Reducing the risk of NHS disasters

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ABSTRACT

How could we better use public inquiries to stem the recurrence of healthcare failures? The question seems ever relevant, prompted this time by the inquiry into how former nurse Letby was able to murder newborns under National Health Service care. While criminality, like Letby's, can be readily condemned, other factors like poor leadership and culture seem more often regretted than reformed. I would argue this is where inquiries struggle, in the space between ethics and law—with what is awful but lawful. In response, we should learn from progress with informed consent. Inquiries and civil litigation have seen uninformed 'consent' shift from being undesirable to unlawful. If better leadership and culture were sole drivers here, we would likely be doing far better in many other areas of healthcare too. Instead, one could argue that progress on consent has been made by reducing *epistemic injustice*—by naming and addressing *epistemic* issues in ways that enhance *social power* for patients. If this is an ingredient that transforms clinician–patient working, might it also shift conduct within other key relationships, by showing up what else should become unlawful and why? Naming *medical paternalism* may have helped with consent reform, so I continue this approach, first naming two areas of epistemic injustice: *management feudalism* and *legal chokeholds*. Remedies are then considered, including the democratisation of management and reforms to legal ethics, legislation and litigation. In brief, public inquiries may improve if they also target epistemic injustices that should become unlawful. Focus on informed consent and epistemic relationships has improved the medical profession. Likewise, it could help healthcare leaders shift from fiat towards consent, and their lawyers from a stifling professional secrecy towards the kind of candour a prudent public expects.

INTRODUCTION

In August 2023, Lucy Letby, formerly a neonatal nurse at the Countess of Chester Hospital, was convicted of murdering seven newborns in her care and of the attempted murder of six more. In response, the U.K. Government initially ordered a non-statutory inquiry, but this was immediately criticised for being too narrow in scope and for lacking the legal powers afforded by a statutory one.[1]

Public outcry has focused on the appalling nature of Letby's crimes but there has also been grave concern about the alleged failure to investigate by National Health Service (NHS) management. Senior doctors voiced concerns that Letby may be killing children. But it has been reported that, rather than suspending her pending a full police investigation, senior management conducted 'perfunctory' inquiries and planned to return her to working with children, either at Chester or the local paediatric hospital, Alder Hey.[2] Managers even pressed some of the concerned doctors to write her a letter of apology.[2] Given the above, it was perhaps only a matter of time before the government yielded to calls for a full statutory inquiry.

This then brings us to the purpose of this paper. My case is: first, that the inquiry process, as commonly constructed, can provide public hearings and a degree of catharsis but is unlikely to achieve the reform that is needed; second, that this disappointing but predictable outcome might be averted by closer attention to the issue of *epistemic injustice* (on which, more below).

RECURRENT THEMES

The first of these points can be illustrated by reference to previous inquiry reports into improper retention of dead children's organs at Alder Hey Children's Hospital (2001), failures in children's heart surgery at Bristol Royal Infirmary (2001) and failures in maternity and neonatal care at East Kent hospitals (2022). They capture sadly recurrent themes and, latterly, an emerging (even exhausted) recognition that inquiry recommendations are not working:

> The death of a child is traumatic enough without having to relive it ten years later.[3]

> It would be reassuring to believe that it could not happen again. We cannot give that reassurance. Unless lessons are learned, it certainly could happen again, if not in the area of paediatric cardiac surgery, then in some other area of care. For this reason we have sought to identify what the lessons are and, in the light of them, to make recommendations for the future.[4]

> I have not sought to identify detailed changes of policy directed at specific areas of either practice or management…this approach has been tried by almost every investigation in the five decades since the Inquiry into Ely Hospital, Cardiff, in 1967–69, and it does not work. At least, it does not work in preventing the recurrence of remarkably similar sets of problems in other places.[5]

The last of these quotes alludes to repeated similarities. In other words, we might already predict at least some of the findings from the inquiry into the Countess of Chester cases. For example, they will likely include statements to the effect that:

1. Letby was a monstrous exception but she should really have been stopped earlier. Regrettably, there is no easy way to guarantee that her case will not be repeated.
2. Management lacked expertise when faced with a difficult situation of incomplete and conflicting

information. But it should have listened more to consultants' concerns, given greater priority to protecting patients and involved the police sooner.

