising that genuine differences of understanding occur. [475]

Detailed records of the FOI research process were maintained in spreadsheet format. Each Trust was allocated a unique number and the spreadsheet populated by dates of submissions, Trust FOI references, and dates of responses for all 143 Trusts. As substantive replies were received, the replies to each question were then transcribed into a second spreadsheet to aid analysis. Hard copies of all email replies were printed and filed in lever-arch files for ease of reference.

The data received in response to the FOI research process was not as I had anticipated for reasons discussed above. The variability of Trust responses raised questions of how - reliably - to understand and interpret the data. I discuss this, and data analysis generally, in the following section.

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[474] A concern which amounts to PIDA whistleblowing should also fall within the Research Definition.

[475] Differing interpretations were recognised by the *Freedom To Speak Up Report* (see Cover Letter to the Secretary of State for Health). This is a significant point when interpreting the FOI Data and is discussed in Chapter 6 .

3. The Methodology of Data Analysis

3.1 Interview Data

The interview data took three forms: digital audio recordings of the whole of each interview, the professionally typed transcripts and lastly handwritten contemporaneous notes. The order was dictated by the snowballing process and participant availability, although interviews of the whistleblowers themselves were a priority in the early phase primarily because for me they were a fundamental component of the empirical research. [476] Once the interviews were finished the data comprised over 37 hours of recordings and several hundred pages of typed transcript. [477]

The transcripts served as working texts. To order the material I initially adopted a preliminary and high level system of coding based on elements of the research question, the storytelling approach to the study and the focus on understanding whistleblowing conflict, including the wrongdoing and whistleblower aspects. These codes were intended to capture high level umbrella themes that could be sub-coded into subsidiary themes as the data analysis developed. The main umbrella themes I decided on were Storytelling/Narratives, Point of View/Perspective, Conflict/Resolution, and Public/Private Interests and the coding to identify these themes was applied to each transcript as an initial ordering process. Being swamped by the

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[476] By which I mean without whistleblower data the study would not be able to make the claims for authenticity and authority of the experiences of whistleblowers themselves, which is central to the study.

[477] Once corrected for accuracy the transcripts were printed and used as working copies.

material was a concern and my research instinct was to seek a high-level sense of key themes within the content before embarking on the exercise of sub-coding and a more detailed interpretation of transcript data. [478]

I coded transcripts group by group (whistleblower, then NHS, then third party) to see if an initial sense of a group's umbrella narrative emerged. The umbrella-coding was carried out as a written exercise working on the hard copy text of each transcript. The next stage was to sub-code the texts, to develop a more detailed picture of the themes present within the language of the transcripts. For example: the sub-codes of the umbrella code "Conflict/Resolution" included "suffering", "retaliation", "storytelling", "emotion", "mediation/ADR", "workplace mediation", "litigation/employment tribunal", "treasury approval" and "NDA"; the sub-codes for the umbrella code "Point of view/Perspective" included: "self-reflection", "self-awareness", "recognition", "entrenchment", "acknowledgement of other" and "NHS brand".

This exercise was conducted whilst also listening to the recording, stopping and restarting throughout. The objective was to remind myself of the live experience of each interview, to recall the memory of the conversation and allow that experience to feed into the coding exercise. It also increased my familiarity with the detail of each transcript, and helped to identify important moments, narrative

[478] The umbrella codes reflect the research question although I was aware of the importance of being open to other themes that presented themselves to prevent the coding exercise from creating rigid thought patterns. My instinct was to respect the fluidity of language and to try to ascertain as closely as I could what the participant meant.

themes and potential supporting quotations to support themes and sub-themes. [479] Working with the three different forms of interview data also helped me to immerse myself in it.

Part of my work as researcher was to reflect on my perceptions of the three different forms of interview data: the live interview, the recording and the transcript text. Listening again to each recording had a powerful quality of memory and emotion, recollection of the interaction and rapport with the individual, and the physical location of the interview. Reading a transcript while simultaneously listening to the recording had the effect of illuminating both; the meaning of the words on the page was more alive when heard in the voice of the storyteller and the ability to dwell on the words on the page could amplify the meaning, which felt as though it reinforced the effect of the recording.

On occasion, also, I picked up on interesting inconsistencies that were not as evident in the interview itself which suggested the relevance of the reflective exercise. In some cases participants spoke without pause or hesitation where the sense of the recorded speech can be followed but it can be harder to follow in the transcript. What only became clear to me as I worked through the transcripts in this way was that all three forms of interview data are qualitatively different and all three must be assimilated or re-assimilated in order to triangulate the language and experience into the most faithful form I could.

[479] Recalling how a participant told their story (rather than only reading it) made a difference in bringing it to life and recalling words and phrases.

As mentioned, the study has been designed to consider and present participant data on three levels: as an individual participant narrative, as a group narrative, and as between the three groups. This was an experimental design in a sense. [480] I wanted to juxtapose the stories of participants in the same group to see what if any differences arose out of that process. [481] As well, in turn, I wanted to juxtapose the narratives of each group (with their internal complexities) to establish a dialogue between the group narratives and their perspectives about whistleblowing. At an intra-group level I was seeking out both the stories told by one group only (and what did those stories tell us about how that group saw NHS whistleblowing conflict) but also were there areas of consensus where the narratives of the different groups converged. The perspectives of both individual participants and the groups of participants and how they relate to one another is the heart of the study and the design and methodology is intended to draw out the various perspectives and connections and allow them to speak.

I now turn to the methodology of the analysis of the FOI Data.

3.2 The FOI Data

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[480] Not with a view to constructing unsupported or forced narratives, however. As Kate Kenny puts it: "in such qualitative studies…… limitations are many. The researcher can only attempt to paint a reasonably rich and engaging picture of what has been done, allowing the complexities and paradoxes to emerge and try not to rigidly fix the subjects of enquiry, even as this is difficult to avoid. Although the temptation to pretend some kind of coherence is strong within academic research, in the resulting analysis I instead focus on…….contradictions and paradoxes, leaving these as they are and exploring what we might learn as a result". `See *Whistleblowing, Toward a New Theory* at pp.221/222.

[481] I had witnessed some very bitter online infighting within the broader NHS whistleblowing community. It brought home to me the trauma and damage suffered by many NHS whistleblowers and planted the thought that this internal conflict might present itself within the whistleblowing group data.

The FOI Data generated from the replies to the FOI Requests tended to be mainly statistical (as I had expected) but often moderated or qualified by short narrative comment. As discussed above, as I began to review the data it became clear that Trusts construed the concept of whistleblowing differently. Some construed it as though any staff concern raised with the Local Guardian should be considered as whistleblowing for the purpose of my FOI request (I will call these "FTSU concerns", meaning all concerns raised with a Local Guardian regardless of whether or not they amount to formal whistleblowing). [482] Others made a distinction between FTSU concerns which were not (in the Trust's view) PIDA whistleblowing and FTSU concerns that were (in the Trust's view) PIDA whistleblowing. [483]

This is an important distinction for how a case should be handled, and under which workplace policy, but one which can be very difficult to draw in practice. [484] For example, a grievance (such as a perception of bullying) which affects only the individual member of staff may be reported to the Local Guardian but is unlikely to amount

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[482] "FTSU" is the common acronym for Freedom To Speak Up.

[483] The different interpretations of whistleblowing by NHS Trusts (in replies to FOI requests) was also noted by Savage and Hyde in 'Whistleblowing in the time of Covid-19' (at p.60) where they also see Trusts providing confusing replies and apparently misunderstandings of whistleblowing generally. This article was accessed by me on 21 December 2021, after I had written about this subject (in July 2021), so had no influence on this study or my findings on this point.

[484] As discussed above, it is possible that FTSU concerns could amount to whistleblowing within the Research Definition, but not within the meaning of PIDA. The FOI request deliberately invited the Trust to respond in terms of what they understood to be whistleblowing, which is why the data is valuable - we can see what Trusts believe whistleblowing to be. Bullying which affects just the individual member of staff could however fall within the Research Definition (because of the absence of a public interest requirement): see Peter Roberts, 'Motivations for whistleblowing: Personal, private and public interests' in *The International Handbook* at p.217. For a discussion of the public interest test see *Whistleblowing Law and Practice* Chapter 5 at pp.175-215.

to PIDA whistleblowing although it is essentially a subjective perception and so open to debate. [485] The distinction speaks to the interpretation of the FOI Data, so it is important to be clear about the meaning of each Trust reply. My initial step in relation to the FOI Data was therefore to review the whole of each reply carefully in the light of this distinction and using my own judgement and experience to establish its preferred construction and taking account of all indicators.

Although mainly statistical, the replies took many forms. Some Trusts provided simple numbers with no narrative comment or qualification and therefore appeared to present solely whistleblowing case numbers in line with the request. In the absence of factors to the contrary I interpreted these at face value. [486] Other replies were explicit in that the numbers were FTSU concerns and not whistleblowing cases. [487] Yet others - which I have called "overlap" cases - included numbers for both categories ie whistleblowing cases and FTSU concerns. [488] Some Trusts offered no information on the face of the reply either because they claimed exemptions or because

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[485] It will be circumstance-dependent, as any bullying can adversely affect staff performance and therefore patient care.

[486] I also sought to apply a degree of reasonableness when forming a judgement about unexpectedly high numbers. For example, if a reply did not make this distinction clear on its face but reported high numbers of "whistleblower" (say, 100 over 3 years) the overall context of replies from other Trusts and my own experience of what that would mean in practice (and in the absence of other indicators eg high legal spend) suggested that the 100 figure was on balance more likely to mean FTSU concerns rather than PIDA whistleblowing cases.

[487] This category was problematic because, as indicated, FTSU concerns can include PIDA whistleblowing cases ie PIDA whistleblowing is a sub-set of FTSU concerns. Where there was no indication anywhere within the reply that any of the FTSU concerns were considered to be PIDA whistleblowing again I felt the reply should be taken at face value and therefore the numbers should be counted as FTSU concerns.

[488] In almost all of these replies the FTSU number significantly exceeded the whistleblowing number. These replies also sometimes specifically distinguished between the two numbers provided, which was clearer.

they attached Local Guardian reports but did not actually reply to the numbered questions in the request. [489] Other Trusts only provided a figure for concerns raised under the applicable policy which was outside the scope of this study. [490]

As it has relevance to data collection and analysis I set out below the breakdown of the number of replies received (out of the total of 114 substantive responses) which I assessed as falling into each category:

- Whistleblowing cases (excluding Overlap cases): **61 replies**
- FTSU concerns (excluding Overlap cases): **24 replies**
- Overlap cases: **10 replies**
- No Information: **15 replies**
- Policy only: **4 replies.**

Whilst I diligently applied my legal and interpretation skills to this essential first step in interpreting the FOI data it was ultimately a matter of researcher judgement based on knowledge of the field, my experience of the effects of formal whistleblowing, and a considered and reflective thought process which took account of all of the replies to all questions provided by each Trust (including any narrative comment).

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[489] Thereby passing the responsibility for accurately interpreting the report to the researcher, which was unacceptable. These are called “No Information” replies of which there were 15. This does not imply that they did not have other value as data, however.

[490] In these cases, of which there were 4, the Trust did not respond to Question 3 but did respond to Question 8. This appeared to allow Trusts to sidestep seeking data internally as to whether cases were whistleblowing cases or not. Policies were titled in a variety of ways but were not included as part of the reply. I refer to these as “Policy cases”.

The FOI Data is presented within this study as one of the voices within the NHS group narrative in Chapter 6. 114 Trusts responded with individual voices which construed and interpreted together create a narrative of how many whistleblowers have spoken out over the three-year period and how if at all cases were resolved. Once the initial review was completed it was possible to review the replies that fell into each category and calculate numbers of responses to the key questions which (broken down into sub-questions) were: (1) how many whistleblowing cases arose over the 3-year period; (2) how many were resolved; (3) how many went to the Employment Tribunal; (4) how many were resolved by ACAS; and (5) how many were subject to a mediation process. [491] For clarity, in Chapter 6 I have added explanatory footnotes where relevant when citing numerical findings.

The FOI process has a number of uncertainties and limitations as a research method. It was undertaken to add contextual certainty but in fact revealed an extremely mixed and perhaps concerning picture about Trust understandings of whistleblowing. The process did however generate a substantial volume of valuable data only part of which has been employed for this study. [492]

In the following section I discuss the limitations of the methodology and design of the project more generally.

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[491] The term used in the FOI request was "satisfactorily resolved" and was defined to mean that any patient safety issue was resolved as well as any employment issue. This reflects the two aspects of whistleblowing conflict that frame this study, the wrongdoing and the whistleblower.

[492] The unused data was ancillary rather than central to this study and could potentially form the basis of a further research project (see Chapter 8).

4. Limitations of the Methodology

As is typical in empirical studies there are inevitably limitations that arise within the context of any particular study and this study, heavily based as it is on participant interviews, is no exception. [493] For me, the distinctive limitations relevant to this study relate to participant make-up, interpretation of FOI Data, and my own standpoint as researcher, which I discuss below.

Regarding the selection of participants, the participant group was recruited using a snowballing approach framed by my originating network of contacts which I suggest inevitably reflects my own professional background and contacts in the NHS whistleblowing community. My legal background and my experience working with NHS whistleblowers were significant influences when recruiting participants, as they dictated the social and professional profile of my network of contacts from which the process started, although age may have been a distinct factor. [494] As I explain in Chapter 1, I consider this affected the make-up of the participant cohort generally, but in doing so my selection also generated senior, knowledgeable and accomplished participants, through whistleblower and legal contacts respectively, who have made huge contributions to the study. For example, while other studies might have other starting

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[493] For discussion of these challenges see Anna Bryson and Sean McConville, *The Routledge Guide to Interviewing, Oral history, social enquiry and investigation* (Routledge, London and New York, 2014) at chapter 9 (Analysis), and also Lisa Webley, 'Qualitative Approaches to Empirical Legal Research' in Cane P and Kritzer H M (Eds) *The Oxford Handbook of Empirical Legal Research* (Oxford University Press, 2010) at p.926.

[494] I was born in 1959 and qualified as a solicitor in 1985

points for recruitment, emphasising other perspectives, the legal contributions provide repeat-player expertise and inside knowledge of the legal framework and outcomes which could not be replicated by different participants.

The participant group was also influenced by my decision to recruit former rather than current NHS staff, as I discuss above. Although the study has not therefore collated interview data that would have been provided by current NHS employees it has collated data which is I suggest not affected by the very problem the study is addressing, namely the fear of speaking out in the NHS workplace. [495] Overall, although the participant cohort could have been recruited with emphasis on some perspectives rather than others, for me it has sufficient overall balance across the three groups that sustains and supports the design of the study.

A second limitation of the methodology or study design is arguably the potential uncertainties, discussed above, presented by the FOI data and the resulting uncertainty in how it is best interpreted. For example, uncertainties such as the variability in Trust responses ranging from no substantive reply to clear and detailed narrative answers, or a lack of centrally held records preventing responses to some questions; others claimed statutory exemptions (such as confidentiality of material) as reasons why data could not be provided. As discussed above, the replies appeared to show differing

[495] We know from events in 2022 that speaking out remains a problem in parts of the NHS: see the *Ockendon Report,* the *East Kent Hospitals Report* and events at University Hospitals Birmingham NHS Foundation Trust: 'Climate of fear putting patients at risk, say doctors' by David Grossman and William McLennan BBC News Online, 2 December 2022 at bbc.co.uk.

interpretations of whistleblowing by Trusts: the important distinction between PIDA (or formal) whistleblowing and FTSU concerns was highlighted in some cases but in other cases it was apparent that all FTSU concerns were seen as whistleblowing. As I have argued, interpreting this key aspect of the data required a reasoned judgement to be made using my knowledge of the field, skills and experience as well as careful consideration of the whole reply from each Trust and other factors, as discussed above.

Lastly, I would comment briefly on my standpoint as researcher. As mentioned in Chapter 1 and in this chapter, I have worked with and known a number of NHS whistleblowers and unavoidably been greatly affected by their stories and experiences, particularly in leading me to engage in this study. Having since turned researcher it matters that this natural loyalty and admiration is acknowledged as a potential influence on this study and to the extent possible is counter-balanced in the design of this study, and how it is executed. I have at all times been mindful of my own inevitable bias and the core idea of the three groups of participants was deliberately to create distinct perspectives capable of balancing out the often very powerful stories of the whistleblower group.

The whistleblower stories have a strong element of “what happened next” (see Chapter 3) and so can hold the reader very effectively. By structuring the design in this way I have attempted to provide research settings for other relevant voices. I have also remained mindful of the need to provide, so far as possible, balance and impartiality when interpreting and selecting data and to write in

measured terms even when some stories may compel a more emotional response. I have sought throughout to guard against bias and to reflect on my judgements and decisions step by step.

5. Conclusion

Acknowledging the limitations, uncertainties and challenges of an empirical study, particularly an empirical study of conflict in complex NHS whistleblowing settings, I have sought to design this study so far as possible to capture what actually happens as the participants experience the whistleblowing conflict and tell it through their stories. In the broadest sense the structure provides a context which is reflective of a conflict-related dialogue with opposing voices moderated by third party voices, so that is perhaps another sense in which the group narratives interact with one another. The NHS workplace I suggest presents a challenge, partly in accessing current staff, but also because of how some whistleblowers are treated; getting the best data you can I suggest is therefore naturally a challenge, but one which is recognised in the literature, where research is seen as "a trade-off between relevance and rigour [as] nowhere is this truer than in research on whistleblowing". [496]

Approaching and understanding the participant perspectives as stories is intended to elicit individual emotional and psychological experiences, and therefore individual realities, which will inform our thinking about NHS whistleblowing conflict. Grouping these stories is

[496] See *Whistle-Blowing in Organizations,* at p.31.

intended to generate a broader narrative perspective in which individual perspectives are juxtaposed within the group. Juxtaposing the group narratives is a way of hearing them all, as it were, in the same room - including the unaligned group of third parties - the psychoanalyst, the mediator, the regulator, the lawyer and the officer from the National Guardian's Office.

For this researcher, a qualitative approach based on empirical data, designed to reveal a balance of views from those who have witnessed or experienced whistleblowing conflict and how their stories might signpost ways to resolution is in many respects an appropriate design to respond to the research question of this study. As whistleblowing researchers have put it, "the use of qualitative methods….will remain especially important" and the most valuable research of all will be the applied empirical work undertaken "at the 'coalface' of organisational life". [497]

[497] See 'Strategic Issues in whistleblowing research' at pp.528/9.

Chapter 5

The Whistleblower Story

1. Introduction

This chapter is the first of the three chapters setting out the stories told by the participants, group by group. In this chapter I tell the story of the whistleblower group. Chapter 6 tells the story of the NHS group and Chapter 7, the story of the third party group. These three chapters (5, 6 and 7) all follow substantially the same structure, beginning with a brief introduction: the second section of each chapter contains a brief profile of each participant and the story told by that participant in their interview. The third section of each chapter discusses what we learn from the participants and their stories about whistleblowing conflict and the final section provides a brief conclusion; Chapter 6 includes an additional section which presents and discusses the FOI Data. The discussion section of each chapter is structured by reference to the conclusions in Chapters 2 and 3 above, and also analyses the narrative of the group as a whole. The findings and conclusions from the three chapters are brought together in Chapter 8.

2. The Participants, their Profiles and their Stories

Each section below relates to an individual participant and in each case I specify the date on which the interview took place. Each

section begins with a short profile of the participant and then provides an account of the participant's story as he or she told it. I quote the participant verbatim on occasions to provide an authentic sense of voice, so that so far as possible stories are heard in the way they were told. All information about the participant and her story contained in this section is derived from the interview with the participant, not from any other source.

The primary purpose of this section is to set out the data obtained about the participant and their story, to impart their perspectives and perceptions, and to give a sense of their voice and who they are. I do not intend to comment on or discuss the stories in any detail in this section: the participants and their stories are analysed in section 3 below (within the structure mentioned above relating to whistleblowing conflict).

2.1 Terry

The interview with Terry took place on 30 September 2019.

Terry was a registered nurse of many years experience who worked in a senior role at a medical centre. She raised concerns related to the competence of a colleague. She suffered severe retaliation from managers and co-workers and was ultimately dismissed. Her health suffered severely. She was eventually able to bring legal action for dismissal and detriment.

Although Terry realised she was following the Trust's whistleblowing policy, she had no idea of the consequences of doing so. She

suffered severe detriment and eventually her health gave way; she said “the poison was just being meted out against me by my senior managers…..it was very toxic” and her line manager said to her “ ‘You’ve brought it on yourself’ ”. She was relocated to another unit against her wishes and she received death threats: on one occasion her teenage daughter took an anonymous phone call threatening to set fire to the family home. She added, “I was off sick now with depression and prescribed anti-anxiety medication and antidepressants…I just lost time for about six weeks”. Quoting her daughter, Terry said: “ ‘I’d go to college and I’d come back and you were still in bed, you were in bed when I left you, you were in bed when I came home, everywhere was dark, you wouldn’t eat’ ”. Out of the blue, Terry discovered she had legal expenses cover (as part of her household insurance) which funded PIDA claims. The Trust made a written offer of a “mass mediation” to reconcile relations with colleagues but as Terry was dismissed the mediation did not take place.

Terry’s case followed a typical NHS whistleblowing narrative pattern in that her act of whistleblowing had a significant effect on those around her, divided option in the workplace, resulted in severe retaliation against her and ended in her dismissal. As for wrongdoing, the colleague left the workplace immediately, but Terry never knew whether treatment of patients by the colleague was ever investigated. An investigation into Terry’s whistleblowing by the Trust found that Terry’s actions amounted to whistleblowing but Terry found out much later that the Trust investigator was later punished for drawing a conclusion seen as disloyal to the Trust.

2.2 Hilary

I interviewed Hilary twice: on 9 September 2019 and 12 November 2019.

Hilary was a consultant who raised concerns relating to unsafe practices at a medical centre (the Centre). [498] After raising her concerns, which were repeatedly ignored by managers, Hilary says she was subjected to spurious claims portraying her as a trouble-maker and was subsequently bullied and ostracised by colleagues. Hilary was signed off with work-related stress; she came under significant pressure from her employer who retaliated against her by treating her with hostility, and placing her on special leave, thereby removing her from her workplace. [499] The special leave lasted for an extended period, during which her health and well-being suffered. During this period, a patient incident occurred at the Centre which made her whistleblowing concerns appear very prescient. Further, Hilary said, it was clear to her that certain managers, senior leadership, and workplace colleagues were involved in the retaliation against her. Her employer continued to retaliate against her over this period, and sought to end her employment on the basis that she entered into a non-disclosure agreement ("NDA") about her whistleblowing, which Hilary consistently refused to do. Eventually, after the extended period of special leave, it was possible for Hilary to return to work. [500]

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[498] Hilary did not realise she was a whistleblower until long after her initial disclosures.

[499] Special leave is in effect a form of suspension.

[500] As discussed in Chapter 1, I suggest it is more typical for retaliation to lead to resignation or dismissal, so it is relatively unusual for a whistleblower to return to work - other examples are given by Frank, below. However, I cannot comment further, or in detail, about the wider circumstances of the case, for reasons of anonymity.

Unusually in NHS settings, during the period of special leave Hilary attended a number of mediation sessions ostensibly to facilitate her return to work. Although initially she was optimistic about the prospect of returning to work, Hilary described these sessions as difficult, and in one case, traumatic. She describes being bullied by colleagues in one session, and threatened with a formal complaint; she also felt unprotected by the mediator, who she described as "quite weak". In a later session, facilitated by an experienced external mediator, a colleague who had bullied her read out a statement which was "very negative and…hard to listen to…as though I had brought the whole thing on myself" [because of her whistleblowing]. Hilary saw it very differently: [the colleague] "did not like me exposing the truth about what happened". Again she felt vulnerable, saying she expected "more challenge" from the mediator towards the colleague's aggression towards her.

Hilary also tells a story of a further mediation session, to address what appears to be the legacy of whistleblowing in cases where the whistleblower remains in, or returns to, the workplace. [501] Having returned to work, Hilary continued to be victimised by colleagues apparently because of her whistleblowing. [502] A further mediation session was therefore arranged - apparently in the nature of "peace talks" (as another participant put it) - to mediate the difficult working relationships that were affecting the whole team. [503] Hilary and her whistleblowing story, and its emotional and relational consequences, she said, were a significant focus for the mediation. Although the

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[501] The theme of the emotional legacy of whistleblowing is also mentioned below by another participant (Frank).

[502] From the descriptions Hilary provided it appears there was visible personal animosity directed towards her.

[503] Paul refers to "peace talks" in his story, below.

mediation was “in some ways better than I expected” she felt there was too much pressure to “come to some sort of agreement” and that the outcome was not in her “best interests”.

Hilary experienced mediation as a controlling mechanism exercised by the employer, in order to manage the whistleblower and effectively therefore the conflict. She says of mediation: “It’s about managing people, controlling people to keep them quiet and you feel like you’ve got to cooperate”. Similarly, she sees it as open to manipulation because of its confidential nature: “what goes on behind that cloak or that veil of mediation actually isn’t a genuine process”. [504]

Hilary also describes mediation as a site for telling and listening to stories, and for “being able to understand the other perspective”: “obviously, if I’m excluded, the narrative [told by others] can be a different narrative….the trouble-maker…impossible to work with” and managing such multiple complex perspectives can be challenging for the mediator. Ultimately, she says, understanding whistleblowing is about hearing the stories - “they need to listen to the stories” - and while mediation can be a site for doing that, it can also, for her, be a site in which whistleblowers are silenced and controlled.

Hilary’s case is also unusual in that, as the data below shows, any form of mediation or similar facilitated dialogue between an NHS whistleblower and her employer, regardless of circumstances, appears to be rare. As the data from her whistleblowing story shows, Hilary was determined to speak out in the interests of

[504] For example, she said it “stopped [her] from raising another grievance” against a colleague.

patients: she refused offers of a settlement payment/NDA for that explicit reason and continued to speak out notwithstanding the retaliation and pressures inflicted upon her by the Trust over an extended period. [505] This principle, of speaking up in the interests of patients, appears to inform Hilary's perspective both of her whistleblowing and her experience of mediation.

2.3 Howard

The interview with Howard took place on 12 September 2019.

Howard had responsibility for certain aspects of patient safety at an NHS Trust. He raised concerns about the administration of certain treatments for patients and also about staff shortages. He was subjected to detriment over a long period and ultimately dismissed. Howard brought legal proceedings, but the tribunal did not consider he had been dismissed as a result of whistleblowing. He felt that his treatment by his employer had undermined his entire career.

For Howard, his concerns for patients were serious and were subsequently recognised as such. [506] He appeared highly principled in relation to the whistleblowing, but was repeatedly undermined and sidelined by managers. He was distanced from Trust decision-making by a new management structure and had unqualified managers put in authority above him notwithstanding his responsibility for certain aspects of patient safety. He did not realise

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[505] She said "I knew the lessons….would not be learned unless people knew the full story……..because there was nobody who was standing up and telling the truth" [about the wrongdoing and her whistleblowing].

[506] The Care Quality Commission (the main health regulator in England - see Chapter 1) ("the CQC") wrote a highly critical report agreeing with his concerns.

he was a whistleblower until, long after raising his concerns, the president of his professional body alerted him to the possibility. [507] Howard was threatened with disciplinary action if he pursued his concerns. He was signed off with work-related stress caused by overwork and the detriment he was subjected to, and was then suspended and eventually dismissed. He was severely bullied during this period: he describes a key meeting as "a kangaroo court, it was the most horrible meeting I think I've ever been to in my life and it was a very, very unpleasant meeting, very unpleasant indeed". The manager "twisted everything I'd said". He received a letter in which the manager "threatened that if I continue to raise concerns there would be ramifications".

Howard described his experience as being "funnelled" towards the employment tribunal. Although he established that he had raised protected disclosures, and was unfairly dismissed, the judge did not accept that the disclosures were the primary reason for his dismissal. His story appears to follow a pattern typical for NHS whistleblowing whereby his disclosures of wrongdoing are followed by retaliation and eventually dismissal. [508]

Howard said that he believes that personal animosity against him by a senior manager who "had it in for me" played a part in the retaliation against him following his whistleblowing. [509] He recognises this personal animosity (I suggest a perception of injury)

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[507] "I became a whistleblower inadvertently, I was an accidental whistleblower. As far as I was concerned I was simply doing my job" and "didn't really understand the whole whistleblowing issue".

[508] See the *Freedom To Speak Up Report* generally and the discussion at Chapter 2 section 5.

[509] This followed a clash he had had with the relevant individual over a pay negotiation some years earlier: "I was utterly naive…some individuals in management had decided they wanted me out so their job was to get me out".

as “undoubtedly” relevant adding that “human factors are very, very real” in whistleblowing cases. [510] He describes his emotions at the end of our interview with disarming honesty: “If I’m honest this maybe doesn’t paint me in a very good light…but it [how he was treated] undermines my entire career and it goes back to when I was at school, studying hard for a qualification which is universally recognised as being arduous and whatever. It just devalues my entire career and I don’t want it to end that way. This is why the apology is important to me. I want an apology, I want an acknowledgement that I was right….that would mean a great deal”.

2.4 Joanne

The interview with Joanne took place on 20 September 2019.

Joanne was a senior executive at an NHS Trust. She received a serious and credible whistleblowing report from a consultant which she, in turn, raised with the Trust CEO. She said that she was immediately demoted and systematically and severely bullied by an interim director newly appointed as her direct line manager. Her health deteriorated over time as she was repeatedly victimised. It is hard to overstate: the initial response from the CEO was to swear at her and question her loyalty to the hospital, “I am the ******* [Hospital Name] you stupid bitch”; she was relentlessly bullied by the interim director; she was ostracised, walking through the hospital she felt “like an absolute leper…they suddenly can’t even look at me…its as if I’ve committed a crime…this is absolutely

[510] Howard was initially reluctant to mention this factor. He says: “I was unsure as to whether to not bring in the pay dispute because that can muddy the waters” the implication being that if personal animosity is a factor in how he was treated, it would undermine his whistleblowing claim.

horrific". At one point she is locked in a windowless office for an entire day (an account which the Trust disputed).

She became extremely unwell and unable to work, and was ultimately dismissed. She eventually suffered a serious breakdown which manifested in "dissociative episodes" where she had periods of memory loss. On one occasion "a lady found me in the snow in my pyjamas down in the street"; on another she unconsciously drove her car onto tramlines and "they had to shut the tram system down for four hours while they cut my car off the tramlines"; she had no memory of that episode and "can still only talk about it from the police report". Her attempts to bring legal claims were compromised by a personal commitment she had made privately not to disclose information relating to the original whistleblowing report made to her, potentially hampering her ability to make PIDA claims because to do so would have required her to provide evidence of her disclosures.

The circumstances of Joanne's case are unusual, although the pattern of retaliation and dismissal are not. She both received a whistleblowing report and was herself a whistleblower, neither of which she appeared to understand at the time, only realising fourteen months later that she was a whistleblower. The concerns raised appeared very serious but have never been made public. [511]

Joanne privately undertook not to disclose certain information which appears to have compromised her possible PIDA claims for detriment and dismissal. She was offered a financial settlement contingent on signing an NDA, but refused. Mediation was never

[511] The wrongdoing itself is not in the public domain and I have agreed not to include any details of that story in this study.

suggested. Although Joanne sought other legal recourse she was unable to bring PIDA claims for the reason given.

2.5 Frank

I interviewed Frank on 10 September 2019.

Frank is a retired senior union official with over 25 years experience at 8 different unions including substantial experience of NHS whistleblowing.

Frank told three NHS whistleblowing stories during our interview in which he had personal involvement, either supporting or representing whistleblowers. Two cases concerned the effect of cuts on staffing levels, one in an outpatient setting, the other in an acute hospital. Both whistleblowers were severely bullied according to Frank; in one case managers repeatedly victimised the whistleblower and in the other the whistleblower became seriously ill because of the bullying. The third case concerned a clinical researcher who raised concerns about bullying and racism that were jeopardising diagnosis of cancer specimens. Again, retaliation followed and the whistleblower's career was substantially compromised.

Frank highlighted the phenomenon of the long term legacy of whistleblowing amongst managers and co-workers affected by the whistleblowing vis-a-vis the whistleblower. The legacy may express itself as "low-level" bullying which may be hard to discern and difficult to stop. In one case, for example, managers and co-

workers continued to victimise and bully the whistleblower for some years after the incident, eventually forcing her into early retirement. [512]

Frank can see a role for mediation where both parties want to settle although generally this means dealing with the termination of the whistleblower's employment, not solutions related to the wrongdoing. He adds: "I'm not against mediation but I've rarely seen it work well…whether it works well or not depends on the circumstances by which it comes about…do both sides actually want to settle?"

2.6 Geraldine

The interview with Geraldine occurred on 25 October 2019.

Geraldine has very substantial experience supporting and representing whistleblowers and is deeply engaged with them as people. [513] Her data revealed particularly the appalling personal harm inflicted on whistleblowers. She thought the "crushing" of whistleblowers was a by-product of the organisational response to whistleblowing rather than its main objective of defending its interests and that it was particularly important to hear organisational perspectives about whistleblowing. [514]

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[512] Frank says, of one case: "they never forgave her" and "that was a classic example…. a lot of it was the people who she had outmanoeuvred never forgave her and just kept going for her".

[513] Geraldine did not say what proportion of her cases were NHS but she was very conversant with NHS settings.

[514] This is one of the objectives of this study and part of its design - see Chapter 4.

Geraldine's story revealed extraordinary dedication and resilience in her commitment to supporting whistleblowers. She described her approach to whistleblowers as "tough love", or "critical friend" - prepared to have difficult conversations. As she sees it, whistleblowers can become obsessed with their own cases and in her view need to be pushed to move beyond their experiences. [515] The most common complaint from whistleblowers, she says, is that they are "not listened to" and in her view they should be "more measured" in telling their stories. [516]

However, she also describes some appalling personal suffering of whistleblowers and has received calls from whistleblowers in the most desperate circumstances. The following are verbatim quotes from Geraldine which illustrate five extreme cases and tell a horrendous story of their own: first, "one person was so desperate and he was losing his house, he got on the roof and covered himself in petrol"; secondly, "I had another person who was walking down a motorway and the police phoned me to say 'the only number in their phone was this number. Are you a relative'?" Thirdly, "we had another lady who covered herself with [her own menstrual] blood"; fourthly, "we had another member of the NHS got herself in her car, took herself to a lonely place and tried to gas herself with the

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[515] She says: "everyone becomes self-obsessed…*its me, me, me* and I see that a lot in whistleblowing. I think that's the big failing…it's all about having your voice heard, having your point of view listened to". Contrast with Eileen Chubb who is a well-known activist when she says: "There is no ME in whistleblower" and that whistleblowing "is an act without self-interest…..and there should only be one interest involved and that is the public interest".

[516] For Alford, whistleblower stories are made up of half-truths, lies and cliches that people tell themselves in order to avoid confronting the harder truths that they otherwise have to face. He sees whistleblowers as not being honest about their stories, because if they were, they would have to accept that "above all..their sacrifice will not be redeemed" and "no-one will be saved by his suffering, not even himself." The organisation will not be improved and those who worked with the whistleblower will not become more moral by virtue of his example.

hosepipe". [517] Lastly, "somebody else took himself off to a lonely beachhead earlier this year".

These are sobering stories, yet Geraldine sees the harm inflicted on whistleblowers as incidental to the organisational response rather than its main objective and possibly driven by legal advisers: "I'm going to be more generous with employers. I don't think organisations set out to crush people, lawyers do". As she sees it organisations "set out to protect themselves because they have funding to lose". The stories we need to hear from organisations are the stories of wrongdoing, not the whistleblower: "to me the most important storytelling should be from an organisational perspective and how they relate to the whistleblowing, not the whistleblower"..."we have to move away from the whistleblower's story and we have to hear the story of the organisations". She uses an image of parties sitting together in the same room, the whistleblower and the manager, but seeing totally different perspectives of it: "Isn't this all about perceptions? Where you're sitting, you are looking and seeing 'this' but if I was drawing the room from the other side we'd both see something different. But we're both in the same room and we have to remember that". She sees mediation as having the potential to reveal these perspectives to the disputing parties.

Geraldine also believes in the potential of mediation for honest conversations. At the heart of the process are the "great conversations" that can come about when you "engage with the person" on a human level. She sees "a place for mediation as soon as something goes wrong" - calling it "early intervention mediation" -

[517] It should be noted that she refers here to multiple NHS cases.

and says this: “If you gave mediation a colour, I’d call it beige….but its not…actually I think mediation’s green…it’s an empowering word, its something that gives you authority”. This is a positive view of mediation, based I suggest on her belief in the power of straight talking and honest communication. While Geraldine is not speaking exclusively about NHS circumstances, the principle of early intervention has received support in the *Freedom To Speak Up Report* and the Patient’s First Submission (Early Intervention Scheme) for example. [518]

2.7 Paul

The interview with Paul occurred on 17 September 2019.

Paul is a claimant solicitor with substantial experience advising NHS whistleblowers. In his experience, NHS organisations respond to whistleblowers by repeatedly implementing a strategy designed to crush them. The strategy appears to escalate whistleblower conflict, while no action is taken by the NHS Trust to address the wrongdoing. Mediation is a rarity in his experience and financial settlements with whistleblowers require Treasury approval which is extremely difficult to obtain. Paul presented as pragmatic and realistic and says he would always advise NHS whistleblower clients to avoid litigation.

[518] See the *Freedom To Speak up Report* at p.135, recommending early stage internal mediation. See also the *Patients First Submission* Annex 6 - Early Intervention Scheme - although this scheme is orientated towards investigation and gives the whistleblower a significant role. To my knowledge it was not ever taken up or piloted within the NHS.

Paul claims that nothing material has changed in the NHS' treatment of whistleblowers over the last 10 years and sees an awareness among staff that speaking up is "just not a good idea". It is his view that the NHS response towards the whistleblower is framed so as to protect its reputation above all other considerations and that litigation should be avoided by the whistleblower at all costs.

Paul describes the steps of the NHS strategy in detail. [519] The whistleblower will be ostracised and subjected to detriments such as unsubstantiated false allegations apparently calculated to provoke conflict; the conflict and potential litigation can be part of the overall strategy. Paul has seen the NHS use this approach repeatedly: "After 10 to 12 years of NHS whistleblower litigation….this…is the pattern that plays out *again and again and again and again*".

Litigation is "all out war" and will cause emotional trauma so that some whistleblowers become unable to work. [520] Paul sees a ministerial-level perspective behind the strategy, namely that the average employment tribunal claimant is seen as "a chancer" and

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[519] Key elements include: questioning the whistleblower's performance and conduct (including false allegations of dishonest behaviour) as a pathway to performance management or disciplinary process followed by suspension ("which can last years"); repeated detriments executed against the whistleblower eg not paying excellence awards, conducting unfair appraisals, setting "hideously unfavourable" job plans; the continuing detriments make litigation very complicated and the value of any claim is not particularly substantial (as the whistleblower usually continues to be paid and is often only dismissed at the very end of the process) and is far outstripped by the legal costs; eventually the Trust will dismiss the whistleblower who will then need to make a dismissal claim. The complexity of the claims makes legal action extremely expensive and extremely difficult as a litigant in person. The pattern described is reflected in the experiences of Joanne, Howard and Terry above.

[520] He adds: "what very often happens is that whistleblowers start to develop disabilities through mental conditions which means that they can't work" which opens up Equality Act avenues ie disability claims rather than PIDA claims.

that a large proportion of claims are without merit: “people are trying it on”. [521]

Paul does not see mediation as a real-world alternative to litigation: he has hardly ever seen mediation in an NHS whistleblowing setting. [522] He has seen it used in “a kind of peace talks scenario” which can have a positive effect, but resolving NHS litigation by mediation is extremely unlikely. He describes the need for Treasury approval as “the biggest reason why mediation doesn’t happen”…. “that’s the reason why mediation doesn’t happen”. [523] He often now advises clients that forward-looking non-legal negotiation (but with legal advice in the background) may be their best option.

The execution of a strategy of retaliation speaks as a way of crushing the whistleblower, without a legal or policy basis for a lawful claim, but which provokes destructive litigation - one way or another the whistleblower cannot escape or “win” such that the outcome for the whistleblower appears almost pre-determined.

2.8 Esther

The interview with Esther took place on 21 November 2019.

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[521] In storytelling terms, there may be a number of narratives embedded in this account which are vying for dominance: the narrative of the genuine (even heroic) whistleblower fighting against enormous odds, the narrative of the disingenuous whistleblower with ulterior motives, the narrative of a destructive NHS careless about the well-being of staff who raise concerns, and the good news narrative of the heroic NHS defending itself against spurious claims.

[522] He adds: “I’m struggling to remember the last mediation I attended in an NHS whistleblowing context…it would have been 2012…which was a complete waste of time and I strongly suspect was set up purely to cost money”.

[523] When he broaches it with the Trust lawyers, they say: “we can have a mediation if you like but I’ll tell you now our offer is going to be ‘withdraw your claim and we won’t pursue you for costs’ ”.

Esther is a claimant solicitor with substantial experience advising NHS whistleblowers. [524] She shows empathy for her clients and told stories about the difficult circumstances arising every day in hospital settings. As Esther sees it, for mediation to have any purpose there must also be an investigation of the wrongdoing, pointing to an important connection between addressing the wrongdoing and addressing the whistleblower conflict. However, she adds that it is not appropriate to mediate the public interest - the wrongdoing - which, for her, should be a matter for investigation. For this reason, while she is positive about the human potential of mediation, in Esther's view it is not realistic to mediate whistleblowing conflict once it has developed into a legal dispute.

Esther gave illustrations of workplace conversations "going wrong" and leading to whistleblowing conflict. She has seen the NHS use a strategy against NHS whistleblowers, but sees it as driven mainly by NHS legal advisers. In her experience, in the vast majority of cases whistleblowers will leave their employment, effectively forced out, by one means or another. As a wider point she sees that the priority for the NHS is to defend its reputation and that consideration will override others in conflict scenarios.

Esther draws the distinction between the wrongdoing dimension and the whistleblower dimension of conflict when she says that for mediation to work the parties must engage in good faith, and the mediation must address the whistleblower/employment conflict (not the wrongdoing) but for the mediation to succeed the wrongdoing must have been properly investigated. Mediating the relationship is,

[524] For clarity, Paul and Esther practise at different law firms.

she says, contingent on some action connected with the wrongdoing. Esther saw investigation of the wrongdoing as the appropriate approach on the basis that you cannot mediate a patient-safety issue: "you can't jump to mediation to resolve that [she gave an example of major financial fraud in the NHS] because it's a very serious allegation" adding "to be honest I think that can only really work if you address the issue. How do you mediate a patient safety issue? It's surely black and white?". Only in the light of an evaluation of the wrongdoing acceptable to the parties, she says, can a mediation of the whistleblower-manager/Trust relationship make sense.

Esther is pro-mediation within her claimant practice generally and describes it primarily as a means of addressing relationships which have broken down. [525] She sounds a note of caution, however, as once a relationship has been damaged there is a fair chance it will not recover, she says. [526] Further, she says, mediation should be seen as positive and offers an alternative to litigation in workplace disputes particularly where the parties are genuine in maintaining an ongoing employment relationship. [527]

Esther has seen mediation used tactically in whistleblowing settings, to close down or silence concerns about a surgeon whose practices

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[525] "I'm a great believer in alternative dispute resolution across my practice because the reality of the situation is that quite a high percentage of people that come to me, the relationship's broken down".

[526] "We've got to be realistic, if the relationship has broken down you can't Sellotape over it because the Sellotape will come off in six months".

[527] "It will only work if both parties really want to engage openly and transparently". The dyadic dispute where there is an ongoing relationship follows the classic formulation of mediation by Lon Fuller. See 'Mediation Its Forms and Functions', [1971] Southern California Law Review 305.

were distressing nursing staff, for instance. [528] Mediation also has it limitations: in another example a formal internal team mediation was undertaken with multiple parties and an external mediator, but was soon (in Esther's words) "completely forgotten about" by the parties (apparently not adhering to any agreement reached), meaning that a claim became inevitable within 12 months. [529] Furthermore, mediation is not seen as a realistic alternative for settling PIDA claims, describing mediated settlements as unrealistic owing to the unwillingness of Trusts to accept culpability for wrongdoing. [530] Esther describes this as a barrier to the use of mediation for settling PIDA claims, along with the need for Treasury approval. [531]

2.9 Nicole

The interview with Nicole took place on 3 March 2020.

Nicole is an employment law barrister and accredited mediator with significant NHS experience who advised me that in addition to usual practice (whereby a barrister is instructed through a solicitor) she practises under a direct access model whereby members of the

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[528] "They didn't undertake a proper grievance process……they wanted to shut it down and this is how they dealt with it, we'll have a little mediation." Hilary's data (above) revealed similar perceptions as to how mediation was used in this way.

[529] Her client was "put through a workplace mediation where there were lots of people involved….it was a qualified mediator…a mediation agreement…they all signed up but literally two months later it was just completely forgotten about….put to one side..and about a year later we had to bring a claim."

[530] "I think mediating whistleblowing legal disputes is unrealistic".

[531] "The Trust will have creative ways in which they'll go about that if they just need to get it settled, but they say they can't….. 'We have to get Treasury approval and we just won't get it' ".

public can instruct her directly in appropriate cases. [532] In her current practice Nicole typically represents whistleblowers in the banking sector. In stark contrast to NHS cases, in the banking sector almost all of her cases settle at mediation. [533]

Nicole is a strong believer in the potential of mediation for connecting the disputing parties at a human, emotional, level. [534] She describes her impression of NHS organisations (having advised some) as "a wobbly nebulous kind of monster" and as "bureaucratically heavy, it's not nimble…it's just this sort of lumbering, lumbering giant…you've got a lack of continuity of personnel…whether its the consultants, the nurses, the lawyers, the admin staff". She sees dysfunctional teams and departments within NHS workplaces which can complicate whistleblowing claims by suggesting multiple alternative reasons for retaliation against the whistleblower unrelated to the whistleblower's disclosures; this may include personal animosity between the whistleblower and colleagues which she describes as a "really common explanation [by the NHS] for the treatment of whistleblowers". [535]

Claims can also "take flight" very suddenly out of nowhere in dysfunctional team settings, which she sees as particular to the

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[532] This is specifically confirmed by her personal profile on her chambers website (accessed on 6 December 2022).

[533] Typically mediations take place "post-discovery" where she has identified the key components of the legal argument eg evidence of causation between protected disclosures and the detriment or dismissal ie at the point at which the employer has realised there is a problem. She describes herself as "a huge fan" of mediation.

[534] "A really skilful mediator will unlock the human potential of the discussion"….. "where you've got people talking to people, making eye contact, people listening, it's so powerful."

[535] She sees "dysfunctionality….consultant in-fighting….factionalism and interpersonal difficulties within departments." Further, "factionalism was actually quite difficult to penetrate in terms of deconstructing the alternative reason for either the dismissal or the detriment".

NHS. [536] Also, she says "something is wrong within the employment practices of the NHS"……."these sort of unwieldy HR disputes that become bigger than they should be, then suffer from not having people around the table looking at each other eye to eye".

Nicole found mediation to be very effective in settling her whistleblowing cases in the banking sector and saw it as having the potential for settling PIDA claims in NHS cases. In banking cases, she says, usual practice would be for the bank to make a settlement payment to the whistleblower and the whistleblower would sign an NDA, but in a form which enabled the whistleblower to pursue the whistleblowing in the future, for example with regulators. [537] Nicole was unaware of the need for Treasury approval for settlement payments in NHS cases but did not see a reason in principle why the NHS might not follow usual practice in the banking sector in relation to the use of NDAs. [538]

2.10 Alan

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[536] One consultant's act of whistleblowing made the factionalism "even more acute" and "as the dysfunction increases…all of a sudden this 'thing', the 'alternative reason' takes off, it takes flight, and that's something I think is quite particular to the NHS".

[537] In the banking sector although an NDA (with a financial payment) would be signed as part of the settlement the NDA would be explicit that the employee was not prohibited from making protected disclosures relevant to the wrongdoing and could continue to pursue the public interest matter with regulators or through the courts. In this regard, s.43J of ERA provides that any agreement that would prevent the making of protected disclosures is void. In these circumstances the bank presumably has a degree of confidence that it can defend the whistleblower's allegations with regulators and has weighed the risks carefully.

[538] As I discuss below, neither of these possibilities appear feasible in NHS cases: settlement payments have to be justified to the Treasury and in practice the NHS will litigate the case rather than sign a settlement which would leave a whistleblower free to pursue her whistleblowing externally. Signing NDAs has been against NHS policy since at least 2013. See Nick Kituno and Hayley Kirton, 'Trusts spending £1m+ a year on settlement deals with gagging clauses despite a crackdown on these conditions in recent years' Health Service Journal Online 1 November 2021 accessible at https://www.hsj.co.uk.

The interview with Alan took place on 27 February 2020.

Alan is an employment law barrister who represents both defendant NHS Trusts and claimant whistleblowers. [539] In his experience NHS whistleblowing cases almost always end in an employment tribunal hearing because Treasury approval is required for an NHS Trust to agree a financial settlement with a whistleblower and obtaining Treasury consent is extremely difficult. [540] He describes obtaining Treasury approval as "a huge problem" and the main reason that settlement mediation does not take place. Generally, in his wider employment practice, Alan believes mediation has the potential to create human connections within conflict but has never seen mediation used in an NHS whistleblowing case.

Alan represents NHS Trusts as well as whistleblowers and so has experience from both perspectives. He describes NHS workplace culture as "brittle" and cites poor management and bullying of NHS staff as commonplace; conflict can erupt suddenly and unexpectedly. Personal animosity between colleagues is common: "you just see huge fallings out…the development of cliques….a department of a dozen nurses and suddenly four of them won't talk to the others". Once a legal claim has been started by a whistleblower, the NHS response is to deny and defend claims vigorously. Treasury approval for financial settlements is a significant barrier to reaching a compromise as it is rarely obtained (according

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[539] Note that Alan acts for NHS Trusts in a proportion of cases and as mentioned in Chapter 4 his views should be seen as equally applicable to the NHS Story. Alan practises in a set of barristers chambers which encourages broad-based practices for its barristers.

[540] By contrast, his non-NHS cases invariably settle: "I won't even see the papers".

to Alan). Once a trial date is set for an NHS whistleblowing case, in Alan's experience it invariably goes ahead.

He believes in the potential of mediation and sees it as a "semi-psycho-therapeutic" process: "my approach to mediation is based on the belief that all disputes are really about interactions between human beings and interactions by human beings are always clouded by people's interaction with themselves". In his view, also, "disputes are often a proxy for a lot of other things…building up in them since they were bullied in the playground". [541] He does not see the need to address the wrongdoing as a pre-condition to mediation.

2.11 Jacob [542]

I interviewed Jacob (by telephone) on 10 March 2020.

Jacob is an employment law barrister who represents NHS Trusts in some cases and NHS whistleblowers in others. He sees widespread misunderstandings of whistleblowing saying it can be perceived as "a dirty word". Some whistleblowers adopt "martyr status" and some are "still living their claims" or "a little bit like war wounded". He sees independent investigation of wrongdoing as "a step that's missing" in the whistleblowing process: "I think the reason why the disputes blow up in the first place is because there's never really been a good investigation…[the whistleblower] is just being fobbed off all the time….you can see why they think they're not being listened to". In his experience whistleblowers need to know their

[541] This view, that conflict is borne out of historic or unresolved emotions or experiences is discussed further below.

[542] Note that, as with Alan, Jacob also acts for NHS Trusts in a proportion of cases and as mentioned in Chapter 4 his views should also be seen as equally applicable to the NHS Story.

concerns about the wrongdoing have been impartially investigated before they can make emotional and psychological progress, or consider resolving the whistleblower conflict.

He identifies poor communication and subjective interactions between co-workers as a factor in some cases; he also identifies the divide between clinicians and managers as a cause of conflict in NHS whistleblowing. How a case is handled once a concern has been raised can be as influential to its trajectory and outcome as the seriousness of the wrongdoing itself. He advocates improved early investigation and good communication as important factors in case-handling. Jacob also cites an example of a senior clinician who withdrew his concern following an investigation of the wrongdoing by an external barrister. Investigating and feeding back to the whistleblower about the wrongdoing appeared to diffuse the potential for whistleblowing conflict.

He sees mediation as a route to investigation: “if you had a mediation, I think one of the outcomes often could and should be someone to say, ‘well, look, this hasn’t really been investigated, let’s get someone to do it’ ”. The failure to investigate or discuss the wrongdoing may not only inhibit resolution of the whistleblower conflict but may also exacerbate it by harming the whistleblower.

3. Discussion

The discussion in this section is structured by reference to the questions and conclusions in Chapters 2 and 3. To recap, these are: (1) do the group stories show that whistleblowing is perceived as an

injurious experience and, if so, why; (2) should stories of the wrongdoing be taken into account when considering the whistleblowing conflict; and (3) should stories of retaliation against the whistleblower be seen as an expression of grievance by the NHS organisation? I will also discuss the group narrative as a whole and comment as to what the group stories and narrative, looked at in these ways, have told us about whistleblowing conflict and its resolution.

3.1 The perception of an injurious experience caused by the act of whistleblowing

Whether an individual perceives an injurious experience is highly subjective and contingent on many factors, according to the Felstiner Model. One of these factors will be the circumstances giving rise to the injurious experience. The whistleblower stories suggest the range of different circumstances that might apply. The perception of an injurious experience can only be inferred by another (that is, the whistleblower, who is not the injured party) from what they witness of the actions of others. In a whistleblowing setting, the whistleblower will speak up and will then witness the response of those in the workplace to the whistleblowing, which may be what she expected, or it may not. [543]

For some, the whistleblowing may not be perceived as injurious and the response may be supportive. Others may perceive the whistleblowing as injurious but take no action, in which case the whistleblower may be unaware of how the whistleblowing has been

[543] In all four whistleblower stories (Hilary, Joanne, Howard and Terry) the response of retaliation came as a shock to the whistleblower. Three of the four did not realise they were whistleblowers and appeared to believe in good faith that their concerns would be addressed at some stage.

perceived. However, we know that in some cases (including in the stories told by the four whistleblower participants) the response to the whistleblowing may include hostility and retaliation directed at the whistleblower inferring the perception of injury. An inference is that the injured party is blaming the whistleblower for the perceived injury and decided to voice this to the whistleblower. The injurious experience must be perceived by an individual. So in any given case there must be an individual who can exercise the capacity of the organisation to effect retaliation; this is a feature of the whistleblower stories in the group. [544] In this sense I suggest, the whistleblower is telling a story of her experience in which she is looking backwards at the effect on others of her whistleblowing only after she has begun to experience retaliation. Only at this stage, it seems to me, can the whistleblower know that the whistleblowing is perceived by those around her as injurious.

This suggests that the whistleblower perceives the response to her whistleblowing through a mix of signals from colleagues, some of whom see the whistleblowing very differently from how the whistleblower describes it in her story. It appears that those who retaliate have reached the stage (in the Felstiner Model) of blaming, or voicing a claim, against, the whistleblower, sufficiently convinced of their grievance to act upon it. If this includes recipients with capacity to direct the actions of the organisation, it suggests the trajectory of the organisational response is established at an early stage of the whistleblowing process and may be difficult to influence thereafter.

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[544] In all four whistleblower stories the whistleblower identifies one or more specific individuals who appear responsible for the retaliation against them. These are: for Hilary, a manager and a colleague; for Terry - two senior individuals; for Howard, a senior manager; and for Joanne the CEO of the Trust.

In this narrative group, stories are told from the perspectives of the whistleblowers and their allies, not from the perspective of those who might perceive injury. The key stories are those of the whistleblowers themselves, each of which raises different questions about who perceives an experience of injury and why. In Hilary's case she identified several individuals who she believed were implicated in retaliation against her. Hilary suffered multiple forms of retaliation after her whistleblowing from these individuals inferring that despite their different roles each took steps to harm or damage her or her employment position.

The facts surrounding the other three whistleblower stories were different in each case but each story identified individuals who appeared to take identifiable steps to inflict detriment on the whistleblower.

In Howard's case he was seriously bullied and eventually dismissed by a senior manager, but other individuals, as he saw it, also took steps against him (an under-qualified senior nurse re-wrote Howard's report and circulated it without his knowledge, another staff member falsely alleged that he had doctored minutes of a meeting). For Joanne, the CEO of the Trust immediately demoted her and made this known within the Trust. Thereafter she was systematically humiliated and bullied over a fourteen-month period by a new HR director installed as her new line manager.

Terry's whistleblowing was divisive - "very toxic" in her words - within her workplace. She suffered retaliation that was both organisational (she was relocated to another unit elsewhere) and personal (she was vilified at work by colleagues and received what

amounted to a death threat). Her whistleblowing was a threat to the organisation and upset colleagues (the relevant colleague was popular). The retaliation was inflicted both organisationally, therefore, and by colleagues personally.

In all of these cases, while many factors are at play, there appears to be a strong inference from their actions that managers and colleagues perceived injury following the act of whistleblowing. The inference is drawn by construing the retaliation as a response to the act of whistleblowing, but the reaction may be caused by other factors (such as personal animosity). [545] Retaliation is expressed through organisational action and/or personal action, implying that perceptions of injury are experienced both by those able to exercise the capacity of the organisation, with the organisation's resources available to them, and by other colleagues who retaliate in their personal capacity. The latter group, witnessing the organisational retaliation, may conclude that they are unlikely to face disciplinary action because the retaliation is apparently official. [546]

The reason why this matters is that although the perception of injury (and other stages of transformation described in the Felstiner Model) are invisible personal and subjective experiences, contextualised by the social, cultural and other factors described by the model, the grievance that appears to express itself in the form of retaliation has real-world consequences for the whistleblower. Although the inference that injury has been perceived (and acted upon) by individuals seems to be substantiated by the whistleblower stories,

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[545] This is discussed further below.

[546] Evidence to the Freedom To Speak Up Review shows that managers are rarely held to account - see paragraph 3.2.28, there are "no sanctions for the mis-use of power" by managers.

those stories do not show us exactly what has caused the perception. The studies considered in Chapter 2 provide some context, suggesting that actions which violate norms or threaten reputation will be punished but obviously these are very generalised principles as yet unsupported by story data. The stories tend to suggest that retaliation on behalf of the Trust is more serious than that of colleagues in that the Trust has capacity to take very real steps to diminish the whistleblower's role (this was so for Terry and Howard).

Lastly, Frank describes the long term after-effects in the workplace resulting from whistleblowing in circumstances where the whistleblower remains in the workplace. Notwithstanding that the whistleblowing conflict is no longer active in a formal sense, there can be a continual (if low-level) bullying of the whistleblower by managers and co-workers which can last months or years beyond the whistleblowing - this also affected Hilary.

This phenomenon was not common within the group narrative perhaps because NHS whistleblowers are not usually returned to the workplace, but where they do, it points to the possibility of an ongoing legacy of unresolved interpersonal conflict or personal animosity which could endanger patient safety. It shows perhaps the depth of the perception of injury felt by colleagues and the entrenched emotions of grievance which are slow to dissipate (or perhaps never dissipate).

3.2 Stories of wrongdoing

The stories told by the whistleblowers, although they are also much more, are essentially stories of the wrongdoing. The four whistleblower stories frame the narrative of the whole group and arguably the narrative accounts of the NHS and Third Party group too. To a greater or lesser extent, all the narrative interviews obtained for this study relate back to the whistleblower stories and take meaning from them by responding to them: for example, retaliation against the whistleblower has meaning because it is apparently an adverse reaction against an ostensibly ethical act by the whistleblower and without it being a response to the whistleblowing it would have a different meaning. This is a response to the whistleblowing narrative in the sense that the wrongdoing is an inherent part of the story and without it, the narrative about retaliation would be a different narrative. To begin, I will comment on the whistleblower's stories as stories, including their narrative structure.

(a) Narrative structure

The four first-hand whistleblower accounts contain elements in common which create a recognisably similar narrative shape or structure. All are first-hand accounts of personal experience and, in that sense, adopt the point of view of the narrative whistleblower persona, although their stories vary in many respects. Common elements include: an account of the whistleblower herself, her professional role and background; the wrongdoing, how it arose, her deliberations about what to do, her decision to speak out and the process of doing so. Also, the response of the organisation, the consequences for the whistleblower, the retaliation from managers and colleagues; then, over time, her dismissal, followed by the

experience of legal proceedings and their outcome - these are also part of the narrative structure. [547] The whistleblower stories are presented as stories of what actually happened, from the storyteller's perspective, and are therefore presented as a truthful record of events in accordance with storytelling theory.

The stories, at the same time, each contain their own fabric of circumstantial detail and are told in a different style, language, tone and at varying pace and emotional intensity. As well as following a recognisable shape, these stories also contain some unpredictable events which, to an outsider, can seem serendipitous but highly influential in how the narrative develops. These events sometimes apparently have little to do with the merit of the wrongdoing or the agency of the whistleblower. [548]

At an early stage, the whistleblower establishes the significance of the wrongdoing and how it could harm patients, presenting the data as plausible and clear cut. In two of the four stories, the whistleblower proposed solutions at the same time as raising concerns, showing the whistleblower to be constructive and collaborative. I suggest that explaining the wrongdoing in this way provides justification or support for the decision to blow the whistle, particularly in contra-distinction to the retaliation that follows. This helps to portray the whistleblower as ethical and rational and positions the retaliation as unjustified, unfair and irrational.

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[548] One example is the discovery by Terry that she had substantial legal expenses cover on her house insurance that enabled her to fight both a detriment claim and a dismissal claim.

At the beginning of the story, the whistleblower usually describes or references the whistleblower's professional role, responsibilities and years of experience. The whistleblower, I suggest, positions herself as a thoughtful and professional practitioner whose first priority is the well-being of patients. These introductory comments tend to validate her decision to speak up professionally and ethically - she is an experienced practitioner and has not acted thoughtlessly or rashly. In this way, the whistleblower establishes her credentials as a reliable storyteller, her good faith and truthfulness, perhaps thereby pre-empting opposing narratives of managers and colleagues. As Alford sees it, the whistleblower is both the storyteller and the one the story is about. [549]

Three of the four whistleblowers told me that they did not know they were whistleblowers until months after raising their concerns. The fourth (Terry) knew she was raising a concern under the whistleblowing policy but had no understanding of what that meant, or its potential consequences for her. This claim (of not knowing you were a whistleblower) may seem naive perhaps, but it is not uncommon for whistleblowers not to appreciate their legal status as whistleblowers. [550] The claim has a role in the story, however, as it reinforces the sense of the good faith of the whistleblower and locates her as a victim, not an instigator, of the conflict. [551] For her,

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[549] See *Whistleblowers, Broken Lives and Organisational Power* at p.65. Alford sees the whistleblower as having more than one voice: the voice of the storyteller and the voice of the character in the story.

[550] From my experience collating whistleblower accounts for the Patients First Submission it was very common to hear this. Many NHS workers who raised a concern in everyday circumstances would not understand they may be whistleblowing. Even in more serious circumstances such as these four cases it is not as surprising as it first seems.

[551] Susan Douglas and Sara Cobb explain that participants in mediation tell stories in which they are positioned as the victims of the actions of the counter-party and it is the counter-party who must change, not the storyteller. See Susan Douglas, 'Differing Models of Mediation' at p.36. Also, see Sara Cobb, 'Creating Sacred Space' at p.1022.

the retaliation has been unfairly visited upon her, and does not result from the whistleblowing (although we know that under the Felstiner Model individuals at the Trust may perceive injury).

The narrative structure of the whistleblower stories, for me, legitimises the wrongdoing, in that the credibility of the wrongdoing is underpinned by the credibility of the whistleblower disclosed through these stories. It also calls into question the retaliatory response of the organisation and pre-empts the narratives of under-performance, of the difficult employee, or the trouble-maker, which can be strategically used against whistleblowers. [552] The real-world significance of the wrongdoing is inevitably a matter of perspective: patients may very well have been harmed or prejudiced in the real world, but the whistleblower stories do not usually make that clear, as seen with the stories heard here.

What the stories do establish however, is the connection between the whistleblower and the wrongdoing - that the whistleblower has suffered because she raised the wrongdoing and is thereby emotionally invested in it. I suggest that what the stories tell us is not so much that the wrongdoing matters in an objective sense (although it seems very plain that it does) but that it matters very much to the whistleblower - as I will explore further below.

(b) The nexus between the wrongdoing and the whistleblower

The connection, or nexus, between the wrongdoing and the whistleblower can be seen as an emotional and psychological reality for the whistleblower. Although I suggest this can be supported by

[552] See *Whistleblowers, Broken Lives and Organisational Power* at p.32. Also, the story told by Paul about the NHS' strategic approach to the conflict.

story theory in the sense that as human beings we construct stories to give meaning to our lives (see Chapter 3 above for further discussion), it is particularly so for whistleblowers because they have suffered due to disclosing the wrongdoing and therefore cannot, for many emotional and psychological reasons, now say the wrongdoing does not matter.

Two participants, Esther and Jacob, are explicit about this nexus, both in the context of dispute resolution. Esther sees addressing the wrongdoing (by some neutral investigation or evaluation) as a necessary precondition to mediation between whistleblower and organisation. She sees this as an essentially objective process, because dealing with patient safety should be "black and white" (although, as discussed in Chapter 2, whistleblowing researchers see wrongdoing as highly subjective). I suggest that wrongdoing should be seen as subjective, even within hospital settings, notwithstanding that wrongdoing in such settings is likely to be highly fact-specific. Although there is rightly a view that wrongdoing should be objectively investigated, the wrongdoing, responses to it, and investigations of it are all human actions and interactions. [553] In that sense, in the context of the conflict, understanding the perspectives of the wrongdoing and why (if that were the case) a whistleblower was mistaken in what she thought, will matter as much to the relationships and reconciliation of the parties as the result of the investigation.

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[553] The *Freedom To Speak Up Report* contains a section about investigating concerns (section 6.4, pp.125-129). Paragraph 6.4.5 states: "When a concern is raised, irrespective of motive, the priority must be to establish the facts fairly, efficiently and authoritatively." A degree of independence was seen as essential in an investigation being credible (paragraph 6.4.18) and feedback to the whistleblower important in building trust.

Whatever the evaluation or investigation process might be, Esther has seen mediations fail when the wrongdoing is not part of the dialogue between the parties. Jacob makes a similar point, being of the view that investigation or evaluation is often "a step that's missing" and that parties might agree at least to look into the wrongdoing as part of a mediation process. [554] Either way, bringing the wrongdoing into the dialogue matters. It either matters because patients may be harmed, or it matters because failing to include it is a barrier to making progress in resolving conflict with the whistleblower.

3.3 Stories of retaliation as an expression of grievance and a self-help remedy for ejecting the whistleblower from the NHS community

Retaliation against the whistleblowers is a major component of each of the four whistleblower narratives, and as the profiles and interview stories reveal, is sometimes egregious, causing significant suffering. The NHS appears, through these stories, at times, intent on destroying the lives of whistleblowers. Suffering caused by retaliation is also evident in the stories told by Frank, Geraldine, and Paul - although Geraldine suggests it is a by-product of the Trust defending its interests.

As discussed above, retaliation appears to be inflicted using the capacities and structures of the organisation to manipulate and harm

[554] Note that Jacob also acts for NHS Trusts, so this view should be seen in that light. The Early Neutral Evaluation proposed in Annex 6 of the Patients First Submission suggested using external reviewers and dialogue with a nominated Trust board member. But it also integrated the whistleblower fully into the process which could be more problematic for some Trusts.

the whistleblower. In other instances, retaliation is inflicted by colleagues apparently acting individually, not in an organisational role. Two clear examples are the stories told by Terry and Paul. Terry's whistleblowing divided opinion in her workplace and she suffered organisational retaliation (she was relocated to another workplace against her wishes) and personal retaliation (she was bullied and ostracised by colleagues who were not recipients). Paul describes how NHS Trusts execute their strategy against whistleblowers using the organisational mechanisms and levers at their disposal. [555]

While both are forms of retaliation, they are inflicted by different individuals, some with the capacities of the organisation and reflecting management decision-making, and others in their individual capacities and for their own personal reasons. As suggested above, whether the retaliation is seen as inflicted by the organisation or by a colleague individually, under the Felstiner Model it will derive from an initial perception of an injurious experience by an individual, transformed to a grievance, or claim. The exact nature of the perceived injury or the grievance which follows the whistleblowing will be a matter for each individual, and importantly, not a judgement by the whistleblower. Caroline (a member of the Third Party group) articulates whistleblowing as "a threat to the people" rather than to the organisation as a separate entity. [556] This appears to resonate with the alarming response by the CEO at Joanne's Trust who in blunt terms suggested that she and the Trust should be seen in effect as an indivisible single identity.

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[555] In Hilary's case and Terry's case it was clear to each of them that board-level decisions affected how the Trust treated them.

[556] See Chapter 7.

Nonetheless, because the perception of injury is personal to each individual, if it is not more fully articulated in language, the reasons for it may not be fully understood. If retaliation takes the form of abuse, bullying or organisational action, then it can be understood generally as injury or grievance suffered by recipients at the Trust, but I suggest the reasons felt by individual recipients remain unclear (and may differ from one another). However, the wider point is that the perception of injury forms part of the conflict that may need to be considered as part of any resolution dialogue. [557]

Hilary's story suggests that mediation was used in her case as a vehicle for retaliation, rather than for resolution. Mediation enables speaking and listening but participant behaviour is regulated by the mediator, working within a particular mediation framework. [558] In Hilary's case she felt bullied (which can arguably be construed as retaliation) in all of the mediations in which she took part. By allowing bullying within the mediation setting, Hilary might say, the retaliation is being legitimised or enabled by the mediator and the mediation process. For the colleagues - who appeared to be responding as individuals in all mediations - this is a means (from their perspective) of legitimate expression of their sense of injury or grievance. Arranging the mediation was arguably an organisational act, but the retaliation within the mediation could be seen as the action of individual colleagues. From Hilary's perspective, however, neither the retaliation nor the use of mediation for expressing it, are seen as legitimate.

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[557] See Chapter 8 for a discussion of findings from Chapters 5, 6 and 7.

[558] See the discussion of the role of the mediator in De Girolamo, *The Fugitive Identity of Mediation, Negotiations, Shift Changes and Allusionary Action* (Routledge, London and New York, 2013) at pp.52-62; also Michael Palmer and Simon Roberts, *Dispute Processes,* at pp.154-161.

Retaliation in whistleblowing can be seen as the impersonal exercise of agency of an organisation, but as the Felstiner Model shows, it derives from a human perception of injury and the grievance and decisions that follow from that individual's perception. Corporations and statutory bodies cannot act independently of those who run them, and in this sense the above discussion shows that there will be a locus of the whistleblower conflict within certain individuals, whether they are those who can draw on organisational resources or those who cannot, and that this understanding therefore matters to how the conflict might be approached. If the whistleblowing is perceived as a threat to certain specified organisation insiders, that is something that can be defined, ring fenced and discussed as a focus for conflict resolution.

3.4 The Whistleblower group narrative

The group narrative is shaped by the four whistleblower stories. They explain the wrongdoing and justify the whistleblowing, they show us who the whistleblower is and why their actions are legitimate. The whistleblower tells us about the wrongdoing and why it matters, and as the story develops we come to understand that - apparently - the Trust chooses not to address the wrongdoing (a choice, they say, that makes no sense) and instead chooses conflict with the whistleblower. The stories also tell us what happened to the whistleblower, how she suffered retaliation and how her life was changed. They provide authoritative first-hand accounts of the lived experience of the whistleblower and I suggest present a challenge to any who may think of whistleblowers as difficult, trouble-makers, people who do not fit in. [559]

[559] See 'Cultures of Silence and of Voice' at p.2 where they describe whistleblowers as often "complex".

All four whistleblowers make a compelling case for the rightness of what they did by speaking out about wrongdoing and the dysfunctionality of how they were then treated. As discussed, these stories frame the narrative of the group as a whole, so that the stories of other participants added detail to aspects of this central narrative (such as how the NHS responds (Frank, Paul), the relevance of mediation (Nicole, Alan), or the need to address wrongdoing (Esther, Jacob)) but it is noted that none of the other participants in this group change the fundamental whistleblower story or challenge the whistleblower perspective. [560]

The group narrative, in a sense, then is a story that validates the repeat pattern of the real-world experience of NHS whistleblowers described briefly in Chapters 1 and 2 and the *Freedom To Speak Up Report.* However, I propose that it is also a story that contains the elements of the conflict, relating both to the wrongdoing and the whistleblower, as I will now discuss.

Although there may be factors (which contribute to perceptions of injury by any party) that pre-date the act of whistleblowing (the historic pay dispute between Howard and a manager may be an example), I suggest that the whistleblowing itself can generally be seen as the act which initiates the potential conflict. The whistleblower narratives portray the whistleblowing as a story about wrongdoing: it is a genuine concern about patient safety. As suggested above, we do not know how the whistleblowing is received until the organisation and/or those colleagues affected by the whistleblowing (such as the wrongdoer) respond (although I

[560] Note that this is the case for Alan and Jacob notwithstanding their experience and perspective advising NHS Trusts on some cases.

suggest that the key response is that of the organisation as it has the greater capacity to inflict damage on the whistleblower). At this stage, therefore, it is not known whether the whistleblowing might be perceived as an injurious experience.

The response of the organisation to the whistleblowing claim will indicate how it perceives the whistleblowing. If the organisation retaliates towards the whistleblower, this suggests that the recipients, at a human level, perceive the whistleblowing as an injurious experience, perhaps as a threat to them personally, or perhaps to the reputation of the organisation. Whatever the nature of the injurious experience, and however irrational or subjective it may appear to those inside or outside the organisation, it is (according to the Felstiner Model) an emotional and psychological experience of an individual or, in the language of narrative theory, the story that individuals are telling themselves. The evidence of this, however, is in the response to the whistleblowing and it is only at this stage that the whistleblower might realise that conflict exists. This stage appears to equate broadly with the Felstiner Model stage of blaming, or perhaps even claiming - the voicing of a claim. Put another way, ultimately it is the retaliation by the organisation against the whistleblower that indicates whether individuals within the organisation have perceived the whistleblowing as an injurious experience suffered by them and thus act upon it to instigate a claim.

Conversely, as discussed earlier, the retaliation by the organisation is highly likely to be perceived as an injurious experience by the

whistleblower. [561] We know from all four cases that the whistleblower was shocked by the response of the organisation. We also know from these stories that the organisations did not provide coherent explanations to the whistleblowers of why their wrongdoing story should not be a concern. The stories show that retaliation happened in practice, but the reasons in the minds of recipients could not be explained. The wrongdoing, as it was explained in each case, appeared objectively very concerning, so perhaps there is no legitimate response that can explain unjustified retaliation.

The group narrative may suggest that by the time the organisation responds to the whistleblower, the conflict has reached the blaming or even claiming stage even though the whistleblower has apparently acted appropriately. [562] Retaliation may be the only pathway the organisation can see: if there is no legal or policy route to disapprove of the whistleblowing, the organisation is left with routes which do not have a legal or policy basis. In other words, the organisation does not have a justification for retaliatory action in respect of legitimate whistleblowing by a member of staff. One possible implication from this analysis is that intervention may be desirable to address the conflict before it is even clear that the conflict has arisen or will arise. By the time the organisation retaliates, the blaming, or claiming, may have begun, making the conflict entrenched and difficult to diffuse. This possible sequence of events may present something of a dilemma for the whistleblower, namely, that by the time the whistleblower realises that conflict has

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[561] There is a suggestion in the *Freedom To Speak Up Report* that whistleblowers are "aggrieved" (perceiving injury) "at the way their concerns were treated". See paragraph 6.4.24 on p.128. However, this study is focused more on recipients and the organisational response than on whistleblowers.

[562] In legal and NHS policy terms the whistleblower has not acted unlawfully or in breach of policy - the contrary in fact, having complied with professional duties. See *Whistleblowing Law and Practice* at p.886.

arisen a number of transformations (under the Felstiner Model) may have already occurred in the mind of the recipient.

What is also clear however is that although some participants express support for mediation as a process in the right circumstances, it is little-used in NHS whistleblowing cases, and for whistleblowers, it is not a trusted process, for reasons discussed above. It is seen as having potential for enabling human connections critical to unlocking some disputes (Nicole), as enabling really honest conversations which otherwise do not happen (Geraldine), and as having a semi-psychotherapeutic benefit which may suit it to whistleblowing (Alan).

For others, it can be used strategically to silence and bully vulnerable whistleblowers, and stop them raising legitimate grievances (Hilary), only has value when used to agree termination of the whistleblower's employment (Frank), and can be used disingenuously within a litigation strategy to deplete the whistleblower's financial resources and her will to litigate (Paul). Further, for Esther and Jacob, mediation is pointless unless the wrongdoing is brought into the resolution dialogue in some way. Lastly, but importantly (for all of Paul, Esther, Alan and Jacob), financial settlements with whistleblowers require Treasury approval, which is almost impossible to obtain, and renders mediation pointless. For Paul in particular it is the single most important reason why mediations do not take place.

Accordingly, the group narrative shows that mediation is not seen as a real-world alternative for addressing either aspect of NHS whistleblowing conflict, whether wrongdoing conflict or

whistleblower conflict, nor meaningfully to address broken or damaged workplace relationships. Although mediation was cited as a possible process to assist with internal relationships damaged by whistleblowing according to the *Freedom To Speak Up Report* it appears that notwithstanding its widespread use in other fields it is not a process that lends itself to NHS whistleblowing settings.

4. Conclusion

The group narrative is driven by the powerful and convincing first-hand whistleblower stories which frame and set the tone for the other participant stories within this group narrative. The group narrative provides a vivid picture of what it means to be a whistleblower in the NHS including the personal suffering, professional waste, and the apparent dysfunctionality of the system that appears unable to find better solutions. In terms of conflict, it is arguable to infer that the act of whistleblowing can be perceived as an injurious experience by organisational insiders such as recipients or other colleagues and that real-world indications of this may be in the form of retaliation against the whistleblower.

It is the retaliation that signals not only that the whistleblowing was perceived as injurious, but that by this stage, the perception of injury has transformed (according to the Felstiner Model) to blaming, or quite possibly claiming. Under the Felstiner Model the transformation to claiming occurs when the grievance is voiced to the person believed to be responsible for causing the injurious experience and asks for a remedy. [563] The Felstiner Model does not

[563] 'The Emergence and Transformation of Disputes' at p. 635.

require the grievance nor the claiming to be grounded in law or policy, nor even social probability. [564] The source of the claim is the perception of injury, however subjective that might be, and the retaliation I suggest is the voicing of the grievance. The idea of a remedy is more complex, as it suggests that the organisation should have recourse of some kind against the whistleblower for a claim which is based on a perception of injury arising from a lawful and ethical act. [565] The group stories include ample evidence (as does the *Freedom To Speak Up Report)* that retaliation is often based on false and spurious claims against the whistleblower which arguably provides a degree of legal cover for illegitimate and unethical actions by the organisation which is seeking to justify its actions against the whistleblower. [566]

For me, there is a distinctive aspect to the way in which conflict arises in NHS whistleblowing cases. In the Felstiner Model, the opening scenario is "a population living downwind from a nuclear test site" in which a real-world risk of injury (developing cancer) is assumed. In NHS whistleblowing, the whistleblower is ostensibly acting ethically in raising a concern and in doing so is acting in accordance with NHS policy and her professional duties. [567] This act is in theory pro-social organisational behaviour, and so in the

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[564] Ibid: "The injured person must feel wronged and believe that something must be done in response to the injury, however politically or sociologically improbable such a response might be".

[565] More than that, perhaps: PIDA whistleblowing is based on the concept of "relevant failure", essentially a breach of law or legal norms and yet it gives rise to a claim which is illegitimate and potentially unlawful (eg by causing detriment or unfair dismissal).

[566] "Whistleblowers are…persecuted and find themselves being accused with false counter allegations, despite in most cases a lack of evidence of any wrong doing" - *Freedom To Speak Up report* at p.61. Howard was subjected to false allegations (doctoring minutes of an important meeting) and Paul recognises it as a real phenomenon in the NHS strategy.

[567] See *Whistleblowing Law and Practice* at p.886.

interests of the organisation itself and indeed patient safety. At this stage the whistleblower is often unaware of the implications and is not expecting the hostile reaction of the organisation. Given this setting, I suggest there should be no reasonable expectation that the whistleblower's act of whistleblowing should be seen as injurious. However, the data suggests that this is not so, and it is perceived as injurious by recipients and colleagues within the organisation time and time again.

As we also know from the group narrative, that despite support in the literature for its use, mediation is not widely used nor trusted as a process for resolution. Given that the stories point to almost no alternative pathways for addressing wrongdoing or whistleblower conflict, regardless of the seriousness of the wrongdoing or the credibility of the whistleblower, the group narrative tends to suggest outcomes for whistleblowers which are structurally predetermined by the response of the organisation. If the organisation responds with retaliation the data suggests that the pattern of detriment, potential dismissal and PIDA claim may well follow. [568]

[568] Which reflects the views expressed by Paul about the NHS' repeat strategy towards whistleblowers.

Chapter 6

The NHS Story

1. Introduction

This chapter follows the same structure as Chapter 5: section 2 contains the profiles and stories of the participants (including interview dates), section 4 a discussion of those stories and section 5 a brief conclusion. This chapter also presents and discusses the FOI Data (in section 3). Again, the profiles and stories of each participant are based wholly on the information obtained in the interview with that participant, unless I indicate otherwise.

Additionally, as mentioned in Chapters 4 and 5, two participants within the Whistleblower Group - the barristers Alan and Jacob - also have relevance to the NHS group. Both participants said that they represent NHS whistleblowers in some cases and NHS Trusts in others, and so have experience of viewing the conflict, in legal terms at least, from both sides of the divide. Their profiles and stories are set out in Chapter 5 (Alan at paragraph 2.10, and Jacob at 2.11) so are not repeated here. Their stories understandably tend to focus on legal matters such as barriers to settlement (Alan comments about Treasury approval, Jacob about the wrongdoing/whistleblower nexus) which are discussed in chapter 5. Both also comment to some extent about the NHS workplace, displaying familiarity with it - Alan describes it as “brittle”, while Jacob highlights the divide between managers and clinicians - also mentioned within their stories. Their experience representing clients on both sides of the divide underpins

their presence in both groups. Accordingly, as well as featuring in the whistleblower group discussion in Chapter 5, they also feature in the discussion in this Chapter, in section 4.

2. The Participants, their Profiles and their Stories

2.1 Michael

The interview with Michael took place on 3 December 2019.

Michael was a career NHS manager, now retired, who worked in large and complex acute hospital environments mainly in London from 1982 until 2015. He accelerated quickly through nonclinical and clinical management roles to senior positions just below board level. He had visibility of high level decision-making within various NHS Trusts.

Michael was very successful. He presented as a popular personality, charming, articulate, grounded and collaborative; calm, measured, a natural problem-solver. He said of his first major role working with clinical leads "fascinating, I loved it, I really felt involved…I would spend a lot of time with [the clinicians] working through things, how things would work…you would work to make things happen". Accident & Emergency ("A&E") waiting lists are explored as a "whole hospital" problem to which Michael delivered solutions in a number of major hospitals. [569] He transformed one hospital from the bottom of

[569] Now often termed "ED" for Emergency Department.

the national A&E rankings to a very high ranking within months of arriving. He says he witnessed little bullying and no whistleblowing but acknowledged the fine line between bullying and "being demanding". Michael had 12 days absence for illness over a 30-year career and was intolerant of what he saw as unjustified poor staff sickness records. He had dismissed staff during his career on that basis.

Having not personally witnessed any whistleblowing or bullying, Michael's story obliquely challenges the narrative that the NHS is a workplace rife with bullying, harassment and relationship friction. [570] Michael's narrative perspective is that of a loyal and successful NHS manager who found pragmatic solutions to challenging problems within complex NHS systems.

The 4-hour A&E target was a repeat challenge for Michael but an area where he says he made a difference to the smooth operation of various hospitals. [571] He achieved an excellent target success rate with a newly appointed chief executive (with whom he had a "difficult

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[570] I refer to this narrative on occasion throughout this chapter. Bullying is widely thought to be a problem throughout the NHS. By way of illustration see: The *Freedom To Speak Up Report* section 5.5 (Bullying); the National Freedom to Speak up Guardian's Data Report 1 April 2019-31 March 2020 (which reveals that 36% of cases raised with Local Guardians relate to or include an element of bullying or harassment, while only 23% of cases relate to patient safety); the FOI data obtained for this study shows that bullying/harassment/relationship claims are a significant majority in some Trusts (measured by concerns raised with local guardians). See also Kline R. *BMJ Leader* Published Online at DOI: 10.1136/leader-2019-000159: "24% of NHS staff in England report that they are subject to bullying, harassment or abuse by fellow workers and managers, impacting on increased intentions to leave, job satisfaction, organisational commitment, absenteeism, presenteeism, productivity and the effectiveness of teams, costing the NHS at least £2.28 billion annually".

[571] He describes the nature of the problem as a "whole hospital target that happens to be measured in A&E". He likens it to a bath with no plug in which the water from the taps fills the bath more quickly than it escapes. Early discharge is critical: "60% of an acute hospital's beds are taken up by people who no longer need acute hospital care". If a patient moves wards more than once the hospital is fined.

relationship") notwithstanding having to "close 4 wards because of an outbreak of C.Difficile". [572] These many- faceted "whole hospital" challenges were a significant aspect of the interview and illustrated the everyday realities of Michael's working life. They point to his ability to work collaboratively across a range of professions to achieve a common goal. [573]

Michael was able to navigate delicate circumstances and hubristic leaders. He showed a tougher side of his personality and style with respect to his views about bullying, claiming that it was not a significant problem in his NHS experience: "No, not my experience at all" but drew a distinction between bullying and "being demanding". [574] Managers, he adds, have "every right to be demanding". He sees bullying as being "when there is pressure of whatever kind that is unjustified". He confesses to a low tolerance of staff sickness, considering his own exemplary record: "in my 30 years in the NHS I managed 12 days sickness". He has, nonetheless "dismissed a number of people for poor sickness records. Some people might well consider that a form of bullying….but that's not the case". [575] Management colleagues thought he could be "pretty forthright" to which he replied, "Yes, it's taking the piss". [576]

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[572] C.Difficile is a particularly virulent virus. If one patient contracts it the entire ward has to be closed and disinfected.

[573] "The thing is, its like any area of life, if they [doctors, nurses etc] come to you and say, 'There's this difficulty' and you resolve it for them they then just walk through walls for you……it's the style of management that I have used and I found useful".

[574] Later adding "I don't think bullying is rife in the NHS in as much as I have experienced it". This contradicts the findings of the *Freedom To Speak Up Report* (see above).

[575] Michael acknowledges here that bullying is subjective but is clear that he personally did not bully staff.

[576] Talking specifically about staff sickness.

Michael reveals a steely, as well as a collaborative, side to his management style. He told me of one period where he felt he was being bullied by a female chief executive who he felt exerted "all sorts of other kind of pressure" on him making it difficult "to make normal progress" with projects. He described this in a very equal tone as something he would simply have to work around. [577] He has heard of bullying elsewhere in other NHS locations. [578] He is not denying it went on, and associated it with senior leadership, but witnessed little if any in his own work.

Michael describes an environment in which bullying and whistleblowing do not appear to feature although he recognised the scope for very different understandings and perspectives: "absolutely - we all perceive things very differently - we may be reporting exactly the same thing but I will emphasise the things I find important and you will emphasise the things you find important and therefore the person listening to both stories will get a very different impression from both of us".

He used this storytelling idea to pose a hypothetical question about whistleblowing: he cited a real-life example of an unnamed but internationally-renowned surgeon who took on hopeless cases

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[577] He told me about the external political bullying that was commonplace in the upper levels of the NHS such as the "constant belittling phone calls that you get from the Department of Health, 'what the **** are you doing?' " and of a call he personally received from the then Secretary of State for Health after a private local solution to shorten NHS waiting lists was covered on the BBC news. The Health Secretary rang through to him and (in his words) "Basically called me a **** for embarrassing the government".

[578] "I have certainly heard a lot of people in other Trusts talking about how they have been bullied…to do things which they didn't feel particularly happy about in order to meet various targets and that I think is where a lot of the bullying has happened".

beyond the capabilities of others. His death rate was - inevitably - higher than the average (for other less demanding types of surgery). His capabilities were beginning to fail “and he’s got wobbly hands”. Michael asked, rhetorically, whether these circumstances might amount to wrongdoing or be the subject of whistleblowing. However, if this exceptional yet ageing surgeon could still save or improve a deeply compromised life when others could not (even with his slightly compromised skills) the surgery may be justified. Equally, he pondered, from other perspectives, this may amount to wrongdoing which could lead to whistleblowing. Michael posed the question rather than offering a firm view.

2.2 Philip

I interviewed Philip on 12 December 2019.

Philip was a surgeon who spent his consultant career at a regional acute hospital Trust and has now retired. For most of his career he was the sole consultant surgeon in his field at the Trust and as he put it “was truly one of the last of the generalist surgeons [in his field] in the sense that [he] had to know something about everything within the speciality”. His role presented huge challenges of knowledge and expertise, physical endurance, dedication and commitment. He was on call every night: “one in one, that means every day…but it was very stressful being on call every single night”.

The demands of Philip's “single-handed” role appear extreme even by NHS standards. His narrative expressed an ever-present concern about delivering high quality care in such challenging circumstances: “I was always aware of the quality issues” yet “I managed to run a good service, I believe, for 30 to 35 years”. The balancing act was maintaining quality of service across the whole of his field every day (and night) while also “having to respond to emergencies” recognising that being so stretched could lead “to outcomes that were sub-optimal”. He spoke with restrained emotion about paediatric emergencies in particular: he was in a hospital 10 miles away running an out-patient clinic when a child’s tonsillectomy haemorrhaged: “you have a problem, because I’m doing a clinic here with no junior staff and we had to put these kids in an ambulance and bring them on a blue light to where I was working and then resuscitate a child who might half-exsanguinate”. [579] He adds “it just wasn’t good practice”.

His metaphor for the NHS dilemma of unlimited demand and finite resource is a “three point triangle” requiring “quality, quantity and cost” to remain in balance. [580] Philip witnessed medical accidents causing death, injury and anguish but never witnessed formal whistleblowing by others, nor did he formally blow the whistle on any colleagues. He contemplated doing so on one occasion towards the end of his career, following negligent surgery by a colleague which

[579] I.e. remove blood from the bleed area.

[580] He added: “whatever you do you could not improve cost…and meeting your financial targets was the single most important thing, way above quality and quantity”.

hastened the patient's death, but another solution presented itself. [581] Philip added: "its the real world, but that's one of my experiences of it. That sort of thing is happening up and down the NHS".

He also questioned the meaning of bullying, referring to the social or cultural reasons why it might occur, and pointing to its highly subjective nature. He says, is it: "not letting go of somebody's slightly poor performance" or "off-hand" treatment of patients? Staff can feel "got at…they don't think its strictly fair that they're doing their best… they may regard that as bullying". He adds; "I don't know what bullying is. I've never personally experienced bullying in my departments but I can imagine that's what it is". On one occasion, however, he saw a young female speech and language therapist unfairly forced out of her job. [582]

As a senior consultant, Philip was presented with management decisions about the conduct of the surgical practice within the Trust and took on increased management roles later on in his career. Recruiting good consultants was difficult: the Trust was not a prestigious teaching hospital and private practice opportunities were limited.

Philip's story is one of huge commitment to his patients over a lengthy career. But it is also a story of realism and pragmatism, as

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[581] He told the story of his elderly neighbour (in his hospital as a patient for thyroid cancer) whose operation had gone very badly wrong "where I [Philip] could have blown the whistle". Philip mentioned it to the medical director who said "that surgeon…..we're stopping him doing any more thyroid cancer surgery".

[582] She was "rattling cages" and was dismissed on the pretext of a mistaken data breach, which he described as "extremely harsh". This was not whistleblowing, but the story provides a behavioural context.

Philip saw wrongdoing within the NHS, including significant medical errors that harmed patients, but worked within the system without feeling he should blow the whistle. He questions the meaning of bullying, acknowledging its subjective nature. Notably, however, he accepts that mistakes and accidents are inevitable in a complex modern healthcare service with finite resources and that provided professionals are acting to the best of their ability within their competence that is as much as can be asked of them.

2.3 Tom

The interview with Tom took place on 27 September 2019.

Tom is a retired NHS consultant, who formerly worked at an acute NHS Trust. The clinic in which he worked was under consistent pressure to hit targets: "it's the nature of the service….if there are 60 patients that week you see 60 patients. If there are 40 patients, you see 40 patients. If there are 80, you see 80….hospitals are penalised if they breach the target". The clinic was the subject of whistleblowing allegations. The act of whistleblowing and the way the Trust responded caused disruption to the clinic and distress to Tom and his colleagues.

The unique contribution of Tom's data to the study is that it reveals the first-hand experience of being subjected to whistleblowing allegations as a wrongdoer. [583] Tom told the story of a locum

[583] I discuss wrongdoing in Chapter 2. The allegations were not directed at Tom personally - the clinic was the site of the alleged wrongdoing.

registrar who was contracted to work at Tom's clinic for three weeks but left without giving any notice or explanation after two. [584] The locum failed to keep records or send patient follow-up letters. [585] Without warning the locum made public allegations about unsafe practices at the clinic (primarily over-work and under-staffing) which had the potential to harm the reputation of both clinic and hospital.

The subsequent investigation by hospital management was professionally humiliating and damaging for Tom and his colleagues. The hospital investigators refused to explain the allegations to Tom. Tom felt the investigation process was unfair and that he was badly treated. Tom subsequently discovered that the whistleblower had been professionally discredited, a fact missed by the hospital during the recruitment process. [586] In the language of whistleblowing research Tom can be seen as a "wrongdoer" against whom allegations have been made, which makes his perspective within this study unique and his story therefore highly relevant to some aspects of how whistleblowing conflict is experienced by those around the whistleblower. [587]

Tom's story is not a typical whistleblowing story, however, in the sense that the whistleblower left the workplace and immediately went public with his allegations. In Tom's view, the whistleblowing was

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[584] Tom said: "I only saw him on two or three occasions and he seemed deferential and polite…. rather unobtrusive".

[585] These are a mandatory clinical requirement. Tom described the whistleblower as "a complete disaster" as a clinician.

[586] The whistleblower had acted similarly on previous occasions including writing directly to patients. Tom's google search revealed these facts.

[587] As I discuss in Chapter 2, the term wrongdoing is recognised as highly subjective and does not necessarily infer any actual malpractice.

vexatious and seemed calculated to cause maximum damage to the clinic and the people who worked there, including Tom. Tom's internet search revealed the whistleblower as "a guy who was completely undeserving of any credibility who had previously made vexatious disclosures"; Tom views him as a fantasist. [588]

Tom experienced the effect of the whistleblowing through the medium of the Trust's investigation of the whistleblower's allegations. The hospital's response was to classify the matter as whistleblowing and apply its whistleblowing policy. Tom's experience of the investigatory process was of being undermined, and humiliated: "it's professionally humiliating and I felt very upset". [589] He was sufficiently angry to go to the Chief Executive, who responded: " 'It's one of those things that happens all the time. Thanks for popping in' and off he went and off I went and that's all that happened." Tom did not see whistleblowers as "synonymous with troublemakers" but felt that "the whistleblowing apparatus was used inappropriately".

As Tom portrays it, the Trust's top priority was to defend its reputation regardless of the harm to staff. The allegations were "about the stress and people being overworked and not being safe" and were "very critical of the service" yet all of the issues had been repeatedly raised by Tom and his colleagues with managers over a prolonged

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[588] Tom added: "He must have been some sort of fantasist where he thought he would get his moment of fame as on both occasions it involves the press, it involves writing to patients, it involves him championing the underdog; he becomes, misguidedly, or possibly with an element of truth in it in some cases, he becomes the champion of the patient and he's going to show the malign hospital up for what it is. It's a kind of fantasist".

[589] Tom was interviewed by his Clinical Director who would not share the allegations. "This is absolute bloody madness" was Tom's comment.

period and never acted upon. [590] The Trust issued a public response to the allegations which included untrue statements, for example, that additional staff had been recruited. They had not: “needless to say no extra staff had been recruited…..everything stayed exactly the same”.

From Tom’s point of view he and his colleagues had been humiliated by the Trust because of the actions of a vexatious whistleblower. The Trust had prioritised reputation above both staff and patients. Tom had no information about any consequences for the whistleblower and the wrongdoing - that is, the under-staffing and overworking - was not addressed by the hospital. For Tom, the purpose of the investigation was solely to protect the hospital’s reputation, not to address the wrongdoing or to protect staff.

2.4 Margaret

The interview with Margaret was on 9 March 2020.

Margaret is a former NHS consultant.

Margaret appears profoundly disillusioned with the NHS; she witnessed one egregious whistleblowing case affecting a colleague. She sees a need for radical change in the NHS. She views whistleblowers as naive and whistleblowing as pointless and unable

[590] Tom says these matters were “mentioned on numerous occasions at management meetings - we’ve been like this for years”. Those conversations could have been protected disclosures under PIDA.

to effect change. The NHS is centrally controlled, and unaccountable "poisonous" chief executives and senior managers exercise authority over clinicians who are regulated and professionally accountable: the divide between managers and clinicians is a site of conflict: "so… there's always a conflict then between clinical decision-making and management decision-making". The CEO's job, she says, is "to shut me up, shut everything down, see the Trust's ok and report into the centre… to say he's hit his targets". Margaret says the NHS sees patients as secondary to bureaucratic requirements imposed on nurses and other practitioners: "so you have all this data and these people managing this data and meanwhile you could be dead in your bed and nobody would notice. It's 'blame the doctors' ". She provides narratives of egregious systemic failings causing harm to patients and staff and predicts a future scandal around end-of-life care. [591]

Margaret witnessed tragic personal consequences for a colleague who decided to blow the whistle, and suffered severe retaliation. [592] Whistleblowers are left with few good options, she says: "have you got enough money to survive? Which is worse, being pilloried, going through hell, perhaps dying or committing suicide or just carry on

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[591] Specifically, the misuse of the Liverpool Care Pathway is "one of the biggest scandals that hasn't come out…it was totally abused….people were put on that end of care pathway on Fridays so they had the beds on Monday"). Also, Margaret articulated a range of criticisms including the following: (1) the NHS is centrally controlled and behavioural norms are established centrally (the NHS is "so controlled centrally, CEOs are "poisonous" and "the central NHS are telling them to be that poisonous"); (2) targets eventually lead to "corruption"; (3) silencing criticism is a major priority: (4) bureaucracy and data recording take priority over patient care; (5) regulated healthcare professionals are dominated by unregulated hospital managers and the result is conflict; real long term change requires the NHS "to be clinically-led".

[592] The whistleblower had raised two concerns, "both of them completely justified and completely objective". The retaliation against him included a specious claim that the whistleblower had "committed fraud". The hospital management "went for him ….and isolated him, he wasn't allowed to speak to anybody, the usual".

keeping your head down - or leave? I don't think you've got much option."

She sees Freedom to Speak Up (including the Local Guardian system discussed in Chapter 1) as "meaning nothing… because you can't enforce it" and perceives whistleblowers as "the earnest ones", naive and idealistic. Margaret contends that not all whistleblowing will provoke an adverse response and the objectives of the Trust in defending its reputation render dialogue (including mediation) meaningless. Speaking out can be professional suicide: "I would never advise anybody to whistle-blow".

Margaret explained her perspective about whistleblowing. She draws a distinction (not reflected in either the Research Definition of whistleblowing, or in PIDA) between whistleblowers who criticise or blame the Trust and those who do not (in other words they raise a concern about an individual but without implying criticism of the Trust) which dictates how the Trust responds. Criticism of the Trust, for Margaret, is the defining aspect of whistleblowing and the decisive factor in how the organisation reacts. [593] If you "snitch on somebody else…we [the Trust] like that because then they could get the blame, we're squeaky clean. That I suppose is what I see [as] whistleblowing". She also sees whistleblowing as naive or idealistic: "it's always the earnest ones that think, gosh, this isn't right". Ultimately she believes the personal cost is too high: "I would never advise anyone to whistleblow".

[593] She says "whistleblowing, when you get it in the neck is if you criticise the Trust".

Margaret had an equally bleak perspective about the possibilities of dialogue, or mediation, relating to whistleblowing conflict: “they’re not interested in discussing it”. She saw mediation as “a joke” and otiose, as “they are there to cover up…to find the blame in somebody else”. I asked whether “honest, sensible dialogue” might serve a purpose? She said “It’s not going to happen”. She sees the response as universal within NHS management norms: “that’s what they do, this is the whole of the NHS management”.

2.5 Frances

I interviewed Frances on 20 February 2020.

Frances is a barrister and mediator practising employment law who represents mainly NHS defendants in a range of employment cases, including whistleblowing. As well as defending NHS Trusts in employment tribunals Frances has recent experience attending mediations and conveys strong familiarity with NHS workplace practices and mediation settings. Frances describes whistleblowers as “never clean” and says there is “always" an alternative narrative to the whistleblower’s version of events. In one account the whistleblower is described as “a problem employee” with a history of relational friction. [594]

Frances is pro-mediation which she thinks is under-used by Trusts in whistleblowing circumstances and sees it as having potential in some

[594] Partly resulting from her manner, Frances says.

cases. Her story is partly about why mediation may work in some circumstances but not others. The gateway to mediation, for her, is “genuine” whistleblowing: Frances does not define genuine, but her story suggests it includes a credible patient safety concern, raised by a credible whistleblower, without an ulterior motive (such as personal animosity). However, the requirement for a “valid” or “genuine” concern, is the subjective judgement of the organisation: “there has to be a recognition by the organisation that a valid concern has been raised before mediation has a role”.

Mediation, she says, has a role in "rebuilding relationships” or dealing with “relationship fallout” although she admits “it’s very, very hard to mend those relationships but I think it’s potentially possible”. Mediation she says could address “any issue that arises in the workplace" as a consequence of a genuine concern, particularly “in working relationships or in the way that the issues have been addressed”. Other considerations include timing (“the earlier…the better chance of success”) and the relative seniority of the parties(“I think it gets particularly harder when one party is subordinate to the other”, if parties are of equivalent status then “it can be addressed…..even if there is some ill-feeling”).

However, although mediation can address the "spin-off” relationship issues it cannot address the wrongdoing itself: “the key reason is the public interest….they [the NHS] are a public body…there’s a huge issue in terms of settling cases where there’s a whistleblowing [ie

wrongdoing] element" and those issues should be "dealt with independently" not within a mediation setting. [595]

It is not a forum for settling legal cases, however, partly because of the wrongdoing and partly because of the need for Treasury Approval for compromise payments - both are major problems, she says. [596] The whistleblower invariably seeks a compromise payment: she adds "I've never known a claimant who's brought tribunal proceedings not to want a financial sum", implying the need for Treasury approval, which she has never obtained. Cases can be settled on a "drop-hands" basis, where both parties agree to end the litigation and bear their own costs.

Frances acknowledges that the mindset of the whistleblower can be a barrier to mediation: if there is no trust in the process, whether "perception or reality", mediation is unlikely to work. Whistleblowers can suffer from "paranoia" (Frances' word) and lose the ability to trust the NHS system, including the mediation process, seeing it as belonging to the NHS. When whistleblowers are "so far down the rabbit hole" she says there's not much that can be done". Ultimately Frances accepts that "the ability of mediation to resolve conflict

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[595] Jacob, who also advises NHS Trusts, saw investigations as being effective.

[596] Frances' view resonates with Alan's - Alan advises NHS Trusts, as well as whistleblowers. Treasury approval is required to make an extra-contractual payment as part of a settlement with an NHS worker. Frances says: "I've not had success in going to Treasury *ever* …..whenever I've gone to Treasury to seek approval and filled in the correct form with all the details, why it makes commercial sense, what the litigation risk is, its been denied on every occasion". Her reflection here is that "transparency [is] the most important thing over cost" so that following due process trumps settlement even if that is not the best economic outcome. Frances pointed me to the relevant government guidance: *Managing Public Money* Section 4.13 (Special Payments) Published by HM Treasury, See https://assets.publishing.service.gov.uk/government/data/file/835558/Managing-_Public_Money with annexes 2019

requires both actual independence and perceived independence" by the parties so “it actually doesn’t matter if its perception or reality”. [597]

2.6 Catherine

My interview with Catherine took place (by telephone) on 8 February 2021.

Catherine is an experienced employment law specialist and a qualified mediator working in a firm of solicitors which advises NHS organisations.

During our interview Catherine appeared to shift from her identity as a trusted NHS legal adviser to her identity as a mediator and vice versa and this dual role shaped her perspective for our interview. Her mediator role seemed to enable her to shape solutions which her legal adviser role did not.

Catherine is highly sceptical about whistleblowers and does not experience them as “paragons of virtue”. The whistleblower “never comes to the table clean”….“there’s always a context, isn’t there, it’s never black and white”, pointing to contested narratives at the heart of the conflict. She says: “there’s always a back story…a personality clash or performance issues”. Whistleblowers may have a “conspiracy” mindset or “they may have a bit of a personality

[597] She adds at the end of our meeting: “It's something I hadn’t thought about before…..actually the role of the whistleblower in the mediation and I think that’s a huge factor”.

disorder" or think it's "a big cover-up" - adding "this is awful me saying this but this is my experience". Whistleblowers "are not saints in my experience but you [the whistleblower] get yourself in a position where you are a victim or you have to be right on everything".

Catherine also finds whistleblowers unreflective about their own role in whistleblowing conflict. She says: after listening to a whistleblower "talking at us" for an hour "there was never any reflection on the whistleblower's part about the role they may have played". She recognises that whistleblowers can find it difficult to let go of entrenched beliefs about the wrongdoing they have disclosed and that a whistleblower's emotional entrenchment can present a barrier to communication: "once you get yourself in that trench it's really hard, emotionally, for people to get out of it and no amount of money in the world is going to help you". She sees a level of trust as being a significant factor and once the whistleblower no longer trusts anyone the employment relationship "unravels".

Catherine's narrative divides mediation into "termination" cases (ending the whistleblowers employment with the NHS) and "ongoing relationship" cases (where the mediation attempts to establish new workplace arrangements where colleagues in conflict can co-exist). She says: "it's a lot easier if what you're mediating is the end of a relationship, isn't it? I think the harder ones are where there is still going to be an ongoing relationship because people are hurt by that stage". The narrative of reconciliation collides with the emotional reality of the conflict, however: "I can't think of any cases where relationships have been rebuilt after the mediation" adding "I suppose

most mediations are ‘successful’ because there's an end to the relationship. That’s the reality isn’t it?”

About the need for Treasury approval, Catherine (contrary to other participants, such as Paul, Alan and Frances) saw obtaining it as a matter of know-how about how best to approach the Treasury. [598] A positive story to “the right people” that settlement has a service benefit, rather than a negative story of ameliorating the effects of litigation, has greater prospect of success (and has worked for her on the majority of her recent cases).

For Catherine, her story requires the whistleblower, alone, to do the emotional “heavy lifting” of coming to terms with her trauma and moving on: “you’ve got to be able to think, ok, that was awful, but what do I need now to help me get on with my life?” It is for the whistleblower to overcome her anger and distress and let go of any wish for vengeance: “the minute you want vengeance on that person, it won’t work”. In one recent mediation (“my only one that has been unsuccessful”) the whistleblower wanted her line manager sacked for bullying: “in her mind she was bullied. It wasn’t bullying. It was bad management.” Catherine does not acknowledge the subjectivity of perceptions of bullying here, however, suggesting her self-confidence in her own perceptions of the whistleblower. [599] Her story, however, provides a stark contrast, for this study, to the persona of the whistleblower portrayed in the previous chapter.

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[598] Those who commented about Treasury approval as a barrier to settlement including Frances (who advises NHS organisations), Paul and Esther (who advise claimants) and Alan (who represents a mix of claimants and NHS Trusts); all said it was almost impossible to obtain.

[599] See Lizzie Barmes, *Bullying and Behavioural Conflict at Work, The Duality of Individual Rights* (Oxford University Press, 2016) at p.15.

The stories in this section 2 present a range of individual narrative voices with NHS-related perspectives. [600] However, they do not represent the totality of the NHS voice: in the following section I will now set out the FOI Data mentioned previously which contribute to the NHS narratives, aggregating with the participant data in presenting the overall group narrative.

3. The FOI Stories

The FOI Data appears to suggest two narratives. The first is a narrative about resolution of whistleblowing conflict. The second is a narrative about Trusts - apparently - with no, or almost no, whistleblowing. Inferences can be drawn about both narratives, but both also raise multiple questions. I discuss each in turn below. A further finding is that the FOI replies appear to reveal different interpretations of whistleblowing by Trusts, which I also discuss below.

3.1 A Resolution Story

In Chapter 4 I highlighted the distinction implicit in the FOI Data between cases of formal (or PIDA) whistleblowing and concerns which may not be seen as formal whistleblowing. I set out below data that relate, as far as I can ascertain, solely to formal

[600] Note that Alan and Jacob also represent NHS Trusts and their views, cited, are also relevant to the group.

whistleblowing cases. [601] The data show the numbers of whistleblowing cases, the number that the relevant Trusts consider to be resolved, the numbers that went to the employment tribunal, and the numbers which were the subject of mediation. I set these out below:

- Total number of Trust responses: **114**
- Number of Trust responses considered to be whistleblowing responses: **71** [602]
- Total number of whistleblowing cases: **1,583**
- Total number resolved: **1,141**
- Employment Tribunal cases: **20** [603]
- Resolved by ACAS: **7**
- Subject of mediation: **7** [604]

For reasons discussed in Chapter 4, these data should be treated with caution. They do however suggest some relevant observations, such as: (1) the average number of whistleblowing cases per NHS Trust over the 3 year period is just below 14 per Trust, so

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[601] See the FOI methodology in Chapter 4 for further comment on the important distinction between "formal whistleblowing" and FTSU Concerns. As indicated, FTSU Concerns are all matters raised with Local Guardians, a broader range of issues than solely formal whistleblowing. Some FSTU Concerns may also amount to whistleblowing, but in many Trusts it is possible to raise a formal whistleblowing issue through other avenues such as line managers. Here, I am referring throughout to formal whistleblowing unless I say otherwise.

[602] Including 10 overlap cases (see the FOI Methodology in Chapter 4).

[603] Reported by only 9 Trusts.

[604] The replies from two Trusts, Lincolnshire Partnership NHS FT and Birmingham Community Healthcare NHS FT suggest that up to a total of a further 38 cases may have been handled with some sort of informal facilitated conversation (not formal mediation) although there is doubt as to whether all cases are in fact whistleblowing and the form of the process.

approximately 4.6 cases per Trust per year, [605] (2) that Trusts appear to resolve a high proportion of whistleblowing cases ie just over **72%**, (3) of all cases, only a tiny proportion are the subject of legal proceedings ie **1.263%,** [606] (4) of this proportion fewer than half were resolved by ACAS conciliation ie **7 of the 20** ET cases, [607] and (5) of all whistleblowing cases an even smaller proportion are resolved by mediation ie **0.442%.** [608] Furthermore, the 7 mediations referred to in the above figures occurred in only **4** Trusts. [609]

Recognising (as I discuss further below) that there is uncertainty about how different Trusts interpret whistleblowing, taking the FOI replies at face value, Trust responses seem very clear that a substantial proportion of formal whistleblowing cases are resolved satisfactorily within the meaning of the FOI Request. [610] This is a good news narrative if it reflects a real-world reality; it infers that Trusts have in place internal processes (not legal proceedings, nor

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[605] This appears plausible. From my knowledge and experience it would be counter-intuitive to see very high numbers of formal whistleblowing cases, bearing in mind all that we know of the risks to staff of speaking up and the potential conflict it causes. To sense-check the numbers: if, for example, we removed all Trusts where whistleblowing cases over the 3-year period exceeded 50 (of which there were 10 Trusts), you would deduct 980 whistleblowing cases from the calculation; of these 980, 793 were said to be resolved. Assuming the same mediation figure (for simplicity) the percentage of all cases (now reduced to 603 rather than 1,583) mediated increases to **1.16%** and of cases resolved (now 348 rather than 1,141) increases to **2.01%**. The point here is that even if significant allowances are made for misinterpreting the FOI replies, the data suggests that it is still only a very small percentage of whistleblowing cases being resolved by mediation.

[606] Or 1.752% of the cases resolved ie 20/1,141 as a %.

[607] ACAS conciliation is offered in relation to ET cases.

[608] Or 0.613 of the cases resolved ie 7/1,141 as a %.

[609] If Lincolnshire Partnership NHS FT and Birmingham Community Healthcare NHS FT were included, all mediations would still only have occurred within **6** Trusts.

[610] The wording of the relevant question is as follows: "5.1 how many [whistleblowing cases] were resolved satisfactorily (by which I mean any clinical, malpractice or other issues were addressed and any dispute with the Whistleblowing Worker was amicably resolved)?".

mediation) that are capable of distinguishing formal whistleblowing from other (non-whistleblowing) concerns (which appears to vary between Trusts), and the processes and skills to find solutions both to matters of wrongdoing (the wrongdoing conflict) and the dispute with the whistleblower (the whistleblower conflict). Such processes might include informal conversations, negotiation, facilitated conversations (not formal mediation), internal investigations, or other possible interventions, (although this data was not obtained through the FOI process).

This data seems consistent with the finding in the *Freedom To Speak Up Report* which suggests that "thousands of reports of incidents and matters of concern are dealt with satisfactorily all the time" but that there is also a "marked lack of the skills needed to resolve difficult and sensitive situations".[611] But it remains that, if 72% of cases are resolved, the inference is that 28% are not.

Although the FOI narrative is at first glance a good news story in which wrongdoing is addressed and the relationship with the whistleblower is maintained, whether this is the case and how this happens is not apparent. One possible interpretation is the corollary of the argument suggested in earlier chapters; in other words, although whistleblowing creates a perception of an injurious experience in some NHS cases, it does not do so in all cases - indeed it does not do so in a majority of cases, as the Felstiner Model suggests. [612] This suggests that some form of whistleblowing occurs,

[611] See the *Freedom To Speak Up Report,* Cover Letter to the Secretary of State for Health at p.2. It seems inevitable that Trusts may have different understandings of whistleblowing, but this is not portrayed as a major issue in the report.

[612] See 'The Emergence and Transformation of Disputes' at p.636.

that the organisation not only does not retaliate, but also addresses the wrongdoing constructively, so that no conflict arises and a substantial majority of cases are resolved. Even if that is plausible, which I suggest is questionable bearing in mind what this study has revealed about NHS behaviours towards those who speak up, it is not all good news: the FOI data also tells a story of unresolved cases. Both narratives, the good news narrative and the narrative of unresolved cases, form part of the overall FOI story and so they are interconnected; you cannot take one without the other, but both leave significant open questions about the meaning of the NHS story - and what is really happening on the ground. It should be noted, however, that while the FOI data can provide statistics about apparently resolved cases, the FOI Data inevitably, given its nature, has limitations, including the lack of information it provides about the nature of the underlying whistleblowing it is reporting and how the cases are resolved in practice.

3.2 A Story of NHS Trusts with no whistleblowing (or virtually no whistleblowing) [613]

The FOI data includes 9 Trust responses confirming no whistleblowing cases over the three-year period. [614] A further 8 Trusts report only 1 case and a further 5 reported only 2 cases. These data also imply a good news story, namely, that formal

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[613] I include Trusts with no more than 2 formal whistleblowing cases over the 3-year period.

[614] To reiterate, as mentioned above, whistleblowing means formal whistleblowing unless I indicate otherwise in this context. The 9 Trusts were: Gloucestershire Health and Care NHS FT, Milton Keynes NHS FT, Moorfields Eye Hospital NHS FT, Northumbria Healthcare NHS FT, Royal Berkshire NHS FT, Sherwood Forests NHS FT, Somerset Partnership NHS FT, South Tees Hospitals NHS FT and The Walton Centre NHS FT.

whistleblowing is virtually non-existent in 22 of the 114 Trusts who responded. Formal whistleblowing numbers (or indeed FTSU numbers of concerns) can be a sign of a healthy environment where staff feel safe to speak up, or the opposite, a sign that workers are fearful of doing so.

The numbers alone however cannot tell the story, which again raises significant questions. In some cases, Trusts provided narrative responses intended to clarify or flesh out bare statistics. For example, The Royal Berkshire NHS FT indicated that "employees don't tend to use the whistleblowing route - it is more common to raise issues via the FTSU guardian". This comment again raises questions (for instance, how does the whistleblowing route differ from the FTSU route, and why do they prefer it) but may also suggest that the Local Guardian route is gaining trust with workers. Northumbria Healthcare NHS FT gave the following response which if anything increases concern: "Northumbria Healthcare NHS FT does not employ whistleblowing workers and is therefore unable to provide any information for questions 3, 4, 5…etc." [615]

3.3 Understandings of whistleblowing in FOI Data

The FOI Data is a valuable addition to the study as it provides data derived from many Trusts, offers statistical context and suggests insights as to how Trusts view whistleblowing; it also enables some narratives to present themselves. Some of the data appears very

[615] This Trust is mentioned as a contributor to a book about conflict in the workplace, which makes the reply even more puzzling: see David Liddle, *Managing Conflict: A Practical Guide to Resolution in the Workplace,* (Kogan Page Limited, UK, 2017) at p.xii.

stark - such as the very small incidence in the use of formal mediation, and the very high proportion of cases which are apparently resolved. I suggest the biggest challenge in connection with the data was one of interpretation.

As discussed, it was apparent that in practice Trusts may see, handle and categorise the raising of concerns - so, what they understand as whistleblowing - differently. The FOI process is a relatively blunt instrument which is not readily able to capture nuance and complexity and whistleblowing, and the sometimes fine distinctions between cases, may mean Trusts interpret them and respond to them in different ways. [616] The FOI Request deliberately invited Trusts to respond in relation to cases which they would "usually consider to be whistleblowing cases" (Q.3 of the FOI Request) and the variety of responses suggests that this differs between Trusts, as discussed. While I have sought to be as clear as possible about my method of analysing the data, and suggest it has generated valuable narratives, it is nonetheless an area where further research should be considered.

In the discussion that follows I will comment on the group narratives including where relevant the FOI stories discussed above.

4. Discussion

[616] Differences in interpretation were also noted from FOI replies in one other study (which post-dated my FOI research) see 'Whistleblowing in the time of Covid-19: findings from FOIA requests' (selected papers from the International Whistleblowing Research Network conference at Maynooth University, 2021, Middlesex University Research Repository at https://eprints.mdx.ac.uk/34505/)

The following analysis of the participant data is structured around certain aspects of whistleblowing conflict (as discussed in Chapter 2) which are highlighted in my conclusions to Chapter 3. Briefly, therefore, I consider (1) whether the group stories show that whistleblowing is perceived as an injurious experience and, if so, why; (2) stories of the wrongdoing alleged by the whistleblower so that these are taken into account when discussing the whistleblowing conflict; and (3) stories of retaliation (and the freedom to retaliate) as an expression of grievance against the whistleblower. I will also discuss the group narrative as a whole and comment as to what the group stories and narrative, looked at in these ways, have told us about whistleblowing conflict and its resolution.

4.1 The perception of an injurious experience caused by the act of whistleblowing

Tom's story shows first-hand that he perceived the whistleblowing allegations directed at the clinic as an injurious experience. Tom was, as a consultant at the clinic, in the position of the wrongdoer, and therefore particularly vulnerable to perceiving injury. He conveyed a palpable sense of grievance and anger for multiple reasons: the allegations felt unfair, and had already been repeatedly raised by Tom and his colleagues with managers and no action taken; the whistleblower was plainly vexatious, and not credible, having been struck off twice by the GMC for his inappropriate conduct, according to Tom's research; this information was readily available on the internet and could easily have been picked up by HR, so the incident could have been avoided. The public nature of the allegations was

humiliating for Tom and others who ran the clinic (they had to repeatedly reassure patients); and perhaps most of all, Tom felt deeply aggrieved by the humiliating treatment he received from managers who were unwilling to trust him even with the allegations notwithstanding that he was a senior consultant with decades of experience. Tom and his colleagues felt deeply insulted and unsupported by hospital management.

This incident had occurred a few years prior to our interview but the emotions still seemed raw - suggesting a legacy of emotional and psychological distress associated with the whistleblowing. Having himself raised similar issues previously, Tom did not dispute some aspects of the allegations, but knew them as simply part of the demands of the job. Tom saw himself as a victim in these particular circumstances and in my view, he felt a clear sense of grievance. Tom's was a powerful account. This first-hand perception of injury is not replicated elsewhere in the group data, and as such, provides insight into the story of a clinician who has been placed in the position of a wrongdoer by a whistleblower. Tom's story illustrates the subjective nature of perceptions of the whistleblower, the wrongdoer and the wrongdoing and shows, from Tom's viewpoint, how these elements can look very different when compared to the more typical whistleblower narratives contained in the *Freedom To Speak Up Report* (and as discussed in Chapter 2).

Margaret was supportive of her whistleblower colleague as she saw the merit in his concerns, and shared them, suggesting that colleagues can be supportive as well as retaliatory in their response

to whistleblowing. Michael and Philip appear reticent, or equivocal, about whistleblowing and whistleblowers, as both claimed not to have witnessed whistleblowing - echoing the no-whistleblowing story suggested by the FOI data. Philip (and presumably others around him) witnessed significant patient harm due to medical negligence yet no whistleblowing occurred, pointing to the bystander response (a response which - unlike whistleblowing - I suggest does not run the risk of being perceived by colleagues as an injurious experience). [617]

Frances and Catherine, as NHS legal advisers, are to some extent proxies for their NHS clients. Their stories do not betray a perception of injury by them as individuals but their language and terminology towards the whistleblower is generally pejorative: whistleblowers are "never clean", "never come to the table clean", "there's always a back-story", "it's never black and white", "they may have a bit of a personality disorder" and "not saints in my experience". Jacob sees whistleblowers as sometimes "still living their claims" and seeking "martyr status" but is not directly critical. Further, although we cannot necessarily infer a perception of injury on the part of Frances and Catherine as individuals, there is an absence of empathy for the suffering of the whistleblower: for example, running a complex and stressful PIDA case is not seen as onerous for whistleblowers (by Frances) and whistleblowers need to "get over" their deep and distressing anguish in order to move on (says Catherine). Alan and Jacob see contextual elements of workplace behaviours which may point to perceptions of injury by colleagues: Alan see dysfunctional

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[617] This bystander phenomenon is discussed in the context of the POB Model (see Chapter 2) by Miceli, Near and Morehead Dworkin in *Whistle-blowing in Organizations* at p.35.

teams in a “brittle” workplace, so that conflict suddenly erupts, while Jacob sees whistleblowers being “fobbed off” and says that whistleblowing is “a dirty word”. However, neither barrister, I suggest, expressed themselves unsympathetically, let alone pejoratively, towards whistleblowers. Frances and Catherine, by contrast, exude an underlying feeling that whistleblowers are not seen in their true light, that the NHS is perhaps the victim in this conflict and such damage as whistleblowers suffer is largely self-inflicted.

While Tom’s powerful first-hand story spells out plainly why and how a colleague - particularly a committed clinician identified by a colleague’s allegations as a wrongdoer - can perceive an injury from an act of whistleblowing (and a transformation to a potential grievance), the stories of the other participants are more mixed. Margaret’s personal response is probably the opposite to Tom’s, as she agreed with the concerns raised, her perspective being that of a supportive clinical colleague rather than a manager or wrongdoer (but nonetheless illuminating). Equally, the fact that severe retaliation followed against her whistleblower colleague infers that the Trust perceived his whistleblowing as injurious. For me, the narratives of accomplished and experienced professionals presented by Michael and Philip are perhaps the most enigmatic: at face value, neither has witnessed whistleblowing; yet both in different ways pose multi-faceted and rhetorical-sounding questions, namely, what amounts to whistleblowing (Michael) and what is bullying (Philip). Both also however recognise that bad things happen in the NHS, and yet apparently staff do not speak up - so, no whistleblowing.

4.2 Stories of wrongdoing

In terms of conflict analysis, although the content of the wrongdoing matters - such as its seriousness and the patient harm it might cause - it is its role and purpose in the narratives of the participants which disclose its emotional and psychological relevance to the conflict: where the wrongdoing sits within either or both of the wrongdoing conflict and the whistleblower conflict. For example, in the narratives of lawyers Frances and Catherine, and generally also for Alan and Jacob, the wrongdoing is generally a secondary consideration because by this stage the conflict has re-orientated from the wrongdoing to the whistleblower. As legal advisers, Alan, Jacob, Frances and Catherine's roles are likely to increase towards the later stages of the whistleblower conflict, where a dispute has emerged and both parties may be seeking legal advice. The focus of the conflict at this stage is on the whistleblower, not the wrongdoing, and Frances and Catherine's narratives reflect this. Jacob, as discussed in Chapter 5, sees a connection, or nexus, between the two - that the wrongdoing must be addressed because of its emotional relevance to the whistleblower. This is not the case for Frances and Catherine, however: the real interest of their stories is how they see and perceive the whistleblower. The wrongdoing, with one significant exception, is generally offstage.

Both Frances and Catherine express open scepticism about whistleblower motivations and it is in that context that Frances discusses why it matters whether the whistleblower raised a "valid" or "genuine" concern about the wrongdoing - this is the exception

mentioned above. [618] In Frances' view a valid (or genuine) concern is a gateway, or pre-condition, to settlement discussions. That judgement, however, is a matter for the Trust, and as discussed, wrongdoing can be seen essentially as subjective, so opinions are likely to differ. The Trust will want to be sure the concern is not specious and that the whistleblower has no ulterior motive. A valid concern may also infer a recognition by the Trust that it is culpable, but Frances was not explicit on this point. Nonetheless, in Frances' narrative, notwithstanding scepticism about the whistleblower, the story of valid wrongdoing unlocks the possibility of mediation and in that sense the story of the wrongdoing matters for the trajectory of the conflict and its resolution. However convincing the whistleblower's story of wrongdoing, there is no certainty that it will be seen like that by the Trust; furthermore, we know from the FOI narrative that mediation is barely used for addressing whistleblowing conflict (and other barriers exist, such as the need for Treasury approval), suggesting that the prospects for settlement may be very slim in practice. [619]

Whether adverse events, or unacceptable behaviours, are seen as wrongdoing within the participant stories seems to be a matter of perspective. All of Michael, Philip and Margaret are hugely experienced and have witnessed significant events including repeated clinical negligence, appalling mismanagement and morally questionable behaviours some of which may be seen as illegal, immoral or illegitimate practices. Michael experienced egotistical and

[618] I discuss this briefly in Frances' story, above. There is a sense that the credibility of the whistleblower dictates the view of the wrongdoing implying attribution error perhaps (see Chapter 2).

[619] Alan also saw Treasury approval as a major barrier to settlement.

paranoid leadership first-hand but was able to circumnavigate its consequences. Philip witnessed adverse surgical outcomes and he personally was under significant stress for many years, yet his narrative is one of perseverance within impossible systemic pressures - because that's the job. For Philip, there is an acceptance that medical negligence (as distinct from malpractice, so intentionally taking greater than usual risk of harm) is a fact of life in surgical practice. So, for Philip and Michael, I suggest that even negligence that causes very significant harm or results in avoidable death, or significant systemic failings which are potentially resulting in harm for patients, should not be perceived as wrongdoing. They are an inevitable part of the system.

This is not, however, how Margaret perceives and narrates it. Much of her narrative consisted of stories and vignettes of wrongdoing both personal and systemic. At a senior level for much of her career, she witnessed appalling and dishonest decision-making by "poisonous CEOs" and paints a picture of an extremely dysfunctional system, and egotistical decision-making resulting in huge waste of resources and failings in care. She has witnessed abuse of the Liverpool Care Pathway (an end-of-life palliative care approach) being mis-used for the convenience of nursing staff resulting in multiple early deaths. She witnessed appalling retaliation against a consultant colleague (described in her story, above) which for her was out of all proportion to the original wrongdoing. [620] It can be said that the retaliation

[620] The *Freedom To Speak Up Report* highlights this phenomenon, describing "a culture of blame which leads to….considerable suffering, utterly disproportionate to the nature of the problem" in the Cover Letter to the Secretary of State for Health at p.3.

becomes the wrongdoing story, being the illegitimate practice, but exercised on behalf of the organisation.

The overriding impression from Margaret's story was of disillusionment, of system-wide failings that she was powerless to stop; that the personal cost of whistleblowing was too great and there were no good pathways or forums for resolving the complex dilemma faced by whistleblowers.

In Tom's account, the wrongdoing story is not told by the whistleblower (as it often is) but by the alleged wrongdoer. Tom is positioned as a wrongdoer by the whistleblower's allegations regardless of their merit. Tom's perspective, that of an alleged wrongdoer, throws a different light on the allegations themselves (usually framed by the whistleblower, as in the whistleblower stories in Chapter 5), the response of the organisation to the wrongdoing (which is usually invisible to the whistleblower) and the response of the organisation to the wrongdoer (again, usually invisible to the whistleblower). We see all of these elements of the whistleblowing in Tom's story, and from Tom's perspective. We also see the alleged wrongdoer's perspective of the whistleblower, which is unusual (although, as discussed, the whistleblower is not typical either). Tom's story emphasises the power of the perspective from which the story is told, particularly I suggest where the storyteller is very credible (experienced, accomplished). From Tom's account we see a vexatious whistleblower, and a Trust leadership which places reputation over staff well-being and why he and his colleagues felt as they did about both the whistleblowing and the organisational

response. Tom's story is an unusual scenario, but in more typical circumstances might encompass his personal response towards the whistleblower (a workplace colleague) - in particular, whether he might have retaliated.

The dominant narrative of this group towards wrongdoing, for me, is one of scepticism, pragmatic realism and resigned acceptance. The stories of the majority of group participants - Philip, Michael, Tom, Frances and Catherine - all seem to recognise that in acute hospital settings much can and does go wrong (though error and negligence, rather than knowing or reckless harm) but that is to be expected and, save perhaps in the most extreme cases, appears not to justify whistleblowing. Tom saw understaffing as undesirable and tough on staff, and tried to change it, but lived with it - yet in his story was positioned by the allegations as a wrongdoer. Philip saw egregious negligence but for him there were other ways to solve the problem (stop doing over-complex surgery, encourage someone to move on) - and in his story, Philip might have blown the whistle but decided otherwise. Jacob, as described in Chapter 5 and mentioned above, seems less focused on the difficult frontline realities of wrongdoing, and more on what wrongdoing may mean for conflict and its resolution.

For Frances and Catherine wrongdoing was a background consideration which, broadly speaking, the whistleblower had to leave behind emotionally to resolve today's legal problem or mediation. Margaret saw the wrongdoing all too clearly in a deeply flawed system, but for her whistleblowing was not the answer. This

narrative for me does not suggest that wrongdoing is ignored or that participants are wilfully blind, but that there is a high degree of normalisation of patient harm within some NHS settings and that there is no certainty, and perhaps much subjectivity, about the wrongdoing that might be seen to ground "genuine" whistleblowing. It may also imply that for some (here, experienced) NHS staff, there will usually be a route, or a personal decision, that will circumnavigate whistleblowing.

4.3 Stories of retaliation as an expression of grievance and a self-help remedy for ejecting the whistleblower from the NHS community

Margaret's account of the retaliation she witnessed against a whistleblower colleague is a vivid illustration of this phenomenon, which ended tragically for the consultant and his family. The consultant criticised the Trust over specific issues, so the Trust "went for him", "isolated him" and reported him to the GMC on the basis of false allegations. [621] For Margaret, retaliatory action follows when you "blame [or] criticise the Trust" but it is "fine" if you criticise a co-worker without implicating the Trust; this is not a distinction recognised within the Research Definition, nor PIDA, nor made by any other participants. It suggests that retaliation can be inflicted by those managers who can exercise the capacity of the Trust but seems to rule out inter-personal retaliation by, say, the individual wrongdoer. Here, the Trust retaliated aggressively against the consultant. Margaret was personally supportive of the consultant's

[621] Fabricated claims and false allegations against whistleblowers as part of the pattern of retaliation is not unusual. See the *Freedom To Speak Up Report* at paragraph 3.2.7.

whistleblowing, which appeared to be critical of the system, not particular individuals; the implication being that the retaliation emanated only from the Trust. However, this may be a valuable insight as to the nature of the conflict, as it infers that there may be many cases where the wrongdoing is systemic, or management-driven and recognised as such by colleagues, so that no retaliation emanates from colleagues other than managers on behalf of the organisation.

Tom's story amply illustrates a perception of injury - or perhaps injuries: Tom was left with a legacy of difficult emotions resulting, it appeared, both from the initial act of whistleblowing (not directed at Tom personally) and from the belittling Trust investigation. Tom had done nothing wrong, but was made to feel he had by both the whistleblower and the Trust. These emotions may well have transformed to the grievance stage under the Felstiner Model - I certainly sensed anger and frustration at the interview - but Tom was not in a position to voice the grievance very easily. He spoke to the CEO of the Trust, who apparently dismissed it (perhaps adding to Tom's sense of grievance); the whistleblower was not in the workplace, so communication was realistically out of the question. However, these unusual circumstances perhaps illustrate the dilemma of what to do with the emotional and psychological consequences of an injurious experience, or grievance. Tom, for practical purposes, had no pathway to voicing his grievance either with the whistleblower, by retaliation, nor with his employer - beyond the extreme measure of moving employment perhaps. This story

provides a valuable insight into the perceptions of those, wrongdoers or others, affected by whistleblowing. [622]

Having not witnessed formal whistleblowing Michael and Philip's narratives did not relay any accounts of retaliation. Alan highlights dysfunctional workplace relationships, but did not comment in any detail about retaliation. Jacob sees the effect of retaliation on whistleblowers (who are "like war wounded") and sees whistleblowers "not being listened to" but also makes no substantive comment about retaliation.

According to the *Freedom To Speak Up Report* (and whistleblower group participants) NHS legal advisers are heavily implicated in aggressive - retaliatory - litigation approaches towards whistleblowers rather than solution-finding. [623] I suggest this is relevant background for the scepticism and apparent lack of empathy for whistleblowers conveyed by Frances and Catherine. [624] Unsurprisingly perhaps neither described cases of retaliation by NHS organisations, and broadly speaking both described whistleblowers in pejorative terms, suggesting they were instrumental in not settling the litigation, or not addressing their trauma. Professional advisers are inevitably one step removed from the workplace conflict and its emotional consequences; I suggest that, as accomplished professionals, both Frances and Catherine would engage with assertive litigation strategies against whistleblowers as necessary to fulfil their

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[622] It is also a reminder perhaps that the term wrongdoer has pejorative overtones which may bear no relationship to the objective facts on the ground.

[623] See the *Freedom To Speak Up Report* at paragraph 24. Also, the account given by Paul, in Chapter 5.

[624] By contrast Alan and Jacob both expressed empathy for whistleblowers.

professional duties to their NHS clients. This may also be the case for Alan and Jacob, yet the tone and language of their stories, for me, was more understanding of the challenges whistleblowers face: Jacob highlighted the need to address the nexus between the wrongdoing and the whistleblower for the whistleblower to make progress emotionally as well as with resolution of the whistleblower conflict; Alan emphasised that the whistleblowing conflict is about complex human interactions and approaches that took account of that should be seen as appropriate to these settings. [625]

Generally, however, the perspective of this group contrasts starkly with that of the whistleblower group. Retaliation is perhaps the core experience of the whistleblower, as a whistleblower, and can destroy their lives and careers. Although Frances and Catherine must have some insight into the effect on whistleblowers there appears to be little empathy for them, in contrast to the more sympathetic stories of Jacob and Alan; Margaret witnessed retaliation first-hand, and it has marked her. For Michael and Philip, there is little data to go on, but a sense perhaps that other solutions are possible, thus avoiding whistleblowing - and the risk of retaliation - altogether.

4.4 The NHS group narrative

As discussed in Chapter 2 (in the context of NHS workplace behaviours),some studies see the NHS as driven by the imperative of protecting its reputation, promoting good news and minimising bad

[625] Alan emphasises the "semi-psychotherapeutic" quality of mediation, whilst at the same time recognising the barriers that prevent its use in these settings, such as Treasury approval.

news. [626] This behaviour is evident in Tom's story, in which reputation is prioritised over the well-being of both staff and patients, Margaret's story, where criticism of the Trust resulted in severe retaliation towards the critical consultant and Michael's stories of government pressure. [627] The FOI Data also tells two good news stories: the story of no whistleblowing - that 22 Trusts have had no, or very little, formal whistleblowing over the relevant 3 year period and the story of resolution, that over a 3-year period the NHS resolved the substantial majority (72%) of its formal whistleblowing cases. While good news stories are not the dominant narrative of the group, the narrative suggests that pressure to find and tell those stories is often present.

Michael's story, and Philip's story both contain examples of clinical and managerial wrongdoing, some of which is disturbing and quite shocking, but both stories are effectively silent about whistleblowing. Both participants' narratives can perhaps be understood as stories in which the storytellers are loyal, committed professionals and problem-solvers who find ways to navigate the complexities of the NHS in the interests of patients. Both stories suggest that dealing with impossible situations, whether clinical pressures or hubristic leadership, is to be expected; also, that it is normal within a complex acute healthcare system that there will be significant clinical negligence, that it is also to be expected, and does not justify

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[626] See Chapter 2, section 2, including the studies by Rachael Pope, and Mary Dixon-Woods and colleagues, cited above.

[627] See Michael's story above about weekly abusive phone calls received by Trust CEOs and the abusive call he received directly from the Secretary of State for Health.

whistleblowing. [628] My sense is not that these two accounts are by design explicitly pro-NHS, but that they plausibly represent the real-world experience of many clinicians and managers. In other words, NHS workers are committed professionals who persevere in difficult circumstances to provide the best possible care for patients; however, it is normal and to be expected that some failures of care will occur in hospitals but they do not in themselves generally justify whistleblowing.

One other aspect of the group narrative is how the whistleblower is perceived by participants within the NHS group. The narrative conveys a sense of scepticism about whistleblowers and their allegations of wrongdoing, although less so in the case of Alan and Jacob. For Tom, the whistleblower was vexatious and without credibility. For Margaret, the whistleblower is an idealist, perhaps naive. For Frances and Catherine whistleblower motivations are always questionable, whistleblowers are “never clean” - a powerful image. Their trauma is a barrier to progress which they must address - such is the implication. [629] These perceptions are generally not contextualised by descriptions or narratives about the wrongdoing, such that the scepticism about the whistleblower appears also to extend to the wrongdoing - the two are closely associated from this perspective.

The group narrative conveys a mixed picture of resolution, and mediation. Mediation is seen by Frances as having potential to mend

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[628] To provide context, I discuss numbers of avoidable deaths within NHS England in Chapter 1 above.

[629] Alan and Jacob recognised that whistleblowers suffer trauma, in their accounts.

workplace relationships but only where the whistleblower has a genuine concern; traumatised whistleblowers do not trust the mediation process. Mediation is a forum to agree termination of employment but Treasury approval for compromise payments is a real barrier. Margaret sees mediation as “a joke” - the NHS is interested only in defending its reputation and mediation implies culpability - and no good options for whistleblowers. For Alan, mediation has human potential, and Jacob sees it as part of the solution to address the wrongdoing/whistleblower nexus, but both acknowledge the current reality of the barriers to settlement - such as Treasury approval - that render it otiose. The FOI Data tells us mediation is hardly ever used to resolve whistleblowing cases, but also that 72% of cases are resolved, suggesting a good news narrative, although the exact nature of that narrative is unclear.

5. Conclusion

There is an overriding sense, for me, of scepticism about both whistleblowers and the value of whistleblowing within the NHS group narrative - recognising the more sympathetic views expressed by barristers Jacob and Alan. The data consists of a very particular make-up of participants alongside very high level FOI Data, each of which makes a very different yet significant contribution to the overall picture.

The idea that whistleblowing can inflict a perception of injury was confirmed by Tom personally, but he is positioned as a wrongdoer,

not a recipient, so perhaps more likely to perceive injury personally. Margaret witnessed retaliation against a colleague: she identified the divide between managers and clinicians as a site of conflict and suggested that, for her, the key quality of whistleblowing was being openly critical of the Trust. Criticising a colleague without implicating the Trust would not lead to recrimination.

The dominant tone, or theme, for me, is that overall the participants appeared unconvinced of the merit or value of whistleblowing. I suggest this revealed itself in a number of ways. Most obviously perhaps in the open scepticism of Frances and Catherine towards the credibility of whistleblowers but also by the apparent irrelevance of the wrongdoing - none of it was visible - but also the plain unwillingness to engage with the wrongdoing as part of the dialogue or mediation with a whistleblower. The whistleblowers, with the possible exception of those with "genuine" claims (the implication being that many claims are not genuine), are seen in pejorative terms and usually as having ulterior motives. Equally, they are seen as traumatised, but responsible for both inflicting it upon themselves and for resolving it, and moving on emotionally and psychologically. There was no sense from Frances and Catherine of any NHS culpability for the trauma inflicted on the whistleblower. [630]

Alongside the open scepticism, I sensed, was the realism and pragmatism of Michael and Philip particularly, but Tom and Margaret too. All of them in different ways signalled their recognition and to

[630] Again, Alan and Jacob appeared more cognisant of the suffering and trauma of the whistleblowers., perhaps reflective of the fact that both will represent whistleblowers as clients in a proportion of cases.

some extent acceptance of the tough and unpalatable realities of the way the NHS is run, and the equally unpalatable reality of the levels of harm to patients (discussed in Chapter 1 above). As I have commented above, however, Michael and Philip appeared to accept that some degree of harm and error was unavoidable and generally speaking did not warrant whistleblowing. Tom it appeared had raised issues before about understaffing but as nothing had been done about it was resigned to getting on with his job. Margaret saw whistleblowing as dangerous for an individual, and ineffective. Overall, the sense of the narrative was that whistleblowing was not likely to be an answer to improving the NHS. One implication from this is that whistleblowing might be seen as aberrant, signalling that the whistleblower does not understand how the system works, which could serve perhaps to ostracise and isolate her.

The lawyer participants spoke in detail about mediation, but it seems clear that it has at best a limited role as a forum to resolve internal relationship fall-out. Significant barriers exist to settling legal cases by mediation (especially the need for Treasury approval) which render mediation otiose and operate as deterrents. [631] The FOI Data also shows the use of mediation in only a tiny number of instances. However, the FOI Data suggests that in some Trusts formal whistleblowing hardly exists and that a substantial proportion of such cases (72%) are fully resolved. These data are not straightforward to construe, but this may imply that in the majority of cases the whistleblowing is not perceived as injurious and so grievances do not arise. This, I suggest, is an over-simple or perhaps too convenient

[631] Frances and Alan see this as a major barrier, Catherine less so.

an interpretation given the complex factors involved, but points to the need for further research, which I touch upon in Chapter 8.

Chapter 7

The Third Party Story

1. Introduction

This chapter follows the same structure as Chapters 5 and 6: section 2 contains the profiles and stories of the participants (including interview dates), section 3 a discussion of those stories and section 4 a brief conclusion. As previously, the profiles and stories of each participant are based wholly on the information obtained in the interview with that participant, unless I indicate otherwise.

2. The Participants, their Profiles and their Stories

2.1 Damian

I interviewed Damian on 22 October 2019.

Damian is a mental health professional who formerly practised in the NHS. He has experience working with NHS and other whistleblowers.

He sees some whistleblowers as people of exceptional moral courage and states this openly to them in his practice. Damian runs a group of whistleblowers “along psychodynamic lines” and opens the sessions saying “I have not done what they’ve done…..you’ve all been, in a way, have had more moral integrity than I’ve had”. Damian tells a story which gave him an insight into the paranoia of

some of his whistleblower clients, as he describes it. Damian's experience, during a group session, led to a realisation that "the paranoid feelings that I was feeling in the group…..were real – yes, the feelings were real…that was the world they lived in".

Damian's story is about how he sees whistleblowers, their motivations and their suffering. In his practice, he encourages a sense of identity and pride in being courageous. Whistleblowing for him has a pro-social purpose and he uses the term "social discloser" rather than whistleblower owing to the negative connotations of whistleblowing. He estimates that roughly one third of his clients are NHS whistleblowers; he sees the NHS as harming whistleblowers deliberately and cynically and sees mediation as pointless because it requires an admission of culpability by NHS organisations which they find unacceptable.

Damian's narrative describes whistleblowers as falling into three groups: a third are "vexatious", a third are "not very intelligent…just 'sort of like that, innit'…not very clever and they could have dealt with it some other way than 'bigging it up' " and the last third "are the genuine ones". The third group includes those with religious beliefs or a moral integrity that goes beyond identification with their workplace: "I've been impressed by that actually". He sees a thread of moral integrity that overrides self-preservation: "What unites all these people is they seem to have some moral integrity that many people don't have….and…I would say I don't have myself. You know, I have moral integrity, I do the right thing – but when it comes to self-preservation I don't put myself and my family in danger".

One important theme of Damian's story was the role of grievances held by the whistleblower as a factor in deciding to speak up: "I'd say 10% of them were professional irritants….they manage their own psychological equilibrium by having a 'bad object' to go to war with". He recognises that this could cause difficulty: "the trouble is the best projections fit, so the ones, they had a justifiable cause for grievance but they use a justifiable cause for grievance like an addiction, you know, and once they resolve one they find another and having them in the [psychodynamic] group was a liability" and "that sort of person, you've got to watch out for".

He sees whistleblowers hold a range of grievances: "some people are miffed because they've been overseen for an advancement….. there's a failed love affair, which is a big one", or unresolved anger towards family members "that gets transferred onto the organisation… so you have to weed them out carefully ……because if you don't take them on then they'll hold a grievance against you". He adds: "I can tell – it sounds omnipotent I know – but I can tell just when they come up the stairs that they're so uncoordinated with their clothing and strange hats and… it's an appalling thing to say but you can tell when they come up the stairs the genuine ones from the disingenuous ones… the 'disingenuous ones' are genuine too, they have a justifiable cause for grievance but it's not with the people they are aggrieved with [within the organisation], it's something from their past that's become an idee fixe basically and my problem is not becoming seen as the next person they can feel aggrieved with". As I discuss further below, this is an important observation about

whistleblower motivations (or what might be seen as ulterior motivations) that may feed directly into the conflict.

A further insight into the whistleblower's inner life is that they "re-enact" or re-live stories from their past; Damian calls this "trans-generational historical experience". He says: "I just tell them to tell me their story and within that story you can get the facts….you can always get a feel for it". He continues: "you can feel if it's somebody trying to pull the wool over your eyes or if it's got trans-generational historical significance for them….. I often say if this is happening in the present, has this ever happened to you in the past and then they tell you a story from their past which actually mirrors completely what's happening in the present, so it's a re-enactment actually". The whistleblower's past story may contain the seeds of the "bad object" against which the whistleblower is now reacting in the act of whistleblowing, often with significant emotional intensity: "if I have a vested interest in it from an emotional level, and unexplored emotional volcanic reasons, I might actually go for it hell for leather for all sorts of personal reasons – that's the thing". If something happened in the past that they couldn't resolve, they find something in the present that justifies it, they can… go to all… its a way of righting your wrongs".

Damian narrates a story of a significant moment of realisation for him in understanding the subjective perspective of the whistleblower and how whistleblowers experience the world. He took a break during a group session and thought he was being watched by a stranger in the street: "I suddenly realised the paranoid feelings that I was feeling

in the group and which I was trying to pathologize in my patients were real….. that's the world they lived in". He adds: "I felt scared actually because if they shared their stories with me I then became somebody who knew about these stories".

Damian explains that he listens to whistleblower stories as though they were dreams and interprets them as metaphors. [632] He says: "every story…..is a dream, and a dream has a reality to it, but every narrative also has an unconscious element to it". As Damian views it "metaphors are real" in the sense that the metaphor seeks to capture the underlying emotional and psychological reality. He adds: "anything anybody tells a psychoanalyst you take it….as a metaphor, you know."

In Damian's narrative, NHS organisations "definitely" act cynically to crush whistleblowers. The strategy is not unique to the NHS but "I think it's more crushing in the National Health Service because people expect something more ethical from the National Health Service… it'll be just one less person to have to pay in the NHS". Damian names the effect of this as "iatrogenic": "they're people whose problem is iatrogenic – great word" by which he means "a problem that's been caused by something in the institution driving them mad". Although the underlying wrongdoing may not be especially serious (Damian says "the issue is usually quite small, sometimes quite small") "it's the response of the institution towards the individual to quash the individual and silence them" that inflicts harm. He sees this as a form of illness resulting directly from the

[632] Sometimes figures or stories from Greek mythology eg Cassandra, destined never to be heard.

response of the organisation. [633] The whistleblower's health is "at the mercy" of those who retaliate against her. He adds: financial settlements are not available to NHS whistleblowers and litigation is also "definitely" employed as part of the NHS approach. Mediation is not used as a method of resolving legal disputes: "I don't know how mediation works because the organisations who are being whistle blown have no interest in mediation, they want to destroy the messenger". In Damian's story the NHS want to protect their name and they don't care about mediation - if they mediate, he says, "they have to admit there's something to be mediated about". [634]

The psychodynamic group is a valuable therapeutic community, in Damian's view. [635] Damian describes the therapeutic process as one of re-socialising whistleblowers by belonging to a community: "you need a group to belong to rather than blow the whistle against each other". Many have suffered, he says, and need to re-assert their identities as people who have acted pro-socially, and they should feel proud of that. [636] Whistleblowers are often rejected by their communities, so must guard against "the same things that led to the disintegration in the other groups they used to belong to, work - and family sometimes". The group provides a community setting for therapeutic conversations.

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[633] Damian works as an expert witness: "one of my jobs is to write court reports about people who have been driven mad by the system".

[634] "I've seen banks bring a massive amount of money to bear…the best way is to get the most expensive lawyer you can get and crush the whistleblower and the whistleblower, when the money runs out, that's the end of it."

[635] "My job is to try and provide a safe space where people can actually feel they do have a sense of belonging to a group that actually shares some moral integrity".

[636] See 'Whistleblowing, its importance and the state of the research'.

In his therapeutic practice, Damian encourages whistleblowers to look forward to a better time: even though it's horrendous to suggest it you have to let the traumatic experience take a back seat and let something else grow through the concrete – what I call flowers in the concrete" - a metaphor for emotional and psychological progress. Damian suggests that some whistleblowers have unknowingly invested in emotions that can harm them: "I think by actually taking responsibility for what you invest in, investing in a bad object will actually ruin your life at the end of the day".

2.2 Caroline

I interviewed Caroline (by telephone) on 29 October 2019.

Caroline formerly worked at the National Guardian's Office. The National Guardian's Office was created following recommendations in the *Freedom To Speak Up Report*. [637] Caroline recognises that the insights of organisational insiders are uniquely valuable for making change; what defines them as whistleblowers, however, is the NHS response to the whistleblowing. There is a growing recognition within the NHS, she says, that it is pursuing whistleblowing policies which are positively harmful to staff.

In a previous role she was approached by organisation insiders on several occasions "and able to make some really impactful changes".

[637] The original scope of the role was summarised in the *Freedom To Speak Up Report* at Principle 15 – External Review on pages 18/19.

This is a key insight for her: “the people who work in organisations have the most up to date and insightful information” but change will only happen if the concern is raised with the right person: “if it comes to the right person who can actually make changes, it’s a really effective way of learning things about organisations that you wouldn’t otherwise know”.

As she sees it, Local Guardians (see Chapter 1) are agents of change, as well as fielding whistleblowing concerns. [638]

A key aspect of Caroline’s story is that how NHS organisations respond to the whistleblowing defines the whistleblower as a whistleblower and it is this that determines the trajectory of the conflict (Damian makes a similar point). She says: “it’s the response of the organisation which actually turns them into something that they never intended to be in the first place”…..“no one wakes up in the morning saying ‘I think I’m going to be a whistleblower today’ ”. [639] The key focus is on the initial contact: “so actually I think it’s at the really early intervention stage if you get it right, things go right”. She adds: “I think what everybody agrees on is that if the very first contact that that person has didn’t go well then things sort of spiral out of control afterwards and because people know that it didn’t go well their behaviour then changes.”

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[638] Caroline argues that “as the organisations improve their speaking up culture, their rating improves, so……it’s not that they get really outstanding and then people are sort of happier to speak up, it’s actually the other way round – speaking up leads to improvement”.

[639] Also: “I don’t use the term whistleblower unless somebody self-describes that way because for some people the idea of being a whistleblower is just really, it doesn’t fit with their values because what they feel they're doing is actually just doing their job”.

Caroline does not advocate a single narrative explaining why organisations reject whistleblowing, and sees “many different reasons” for that. Trusts worry about bad publicity: they may be “fearful about regulators”, or “don’t want bad stuff to come out”. She interprets it in the end, however, as a people-problem: “essentially, it’s a threat to the people and it takes a very kind of courageous organisation with excellent leadership to welcome bad news”.[640] Nonetheless, Caroline sees the repeat pattern of Trusts retaliating against whistleblowers and sidelining the wrongdoing: “time and time again I’ve heard this in the past which is that somebody says, ‘Look, I raised the clinical issue or a safety issue and the thing that then gets focused on is the HR [employment-related] side of it’ and that’s because the safety issue just gets left by the wayside”.

For her, Local Guardians can minimise conflict by using informal approaches rather than formal channels, to “get away from the formal sort of train track approach towards grievance or the employment tribunal”. Some Trusts are piloting new conflict-orientated approaches: “they’ve said, ‘right, we’re not going to have a grievance policy, we’re going to change it to a resolution policy’ …..because when things become beyond a point of no return, then you get really entrenched views”.

Caroline comments that staff are harmed when whistleblowing interactions develop as conflict and believes this is now more widely recognised: “these are people who’ve given decades of really

[640] This is a critical insight for understanding conflict, as I discuss below: only individuals (not organisations) can perceive injurious experiences, which is the starting point for dispute emergence under the Felstiner Model.

excellent service and at a time when they need the organisation most, the organisation turns around and starts doing things through policies which are very harmful" adding "the things that we'll do for our patients automatically, we don't automatically do for our colleagues, there's something really strange about that". Her narrative suggests that harmful practices generate unhappy workplaces, which fuel animosity and conflict, adding: "in one of the case reviews we did in a single department there were 50 grievances and counter grievances. Now there's a massive cost in that". [641]

Caroline also discusses mediation as a means of addressing whistleblowing conflict. In NHS organisations, she says, mediation is usually seen as a Human Resources (HR) method of dealing with employment grievances. Her story suggests the association with HR deters staff from using mediation generally: "people don't want to go anywhere near HR….HR has got a kind of rather hard edge to it". In whistleblowing cases, she says, whistleblowers lose all trust in organisational attempts at resolution and what matters is the story a whistleblower is telling herself, her perception of the external facilitator: "whether somebody [a facilitator or mediator] is internal or external, it's about the perception of the person who is going through that process, that's what really matters". Caroline sees mediation used as an HR box-ticking exercise, part of a superficial narrative, but not addressing the real story of the underlying conflict: "the offer of mediation is a box that has to be ticked…. It's not being offered in a way of looking to resolve, it's just like oh, we've offered you

[641] Case reviews are available on the National Guardian website at www.ngo.org.uk.

mediation, tick, now we can do the process we really want to do which is to get rid of you".

2.3 Naomi

The interview with Naomi took place on 26 November 2019**.**

Naomi is an inspector of NHS Trusts for the Care Quality Commission ("CQC"), the main regulator of health and social care in England. [642] Her job requires her to get under the skin of the NHS organisations she inspects to identify behaviours or concerns which might compromise patient safety. She tells stories of "toxic culture" within hospital departments where staff were very scared to raise concerns with managers (although they would do so in the safety of confidential meetings with Naomi and her CQC colleagues). [643]

NHS Trusts can be enormous organisations: "they're extremely large, they're extremely complex, they have boards, they have leadership teams that are divided into divisions. They have over 6,000 staff. They have budgets of millions". She explained the process of how the inspectorate identifies hospitals or departments in which staff are frightened or unwilling to raise a concern because they will suffer the consequences. She commonly inspects hospitals where staff are

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[642] See Oliver Quick, *Regulating Patient Safety,* at p.78.

[643] Naomi tends to refer to "culture", or "toxic culture" throughout her story, but this study is not a study about NHS culture. I draw a distinction between NHS culture (which is beyond the scope of this study) and the behaviours of staff towards one another particularly when raising concerns. See Chapter 2 .

often under intolerable pressures and being harmed but are frightened to speak out.

Naomi's story is from the perspective of a regulator of large complex NHS Trusts. One of the aspects of her role was to listen to staff to assess the credibility of their narratives. The inspection process was substantial and complex, but intuition about the stories she hears is a key factor in weighing up whether a unit, or department, is safe for staff and patients. [644] Part of Naomi's narrative was that avoidable deaths happen every day. [645]

CQC inspections entail multiple meetings with Trust leadership and various groups of clinicians. Inspectors are looking for signs of dysfunctional behaviours, such as bullying or unsafe practices (for Naomi, "toxic cultures"). Naomi said that most of the time toxic culture "comes out", but not always: "where it struggles to come out is where people are really very scared about speaking up because they're worried about, you know, basically a career limiting type of thing". She described very tense meetings: "we do occasionally go into situations and you kind of know that there is something going on there. You know it. You can sense it. It's almost there's a tension. People are almost being a bit too, kind of, speaking the party line on things and you just know there's something going on and people are

[644] See the *East Kent Hospitals Report* which listed the missed opportunities to grip the Trust failings. These included a 2014 CQC inspection which included 6 visits and ended with a very critical report. The report states that "the CQC noted an unusually high number of staff raising concerns about safety directly with its inspectors" at p.5.

[645] Avoidable deaths are discussed in Chapter 1. I asked about a press report the day before the interview about an autistic teenager who died in hospital having gone without fluids for days. Naomi replied: "It should never, never happen……I would say that probably the complete failure of that was around communication….it can happen so easily". She adds: "people are dying in hospital the whole time because things like this happen" .

scared to say, and those are very, very difficult situations". Trust in the inspectorate, she adds, is vital in unearthing what is really going on and builds up over multiple visits.

Naomi told a story of attending a "packed" meeting of around 30 junior doctors on their "third big inspection" and it was very evident there were concerns. [646] This was followed by a meeting with the consultant body in which two of the consultants were in tears, "feeling that it was essentially unsafe." A meeting with the senior leadership team established deep frustration with poor leadership by the Trust CEO which "was creating a very unsafe situation for patients and frontline staff". Ultimately, the CQC imposed a change of CEO. Naomi's narrative sees one individual, or a small number, at the centre of these difficult circumstances: "what I have seen in a few cases is that the top team can either make a huge positive or a huge negative difference really quite quickly throughout the organisation. They're very, very influential." Equally, in very large organisations, some conflict and friction is inevitable: "we accept that, in an organisation of 6,000 staff, whatever, you will never have no issues…..it's absolutely impossible."

However, Naomi added that judging whether a member of staff was genuine, when reporting wrongdoing confidentially, was potentially complex and required careful questioning of the whistleblower. As Naomi puts it, it is a matter of asking questions, although a CQC inspector will have little or no prior knowledge of the whistleblower

[646] "Normally you have a 'nicey, nicey', what's going well this year, but they did not want to do the nice. They'd got a list. They'd pre-agreed it. There was some very concerning stuff about quality of care and safety of patients, particularly out of hours. They had raised these issues but they hadn't felt listened to with it."

(unlike a line manager). Some conversations can require particularly careful navigation: “I think where it gets really, really difficult is when [the worker/whistleblower] is themselves personally in some sort of HR type process” [such as performance management] as there might be “a vexatious component to it”. The whistleblower’s personal HR process should not obfuscate her genuine concern, but could influence the CQC perception: “is the person raising some perfectly valid things…. or is this person actually just making trouble?” For Naomi, it is a matter of judgement in all the circumstances: “We just ask questions really, to try and understand it. But it’s not straightforward”.

Naomi sees a place for facilitated or mediation conversations to address some workplace conflict - what another participant called “peace talks”. She saw two cardiac surgeons “at one another’s throats”: “both of the individuals were at fault to a degree and the problem was nobody had ever properly done the work to mediate between and actually try and address it.” It required “some very skilled individual, external to the organisation to come in and work with these two individuals and actually mediate and see if they could get them to work together.” For Naomi, mediation may have merit in these circumstances, but she did not see it as suitable for whistleblowing owing to the greater complexity added by allegations of wrongdoing. [647]

[647] Naomi referenced other quite basic form of mediation again not suitable to whistleblowing however, the WRES scheme (the Workforce Race Equality Standard). This is now “really common practice” more so in London because “obviously, the percentage of BME staff in the capital is huge”.

Naomi's narrative also touched on the role of Local Guardians. Formal whistleblowing schemes such as helplines, are being supplanted by the Local Guardian regime, which Naomi sees as positive: "it's giving a very good message that people should feel able to speak up and I think that's really important". [648] For Naomi, there is a growing association within the NHS between staff satisfaction and patient care and she sees the Local Guardian system as part of that trend towards staff well-being: "so, the really big change that has happened, to my mind, is that there has been a recognition that happy staff provide good quality care".

One consequence of this, as Naomi sees it, is that whistleblowing through formal channels (such as a helpline) is being "practically phased out…..because actually, it's been replaced by the FTSU regime". She adds: "quite a lot of the Trusts that I now inspect do not any longer have things like a whistleblowing line……because they were not being used….and the interesting thing is….whistleblowing has kind of gone to a degree, although the concept of speaking up, which is what it was, has largely gone to the FTSU Guardian". According to Naomi, Trusts are still required to have whistleblowing policies and procedures, but distinct data about numbers of formal whistleblowing cases is often not available: "I think I'm seeing that fading out actually". So far as the CQC is concerned "we classify any

[648] Naomi says "the number of contacts to a FTSU Guardian are, by and large, much higher than they ever were to whistleblowing [help] lines". What seems clear is that the number of headline contacts with guardians has increased substantially over the last 4 years or so: the National Guardians Report 1 April 2020-31 March 2021 states that cases reported are over 20,000 for the year compared to 7,000 in the 2017/2018 period. It is significant but does not tell you how many cases are formal whistleblowing, a point raised in connection with FOI Data, above.

member of staff who contacts us about anything, we classify it as whistleblowing". [649]

2.4 Lionel

I interviewed Lionel on 15 January 2020.

Lionel is a practising solicitor who acted for a number of families whose babies died because of poor cardiac surgery in the mid-1990s at Bristol Royal Infirmary. Poor cardiac surgical practice by two surgeons were responsible for a significant number of avoidable infant deaths over the period from 1984 - 1995. [650] The case is associated with Stephen Bolsin, a young anaesthetist at the time, who blew the whistle about the unusually adverse mortality rates arising from the surgery. [651] Lionel attended the 1997 GMC hearing related to the two surgeons and the subsequent public enquiry, chaired by Sir Ian Kennedy, which lasted from 1998 to 2001. [652] The final report of the enquiry, the *Kennedy Report*, was published in July 2001. [653]

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[649] The blurring of whistleblowing and FTSU Concerns is discussed in Chapter 6 (FOI Data).

[650] The Bristol case is fully documented in the public domaine following GMC Hearings and a Public Enquiry. See Department of Health, *Learning from Bristol, The Report of the Public Enquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995* (CM 5207(1) 2001) by Professor Sir Ian Kennedy (hereinafter *The Kennedy Report*) and Department of Health, *Learning from Bristol: The Department of Health's Response to the Report of the Public Enquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995* (CM 5363 2002) at www.gov.uk/government/uploads/273320/5363.pdf.

[651] See *The Kennedy Report.*

[652] Ibid.

[653] Ibid.

Lionel tells a heartbreaking story of the babies who died and the families who suffered; the whistleblowing was a matter of life and death for the families. He says the whistleblower's s narrative was ignored even though he provided detailed data of poor surgical outcomes. [654] The narrative of the competence of the senior (and likeable) surgeon was the dominant narrative and the story of surgical incompetence told by a young anaesthetist was a subservient narrative and, Lionel says, proved ineffective to change the mindsets of senior colleagues. The pattern extends to conflict resolution too, in Lionel's mind, as he sees attempts at mediation of whistleblowing cases such as this as "a non-starter" as the NHS is unwilling to accept unwelcome news.

Lionel's perspective is partly as a witness of events at the time (such as the public enquiry) and partly as an advisor to families suing the Trust. He witnessed evidence from key players, including the two surgeons conducting the heart operations, senior leaders at the Trust and Stephen Bolsin, the whistleblower. His story shows how perceptions of events can differ dramatically.

Lionel's narrative also described the resilience of the dominant NHS narrative protecting the two paediatric heart surgeons, against the whistleblowing. Bolsin was new and junior and within a year of arriving from a major London hospital "started to raise concerns within the unit… but hit a brick wall". He collated data showing "that

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[654] Sir Ian Kennedy in the *Kennedy Report* commented that: "In the period from 1991 to 1995 between 30 and 35 more children under one died after open heart surgery in the Bristol Unit than might be expected had the unit been typical of other PCS [paediatric cardiac surgery] units in England at the time".

far more kids were dying at Bristol than anything he was used to and the surgeons [were] taking all day, maybe ten, twelve hours in extreme cases, to do one operation". One surgeon in particular was a popular figure: "there's anecdotes that his Volvo was the last to leave. You know, he was a very likeable guy and when children did die…..[he] always seemed to be able to reassure parents that the anatomy wasn't as they'd expected it, the defect was more complicated. No parents really thought that anything had gone wrong".

A "pivotal" moment, for Lionel, was in 1992 when Bolsin took a stand about a forthcoming operation on a child called Joshua Loveday. [655] Joshua died after the operation and following that matters became public. Private Eye magazine was the first to publish, but with minimal impact. The article said that "insiders were calling the Bristol heart unit 'the killing fields' and 'the departure lounge' ". The surgery "carried on for another two years after that…..which is astonishing". Bristol was "an open secret" in medical circles, Lionel says.

Bolsin suffered life-changing retaliation, so he was never able to work again in the NHS (there was thought to be an informal practice of blacklisting whistleblowers) and subsequently emigrated to Australia, which "wasn't something he had ever intended to do". [656]

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[655] He unsuccessfully contacted the senior surgeon at Bristol and even the Department of Health to try to stop the operation going ahead.

[656] NHS blacklisting of whistleblowers was a recognised practice and has now been legislated against with the addition of s.49B ERA and associated regulations. See *Whistleblowing Law and Practice* at pp.891/2.

The narrative of competent, committed surgeons appeared to facilitate other narratives in the form of conversations with anxious and vulnerable parents seeking consent for the surgery, according to Lionel. He recounts an example of a family he represented whose baby son was due for surgery. This is what Lionel said: "the parents asked [the surgeon] 'does [our son] have to have this?' And he said, 'yes, he does. It's a life-saving operation' and they asked him, 'well, is there a risk of brain damage?' and his reply was: 'with all the bells and whistles we have now, the risk, it's so infinitesimal. You know, it's non-existent'. [657] Of course, he did suffer very severe brain damage. The boy subsequently died." [658] The prevailing narrative appeared to protect the surgeons from criticism: "Almost every case, [the surgeons] would say, 'Oh, 90% chance of success' – you would have expected them to have hedged their bets by being pessimistic". [659]

Lionel believes staff knew that the risk of death or brain damage was being substantially understated by the surgeons but were unwilling to speak up. [660] There were longer term consequences for the families

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[657] "They'd had a relative suffered some brain damage in some sort of operation. So, they were very clued up".

[658] The case was settled with the Trust admitting liability. Lionel described it as a clear cut case of failure of consent "where the parents had asked very specific questions and they recovered a significant settlement."

[659] Lionel spoke at length - which I have not replicated here - about these "consent" conversations and how they were normalised within the workplace but very misleading for parents. It is striking how he recounts verbatim conversations from over 20 years ago.

[660] Sir Ian Kennedy said that Bristol "was awash with data….[but]...little, if any, of this information was available to the parents or to the public" and that "such information as was given to parents was often partial, confusing and unclear" - see the *Kennedy Report* at p.3.

arising from these conversations which Lionel described in emotional terms. [661]

As for resolution of conflict between whistleblowers and Trusts, although Lionel uses mediation to settle medical negligence cases in his own practice, he did not see it used either internally for workplace mediations in hospitals, nor for whistleblowing cases. He called mediation "a non-starter in the whistleblowing field…..all in all, with what I know of whistleblower cases from following what's reported, I don't think mediation is going to make a fat lot of difference". For Lionel, he said that in his opinion very little has changed for whistleblowers between the time of the Bristol case in the late 1990s, and the present day.

2.5 Linda

The interview with Linda took place on 4 March 2020.

Linda is a mediator, conflict-resolution coach, and published author. The story she tells is of the NHS inflicting mental and emotional harm on whistleblowers. For her, mediation offers a structured framework for human connection and healing which can be effective in whistleblowing settings.

[661] Three parents committed suicide: "almost invariably the parents didn't know that there'd been any kind of error. They weren't aware of it. They thought that their child was unlucky……they didn't forgive themselves for not asking more questions".

Communication is at the heart of Linda's story and her narrative emphasises the place of justice within whistleblowing conflict and the need for the parties to hear honest stories of mental health struggles. Linda advocates the role of resolution frameworks as secure environments for telling and hearing difficult stories and the power of saying sorry, ending one story and starting another. She sees how unresolved stories are not forgotten in whistleblowing cases as whistleblowers re-enact past experience when blowing the whistle. The mediator has an important role orchestrating these stories, and thereby creating human connections.

Linda's story is about conflict and resolution, her perspective that of a mediator. She believes mediation provides a framework for expressing difficult emotions to enable conversations that can make a difference. Having a "structure in which to put these feelings is very important" and creates the opportunity "to have a deeper understanding". [662] Mediation, says Linda, enables people in conflict to take responsibility for their life experience and their decisions. The mediation framework "allows the anger and hatred to dissipate….an opportunity to be safely vulnerable without having to let go of your principles". It also allows disputing parties to make conscious choices and decisions, and to articulate them clearly. Far better, she says, that parties make conscious choices, because "a lot of these choices that happen during the course of a dispute are unconscious and reactive so what mediation does is help to break down and to slow down". This is important in whistleblowing settings, she says,

[662] In the workplace day to day difficult conversations are often deflected: "in the NHS, you know,… it's very easy to move from 'not enough time' to 'avoid'…'oh, we don't have enough time or money' to 'avoiding' and, you know, it's 'for all the best reasons' "…. "avoid, avoid, avoid….difficult conversations".

because the consequences for whistleblowers can be severe: “three years out of work, not working, no money, anxiety, self-doubt”.

Linda observes a move within the NHS toward conflict management and mediation training but there is a distinction between internal relationship management and complex mediation. Teaching staff to be alert to conflict in everyday conversation can contribute to better workplace practices, she says. For example: “it starts with people… able to have what I’d call 'peer conflict coaching’, listening to each other’s conflicts and how, so, instead of me going to you and saying ‘I hate my boss’ and you say ‘yes, I hate them too’, you say ‘okay, tell me a bit about that, what do you want to do about it?’ So, instead of having a circular conversation you actually enable me to take responsibility for hating my boss and choose whether I want to do something about it or whether I just want to go on about how I hate my boss”. She adds, “it’s about having different conversations”. [663]

She describes a reluctance to mediate in NHS whistleblowing conflict as “dangerous” and sees lawyers as fearful about the use of mediation as it implies “a cover-up” of wrongdoing by the NHS. Yet mediation is a framework in which disputants can make conscious choices when reaching agreement which “ are often good choices”. A particular challenge in whistleblowing is the public interest status of the wrongdoing, but for Linda the wrongdoing is just one aspect of the negotiation between the parties. The whistleblower may - through the mediation - be able to negotiate ways to contribute to service

[663] Linda broadly equates the ability to have different conversations with improving workplace behaviours. To have them, workplace relationships must have evolved to permit a new conversation.

improvements. [664] For Linda, whistleblowers appear unaware of the potential of mediation and view it through the filter of their legal advisers. [665] Discussing mediation with a mediator might generate a "possibly quite different" response from a discussion with a lawyer. Linda also sees whistleblowers as fearful of being pushed into mediation, a process that many would not necessarily have experienced.

Linda conveys a strong narrative of mediation as having healing or therapeutic potential, relevant to traumatised whistleblowers. Mediation "addresses some of those questions around….the rest of your life, also how are you going to deal with this trauma? That's a really important part of the process in my opinion". Even without resolution, mediation can help whistleblowers be clear about their decisions. She sees the need for justice and accountability within the conflict for mediation to work which may mean parties, or one of them, accepting culpability and saying sorry (or as Linda puts its "fess up"). Linda also sees a connection between accepting culpability and, with that, an acceptance that workplace practices (such as bullying management styles) must change. This is personally difficult for those involved, such as managers, and for Linda requires "stronger acknowledgement of what mental health issues are" as failing to do so means no progress.

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[664] Available data suggests this is unrealistic: see *The Freedom To Speak Up Report* generally. It is also contrary to data collated for this study. Failings in the NHS' service to patients may have legal, regulatory and professional dimensions that cannot and should not be addressed by private negotiations between whistleblowers and managers.

[665] Adding: "if they're talking to their lawyers they're not going to mediate".

Linda's narrative about mediation includes the need for a mediator with strong listening abilities which enable her to orchestrate the emotional connections between the parties: "when I listen to clients I hear something different to what their opposite party is hearing and I am then able to help them communicate the message differently with the added understanding that I have because I can hear it more fully". The mediator manages the pace of the conversations: "I will, in mediation, stop conversations happening that might be destructive and slow them down a bit, you'll slow down the conversations and….the mediator will choose what we don't talk about as well". The mediator will want to establish the underlying issue which is "driving the anger" and which is "generally not the presenting issue".

For Linda, disputants must take responsibility for their life experience and how it affects the conflict, as people in conflict will recreate, or re-enact, early or unresolved life experiences within the dispute. Equally, however, conflict can thereby be an experience of personal growth: so, "if you look at the child who feels that they're not being listened to or their sibling is being dealt with more fairly – that is going to be triggered or, you know, a feeling of not fair, not justice that can be very primal and come from a very young age". Linda adds: "it's almost the best thing that you can ever have because why are we here, well, to resolve all our nonsense".

3. Discussion

As with Chapters 5 and 6, the following analysis of the participant stories is structured around the aspects of whistleblowing conflict highlighted in my conclusions to Chapter 3. Briefly, these are: (1) whether the group stories show that whistleblowing is perceived as an injurious experience and, if so, why; (2) stories of the wrongdoing alleged by the whistleblower so that these are taken into account when discussing the whistleblowing conflict; and (3) stories of retaliation as an expression of grievance (or the voicing of a claim) against the whistleblower. I will also discuss the group narrative as a whole and comment as to what the group stories and narrative, looked at in these ways, have told us about whistleblowing conflict and its resolution.

3.1 The perception of an injurious experience caused by the act of whistleblowing

Damian's story, from the perspective of an experienced mental health professional, is about the emotional and psychological lives of whistleblowers and for that reason matters to this study.

Damian expresses great admiration for whistleblowers' moral courage for speaking up about issues of social importance. He speaks of them as social disclosers. He perceives whistleblowers as falling broadly into three groups: first, those he sees as vexatious; secondly, those he perceives as "not very clever who could have dealt with it some other way than 'bigging it up' "; and thirdly, those he

sees as “the genuine ones”. [666] His narrative provides vivid insights to how whistleblowers experience the world. These include his own story of experiencing paranoia (experienced, he says, by some whistleblowers), and of weeding out potential clients who habitually hold grievances and who he believes may at some point hold a grievance against him. Damian also recounts whistleblower motivations, including failed love affairs (which he says is common), a variety of workplace grievances and the re-enactment of unresolved childhood trauma or other historical grievances. Whistleblowers also, he says, re-enact past events (which thereby have trans-generational historical significance) so that the whistleblowing “mirrors completely” a story from their past. Few of these motivations are likely to be obvious or visible to recipients.

While the inner lives of the whistleblowers form the greater part of Damian’s narrative, he alludes briefly to some underlying stories of wrongdoing. Often, he says, “the issue is…quite small” but the institution responds by quashing and silencing the individual. He sees the NHS organisation (rather than wrongdoers or colleagues necessarily) as deliberately and cynically setting out to crush whistleblowers; the pattern of organisational behaviour is very clear to him. His narrative stands out for its frank assessment of the state of mind of many whistleblowers: two thirds of his clients are seen by him as not genuine, either vexatious or for other reasons, and not credible. That, in a sense, re-sets the landscape for discussion as it infers that, conservatively speaking, a significant majority of

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[666] He adds: “It sounds omnipotent I know - but I can tell just when they come up the stairs that they, they’re so uncoordinated with their clothing and strange hats and…..its an appalling thing to say but you can tell when they come up the stairs the genuine ones from the disingenuous ones”.

whistleblowers (including a majority of NHS whistleblowers) are not perceived - by Damian - as genuine.

This begs many questions: although we have Damian's perception of the people, we cannot weigh that easily against the wrongdoing, having heard little of the wrongdoing stories. As discussed, perceptions of both whistleblower and wrongdoing may be highly subjective. Attribution theory suggests there can be an erroneous over-emphasis on the personal qualities of the individual rather than the situational circumstances (see Chapter 2). We do not know about individual motivations of whistleblowers, but Damian portrays a proportion of whistleblowers as acting on a mix of external grievances (a failed love affair with a work colleague or being overlooked for promotion) or the re-enactment of past grievances or emotional trauma.

At least some of these, I suggest, may be perceived as ulterior motives by recipients. The wider point is that personal factors are relevant to organisational perceptions (by recipients) of both whistleblower and the act of whistleblowing. The data suggests that recipients might perceive some whistleblowers as not credible, and so be more likely to perceive the whistleblowing as an injurious act towards the organisation. This resonates with the scepticism expressed towards all whistleblowers by NHS lawyers Frances and Catherine, and perhaps also the pragmatic realism of Michael and Philip, seen in the previous chapter. That said, it must be emphasised that under the Felstiner Model, how a potentially injurious action is experienced is a matter of individual perception,

and each individual will respond according to the social and cultural factors relevant to that person.

Caroline describes the act of whistleblowing as “a threat to the people” within the organisation, although there may be many localised reasons why. By viewing it in human, rather than organisational, terms Caroline implies the relevance of the Felstiner Model. As discussed, the perception of an injurious experience must be that of an individual, or individuals - probably recipients - at the Trust, the inference being that, in Caroline’s view, those recipients may be willing to act upon that perception, by initiating retaliation. Naomi is less explicit about organisational or recipient perceptions. What she sees however is an authoritarian organisational narrative which resists challenge: she describes a number of instances where even senior clinicians are afraid to speak up despite their distress about working pressures.

Lionel narrates the same phenomenon from witnessing the events at Bristol. [667] Whether the whistleblowing relates to systemic matters (as in Naomi’s story) or other clinicians (Lionel’s narrative of whistleblowing at Bristol) the reaction of the NHS towards the whistleblower is rejection of the whistleblower’s challenge. The Trust in the Bristol case argued that the whistleblower was too “antagonistic” and not collaborative enough when raising concerns, suggesting the significance of how human interactions are perceived in sensitive whistleblowing settings, even when life and death is at stake.

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[667] Recognisable from *The Freedom To Speak Up Report* particularly.

Of the participant narratives, Damian's story throws a particularly challenging light on how whistleblowers may be perceived. It explicitly suggests that some whistleblowers, regardless of their stories of wrongdoing, may be perceived as having mixed or ulterior motives and as not being credible or genuine. There is a broad implication that this contributes to how they may be treated by the NHS. Three stories, Damian, Lionel and Naomi, identify the NHS narrative of an organisation that resists challenge and will punish those who do challenge it. [668] There is no direct data from these accounts that suggests that "genuine" whistleblowers are treated differently from vexatious or less genuine whistleblowers, nor that their treatment is related explicitly to the wrongdoing: the data suggests that all whistleblowers may suffer retaliation. When seen in the light of Caroline's view that whistleblowing threatens the people, and that how the organisation (or rather the relevant people within it) respond determines the course of the conflict, these stories strongly suggest that whistleblowing is perceived as an injurious experience by recipients/managers within NHS Trusts. The reasons for this are not articulated in detail in the data (save that Stephen Bolsin was "antagonistic" when raising concerns) although the idea, or principle, of challenge to the authority of the Trust appears to be the main factor that provokes retaliation by the Trust against the whistleblower.

3.2 Stories of wrongdoing

[668] This resonates with Margaret's comment to the same effect.

Stories of wrongdoing from all group perspectives matter in order to create as much balance as possible between the three group narratives. In this group, although some participants have hands-on NHS experience (Naomi and Caroline particularly) the other participants (Damian, Lionel and Linda) occupy roles in which they are describing and construing the perspectives of others.

In Lionel's account, he tells a detailed story both of the wrongdoing itself and the effects of the wrongdoing on the families for whom he acted. The events at Bristol have since been thoroughly documented (see above) but the point for this study is that in spite of the availability of data and prolonged whistleblowing, the narrative of the capable NHS surgeons appeared to remain largely unchallenged (notwithstanding the internal whistleblowing) until such time as the story came effectively into the public domain. That story, as I suggest, effectively overrode private objections of nurses and others who knew the disastrous results of the surgery and yet felt they had no choice but to remain silent.

We see wrongdoing stories told in Naomi's account which provide slightly different perspectives. The stories told to Naomi by distressed groups of junior doctors and consultants relate to systemic matters, such as unacceptable work pressures and under-resourcing, rather than concerns about individual clinicians. The various doctors appeared willing to speak confidentially as a group to Naomi in her capacity as regulator rather than individually, speaking to a concern not to be singled out. In other cases, however, an individual might speak separately to Naomi or a colleague, to make disclosures,

although Naomi was clear that conversations could be more complex where the whistleblower was in an HR process (such as a disciplinary process) in order to reach a balanced judgement about her credibility. Damian's narrative about his perceptions of whistleblowers perhaps gives Naomi's comments further context.

With the exception of Naomi, who may hear whistleblowing stories personally, participants in this group are unlikely to witness wrongdoing in a front line capacity. It is noticeable nonetheless that narrative focus tends to be on the whistleblower, and the conflict surrounding the whistleblower, and much less so on the wrongdoing. This is particularly the case for Damian, whose only direct observation is that the wrongdoing of his whistleblowers is often something "usually quite small", but also to a degree Linda, given her particular interest in the mediation of the conflict. The general narrative emphasis of the stories is on the whistleblower and as with the earlier analysis of conflict in Chapter 2, the wrongdoing appears primarily as background. Lionel's powerful account of his experience with families at Bristol is perhaps an exception to that.

The wrongdoing is real and harmful (babies die, and Naomi sees distressed consultants in tears) but can also be "quite small" (Damian) and in Caroline's words is "left by the wayside". The variability of the data, and general invisibility of the wrongdoing, I suggest speaks to the unlimited possibilities, and interpretations, of wrongdoing as it is perceived by whistleblowers, some of whom are genuine, and (according to Damian and some NHS participants) many are not. Whilst Bristol is at one end of the spectrum,

wrongdoing at the other end may be easily rectified, being “usually quite small” which serves to reinforce the sense that perceptions of wrongdoing will continue to be a matter of dispute in these settings - but as I argue, is generally superseded by the whistleblower conflict. As I discuss below, this can prove very challenging in resolving the conflict because of the whistleblowers’ emotional and psychological nexus with the wrongdoing.

3.3 Stories of retaliation as an expression of grievance and a self-help remedy for ejecting the whistleblower from the NHS community

As discussed in Chapter 2, according to the Felstiner Model, the transformation from a perception of injury to a grievance (the stage of the model known as blaming) occurs when an individual attributes the injury to the fault of another person (or social entity). By including “fault” within the definition of grievance, Felstiner Abel and Sarat limit the concept to injuries which violate norms, but which are remediable. [669] Whistleblowing is generally perceived as violating organisational or legal norms by illegal, immoral or illegitimate practices. [670] Assuming that the perception of injury arises from the act of whistleblowing, by definition it is the whistleblower to whom the injury will be attributed, by recipients. Retaliation against the whistleblower is consistent with the Felstiner Model, which assumes that the injured person (an individual, such as a recipient) feels

[669] See ‘The Emergence and Transformation of Disputes’ at p.635.

[670] See the Research Definition and the idea of “relevant failure” within the meaning of PIDA, discussed in Chapter 1.

wronged and that some action (I suggest, the retaliation) must follow in response to the injury. [671]

Although the data is not specific, Damian's narrative of a majority of non-genuine whistleblowers, may suggest potential for a greater likelihood of the perception of injury by the relevant organisational insiders - for example, where a recipient suspects ulterior motives. If that is plausible, then Damian's account may similarly suggest that the perception of a whistleblower as not being genuine, may also therefore influence the transition to blaming, increasing the likelihood of retaliation as an expression of grievance. As time will have passed since the initial act of whistleblowing, more information may have become available about the circumstances of the whistleblowing, or the whistleblower's reasons for it, making the whistleblower look more, or less, genuine. This may have a bearing on the state of mind of the recipients who perceive injury and may therefore further affect the trajectory of the conflict although where retaliation occurs quickly, as the data often suggests, it implies a decisive sense of injury has been perceived (Terry and Joanne's cases would be examples).

An additional factor from Damian's narrative is his strongly held view that the NHS retaliates deliberately and cynically against whistleblowers, knowingly inflicting harm to remove them from the workplace. Roughly one third of his whistleblower clients are NHS whistleblowers, suggesting his experience is significant. The repeat pattern of retaliation, familiar from the *Freedom To Speak Up Report,* is also observed by Caroline who sees it in her words "time and

[671] See 'The Emergence and Transformation of Disputes' at p.635.

again". The rejection of Stephen Bolsin from the NHS (apparently by informal blacklisting) may seem to be an extreme case of retaliation but Lionel did not see that Bolsin's whistleblowing would receive any different response now: he sees it as "very little different" now. Naomi's narrative reveals that in the 2020s clinicians are still extremely concerned about the consequences of speaking up and tend to tolerate difficult and worrying working conditions rather than take the risk of retaliation because of their whistleblowing.

As with the wrongdoing, most participants in the group hear accounts of retaliation (Naomi's witnessed deep-seated fear of retaliation) and see its effects on the whistleblower rather than witness it first-hand. These stories are nonetheless important as they provide the material for the participant narratives.

I will now discuss the group narrative more generally, touching also on Linda's perspectives on mediation which require consideration.

3.4 The third party group narrative

For me, the third party group's story can be seen as containing two broad narratives, one relating a narrative of the emotional and psychological story behind the act of whistleblowing and the potential of mediation to resolve it; the other narrative places whistleblowing conflict in its organisational or systemic context. I discuss these in turn.

(a) A human story

Damian's narrative provides a frank portrayal of how he sees and perceives whistleblowers, and understands their emotional and psychological challenges. Because of his frank portrayal, his story is both engaging and powerful: it speaks to the sensitivity (touched on in Chapter 8) of speaking of whistleblowers in such terms. Linda's story is about the potential of mediation within whistleblowing settings and owing to her therapeutic approach has resonance with Damian's discussion of the emotional and psychological experiences of whistleblowers. Damian describes various underlying emotional or psychological origins for whistleblowing observed in his practice, including unresolved historical grievances, re-enacted through the whistleblowing, or external grievances (such as failed affairs, or being overlooked for advancement). He also describes some personality types as people for whom holding a grievance is habitual and of whom he is extremely wary.

A key element of Damian's narrative is his description of how his clients break down into three roughly equal groups - discussed above - creating almost a typology of whistleblowers. This is the narrative of one participant only and like all perceptions (as we see from the Felstiner Model and from story theory) is inevitably subjective. However, for the reasons suggested above, his story has particular relevance, I suggest: the assertion that only some whistleblowers are perceived as genuine, coupled with Damian's analysis of the emotional or psychological drivers for why some whistleblowers speak up (such as re-enacting grievances and unresolved emotions) suggests an extremely mixed picture of the whistleblowers

themselves, their motivations, and how they might be perceived by others, most obviously recipients and others within the organisation. This resonates with the scepticism of some participants in the NHS group (Frances, Catherine particularly, but perhaps Michael and Philip) towards whistleblowers; Margaret, too perhaps, who sees whistleblowers as naive or idealistic. The whistleblower group narrative, by contrast, sees whistleblowers as people of credibility and integrity, speaking up for patients. These divergent narratives of how the whistleblower is perceived, her credibility, and the legitimacy of the whistleblowing, reveal the potential for conflict, as I discuss further in Chapter 8.

Another aspect of Damian's narrative, which has resonance with Linda's discussion of mediation, is that the underlying emotions, or grievances, which may drive the whistleblower to raise concerns are only acknowledged in certain settings which enable more personal conversations. [672] They are not usually acknowledged in open discussion or negotiation between the parties but may be, in more appropriate settings. Linda argues that mediation should be viewed as a safe framework which enables difficult emotions to be acknowledged and voiced between disputing parties suggesting that a safe space is needed within which dialogue may take place when the conflict is established.

Linda proposes that the real issue in mediation is "generally not the presenting issue" and her role as mediator includes unearthing the

[672] This resonates with Alan's perspective (representing both whistleblowers and Trusts) of mediation as "semi-psychotherapeutic".

story which is “driving the anger”. [673] This might be childhood feelings of not being listened to, or being treated unfairly in family or other settings. In mediation Linda expects parties to take full responsibility for their own negative emotions and life experience which has lead them to the conflict, but these emotions need to be acknowledged. Further, she sees settlement as requiring an element of justice, meaning that acknowledging fault and being willing to say sorry may be essential to reach agreement. She describes this as a personally challenging step for anyone, whistleblower or manager, requiring a willingness to change.

Both Damian and Linda provide narratives of emotional and psychological realities, the stories that whistleblowers may tell themselves. [674] Damian sees stories of grievance re-enacted in whistleblowing, while Linda sees acknowledgement of them (in mediation) as enabling progress, perhaps healing. [675] Both seem to advocate conversations which allow conscious and deliberate choices about the whistleblowing conflict which lead to rehabilitation, healing, and perhaps resolution. I am not conflating psychoanalysis with mediation in either form or content, or the objective of each process, but it is notable that Damian and Linda both emphasise the significance of the emotional and psychological experience of the

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[673] In this connection, see the discussion of the storying and deconstruction process to reveal a truer perspective of the relative relationship between the parties in *Narrative Mediation* at p.70, and also chapter 4 at p.96

[674] See Chapter 3, Introduction, for discussion of stories as the way we make meaning in our lives through storytelling.

[675] This also resonates with Alan’s view of mediation (see above).

whistleblower as being important to the experience of conflict and therefore to recovery from, or resolution of, that conflict. [676]

(b) An organisational narrative

The second aspect of the group story is based mainly on the narratives provided by Caroline and Naomi. Both have a perspective of whistleblowing as the product, or consequence, of the organisation and how it is lead, structured, funded, staffed from the Trust board down to ward level - there will be multiple factors feeding in to the possibility of concerns being raised. Whistleblowing, and therefore whistleblowing conflict, in this sense does not exist in a vacuum unconnected to the organisation's workplace, but is integral to it and a by-product of it. As Caroline says, how the organisation responds defines the individual as a whistleblower, so it is the perception of the organisation - or rather, the recipients - that dictates the trajectory of the conflict.

Caroline sees organisations that "don't want bad stuff to come out"; Naomi sees groups of doctors terrified of raising concerns because they fear the consequences. In narrative terms, one interpretation is the authority of the dominant NHS good news story, which is also how it portrays itself to itself, internally and to the outside world. [677] Lionel, too, has seen how this organisational way of seeing can lead to surgeons seeking consent from parents without telling them the

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[676] See *Narrative Mediation* at p.3, and Chapter 3 above, Storytelling in conflict resolution: models of narrative mediation.

[677] Image protection is extremely important to the NHS. See 'The NHS: Sticking Fingers in Its Ears': Protection of Image in the NHS.

truth about the risks to their children - and also of seeking to destroy the life and career of a whistleblower.

For Rachael Pope, adverse organisational behaviours may be explained by moral disengagement theory, in which the organisational narrative plays a significant role. [678] This is not incompatible with the Felstiner Model: it is individuals (not organisations) that perceive an experience of injury from a whistleblower - Caroline calls it “a threat to the people”. So, individuals inside NHS organisations may perceive injury, but how they react is likely to be influenced by the dominant narrative of that organisation; an example from the data would be Joanne’s exchange with the CEO, when she raised her concern. Joanne’s whistleblowing had significant reputational repercussions for the Trust (which would have challenged the dominant narrative of the hospital in the public eye) and she suffered immediate retaliation as a consequence.

A further facet of this organisation story is the apparent unwillingness of NHS organisations to admit culpability in whistleblowing cases owing to its apparent inconsistency with the organisation’s good news narrative. This is cited by some participants (Damian, and Paul) as a barrier to mediation partly for the reason Linda highlights - the need for justice within the mediation, as she puts it. However, as Damian sees it, NHS Trusts have “no interest” in mediating as even entertaining mediation suggests potential culpability. [679] Lionel

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[678] See ‘The NHS: Sticking Fingers in Its Ears’: Selective Moral Disengagement.

[679] This echoes Margaret’s comment to the same effect.

shares this view, seeing mediation as a “non-starter” in whistleblowing cases. Neither Caroline nor Naomi see NHS organisations engaging, in the real world, with mediation in whistleblowing cases. For me, this speaks strongly to the NHS’ need to adhere to its good news narrative, and to protect its image, but perhaps also it speaks to the inherent subjectivity of perceptions of the wrongdoing and perhaps the resistance of the Trust to accept whistleblowing by a whistleblower who lacks credibility (having regard to Damian’s account).

4. Conclusion

The third party group, then, provides two broad narratives, a human story and an organisational story. These stories are told from totally different perspectives but are not incompatible. The human story is primarily about how whistleblowers are perceived, and how they behave and why (by a psychoanalyst) and about the value to resolution of addressing emotional and psychological realities in mediation (by a mediator). The organisational story is one of understanding how NHS Trusts see and respond to whistleblowing and whistleblowers (Caroline) and about penetrating and understanding large NHS Trusts and whether (in the context of this study) they are safe places in which to raise concerns (Naomi). Lionel witnessed among perhaps the worst examples of what the NHS dominant narrative can mean in practice.

These narratives point to certain findings: Damian's description of his perceptions of whistleblowers points to a portrayal of whistleblowers across a spectrum that may straddle all three group perspectives and inform understandings of whether whistleblowing is perceived as causing an injurious experience (naming) or a sense of grievance (blaming) because of the attributes of the whistleblower rather than the seriousness or circumstances of the wrongdoing. [680] Damian, and other participants (particularly in the NHS group) are largely silent on detail about wrongdoing and Damian's narrative focus is firmly on how the whistleblowers are perceived, not the wrongdoing. Such an account has far reaching consequences for the analysis of whistleblowing conflict: the whistleblower's personal and professional qualities and credibility will be important considerations in the application of the Felstiner Model, not only the perception of injury, but in weighing stories of the wrongdoing, and how perceived grievances may express themselves in retaliation directed at the whistleblower. Attribution theory (discussed briefly in Chapter 2) may have a significant role in this respect.

Further, the human story (in both Damian's and Linda's narratives) raises the question of the wrongdoing and its relevance to the conflict. For Linda, it is a factor to be negotiated, like any other, thereby minimising its relevance in the conflict, while she sees justice as an important part of any mediation, which will likely imply a conversation within the mediation about it. [681] Linda does not define justice in this context, but by not seeing wrongdoing as significant to

[680] In this connection, see the discussions of Recipients, and of the Felstiner Model in Chapter 2 above.

[681] It is evident from other data (Frances, Esther, Jacob, for example) that the wrongdoing element is not a matter for mediation.

the whistleblower (the nexus discussed above) she differs from participants in the whistleblower group (notably Esther and Jacob) and Frances, in the NHS group. That said, the paramount focus seems to be on the emotional and psychological realities of the parties, seen through their underlying or submerged stories, which for me appears an important focus of inquiry for whistleblowing conflict and resolution.

The organisational story, by contrast, I suggest is evidence of the continuing dominance of the NHS good news narrative, revealing as it does the extremely difficult pressures it exerts on clinical and other staff and its apparent unwillingness to entertain challenge, however apparently legitimate.

Chapter 8

Conclusions

1. Introduction

This chapter draws together my findings from Chapters 5, 6 and 7, and my concluding comments for the thesis as a whole.

In section 2 below, I discuss my findings from Chapter 5, 6 and 7, organised according to the structure of those chapters (based around the perception of injury, stories of wrongdoing and retaliation as the voicing of grievance). I then comment further about certain issues, and their implications, in a real-world context. In section 3, I explain why this study matters.

To recap: this study is about the nature of whistleblowing conflict; my approach has been to identify, analyse and speak to certain elements of that conflict, and their implications, through a narrative and storytelling lens. The study is not about mediation or other processes, or their design, nor about other forms of intervention. It does speak specifically to mediation, not as a primary subject in itself, but as an aspect of the participant data both with respect to the nature of the conflict and participant needs regarding an effective resolution process. The data relating to mediation has, I suggest, revealed valuable findings about both, including the use (or rather lack of use) of mediation in these complex settings - as I will discuss further below.

2. Findings from the Participant Data and implications for whistleblowing conflict

2.1 Perceptions of whistleblowing as an injurious experience by NHS Trusts

The participant data suggested a number of findings which have implications for whistleblowing conflict.
The whistleblower stories (Hilary, Terry, Howard, Joanne and also Frank) all identified or named individuals within the NHS Trust perceived by the whistleblowers as responsible for the retaliation they suffered. Typically, they were managers or senior leaders, sometimes at board level, or in Joanne's case, the CEO. These individuals apparently exercised the capacity of the Trust against the whistleblower in explicit ways such as dismissal (Terry), long term "special leave" (Hilary), unilateral demotion and dismissal (Joanne), suspension and disciplinary action (Howard). These data are derived from the whistleblowers, but the implication is that the identified individuals are personally engaged with the retaliation against the whistleblowers as though in personal conflict, with some whistleblowers giving accounts of verbatim conversations revealing personal animosity (Terry, Howard, Hilary). [682] This in turn suggests that the reactions of the identified individuals reveal an element of grievance or injury which is experienced at a personal level.

Whistleblowing literature can depersonalise the employer, describing it not as essentially human, but corporate, in character. [683] These data remind us that the response to whistleblowing remains

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[682] These conversations are given or referenced in Chapter 5.

[683] See *Whistleblowers, Broken Lives and Organizational Power*, for example.

intensely human and suggests that individuals within Trusts do perceive injury from whistleblowing. [684] Caroline sees whistleblowing as "a threat to the people" at the Trust, not the Trust itself. In Joanne's story, the CEO - alarmingly - identified herself directly with the Trust. Although the whistleblowers describe conflict as though it is with a corporate entity, the data suggests that named individuals are likely to be intimately involved with inflicting retaliation and so by implication can be involved with stopping it. I suggest therefore that whistleblowing conflict, in line with the Felstiner Model, should be seen primarily as conflict between individuals. This finding may influence how the conflict is viewed, including potential interventions which respond directly to this human to human conflict. This recalls a statement from the *Freedom To Speak Up Report*: "One CEO told us that with hindsight an open and honest conversation around a table might have saved years of legal proceedings, investigations, and anguish for many people, as well as huge cost". [685]

For Margaret, whistleblowing is when the whistleblower criticises the Trust - that is when retaliation occurs - suggesting that criticism inflicts a perception of injury. This was also the experience of the four whistleblowers, all of whom saw retaliation as a direct response to the whistleblowing. According to Caroline, it is the retaliation which defines the whistleblower as a whistleblower. [686] The implication is that some whistleblowing causes injury and has the effect of prompting retaliation, while other whistleblowing (which does not directly criticise the Trust) does not. Where the Trust is

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[684] Tom's account shows how whistleblowing is perceived as injurious by an alleged wrongdoer - he reacts with anger and frustration.

[685] See paragraph 6.1.1 on p.118 of the report.

[686] Ibid.

directly challenged, the trajectory of the conflict may therefore differ; it may escalate rapidly, entrenching positions.

However, notwithstanding Margaret's viewpoint, other data is equivocal about the reasons for perceptions of injury by those individuals at the Trust. Howard can see that a historic interaction with the senior manager may be a factor in the retaliation against him, but suggested it may be irrelevant. The Felstiner Model allows for multiple social cultural and other factors. One of these I suggest may be workplace norms or values. [687] It is a question of how the individual responds, suggesting perhaps that whether or not the organisation retaliates may be entirely arbitrary - it depends who decides.

Other data sees the perception of injury as related primarily to the credibility of the whistleblower. [688] Frances and Catherine always see a back story, or ulterior motives, so they appear to react to that element of the story (we never hear from them about the alleged wrongdoing). These data have implications for the conflict, making the dispute about the whistleblower, regardless of the wrongdoing.

The data appears to support the contention that injury may be perceived by individuals at the Trust, but the reasons why seem to vary. One concerning implication for the whistleblower is that whether or not injury is perceived may be down to one individual (or a small number perhaps) within the Trust, making the Trust response highly unpredictable, notwithstanding the presence of policy against retaliation.

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[687] This would accord with moral disengagement theory, discussed in Chapter 2.

[688] Including Paul (the NHS strategy), Damian (many whistleblowers are not genuine), Frances and Catherine (highly sceptical).

2.2 Stories of wrongdoing

Although the whistleblower stories narrate serious wrongdoing the NHS and third parties groups mention it far less. Lionel describes the egregious events at Bristol and Damian refers to NHS wrongdoing as "usually quite small". Other than the whistleblower stories, limited data about wrongdoing were heard in the stories.

Within the NHS group, however, I perceived a sense of resigned acceptance of the inevitability of high levels of patient harm and sub-standard working conditions (such as understaffing or underfunding), yet much scepticism towards the whistleblower. The impression from the data was that for some pragmatic and experienced managers and consultants, whistleblowing was not the way to deal with a problem. I heard stories of negligence and harm, but not whistleblowing. For some lawyer participants, wrongdoing appeared irrelevant. [689] The focus was wholly on the whistleblower.

The available data suggests wrongdoing can range from the very serious to the far less serious, and may differ greatly in circumstances. For example, some concerns are systemic, or organisational, while others relate to clinical concerns, perhaps specific individuals. For Margaret, whistleblowing which criticises the Trust (such as a systemic matter, so that the Trust is culpable for the wrongdoing) may lead to retaliation, whilst whistleblowing that criticises the wrongdoing of a colleague may not. This observation has some traction in the data as this was the case for the four

[689] Although Jacob, who advises Trusts as well as whistleblowers, saw it as relevant to resolution because of the nexus with the whistleblower.

whistleblowers. This has implications for the conflict: retaliation is more likely to be forthcoming in these circumstances, escalating the conflict.

The impression is also one of infinite permutations of circumstance and seriousness, so within a conflict setting, wrongdoing may be seen as circumstance-dependent and variable from case to case. [690] Unlike the distinction outlined in the previous paragraph, the data does not support a contention that more, rather than less, serious wrongdoing is treated differently from a conflict perspective. Put another way, the data seems to suggest that the seriousness of the wrongdoing is not a determining factor in whether the whistleblower suffers retaliation, nor whether the wrongdoing is addressed. Overall, as discussed in Chapter 2, the data suggests that conflict related directly to the wrongdoing is soon superseded by conflict related to the whistleblower. However, the data also suggests that, for the whistleblower, it remains a relevant consideration (see below).

As the wrongdoing is an intrinsic part of the act of whistleblowing, it should not be thought of as in isolation from the whistleblower, nor vice versa. Any perception of injury will be a response to both elements. Although wrongdoing was seen by the *Freedom To Speak Up Report* as primarily fact-based and capable of investigation, whistleblowing researchers tend to see it as subjective. [691] From a story-based perspective, the whistleblower's story speaks to the wrongdoing, so that the wrongdoing is portrayed subjectively.

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[690] The *Freedom To Speak Up Report* at pp.125-130 concluded at section 6.4 (Investigation of Concerns) that when whistleblowing occurs the emphasis should be on establishing the facts quickly.

[691] See footnote above. For a discussion of wrongdoing as subjective see Chapter 2.

Rival perspectives are likely to exist, not least from the wrongdoer (see Tom's story), but also from the Trust. Whilst an investigation, if one takes place, may resolve matters for the whistleblower, the data suggests a loyalty from the whistleblower to her story of the wrongdoing which points to the subjective nature of the wrongdoing. For the whistleblower, the wrongdoing is what she sees it as; it is her story about it. As other stories take other perspectives, conflict may arise. I also suggest that even if an investigation leads to no further action in respect of the wrongdoing or the wrongdoer, the data shows that a legacy of grievance can generate or prolong ongoing workplace conflict. [692]

Lastly, the data suggests a nexus between the whistleblower and the wrongdoing. Although this is evident in the determined conduct of the whistleblowers themselves, it is explicit in the accounts of Esther and Jacob: both see that resolution of the employment side of the conflict may not be possible unless the wrongdoing is addressed in some way. Jacob sees an agreed investigation as appropriate; Esther sees mediation as wholly inappropriate because, as a confidential process, it should not be used to address patient safety matters. However, the overriding point is that wrongdoing (and conflict associated with it) cannot be easily separated from the whistleblower (and her conflict) and addressing the conflict as a whole requires consideration of both.

This approach, I suggest, has implications for resolution of the conflict, including an acknowledgement of the public interest nature of the wrongdoing, where relevant, and I suggest consideration of the subjective, or story-based, perspectives of the parties alongside

[692] See Hilary and Frank's stories.

any investigatory work. With potential settlement or resolution in mind, the data suggest that mediation and NDA-based settlements are problematic to both whistleblower and Trust because of their confidential nature, so consideration would need to be given to those issues, and to how the two aspects of conflict are to be addressed to provide satisfactory resolution of the whole.

2.3 Retaliation as the voicing of grievance (or a claim) and as a self-help remedy

I argue that under the Felstiner Model retaliation can be seen as the voicing of a claim by the Trust against the whistleblower apparently as a response to the pro-social organisational behaviour of the whistleblower. [693] The whistleblower is arguably acting lawfully and in accordance with NHS policies and professional duties. The data provided by participants in all groups suggest that Trusts, and recipients within them, respond to the whistleblowing with retaliation against the whistleblower. For recipients to express themselves through overt retaliation suggests that the perception of injury (naming) may have transformed to a sense of grievance (blaming) or perhaps claiming, under the Felstiner Model, whereby the retaliation represents the voicing of the claim, and the seeking of a remedy. Here, as I argue, regardless of the merit of the whistleblowing or the whistleblower, there is no legal or policy basis for a claim by the Trust against the whistleblower. As a result, individual recipients within the Trust appear to wish to claim against the whistleblower but have no legitimate pathway or outlet for doing so. Retaliation

[693] The POB Model - discussed in Chapter 2.

appears to be their way of expressing their claim against the whistleblower.

Retaliation is a real phenomenon according to many participants. The stories provide substantial data that retaliation takes place, but little about the thinking or experience of those who inflict it. It appears intended to harm the well-being of the whistleblower, and to signal the intent of the Trust to engage in ongoing conflict until its remedy is granted. As the claim (for me) appears illegitimate (as it is likely to be against Trust policy and possibly also illegal), the remedy remains unarticulated, perhaps to avoid liability, (such as for unfair dismissal). Equally, the Trust cannot simply negotiate an exit with a financial package as might happen in the commercial world because of the need for Treasury approval to compromise payments (which is rarely forthcoming, as the data shows). Retaliation may also emanate from non-recipient colleagues, which will complicate the conflict for the whistleblower, who will then also be contending with retaliation by those colleagues.

The retaliation may have an emotional or psychological grounding, influenced by the social and cultural factors (suggested by the Felstiner Model) which affect the relevant individuals at the Trust. However, it appears to lack any objective or legal basis beyond that, suggesting that the conflict derives from the perceptions of injury and grievance derived from the experiences of the relevant individuals. The whistleblowing stories and other accounts (Lionel for example) imply that, in the Trust's view, whistleblowing is seen as transgressive behaviour, and that the organisational norm (or the dominant narrative) is that it is acceptable to punish it, even if

whistleblowers see whistleblowing as ethical and pro-organisational behaviour.

However, given the legal, professional and ethical workplace setting of the NHS, personal responses must be tempered and moderated by sound professional judgement. Given all of these factors, even in the face of mistaken, naive, or disingenuous whistleblowers, for the reasons given above, I suggest that retaliation should be seen and argued to be illegitimate and behaviourally inappropriate, and that seeing the retaliation as illegitimate should be a principle of any approach to resolution.

One consequence of the illegitimate nature of retaliation, according to Damian, is that it functions as an aggravating element of ("iatrogenic") harm to the whistleblower within the conflict. The data reveals a strong sense of injustice and distress suffered by whistleblowers: you are being unjustifiably attacked for having acted professionally and appropriately. It is distinguishable from facing hostility in the face of a legitimate claim.

One NHS participant (Frances) suggested that the whistleblower should take some comfort from having a right to compensation under PIDA for detriment and dismissal. This, for me, revealed a complete misreading of the effect of retaliation on the whistleblower, and the challenges of bringing a PIDA claim, regardless of the allegations made.

The implications of retaliation for the conflict should also take account of participant data that shows it is extremely difficult to settle PIDA legal cases - this challenge is discussed in the stories

told by Paul, Esther, Alan, Jacob, Frances and Catherine. Howard uses the term “funnelling” to describe his experience, which began with retaliation and led to dismissal, followed by stressful and unsatisfactory litigation - being a pathway he found impossible to avoid. I discuss this aspect further below.

2.4 Discussion: the implications for whistleblowing conflict; areas for further enquiry

Implications for whistleblowing conflict

In this section I will comment further on the implications for whistleblowing conflict of the findings discussed above.

One important aspect of the data which is referred to in the context of mediation, and which Howard calls “funnelling”, is the apparent inability of NHS whistleblowers to settle the legal cases which inevitably arise. This is a structural element present in the data which is, as it were, hidden in plain sight, and which affects the dynamics of the conflict between the whistleblower and the Trust. The various findings discussed below fit within this macro framework for the conflict.

The framework, according to the study data, functions like this: the act of whistleblowing occurs, causing a perception of injury for recipients at the Trust, which prompts the voicing of a claim by the Trust. This assumes the form of retaliation, as a self-help remedy, because the Trust does not have a legal or policy-based claim against the whistleblower, who has acted pursuant to an ethical and

pro-social organisational approach. [694] The effect of the retaliation is either to deter the whistleblower whose career may be impaired but who remains in the workplace, or to force an exit, through inflicting detriment and dismissal. The retaliation, in its effect, often results in litigation. The litigation takes the form of two possible claims under PIDA, for damages to compensate the whistleblower for detriment, such as lost earnings, career damage, distress, and for unfair dismissal. [695] The litigation is complex, difficult and expensive. It is also strategic; because the Trust will be aware that this is the whistleblower's only option (she cannot settle, as I will explain), the Trust may conduct the retaliation in a manner that sets up various possible defences against the PIDA claims (so-called "reason-shopping", which blurs the causal connection between the act of whistleblowing and the detriment or dismissal). Paul describes this approach - he calls it strategy - which he sees used time and time again.

But structural barriers exist which prevent settlement, thereby locking the whistleblower into the litigation save in very limited circumstances: by a "drop-hands" deal (described by the NHS barrister Frances, whereby the parties walk away with no settlement and bear their own costs) or the very occasional termination (described by Catherine). The barriers to settlement include the need for Treasury approval to any extra-contractual financial payment, which is not impossible to obtain, but is very rare (Frances, Paul, and Alan all provide convincing data). [696] Whistleblowers can

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[694] The Trust will argue that this is not so, that there is an alternative narrative, but ostensible the whistleblower is acting in the interests of patients, her professional duties etc.

[695] See the discussion of PIDA in Chapter 1 above.

[696] Note that Alan's perspective includes representing NHS Trusts as well as whistleblowers.

face financial and career ruin, so the need for financial compensation is real and important (Frances confirms this), and the need for Treasury approval therefore significant. The difficulty of obtaining the approval renders mediation (or any other intervention) pointless as settlement is very unlikely and so mediation is not attempted (Paul, Frances, Alan). Although the barrister participants on all sides (Frances, Alan, Nicole, Jacob, Linda) see mediation as having human potential, by and large it is seen as having no role in NHS whistleblowing (Frances, Alan, Damian, Margaret).

Further barriers to commercial-based settlements, in addition to Treasury approval, and which also reflect back on the use of mediation, are first, the Trust need for an NDA (Hilary, Joanne and Terry all turned down financial settlements) notwithstanding that PIDA makes NDAs void to the extent that they inhibit the making of protected disclosures, and, secondly, the very real possibility (now legislated against) that a whistleblower may be informally blacklisted from working in the NHS. [697] For these reasons, and others discussed above (see Hilary's account) mediation has not been a trusted process for whistleblowers.

In short, therefore, the Trust's retaliation has forced the whistleblower from the workplace, and her only option to seek compensation is risky litigation which she cannot settle.

The data supports this structural dilemma for whistleblowers and I suggest that the elements of conflict discussed below sit within this overall framework. In essence, therefore, alternative approaches derived from the findings for this study need to address aspects of

[697] This has now been legislated against - see s.49B of PIDA - and is discussed in Chapter 1.

the framework so as to provide genuine options, or pathways, which enable the parties to develop more effective solutions than the framework described above.

For me, there are three aspects of the data, which have relevance for the conflict in the context just described: first, the role of illegitimate retaliation as a deliberate choice of the Trust; second, the need to address the whole of the conflict, being both the wrongdoing aspect and the whistleblower aspect; and third, the need for appropriate story/narrative-orientated rather than problem-orientated approaches to interventions.

Retaliation by NHS Trusts is, I suggest, a deliberate choice, which appears to derive from the perception of injury by relevant recipients within the Trust. Caroline stated that whistleblowing is “a threat to the people” at the Trust who, for example, wish to protect its reputation. Retaliation has always been been a response to some whistleblowers in some organisations (see Alford, writing in 2001, and Lionel, discussing Bristol in the 1990s) as a method of choice for protecting its interests. [698] It is seen in the data as unjustified, illegitimate, and against NHS policy. It is also clear from the data that PIDA does not deter Trusts from retaliating against whistleblowers. [699] As discussed above, retaliation is also a key link in the chain to adverse outcomes which generally will not benefit any party, but which can be justified by Trusts on the grounds of transparency. [700] The participants see retaliation driven from within the Trust by named individuals. Further, as argued, whether a

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[698] See *Whistleblowers, Broken Lives and Organizational Power.*

[699] This is one argument for reform of PIDA, discussed at *Whistleblowing Law and Practice* at section M at p.19.

[700] Entering into an NDA can be seen as a cover-up by the Trust.

particular individual recipient within the Trust perceives injury or not suggests that retaliation is not a matter of policy, but much more arbitrary. For the pattern of conflict to be arrested, greater recognition of the conflict-based analysis is required, particularly the apparent causal connection between the perception of injury by responsible individuals and the use of illegitimate retaliation as the voicing of grievance. However, for Trusts to be incentivised to change retaliatory behaviour, I suggest alternative, and better, means of addressing the whistleblowing conflict are required.

In this regard, the data suggests the desirability of alternative approaches to address the wrongdoing conflict as well as the whistleblower conflict. We know that retaliation is likely to escalate the conflict; also, that early interventions are thought to be helpful in ameliorating escalation. [701] The data also points to a nexus (in the mind of the whistleblower) between the wrongdoing and the whistleblower that can endure within the conflict. Any approach will need to take account of public interest and patient safety issues, and require practical and independent investigation, but for me (and this is a separate but connected point) addressing the wrongdoing requires greater emphasis on the subjective nature of how the whistleblower sees the wrongdoing. There are reasons why the whistleblower raised the concern, there is a story to be heard, and I suggest that the approach to investigating the wrongdoing should take into account how the whistleblower sees the wrongdoing and how it might be addressed; my argument is that the wrongdoing conflict cannot be addressed solely by a factual investigation. [702] Any investigation may also raise regulatory and professional issues

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[701] See the *Freedom To Speak Up Report at section 6.4.*

[702] Feedback to the whistleblower is recognised as significant in the *Freedom To Speak Up Report,* at paragraph 6.4.29.

which may also need to be addressed (although separately) in relation to relevant individuals.

Any intervention adopted - I am assuming it will be an internal Trust intervention - will need to be alert to difficult emotional or psychological elements, team dysfunction, the emotional as well as the professional context of the whistleblowing, which self-evidently will require skilled and experienced intervenors. It will also require a coordinated and transparent process, so that all parties feel it is fair and just, minimising a legacy of grievance, which is evident in some accounts (Frank and Hilary in particular). The requirements of this intervention will be challenging but addressing the complexities early will by definition prevent them from worsening. A positive intervention at an early stage will also help to defuse difficult emotions of those affected by the whistleblowing, such as the wrongdoer, or recipients, and I suggest this role of deliberately addressing the human, subjective, aspects of the incident should be seen as a major and important aspect of the intervention. Designing and implementing an appropriate process, and how it fits into existing organisational arrangements, will not be straightforward; it could perhaps be thought of as encompassing an ongoing role, rather than one-off, to accommodate legacy issues.

The third aspect of the data I wish to comment on is the need to address more overtly and deliberately the emotional and psychological - the human - aspects of the conflict. To some extent this is captured in the discussion above - the need to address the subjective elements of the conflict in the context of the whole. My contention is that these subjective, or human, dimensions are not considered sufficiently (or given appropriate prominence) within

whistleblowing conflict generally. It is clear from the data (and it would be wrong to ignore it) that there is a genuine phenomenon of some whistleblowers being complex or idiosyncratic personalities, who may be motivated by historic or unresolved grievances (see the stories told by Damian, Frances and Catherine). [703] While such personalities may present challenges (and it is not the job of an intervention process to address all of these), I suggest that potential interventions should seek to accommodate the challenges presented by all healthcare professionals who are concerned enough to speak up. For me, too, narrative-based approaches to interventions offer promise because of the inherent significance of stories and narratives in whistleblowing settings and should, as I discuss below perhaps be an area for further academic enquiry.

I would add a final comment about mediation of legal proceedings: as indicated, barriers appear to exist (particularly Treasury approval) to the settlement of legal proceedings which deter the use of mediation. Mediation also typically addresses only the whistleblowing or employment conflict, and does not (or perhaps cannot) address the wrongdoing because it is a matter of public interest. Parties also have reservations about confidentiality and the use of NDAs to record agreement reached. The apparently low use of mediation or similar process is driven by these factors and addressing them to enable wider use of mediation would require a significant change of policy relating to the need for Treasury approval which may have political implications. My comments above are therefore focused on addressing conflict-related rather than mediation-related issues with the view that other interventions

[703] This is recognised in some literature, see 'Cultures of Silence and of Voice' at p.2, for example.

and approaches to address conflict at an earlier stage is both relevant in the context of the study and more feasible.

Areas for further enquiry

This study has identified areas which have implications for understanding the elements of whistleblowing conflict and finding preferable solutions for NHS whistleblowing conflict. I suggest further research, touching on the areas discussed above, might include: (1) studies of the experiences of Trust recipients (but particularly also senior decision-makers) who appear to endorse retaliatory action against whistleblowers, how they experience the whistleblowing and how they see the retaliation, as legitimate and justified, or not, with a view to better understanding how and why retaliation occurs and what would incentivise individuals within NHS Trusts to desist from retaliation; (2) a study of precedents and approaches within healthcare settings for addressing whistleblowing conflict, specifically including the subjective aspects of wrongdoing, with a view to addressing the conflict as a whole but with an emphasis on human elements; and (3) studies of the use of narrative or story-based interventions (including possibly mediation) within whistleblowing settings, or if necessary other sensitive settings, with a view to understanding potentially applicable approaches. All of these studies will be empirical and qualitative in nature.

I will now make some final comments about this study.

3. Why This Study Matters

For me, gathering the first-hand stories of those, so far as possible, close to whistleblowing conflict to obtain an in-depth account of what happens in the real world, and how it is experienced and witnessed from a range of points of view, was a core objective for this study. It is the starting point for why this study matters. My previous experience (discussed in Chapter 1) signalled to me not only the importance to whistleblowers of their stories but also the importance of balancing the whistleblower accounts alongside stories told from other perspectives. It has never been a matter of reconciling or explaining these diverse perspectives, but presenting them with all their complexities, uncertainties and unanswered questions.

At a practical level, the study reveals the anatomy of the whistleblowing conflict in the NHS. It highlights the separate stages of transformation, according to the Felstiner Model, the relevance of understanding whether injury is perceived, the role of the wrongdoing, and the purpose of retaliation as the voicing of a grievance. This analysis, through the Felstiner Model, places emphasis on the human aspects of the conflict, and the unique response of the individual in the emergence of the dispute. As I argue, stories are also part of this process in the sense that they help us to create meaning in our lives and, as further argued in Chapter 3, can play a role in resolution of conflict. The study matters for these reasons; it proposes a way of viewing whistleblowing conflict which places the individual disputants at the forefront of the analysis of the dispute and signposts a broad approach (storytelling, or narrative approaches), which are relevant to the analysis, as having potential relevance to the resolution of the conflict.

The study also matters because, although it reveals conflicting stories, rather than seeing them as unbridgeable perspectives, it sees them as inherent in the conflict and therefore important to acknowledge and address. Rather than investigate the facts of the wrongdoing and adjudicate on whose story fits the facts, the study suggests that the conflicting stories are core to the conflict and have to be considered and addressed alongside solutions required to address the wrongdoing.

Whistleblowing can, however, be seen as having unique challenges, mainly the element of wrongdoing, but also sometimes in the form of the whistleblower. [704] For some, whistleblowers can be "individuals with (often) complex personal and professional histories and… certain personal idiosyncrasies" and whistleblowing is therefore "fraught with rival interpretations". [705] Whilst the implication, may be that conflict with a difficult whistleblower about rival interpretations will end in the employment tribunal, for me it reinforces the importance of knowing and understanding the participant stories. Without them, it seems to me, the conflict cannot be penetrated: the problem is not understood or solved by retaliating against a whistleblower who has "personal idiosyncrasies" in order to eject them from the workplace. As I argue, both aspects, wrongdoing and the whistleblower, form part of the whole of the conflict.

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[704] The whistleblowing group experiences an overt NHS strategy to discredit whistleblowers while the NHS group is ambiguously silent on bullying and whistleblowing, or sees whistleblowers as "never coming to the table clean". Geraldine sees whistleblowers as "self-obsessed"…"me, me, me"; Damian sees the majority as "vexatious" or "bigging it up", with only a minority "genuine". I suggest that these views are difficult to hear. The study captured significant data that seemed to portray whistleblowers ambiguously or negatively. This contrasted dramatically to the whistleblower group, who told stories of credible and genuine concerns.

[705] See 'Cultures of silence and of voice' at p.2

The study also matters because it reveals that whistleblowing conflict can be seen as conflict between human individuals, not between an individual whistleblower and a de-personalised NHS organisation. The data, particularly the stories told by the whistleblower group, convey a sense that whistleblowers have to contend with a large, complex organisation and different recipients or managers within a many-layered hierarchy. Yet, as discussed, each story also identifies named individuals within the Trust who appear to prosecute the retaliation against the whistleblower. The analysis of whistleblowing according to dispute emergence theory looks beyond the corporate identity of an NHS organisation and sees individual recipients as the counter-parties in the conflict. This analysis also resonates with the focus of this study on recipients, discussed in Chapter 2.

While the practical reality of dealing with a large and bureaucratic organisation is daunting and harmful to whistleblowers, I suggest the study signposts a potential change in how the relationship with the employer Trust might be viewed. How that might translate into a change of approach by the Trust will depend on many factors, including the extent to which new thinking about whistleblowing conflict is embraced in practice by the NHS. Again, however, the study seeks to emphasise and advance the focus on the human aspect of the conflict and the relevance of human interaction in arresting the escalation of any dispute.

Finally: as discussed in Chapter 1, whistleblowing conflict and the apparent difficulty in resolving it, is part of a widespread problem in the NHS that it remains unsafe to speak up. By analysing the conflict I have sought to reveal how the conflict works on the

ground, according to participants able to provide first-hand accounts. By viewing that conflict through a storytelling lens I have adopted an approach which helps us to understand the experiences of those participants, to see how stories contribute to the conflict, and to gain insights about approaches to resolution of the conflict which would contribute to better outcomes for all participants, to improved workplaces and to safer environments for patients.

End

Appendix

Freedom of Information Request

24th October 2019

Dear Sir or Madam,

Freedom of Information Request

My name is Clive Lampard and I am conducting academic research into the use of mediation in whistleblowing disputes. I am submitting this freedom of information request for the purposes of my research and should be grateful for your response at your early convenience and in any event within the statutory deadline.

Please reply to the following questions in relation to the last 3 full financial years for the Trust (I refer to this as being "the Period" in the text of the questions).

1. How many clinical incidents were recorded in the Local Risk Management Reporting System (**LRMS**) during the Period?

2. How many of these were recorded as being incidents of a life-threatening or otherwise serious nature?

3. During the Period, how many cases have occurred (whether or not also recorded in the LRMS) whereby an employee or other worker (all of whom for the purpose of this FOI request I shall call **Workers**) has raised a concern whether about patient safety, clinical or non-clinical malpractice or any other matter? Note: for the purpose of clarity, I refer here to cases which would usually be considered to be "whistleblowing" cases (this may be the case regardless of whether the concern was raised internally, with a line manager or other person within the Trust, or externally, with another organisation such as another NHS body or a regulator such as the CQC). I will refer to these cases in the questions below as **Whistleblowing Cases** and to the Workers who raise the concern as **Whistleblowing**

Workers. I have tried to explain in some detail in order to be as clear as possible about my enquiry and to assist you in responding accurately.

4. Of the Whistleblowing Workers who raised concerns during the Period, how many are still working for the Trust and how many are no longer working for the Trust?

5. Of the Whistleblowing Cases which arose during the Period:

5.1 how many were resolved satisfactorily (by which I mean any clinical, malpractice or other issues were addressed and any dispute with the Whistleblowing Worker was amicably resolved)?

5.2 in how many cases were Employment Tribunal (**ET**) proceedings or other legal proceedings started?

5.3 how many were resolved by ACAS intervention before the ET or other hearing?

5.4 how many were the subject of other attempts at mediation or other form of alternative dispute resolution (eg clinical early evaluation), whether by internal NHS Staff who mediated or by an external mediation provider such as CEDR (the Centre for Effective Dispute Resolution)? I refer to these below as **ADR Cases**;

5.5 how many went to a full ET hearing?

6. In relation to the ADR Cases:

6.1 how many were the subject of a mediation at any stage?

6.2 how many were the subject of another form of alternative dispute resolution (eg arbitration) at any stage?

6.3 how many were resolved by means of the mediation or other form of alternative dispute resolution?

6.4 does the Trust use internal NHS mediators and are they formally qualified as mediators? If so, how many ADR Cases did they settle during the Period?

6.5 does the Trust engage external mediation providers such as CEDR (see above)? If so, how many ADR Cases did they settle during the Period?

7. Does the Trust have a main board director with explicit responsibility for monitoring and reviewing Whistleblowing Cases and if so:

7.1 what is his/her name?
7.2 is he/she an executive or non-executive director?

7.3 how many Whistleblowing Cases were referred to the director during the Period?

7.4 does the director issue a report (eg annually) as to his/her findings? If so, please provide a copy of any such report issued during the Period;

7.5 is any report issued by the director made public or shared with any third parties and if so, who?

8. Does the Trust have a whistleblowing policy? How many concerns were raised under the policy in each of the last 3 full financial years?

9. Please provide the name and full contact details for the Local Freedom to Speak Up Guardian (the **Local Guardian)** for the Trust. Is the Local Guardian a main board director of the Trust?

10. How much did the Trust spend during the Period on legal and other professional fees for advice in connection with Whistleblowing Cases;

11. How much did the Trust spend during the Period in making compromise or settlement payments to Whistleblowing Workers to settle their cases?

12. Did the Trust enter into any Confidentiality Clauses or Non-Disclosure Agreements with Whistleblowing Workers during the Period and if so how many?

In case it assists, please feel free to contact me by email at: clivelampard@gmail.com or on my mobile, which is: 07798 783363.

Thank you in advance for your assistance with this research, it is greatly appreciated.

Yours faithfully,

Clive Lampard

Bibliography

A

Abbott H P, *The Cambridge Introduction to Narrative,* (Cambridge University Press, Second Edition, 2014).

Abraham A, 'The Ombudsman and "Paths to Justice": a just alternative or just an alternative?' [2008] Public Law 1.

Abrams K, 'Hearing the Call of Stories' [1991] 79 California Law Review 4.
__ __ 'The Paths of Stories' [2008] University of Missouri-Kansas Law Review 789.
__ __ and Keren H, 'Who's Afraid of Law and the Emotions [2010] Minnesota Law Review 1997.

Adler J N and Daniels M, 'Managing the Whistleblowing Employee' [1992] The Labor Lawyer 19.

Alberstein M, 'Forms of Mediation and Law: Cultures of Dispute Resolution' [2007] Ohio State Journal on Dispute Resolution 321.

Alford C F, *Whistleblowers, Broken Lives and Organizational Power,* (Cornell University Press, Ithaca and London, 2001).

Anim-Addo J and Gunaratnam Y, 'Secrets and lies: Narrative methods at the limits of research' [2013] Journal of Writing in Creative Practice 383.

Arjona C et al, Senses of Sen: Reflections on Amartya Sen's Ideas of Justice [2012] International Journal of Law in Context 155.

Ashton J, 'When is whistleblowing in the public interest? *Chesterton Global Ltd. and another v Nurmohamed* leaves this question open' [2015] Industrial Law Journal 450.
__ __ '15 years of whistleblowing protection under the Public Interest Disclosure Act 1998: are we still shooting the messenger?' [2015] Industrial Law Journal 29.

Astor H, 'Mediator Neutrality: Making Sense of Theory and Practice [2007] 16 Social & Legal Studies 221.

Awaiz-Bilal Z, 'The duty of candour and apologies as a legal remedy' [2015] Journal of Personal Injury Law 7.

B

Bandes S, 'Empathy, Narrative, and Victim Impact Statements' [1996] University of Chicago Law Review 361.

Bandura A, 'Selective Moral Disengagement in the Exercise of Moral Agency' [2002] Journal of Moral Education 101.
__ __ , *Moral Disengagement, How People Do Harm and Live with Themselves* (Worth Publishers, New York, 2016).

Baruch Bush R and Folger J P, *The Promise of Mediation* (Jossey-Bass, San Francisco, 1994, Revised Edition 2005).

__ __ ‘Mediation and Social Justice: Risks and Opportunities’, 27 Ohio St. J. on Disp. Resol. 1 (2012).

Bartlett K T, ‘Gender Law’ [1994] Duke Journal of Gender Law & Policy 1.
__ __ ‘Objectivity: A Feminist Revisit’ [2014] 66 Alabama Law Review 375.

Barmes L, *Bullying and Behavioural Conflict at Work, The Duality of Individual Rights* (Oxford University Press, 2016).

Baron J B, ‘The Many Promises of Storytelling in Law: An Essay Review of narrative and the Legal Discourse: A Reader in Storytelling and the Law’ [1991] Rutgers Law Journal 79.
__ __ ‘Resistance to Stories’ [1994] Southern California Law Review 255.

Bell D, ‘The Final Report: Harvard’s Affirmative Action Allegory’ [1989] Michigan Law Review 2382.

Bennett T, ‘The role of mediation: a critical analysis of the changing nature of dispute resolution in the workplace’ [2012] Industrial law Journal 479.

Berwick D, *A Promise to Learn - a Commitment to act: Improving the Safety of Patients in England,* National Advisory Group on the Safety of Patients in England 2013.

Betancourt J C, ‘Alternative dispute resolution (ADR) and access to justice: an introduction’ [2017] Arbitration 219.

Blake S. Browne J, and Sime S, *The Jackson ADR Handbook,* (Oxford University Press, 2013).

Bjørkelo B and Hoivik Bye H, 'On the appropriateness of research design: Intended and actual whistleblowing', in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds), *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) p. 133.

Blenkinsopp J, Snowden N, Mannion R, Powell M, Davies H, Millar R and McHale J, 'Whistleblowing over patient safety and care quality: a review of the literature', Journal of Health Organisation and management, 33 (6), pp.737-756 (ISSN 1477-7266).

Blundell H, 'Duty of candour: can the Michigan Model work in the NHS?' [2015] Journal of Personal injury Law 221.

Boon A, Urwin P and Karuk V, 'What difference does it make? Facilitative judicial mediation of discrimination cases in employment tribunals' [2011] Industrial Law Journal 45.

Bourne C, 'Update on Whistleblowing' [2012] Encyclopedia of Local Government Law: Bulletin 5.

Bradley R, 'Interim relief: not likely' [2010] Employment Law Bulletin 2.

Brahams D, 'The CMO's Report, "Making Amends" — a Response' [2003] Medico-Legal Journal 125.

Braithwaite J, ‘Restorative Justice and Therapeutic Jurisprudence’ [2002] Criminal Law Bulletin 244.

Bridgeman J, ‘ “Learning from Bristol”: Healthcare in the 21st Century’ [2002] The Modern Law Review 241.

Brock J, ‘Full and Fair Resolution of Whistleblower Issues: The Hanford Joint Council for Resolving Employee Concerns, a Pilot ADR Approach’ [1999] Administrative Law Review 497.

Brookes P, *Reading for Plot*, (Random House, New York, 1985).

Brown H and Marriott A, *ADR: Principles and Practice,* (Sweet & Maxwell, London, Third Edition, 2011).

Brown A J, (Ed) *Whistleblowing in the Australian Public Sector, Enhancing the Theory and Practice of Internal Witness Management in Public Sector Organisations* (ANU Press, Canberra, Australia, 2008).

Bryson A and McConville S, *The Routledge Guide to Interviewing, Oral history, social enquiry and investigation* (Routledge, London and New York, 2014).

Buchanan D et al, ‘How do they manage? A qualitative study of the realities of middle and front-line management work in healthcare’ [2013] Health Services and Delivery Research at https://ncbi.nlm.nih.gov.

Burrows J, ‘Telling Tales And Saving Lives: Whistleblowing — The Role Of Professional Colleagues In Protecting Patients From Dangerous Doctors’ [2001] Medical Law Review 110.

Busby N and McDermont M, ‘Workers, marginalised voices and the employment tribunal system: some preliminary findings’ [2012] Industrial Law Journal 166.

C

Carroll C, ’Whistleblowing: Ireland’s Protected Disclosures Act 2014 — its context and impact [2015] Compliance & Risk.

Carr I, and Lewis D, ‘Combating corruption through employment law and whistleblower protection’ [2010] Industrial Law Journal 52.

Case P, ‘Claims for illness arising from workplace stress against public bodies’ [2010] Professional Negligence 171.

Cave E, ‘Redress in the NHS’ [2011] Professional Negligence 138.

Choudry N, ‘The EAT’s consideration of the ‘public interest’ test and decision in *Chesterton Global Ltd v Nurmohamed*’ [2015] Company Secretary’s Review 18.

Chubb E, *There is no Me in Whistleblower* (Chipmunka Publishing, 2020).

Christian P J, ‘A Reformulated Model of Narrative Mediation of Emerging Culture Conflict’ 2 IJCER 76 (2014).

Clark, B, ‘Mandatory Mediation in England and Wales: Much Ado about Nothing?’ *Amicus Curiae,* Series 2, Vol 4, No 1, 143-159 (2022).
__ __, ‘Where now for ADR? Some reflections on the Final Report of the CJC ADR Working Group’, *New Law Journal* 2019, 169 (7845).

Clifford A, ‘Teaching Restorative Practices with Classroom Circles’ [2015] San Francisco Unified School District Teaching Resource.

Coates D, and Penrod S, ‘Social Psychology and the Emergence of Disputes’. 15 LAW & Soc’y Rev. 655 (1980).

Cobb S, ‘Empowerment and Mediation: A Narrative Perspective’ 9 NEGOT. J. 245 (1993).
__ __ and Rifkin J, ‘Practice and Paradox: Deconstructing Neutrality in Mediation’ [1991] 16 Law & Social Inquiry 35.
__ __ ‘Creating Sacred Space: Toward a Second-Generation Dispute Resolution Practice’ 28 Fordham Urban Law Review 1017 (2001).
__ __ *Speaking of Violence: The Politics and Poetics of Narrative in Conflict Resolution* (Oxford University Press, 2013).

Condlin R J, ‘The Curious Case of Transformative Dispute Resolution: An Unfortunate Marriage of Intransigence, Exclusivity, and Hype’ [2013] Cardozo Journal of Conflict Resolution 621.

Coombs M I, ‘Outsider Scholarship: The Law Review Stories’ [1992] University of Colorado Law Review 683.

Cortes P, ‘Online dispute resolution services: a selected number of case studies’ [2014] Computer and Telecommunications Law Review 172.

Cowan D, ‘Legal Consciousness: Some Observations’ [2004] The Modern Law Review 928.

Coyle M, ‘The Transformative Potential of the Truth and Reconciliation Commission: A Skeptic’s Perspective’ [2017] The Canadian Bar Review 767.

Craib I, ‘Narrative as bad faith’, in M. Andrews, S.D. Slater, C. Squire and A. Treacher, (Eds) *Lines of Narrative: Psychosocial Perspectives* , (Routledge, London, 2000).

Crenshawe K W, ‘Close Encounters of Three Kinds: On Teaching Dominance Feminism and Intersectionality’ [2010] Tulsa Law Review 151.

Culp D, ‘Whistleblowers: Corporate Anarchists or Heroes? Towards a Judicial Perspective’ [1995-1996] Hofstra Labor & Employment Law Journal 109.

Cunningham C D, ‘A Tale of Two Clients: Thinking about Law as a Language’ [1989] Michigan Law Review 2459.

D

Davies L J, *Resisting Novels: Ideology and Fiction*, (Methuan, London, 1987).

Davies M, ‘The demise of professional self-regulation? Evidence from the “ideal type” professions of medicine and law’ [2010] Professional Negligence 3.

Day A, ‘To Mediate or Adjudicate? An Alternative for Resolving Whistleblower Disputes and the Hanford Nuclear Site’ [2013] Seattle Journal for Social Justice 617.

De Girolamo D, *The Fugitive Identity of Mediation, Negotiations, Shift Changes and Allusionary Action* (Routledge, London and New York, 2013).

Del Gobbo D, ‘Unreliable Narration in Law and Fiction’ [2017] Canadian Journal of Law & Jurisprudence 311.

Del Mar M, ‘System values and understanding legal language’ [2008] Leiden Journal of International Law 29.

Delgado R, ‘Storytelling For Oppositionists and Others: A Plea for Narrative’ [1989] 87 Michigan Law Review 2411.
__ __ ‘When a Story Is Just a Story: Does Voice Really Matter’ [1990] Virginia Law Review 95.
__ __ ‘Shadowboxing: An Essay on Power’ [1992] Cornell Law Review 813.
__ __ ‘Rodrigo Chronicles’ [1992] 101 Yale Law Journal 1357.
__ __ ‘On Telling Stories in School: A Reply to Farber and Sherry’ [1993] Vanderbilt Law Review 665.

__ __ ‘Rodrigo’s Final Chronicle: Cultural Power, the Law Reviews, and the Attack on Narrative Jurisprudence’ [1995] Southern California Law Review 545.
__ __ ‘Rodrigo’s Eleventh Chronicle: Empathy and False Empathy’ [1996] 84 California Law Review 61.
__ __ et al, Fairness and Formality: Minimizing the Risk of Prejudice in Alternative Dispute Resolution’ [1985] Wisconsin Law Review 1359.
__ __ and Stefancic J, ‘Images of the Outsider in American Law and Culture: Can Free Expression Remedy Systemic Social Ills’ [1992] Cornell Law Review 1258.
__ __ and Stefancic J, *Critical Race Theory, An Introduction* (New York University Press, 2017).

Department for Business, Energy & Industrial Strategy, *Confidentiality Clauses Consultation on measures to prevent misuse in situations of workplace harassment or discrimination,* (2019) at https://www.gov.uk/government/consultations/confidentiality-clauses-measures-to-prevent-misuse-in-situations-of-workplace-harassment-or-discrimination.

Department of Health, *Regulation of Health Care Professionals. The Government’s response to Law Commission Report 345* (Cm 8995, 2015).

Department of Health, *Learning not blaming: The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report ‘Investigating Clinical Incidents in the NHS’, and the Morecambe Bay Investigation’* (Cm 9113, 2015).

Department of Health, *The Report of the Morecombe Bay Investigation*, (London, 2015, The Stationery Office) at www.gov.uk/government/publications.

Department of Health, *Providing a 'safe space' in healthcare safety investigations - Consultation* (2016) at https://www.gov.uk/government/consultations/providing-a-safe-space-in-healthcare-investigations.

Department of Health*, Providing a 'safe space' in healthcare safety investigations - Summary of consultation responses and next steps* (2017) at https://assets.publishing.service.gov.uk/government/data/file 610034/safe_space_consultation_government_response.

Department of Health & Social Care, *The Draft Employment Rights Act 1996 (NHS Recruitment - Protected Disclosure) Regulations 2018 - Response to the consultation on protecting whistleblowers seeking jobs in the NHS* (2018) at https://www.gov.uk/government/consultations/protecting-whistleblowers-seeking-jobs-in-the-nhs.

Dixon-Woods M, 'Why is UK medicine no longer a self-regulating profession? The role of scandals involving "bad apple" doctors' [2011] Social Science & Medicine 1452.

__ __ et al, 'Culture and behaviour in the English National Health Service: overview of lessons from a large multi method study' [2014] British Medical Journal Quality & Safety 106.

__ __ 'Synthesising qualitative and quantitative evidence: a review of possible methods' [2005] Journal of Health Services Research & Policy 45.

__ __ ‘The problem of appraising qualitative research’ [2004] British Medical Journal Quality & Safety 223.

Docherty J S, ‘Narratives, Metaphors, and Negotiation’ [2004] Marquette Law Review 847.

Dolder C, ‘The contribution of mediation to workplace justice’ [2004] Industrial Law Journal 320.

Donnelly H OBE, *Written Evidence submitted by Helen Donnelly OBE, Nurse Practitioner and Ambassador for Cultural Change, Staffordshire and Stoke-on-Trent Partnership NHS Trust* to the House of Commons Health Select Committee (Ref CRC0089, 2014).

Douglas K and Field R, ‘Looking for Answers to Mediation’s Neutrality Dilemma in Therapeutic Jurisprudence’ [2006] Murdoch University eLaw Journal 177.

Douglas S, ‘Neutrality in Mediation: A Study of Mediator Perceptions’ [2008] Queensland University of Technology Law & Justice Journal 139.
__ __ ‘Neutrality, Self-Determination, Fairness and Differing Models of Mediation’, 19 James Cook U. L. Rev. 19 (2012).

Doyle B, ‘Alternative dispute resolution: the employment tribunal’ [2015] Arbitration 20.

Drew D, *Little Stories of Life and Death @NHSWhistleblowr* (Matador Publishing, 2014).

E

Eckstein Jackson L E, 'Disengaging From Moral Disengagement: Scant Experimental Evidence For a Popular Theory' [2012] PhD Diss. University of Tennessee.

Economides K and O'Leary M, 'The Moral of the Story: Toward an Understanding of Ethics in Organisations and Legal Practice' [2007] Legal Ethics 5.

Edwards M S Lawrence S A and Ashkanasy N M, 'The role of perceptions, appraisals and anticipated emotions in shaping reporting behaviour in response to wrongdoing' in Burke R J and Cooper C L (Eds) *Voice and Whistleblowing in Organisations, Overcoming Fear, Fostering Courage and Unleashing Candour* (Edward Elgar, 2013, Cheltenham UK and Northampton MS, USA).

Ehrich K, 'Telling cultures: 'cultural' issues for staff reporting concerns about colleagues in the UK National Health Service' [2006] Sociology of Health & Illness 903.

Elkins J R, 'A Bibliography of Narrative' [1990] Journal of Legal Education 203.

England J, *NHS Whistleblowing and the Law* (Law Brief Publishing, 2019).

Erez E, 'Who's afraid of the big bad victim? Victim impact statements as victim empowerment and enhancement of justice' [1999] Criminal Law Review 545.

Erichson H M, ‘Against Settlement: Twenty-Five Years Later [2009] Fordham Law Review 23.

Erwin Z L, ‘Analyzing the Disruptive Physician: How State and Federal Courts Should Handle Whistleblower Cases Brought by Disruptive Physicians’ [2005-2006] Duquesne Law Review 275.

Evans G R, ‘Gagging clauses and the raising of “systematic” concerns’ [2009] Education Law Journal 257.

F

Falklow M G, ‘Pride and Prejudice: Lessons Legal Writers Can Learn from Literature’ [2014] Touro Law Review 349.

Farber D A and Sherry S, ‘Telling Stories out of School: An Essay on Legal Narratives’ [1993] Stanford Law Review 807.

Fasterling B and Lewis D, ‘Leaks, legislation and freedom of speech: How can the law effectively promote public-interest whistleblowing?’ [2014] International Labor Review 71.

B. Fasterling ‘Whistleblower Protection: a Comparative Law Perspective‘ in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds), *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) p.341.

Felstiner W L F, Abel R L and Sarat A, 'The Emergence and Transformation of Disputes: Naming, Blaming, Claiming…' [1981] Law and Society Review 15:3/4 631.

Firtko A and Jackson D, 'Do the Ends Justify the Means? Nursing and the Dilemma of Whistleblowing [2005] Australian Journal of Advanced Nursing 51.

Fisher R, Ury W and Patton B, *Getting to Yes: Negotiating an Agreement Without Giving In,* (Random House Business Books, London, 2012) (Third Edition, Revised and Updated).

Fiss O M, 'Against Settlement' [1984] The Yale Law Journal 1073.
__ __ 'Objectivity and Interpretation' [1982] Stanford Law Review 739.

Fitzgerald J and Dickins R, Disputing in Legal and Nonlegal Contexts: Some Questions for Sociologists of Law, 15 LAW & Soc'y Rev. 681 (1980).

Folger J P, 'Mediation Research: Studying Transformative Effects' [2001] Hofstra Labor & Employment Law Journal 385.

Francis, Robert QC (Sir), *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary* (HC 947 2013).
__ __ , *The Freedom To Speak Up Report, An Independent Review into creating an Open and Honest Reporting Culture in the NHS,* accessible at www.freedomtospeakup.org.uk/the-report.

French R R, ‘Of Narrative in Law and Anthropology’ [1996] Law & Society Review 417.

Friendly H J, ‘Public-Private Penumbra-Fourteen Years Later’ [1982] University of Pennsylvania Law Review 1289.

Fuller L L, ‘The Forms and Limits of Adjudication’ [1978] Harvard Law Review 353.
__ __ ‘Mediation — Its Forms and Functions’ [1971] Southern California Law Review 305.

G

Galanter M, ‘Why the “Haves” Come Out Ahead: Speculations on the Limits of Legal Change’ [1974] Law and Society Review 1.
__ __ ‘Reading the Landscape of Disputes: What we Know and Don’t Know (and Think We Know) about Our Allegedly Contentious and Litigious Society’ 31 UCLA L. REV. 4 (1983).

Geraghty C, ‘Advancing patient safety in Ireland: the American model and cultural change’ [2009] Medico-Legal Journal of Ireland 27.

Gibbons M, ‘Better Dispute Resolution, A review of employment dispute resolution in Great Britain’ [2007] Department of Trade and Industry.

Gierulski W, ‘Quantitative and Qualitative Tendencies as a Key to the Appropriate Facilitation of Dispute Resolution’ 65 Sask. L. REV. 181 (2002).

Gobert J and Punch M, ‘Whistleblowers, the Public Interest, and the Public Interest Disclosure Act 1998’ [2000] The Modern Law Review 25.

Grillo T, ‘The Mediation Alternative: Process Dangers for Women’ [1991] The Yale Law Journal 1545
__ __ ‘Anti-Essentialism and Intersectionality: Tools to Dismantle the Master’s House’ [2013] Berkeley Women’s Law Journal 16.
__ __ and Wildman S.M. ‘Obscuring the Importance of Race: The Implications of Making Comparisons Between Racism and Sexism (or other -isms) [1991] Duke Law Journal 397.

Gunaratnum Y, ‘Narrative Interviews and Research’, in Gunaratnum Y and Oliviere D (Eds), *Narrative and Stories in Healthcare, Illness, Dying and Bereavement,* (Oxford University Press, 2009).
__ __ ’Morbid mixtures: Hybridity, Pain and Transnational Dying’ [2014] Subjectivity 74.

H

Halewood P, ‘White Men Can’t Jump: Critical Epistemologies, Embodiment, and the Praxis of Legal Scholarship’ [1995] Yale Journal of Law & Feminism 1.

Haney Lopez I F, ‘The Social Construction of Race’ in Richard Delgado (ed) *Critical Race Theory* Temple University Press 2000.

Hansen T, ‘The Narrative Approach to Mediation’, Pepperdine Dispute Resolution Law Journal 297 (2004).

Haraway D, ‘Situated Knowledges, the Science Question in Feminism and the Privilege of Partial Perspective’ in *Simians, Cyborgs and Women: The Reinvention of Partial Perspective* Routledge 1991.

Harding S, *Whose Science/Whose Knowledge?* (Cornell University Press, Ithaca, 1991).
__ __ , ‘Rethinking Standpoint Epistemology: What is “Strong Objectivity”?’ Centennial Review 36, No 3 (1992).

Harper C, ‘Mediator as Peacemaker: The Case for Activist Transformative-Narrative Mediation’, 2006 J. Disp. Resol. 595 (2006).

Hastie R, *Inside the Juror, The Psychology of Juror Decision-Making,* (Cambridge University Press, 1993).

Healthcare Safety Investigation Branch Expert Advisory Group Report 2016 at https://assests.publishing.service.gov.uk/hsibreport.

Heffernan M, *Wilful Blindness* (Simon & Schuster, London, 2012).

Hekman S, ‘Truth and Method: Feminist Standpoint Theory Revisited’ [1997] Signs: Journal of Women in Culture & Society 341.

Hetzler D C and Record C, ‘Healthcare Conflict Management: An Obligation of the Board’ [2007-2008] Hamline Journal of Public Law and Policy 401.

Higgins A, ‘Corporate abuse of legal professional privilege’ [2008] Civil Justice Quarterly 377.

Hill Collins P, ‘Comment on Hekman’s “Truth and Method: Feminist Standpoint Theory Revisited”: Where’s the Power?’ [1997] Signs: Journal of Women in Culture & Society 375.

Hoffman E A, ‘Legal Consciousness and Dispute Resolution: Different Disputing Behaviour at Two Similar Taxicab Companies’ [2003] Law & Social Inquiry 691.

Hollway W and Jefferson T, ‘Free Association, Narrative Analysis and the Defended Subject: The Case of Ivy’ [2001] Narrative Inquiry 103.
__ __ , ‘Eliciting Narrative Through the In-depth Interview’, Qualitative Inquiry, Volume 3 Number 1, 1997, 53-70.

House of Commons Health Committee, *Oral evidence: Complaints and raising concerns* (HC 1080 2014).

House of Commons Health Select Committee, *Complaints and Raising Concerns* (HC 350 2015).

House of Commons Library, Briefing Paper, *NHS Whistleblowing Procedure in England,* Number CBP06490, 18 September 2015.

House of Commons Library, Briefing Paper, *Whistleblowing and gagging clauses,* Number CBP7442, 4 January 2016.

House of Commons Public Accounts Committee Report *Whistleblowing* (HC 593 2014).

House of Commons Public Administration Select Committee, *Investigating clinical incidents in the NHS* (HC 886 2015).

Humphrey T, 'Dust in the balance: the use of mediation to resolve disputes in Australian sport' [2008] International Sports Law Review 2.

Hunt J, *Sign Up To Safety - The path to saving 6,000 lives* (Speech at Virginia Mason Hospital, Seattle, 26 March 2014).
__ __ *Zero, Eliminating unnecessary deaths in a post-pandemic NHS* (Swift Press, London, 2022).

I

Irvine C, 'Do you see what I'm dealing with here? Vicious circles in workplace conflict' [2013] Employment Law Bulletin 6.

Isaksen J L, 'From Critical Race Theory to Composition Studies: Pedagogy and Theory Building' [2000] Legal Studies Forum 695.
__ __ Davies M and Seuffert N, 'Knowledge, Identity, and the Politics of Law' [2000] Hastings Women's Law Journal 259.

J

Jackson D et al, 'Understanding whistleblowing: qualitative insights from nurse whistleblowers' [2010] Journal of Advanced Nursing 2194.

James G, The Right Reverend, *Report of the Independent Inquiry into the Issues raised by Paterson,* February 2020, HC31, accessible at www.gov.uk/official-documents.

Jarrett B, 'The Future of Mediation: A Sociological Perspective' 2009 J. Disp. Resol. 49 (2009).

Jehn K A, 'Types of conflict: The history and future of conflict definitions and typologies' in Ayoko O B, Ashknasay N M and Jehn K A (Eds), *Handbook of Conflict Management Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014).

Johnson E, Jr 'Lawyers' Choice: A Theoretical Appraisal of Litigation Investment Decisions', 15 LAW & Soc'y REV. 567 (1980).

Johnson J F and Buckley M R, 'Multi-level Organizational Moral Disengagement: Directions for Future Investigation' [2015] Journal of Business Ethics 291.

Joint Committee on Human Rights, *The Human Rights of Older People in Healthcare* (HL Paper 156-I 2007).

Jones A and Kelly D, 'Whistle-blowing and workplace culture in older peoples' care: qualitative insights form the healthcare and social care workforce' [2014] Sociology of Health & Illness 986.
__ __ 'Deafening silence? Time to reconsider whether organisations are silent or deaf when things go wrong' [2014] British Medical Journal Quality & Safety 709.
__ __ et al, 'Speaking up about Bullying and Harassment in Healthcare: Reflections following the Introduction of an Innovative

"Speak Up" Role in NHS England' in A.Montgomery et al (Eds) *Connecting Healthcare Worker Well-Being, Patient Safety and Organisational Change, Aligning Perspectives on Health, Safety and Well-Being* at https://doi.org 10.1007/978-3-030-60998-6_10.

Judges D P P, 'The Role of Mental Health Professionals in Capital Punishment: An Exercise in Moral Disengagement' Abstract [2004] Houston Law Review 09.

K

Kahneman D and Tversky A, 'Conflict Resolution: A Cognitive Perspective' in Arrow K, Mnookin R H, Ross L, Tversky A and Wilson R (Eds), *Barriers to Conflict Resolution* (W.W Norton & Company, New York, 1995).

Kennedy D, 'Stages of the Decline of the Public/Private Distinction' [1982] University of Pennsylvania Law Review 1349.

Kennedy R L, 'Racial Critiques of Legal Academia' [1989] Harvard Law Review 1745.

Kenny K, *Whistleblowing, Toward a New Theory* (Harvard University Press, Cambridge Massachusetts and London, 2019).
__ __ Vandekerckhove W and Fotaki M, *The Whistleblowing Guide, Speak-Up Arrangements, Challenge and Best Practices* (Wiley, Chichester, 2019).
__ __ Fotachi, M and Scriver, S, 'Mental Health as a Weapon: Whistleblower Retaliation and Normative Violence', [2018], Journal

of Business Ethics, 1-15 https://doi.org/10.1007/s10551-018-3868-4.

Keogh B, *Review into the quality of care and treatment provided by 14 hospital trusts in England: Overview Report* (2013) at https://england.nhs.uk.

Kirkland K, 'Confessions of a Whistleblower: A Law Professor's Reflections on the Experience of Reporting a Colleague' [2007] Georgetown Journal of Legal Ethics 1105.

Kirkup Dr B CBE, *The Report of the Morecambe Bay Investigation* (2015) at https://assets.publishing.service.uk.

Kituno N and Kirton H, 'Trusts spending £1m+ a year on settlement deals with gagging clauses despite a crackdown on these conditions in recent years' (Health Service Journal Online 1 November 2021 accessible at https://www.hsj.co.uk.)

Kline R, 'Leadership in the NHS', BMJ Leader 2019; 0: 1-4, dot:10.1136/leader-2019-000159.

__ __ and Lewis D, 'The price of fear: estimating the financial cost of bullying and harassment to the NHS in England' [2018] Public Money & Management.

Kritzer H M, 'Propensity to Sue in England and the United States of America: Blaming and Claiming in Tort Cases' 18 J.L. & Soc'y 400 (1991).

Kronman A J, 'Legal Scholarship and Moral Education', 90 Yale L.R. 955 (1981).
__ __ 'Living in the Law', 54 U. Chi. L. Rev. 835.

L

Launer J, *Narrative-Based Practice in Health and Social Care, Conversations Inviting Change,* (Routledge, London and New York, Second Edition, 2018).

Law Commission, *Regulation of Health Care Professionals* (Law Com No 345, 2014).

Lebed M R and McCauley J J, 'Mediation within the health care industry: hurdles and opportunities'[2004-2005] Georgia State University Law Review 911.

Lester A, 'Five ideas to fight for' [2016] European Human Rights Law Review 231.

Levit N, 'Legal Storytelling: The Theory and The Practice - Reflective Writing Across The Curriculum' [2009] The Journal of the Legal Writing Institute 259.
__ __ 'Feminism for Men: Legal Ideology and the Construction of Maleness' [1996] UCLA Law Review 1037.
__ __ 'Reshaping the Narrative Debate' 34 Seattle U. L. Rev. 751 (2011).

Lewis D, ‘Is a public interest test for workplace whistleblowing in society’s interest? [2015] International Journal of Law & Management 141.
__ __ ‘Is it time to blow the whistle on the burden of proof?’ [2002] Industrial Law Journal 79.
__ __ ‘Whistleblowers, reasonable belief and data protection issues” [2006] Industrial Law Journal 324.
__ __ ‘Personal and vicarious liability for the victimisation of whistleblowers’ [2007] Industrial Law Journal 224.
__ __ ‘A survey of whistleblowing/confidential reporting procedures used by persons prescribed under the Public Interest Disclosure Act 1998’ [2007] Communications Law 125.
__ __‘Resolving Whistleblowing Disputes in the Public Interest: Is Tribunal Adjudication the Best that Can be Offered?’ [2013] Industrial Law Journal 35.
__ __ ‘Whistleblowers and Job Security’ [1995] The Modern Law Review 208.
__ __ ‘Whistleblowing at Work: On What Principles Should Legislation Be Based?’ [2001] Industrial Law Journal 169.
__ __ ‘Providing rights for whistleblowers: would an anti-discrimination model be more effective?’ [2005] Industrial Law Journal 239.
__ __ ‘Enterprise and regulatory reform - whistleblowing aspects’ [2012] Employment Law Bulletin 4.
__ __ ‘Shipman’s legacy: whistleblowing procedures for all? [2005] New Law Journal 14.
__ __ and Trygstad S, ‘Protecting whistleblowers in Norway and the UK: a case of mix and match?’ [2009] International Journal of Law & Management 374.

__ __ Brown A J and Moberly R, ‘Whistleblowing, its importance and the state of the research’ in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds) *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) at p.1.
__ __ and Devine T and Harpur P, ‘The key to protection: Civil and employment law remedies’ in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds), *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) at p. 350.

Lewis J QC, Bowers J QC, Fodder M and Mitchell J, *Whistleblowing Law and Practice* (Oxford University Press, Fourth Edition, 2022).

Liberati E G et al, ‘Learning from high risk industries may not be straightforward: a qualitative study of the hierarchy of risk controls approach in healthcare’ [2017] International Journal for Quality in Health Care 39.

Liddle D, *Managing Conflict, A Practical Guide to Resolution in the Workplace* (Kogan Page Limited, London and New York, 2017).

Lloyd-Bostock S, ‘Propensity to Sue in England and the United States of America: The Role of Attribution Processes - A Comment on Kritzer’ 18 J.L. & Soc’y 428 (1991).

Loyens K and Maesschalck J, ‘Whistleblowing and power’ in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds), *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) at p.154.

Luban D, ‘Difference Made Legal: The Court and Dr. King [1989] Michigan Law Review 2152.

Luban D, ‘Settlements and the Erosion of the Public Realm’ 83 Geo. L. J.2619 (1995).

M

Macrae C, ‘Early warnings, weak signals and learning from healthcare disasters’ [2013] British Medical Journal Quality & Safety.

Mannion R and Davies H, ‘Cultures of Silence and Cultures of Voice: The Role of Whistleblowing in Healthcare Organisations’ (International Journal of Health Policy and Management, September 2015, 4(x),1-3).

Martin G P and Dixon-Woods M, ‘After Mid Staffordshire: from acknowledgement, through learning, to improvement’ [2014] British Medical Journal Quality & Safety 706.

Massaro T M, ‘Equality and Freedom of Expression: The Hate Speech Dilemma’ [1991] William and Mary Law Review 211.
__ __ ‘Empathy, Legal Storytelling, and the Rule of Law: New Words, Old Wounds’ [1989] Michigan Law Review 2099.

Matsuda M J, ‘Public Response to Racist Speech: Considering the Victim’s Story’ [1989] Michigan Law Review 2320.

McConville M, ‘Development of Empirical Techniques and Theory’ in McConville M and Chui W H (Eds) *Research Methods for Law* (Edinburgh University Press, 2014) at p.207.

McElhinney J and Healy S, ‘Clinical risk management in Ireland’ [2003] Medico-Legal Journal of Ireland 70.

McFarlane G, ‘Clinical negligence disputes’ [2003] Journal of Personal Injury Law 71.

Mendelsohn J, ‘Calling The Boss or Calling The Press: A Comparison of British and American Responses to Internal and External Whistleblowing’ [2009] Washington Universe Global Studies Law Review 723.

Menkel-Meadow C, ‘The Many Ways of Mediation: The Transformation of Traditions, Ideologies, Paradigms, and Practices’ [1995] Negotiation Journal 217.
__ __ ‘Why Hasn’t the World Gotten to Yes? An Appreciation and Some Reflections’ [2006] Negotiation Journal 485.
__ __ ‘Mediation and its Applications for Good Decision Making and Dispute Resolution’ [2016] Public Lecture on the occasion of the receipt of an Honorary Doctorate in Human Sciences (Published online by Intersentia October 2018, DOI: https://doi.org/10.1017/9781780687568).
__ __ ‘Telling Stories in School: Using Case Studies and Stories to Teach Legal Ethics’ [2010] Fordham Law Review 786
__ __ ‘From Legal Disputes to Conflict Resolution and Human Problem Solving: Legal Dispute Resolution in a Multidisciplinary Context’ [2004] Journal of Legal Education 7.

__ __ ‘Mothers and Fathers of Invention: ‘The Intellectual Founders of ADR” [2000] Ohio State Journal on Dispute Resolution 1.
__ __ ‘Remembrance of Things Past? The Relationship of Past to Future in Pursuing Justice in Mediation’ [2004] Cardozo Journal of Conflict Resolution 97.
__ __ ‘Alternative and Appropriate Dispute Resolution in Context: Formal, Informal, and Semiformal Legal Processes’ in Peter T. Coleman et al (ed) *The Handbook of Conflict Resolution: Theory and Practice* (John Wiley & Sons, London, 2014).
__ __ ‘Women in Dispute Resolution: Parties, Lawyers and Dispute Resolvers: What Difference Does ‘Gender Difference’ Make?’ [2012] Dispute Resolution Magazine 4.
__ __ ‘Empirical Studies of ADR: The Baseline Problem of What ADR is and What It is Compared to’ in Cane P and Kritzer H M (Eds) *Oxford Handbook of Empirical Legal Studies* (Oxford University Press, 2010) at p.596.
__ __ ‘The Power of Narrative In Empathetic Learning: Post-Modernism and The Stories of Law’ [1992] UCLA Women’s Law Journal 287.
__ __ ‘Toward Another View of Legal Negotiation: The Structure of Problem Solving’ [1984] UCLA Law Review 754
__ __ ‘Whose Dispute Is It Anyway? A Philosophical and Democratic Defence of Settlement (In Some Cases)’ [1995] Georgetown Law Journal 2663.
__ __ ‘The Trouble with the Adversary System in a Post-Modern, Multi-Cultural World’ [1996] Journal of the Institute for the Study of Legal Ethics’ 49.

Miceli M P, Near J P and Morehead Dworkin T, *Whistleblowing In Organizations,* (Routledge, New York and London, 2008)
__ __ Dreyfus S and Near J P, 'Outsider "whistleblowers": Conceptualising and distinguishing "bell-ringing" behaviour' in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds) *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) at p. 71.
__ __ Near J P, 'Some implications of the voice literature for research on whistle-blowing', in Burke R J and Cooper C L (Eds) *Voice and Whistleblowing in Organizations, Overcoming Fear, Fostering Courage and Unleashing Candour,* (Edward Elgar, 2013, Cheltenham UK and Northampton MA, USA).
Mills S, '"We need to talk" - mediation in the clinical setting in Ireland' [2010] Medico-Legal Journal of Ireland 64.

Mnookin R H, 'Why Negotiations Fail: An Exploration of Barriers to the Resolution of Conflict' [1993] The Ohio State Journal On Dispute Resolution 235.
__ __ and Ross L, 'Introduction' Kenneth J. Arrow et. al *Barriers to Conflict Resolution* W.W. Norton & Company 2007.
__ __ et al, 'Making Peace with Your Enemy: Nelson Mandela and his Contributions to Conflict Resolution [2014] Nevada Law Journal 281.

Moberly R, ' "To persons or organisations that may be able to effect action": Whistleblowing recipients' in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds), *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) at p.273.

Moffitt M, ‘Ten Ways to Get Sued: A Guide for Mediators’ [2003] Harvard Negotiation Law Review 81.

Moore C, ‘Moral disengagement’ [2015] Current Opinion in Psychology 199.
__ __ ‘Moral Disengagement in Processes of Organizational Corruption’ Abstract and References [2007] Journal of Business Ethics 129.

Moore L and McAuliffe E, ‘Is inadequate response to whistleblowing perpetuating a culture of silence in hospitals?’ [2010] Clinical Governance: An International Journal 166.

Mulcahy L, ‘The Possibilities and Desirability of Mediator Neutrality - Towards an Ethic of Partiality’ [2001] Social & Legal Studies 505.

N

National Institute for Health Research, *How do they manage? A qualitative study of the realities of middle and front-line management work in health care,* Health Services and Delivery Research, Volume 1, Issue 4, June 2013, ISSN 2050-4349.

Near J P and Miceli M P, ‘Organizational Dissidence: The Case of Whistle-Blowing’ [1985] Journal of Business Ethics (pre-1986) Feb 1985; 4,000001; p.1.

NHS England, *New measures set to support whistleblowers in primary care* April 2016 at https://www.england.nhs.uk/2016/04/support-whistleblowers.

NHS England, *Freedom to speak up in Primary Care* April 2016 at https://www.england.nhs.uk/wp-content/uploads/2016/11whistleblowing-guidance.pdf.

NHS England, *2016/17 NHS standard contract 2017* at https://www.england.nhs.uk/nhs-standard-contract/previous-nhs-standard-contracts/16-17/.

NHS England, *Freedom to speak up: raising concerns (whistleblowing) policy for the NHS April 2016*.

Nielsen L B, 'Situating Legal Consciousness: Experiences and Attitudes of Ordinary Citizens about Law and Street Harassment' [2000] Law & Society Review 1056.

Nursing & Midwifery Council & General Medical Council, *Openness and honesty when things go wrong: the professional duty of candour* 2014 GMC/OHC - DG/1014.

O

Oberman S, 'Mediation Theory vs. Practice: What Are We Really Doing - Re-Solving a Professional Conundrum' 20 Ohio St. J. on Dispute Resolution 775 (2005).

Okuyama A et al, 'Speaking up for patient safety by hospital-based health care professionals: a literature review' [2014] BMC Health Services Research 1.

Olchowy J R, ‘Russell Banks’ the Sweet Hereafter, Legal Storytelling and the Need for Alternatives to Litigation: Bypassing Court and Bringing This Town Back Together’ [2002] Windsor Review of Legal & Social Issues 115.

Olsen J, ‘Reporting versus inaction: How much is there, what explains the differences and what to measure’ in A.J.Brown, David Lewis, Richard Moberly and Wim Vandekerckhove (eds) *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham, 2014) (hereinafter *The International Handbook on Whistleblowing Research).*

P

Paley J, ‘Narrative Machinery’ in Yasmin Gunaratnam and David Oliviere (Eds), *Narrative and Stories in Healthcare, Illness, Dying and Bereavement*, (Oxford University Press, 2009).

Palmer M and Roberts S, *Dispute Processes, ADR and the Primary Forms of Decision-Making,* (Third Edition, Cambridge University Press, 2020).

Paquin G and Harvey L, ‘Therapeutic Jurisprudence, Transformative Mediation and Narrative Mediation: A Natural Connection’ [2002] Florida Coastal Law Journal 167.

Patients First Submission to the Freedom To Speak Up Review at www.nursingtimes.net/Patients-First.

Pauli C, ‘Whole Other Story: Applying Narrative Mediation to the Immigration Beat’ [2016] Cardozo Journal of Conflict Resolution 23.

Pennington N and Hastie R, ‘A Cognitive Theory of Juror Decision Making: The Story Model’ 13 CARDOZO L. REV. 519 (1991).

Pennington N and Hastie R, ‘The story model for juror decision making’ in Reid Hastie (Ed), *Inside The Juror, The Psychology of Juror Decision Making,* (Cambridge University Press, 1993).

Pigott C, ‘Hinton: an uncompromising decision.’ [2005] New Law Journal 944.

Pollock T, *How To Use Storytelling In Your Academic Writing,* (Edward Elgar, 2021, Cheltenham UK and Northampton MA, USA,)

Pope R, ‘The NHS: Sticking Fingers in Its Ears, Humming Loudly’ [2015] Journal of Business Ethics 1.

Powell T, *NHS Whistleblowing Procedures in England,* House of Commons Library Standard Note SN06490 2013

Powell T, ‘The Multiple Self: Exploring between and beyond Modernity and Postmodernity’ [1997] Minnesota Law Review 1481.

Pronovost P et al, ‘Is quality of care improving in the UK? Yes, but we do not know why’ [2011] British Medical Journal 341.

Public Concern at Work (now Protect), *Whistleblowing Arrangements Code of Practice,* 2008 at protect-advice.org.uk.

__ __ *Where's Whistleblowing Now? 10 years of legal protection for whistleblowers*, 2010 at www.drasuszodis.lt
__ __ *The Whistleblowing Commission: Report on the effectiveness of existing arrangements for workplace whistleblowing in the UK*, November 2013 at www.tuc.org.uk.
__ __ *Is the law protecting whistleblowers? A review of PIDA claims, 2015* at protect-advice.org.uk.
__ __ and The University of Greenwich, *Whistleblowing: The Inside Story* 2013 at www.gala.gre.ac.uk.

Public Administration Select Committee, *Investigating Clinical Incidents in the NHS* (2014-15, HC 886).

Putnam L L, 'Transformations and Critical Moments in Negotiations', 20 Negot. J. 275 (2004).

Pyper D, *Whistleblowing and gagging clauses: The Public Interest Disclosure Act 1998,* House of Commons Library Standard Note (SN00248, 2013).

Q

Quick O, *Regulating Patient Safety, The End of Professional Dominance?* (Cambridge University Press, 2017).

Quinn B, 'NHS's first National Guardian resigns after two months' The Guardian (London, 11 January 2017).

R

Randhawa R K, ‘Science, Religion and Law’ [2000] Flinders Journal of Law Review 81.

Ready D A Jr, ‘The Law, Dominant Paradigms, and Legal Education’ [1991] University of Kansas Law Review 415.

Rhode D L, ‘Feminist Critical Theories’ [1990] Stanford Law Review 617.

Rideout J C, ‘Applied Legal Storytelling: A Bibliography’ [2015] Legal Communication & Rhetoric: JALWD 247.

Riskin L L, ‘Decision-making in Mediation: The New Old Grid and the New New Grid System’, 79 Notre Dame L. Rev. 1 (2003).

Roberts P, ‘Motivations for whistleblowing: Personal, private and public interests’ in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds), *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) at p.207.

Rosenau P M, *Postmodernism and the Social Sciences: Insights, Inroads and Intrusions,* (Princeton University Press, 1992).

Rubinson R, ‘Client Counselling, Mediation, and Alternative Narratives of Dispute Resolution’ 10 Clinical L. Rev. 833 (2004).

S

Salmonson Y, ‘Understanding whistleblowing: qualitative insights from nurse whistleblowers’ [2010] Journal of Advanced Nursing May 2010, p. 2194.

Samuels A, ‘The doctor’s duty of confidentiality’ [2015] Medico-Legal Journal 167.

Sanders A, ‘Part one of the Employment Act 2008: “Better” Dispute Resolution?’ [2009] Industrial Law Journal 30.

Savage A and Hyde R, ‘Whistleblowing in the time of Covid-19: findings from FOIA requests’ (selected papers from the International Whistleblowing Research Network conference at Maynooth University, 2021, Middlesex University Research Repository at https://eprints.mdx.ac.uk/34505/).

Secretary of State for Health, *The Report of the Public Inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984-1995* (Cm 5207, 2001)

Secretary of State for Health, *Learning from Bristol: The Department of Health’s Response to the Report of the Public Inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984-1995* (Cm 5363, 2002).

Seuffert N, ‘Locating Lawyering - Power, Dialogue and Narrative’ [1996] Sydney Law Review 523.

Shojania K G and Dixon-Woods M, ‘ “Bad Apples”: time to redefine as a type of systems problem?’ [2013] British Medical Journal Quality & Safety 528.

Shrewsbury and Telford Hospital NHS Trust, *Freedom to Speak Up Guardian Role* July 2016 at https://newsroom.shropshire.gov.uk/partner-news/sath-freedom-speak-up.

Silbey S S, ‘After Legal Consciousness’ [2005] Annual Review of Law and Social Science 323.
__ __ ‘Legal Consciousness’ in Peter Cane & Joanne Conaghan *New Oxford Companion to Law* (Oxford University Press, 2008).

Singer J W, ‘Persuasion’ [1989] Michigan Law Review 2442.

Smith D, ‘Victims of the bullying bosses.’ [2011] Socialist Lawyer 20.

Smith R, ‘Whistleblowers and suffering’ in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds), *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) at p. 230.

Scheppele K L, ‘Foreword: Telling Stories’ in ‘Symposium: Legal Storytelling’ [1989] 87 Michigan Law Review 2073.

Schneider A K et al, ‘Cooking Up a Deal: Negotiation Recipes for Success’ [2014] Marquette University Law School Legal Studies Research Paper Series 1.

Skivenes M and Trygstad S C, ‘Wrongdoing: Definitions, identification and categorisations’ in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds), *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) at p.95.

Sorabji J, ‘The online solutions court - a multi-door courthouse for the 21st century’ [2017] Civil Justice Quarterly 86.

Stone C D, ‘Corporate Vices and Corporate Virtues: Do Public/ Private Distinctions Matter?’ [1982] University of Pennsylvania Law Review 1441.

Strobl J et al, *Suicide by clinicians involved in serious incidents in the NHS: a situational analysis* 2014.

Sturrock J, ‘The role of mediation in a modern civil justice system’ [2010] Scots Law Times 111.

T

Tarrant C et al, ‘A qualitative study of speaking out about patient safety concerns in intensive care units’ [2017] Social Science & Medicine 8.

Tasa K and Bell C, ‘Effects of Implicit Negotiation Beliefs and Moral Disengagement on Negotiator Attitudes and Deceptive Behaviour’ Abstract and References [2015] Journal of Business Ethics 1.

Taylor B, ‘Shell Shock: why do good companies do bad things?’ [2006] Corporate Governance 181.

Teo H and Caspersz D, ‘Dissenting Discourse: Exploring Alternatives to the Whistleblowing/Silence Dichotomy’ [2010] Journal of Business Ethics 237.

Turkel G, ‘Michel Foucault: Law, Power, and Knowledge’ [1990] Journal of Law & Society 170.

Tushnet M, ‘The Degradation of Constitutional Discourse’ [1992] The Georgetown Law Journal 251.

U

Ury W, *Getting Past No* (Century Business, London, 1992).

V

Valdes J E F, and Schubert W R, ‘The role of dispute boards in the construction industry’ [2017] International Arbitration Law Review 55.

Vandekerckhove W Brown A J and Tsahuridu, ‘Managerial responsiveness to whistleblowing: Expanding the research horizon’ in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds), *The International Handbook on Whistleblowing Research* (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) at p.298.
__ __ Brown A J. Moberly R and Lewis D, ‘Strategic issues in whistleblowing research’ in Brown A J Lewis D Moberly R and Vandekerckhove W (Eds), *The International Handbook on*

Whistleblowing Research (Edward Elgar, Cheltenham UK and Northampton, MA, USA, 2014) at p.522.

Vickers L, 'Whistleblowing in the public sector and the ECHR' [1997] Public Law 594.

Villa-Vicencio C, 'Living in the Wake of the Truth and Reconciliation Commission: A Retroactive Reflection' [1999] Law. Democracy & Development 195.

Vorenberg A, 'Essay: The Moral of the Story - The Power of Narrative to Inspire and Sustain Scholarship' [2011] Legal Communication & Rhetoric: JALWD 257.

W

Walshe K and Shortell S M, 'When Things Go Wrong: How Health Care Organisations Deal With Major Failures' [2004] Health Affairs 103.

Ward C E, 'Mediation: an invaluable component of any alternative dispute resolution forum within the Irish healthcare system' [2001] Medico-Legal Journal of Ireland 63.

Webley L, 'Qualitative Approaches to Empirical Legal Research' in Cane P and Kritzer H M (Eds) *The Oxford Handbook of Empirical Legal Research* (Oxford University Press, 2010) at p.926.

Weinstein L, *The 7 Principles of Conflict Resolution* (Pearson, London, 2018).

Welsh N A, ‘Making Deals in Court-Connected Mediation: What’s Justice Got to Do With It? [2001] Washington University Law Review Quarterly 787.

West R L, ‘Adjudication Is Not Interpretation: Some Reservations about the Law-as-Literature Movement’ [1987] Tennessee Law Review 203.

Wildman S M, ‘Obscuring the Importance of Race: The Implication of Making Comparisons Between Racism and Sexism (Or Other-Isms)’ [1991] Duke Law Journal.

Wilkes L M et al, ‘Nurses involved in whistleblowing incidents: Sequelae for their families’ [2011] Science Direct 101.

Williams G, ‘Negotiation as a Healing Process’ 1996 J. Disp. Resol. 1 (1996).

Williams P, *The Alchemy of Race and Rights: The Diary of a Law Professor,* (Harvard University Press, 1991);
__ __ ‘The Obliging Shell: An Informal Essay on Formal Equal Opportunity’ [1989] Michigan Law Review 2128.

Wilmshurst P, ‘No doctor should be untouchable’ [2013] British Medical Journal 45.

Winick B J, ‘Therapeutic Jurisprudence and Problem Solving Courts’ [2002] Fordham Urban Law Journal 1055.

Winslade J and Monk G, *Narrative Mediation: A New Approach to Conflict Resolution* (Jossey-Bass, San Francisco, 2000).

Winter S L, 'The Cognitive Dimension of the Agon between Legal Power and Narrative Meaning' [1989] Michigan law Review 2225.

Y

Yeoh P, 'Whistleblowing: motivations, corporate self-regulation, and the law' [2014] International Journal of Law & Management 459.

Z

Zaharlick A and Green J L, 'Ethnographic Research' in Flood et. al (ed) *'Handbook of Teaching of the English Language Arts* Macmillan 1991.395

Zamir R, 'The Disempowering Relationship between Mediator Neutrality and Judicial Impartiality: Toward a New Mediation Ethic', 11 Pepp. Disp. Resol. L. J. 467 (2011).