Recommendations may similarly reflect those of past inquiries.[3 4 6 7] These tend to fall into normative ethical categories, with measures that are deontological (duty-based), consequentialist (outcome-based) and virtue-based. Hence, recommendations will likely include:

1. New regulations, policies and, perhaps, laws to be applied to staff and management. For example, there may be more calls to overhaul outdated and ineffective whistleblowing legislation.[8 9] There may be rules on when and how boards have to investigate serious concerns or involve the police. Managers may finally face a regulatory regime, similar to those for healthcare practitioners.[10]
2. More monitoring of consequences (outcomes) for patients—but also, conceivably, for those who raise concerns too. Better understanding of patient outcomes and clinicians' performance has formed part of recommendations, ranging from the Bristol inquiry to those into convicted breast surgeon Ian Paterson.[4 7]
3. Improved recruitment and training to reinforce professional virtues among clinicians and managers. The General Medical Council (GMC) already works with medical schools to embed ethics within curricula.[11] Other regulators, like the Nursing and Midwifery Council, may be asked to do more here.[12] Raising concerns (whistleblowing) and responding properly to them may be given more emphasis.[13]

BROAD PATHS TO RECURRENCE

Of these recommendations, experience suggests the first category tend to be implemented ineffectively or not at all. In 2001, the Bristol inquiry highlighted the need for improved regulation and asked that its scope be extended to include managers (which did not happen). But in 2013, the Mid Staffs inquiry still noted:

> …the regulatory regime that allowed for overlap of functions led to a tendency for regulators to assume that the identification and resolution of non-compliance was the responsibility of someone else. Effective accountability to the public demands a simpler regime of regulation[14]

And in 2020, the Paterson inquiry found similar issues unresolved, stating as follows:

> We recommend that the Government should ensure that the current system of regulation and the collaboration of the regulators serves patient safety as the top priority, given the ineffectiveness of the system identified in this Inquiry.[7]

A duty of candour was among the recommendations of the 2001 Bristol inquiry. But even when developed into a statutory duty of candour in 2014, after the Mid-Staffs disaster, this seems to have made little impact on management thinking and action in the Letby case.[15] Elsewhere, the first prosecution for breaching the statutory duty of candour, involved a woman who died after an iatrogenic injury. But it led to a victim surcharge of just £120, with a fine of £1600. For comparison, the relevant hospital covered court costs of £10 845.43.[16]

We can consider other laws and law enforcement. Whistleblowing legislation has already been whittled by employment lawyers to an 'airy thinness' that offers unlikely reparation for a slender minority of workers harmed.[8 9] Requiring police involvement is no panacea, with the Gosport and Daniel Morgan inquiries reminding us of failures by police to investigate (in the latter case, linked to police corruption).[6 17]

The second category, outcome-based measures, tends to fail due to a propensity to prioritise reputation. For example, the BBC reported that in the 5 years to 2021, U.K. hospitals commissioned 111 invited reviews by medical Royal Colleges, but published only 16, and shared only 26 with hospital regulators. Investigative journalists gained access to only 80 of the reports, but found that 65 contained potential or actual safety concerns.[18] Inquiry reports have long highlighted the need for greater transparency. In 2001, the Bristol inquiry called for:

> …[making] the improvement of the quality of information for patients a priority.[4]
> Patients should be referred to information relating to the performance of the trust, of the specialty and of the consultant unit (a consultant and the team of doctors who work under his or her supervision).[4]

Almost twenty years later, in 2020, the Paterson inquiry had to make a similar call:

> We recommend that there should be a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data, for example, how many times a consultant has performed a particular procedure and how recently. This should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and independent sector.[7]

Despite these repeated calls, it can still be very hard to gather reliable and comparable data on the performance of your surgeon. Calls for risky activities like surgery to be routinely video-recorded, rather like aviation black boxes, have met with limited enthusiasm or action within the profession.[19] That said, the collection and analysis of data looks set to be examined in the Letby inquiry, the Chair having been asked specifically to consider this point.[20]

The third category, virtue-based measures, tends to be ineffectual alone, in the face of power and its dictates. After all, according to ethics experts appointed to advise the Infected Blood Inquiry, the GMC has required medical curricula to include ethics training since at least the late 1990s.[21] Yet when the inquiry into the Gosport War Memorial Hospital found 'that the lives of over 450 patients were shortened while in the hospital', the 2018 report laid bare serious historic *and contemporary* failings by the GMC itself.[6] This has unfortunately undermined its standing as a reliable guardian of medical virtue. In that sense, we need also to look for better structures and processes, rather than relying too much on fashioning better people.

HEALTHCARE FAILURES EXEMPLIFY EPISTEMIC INJUSTICE

This pattern of lessons unlearned suggests a need for new thinking. It also suggests we should think carefully about areas where there may have been some positive change. In this category, I would include informed consent. Over the years, and following both inquiries and civil litigation, there seems to have been an important shift. This includes clear recognition that information disclosure is a key requirement for consent to be lawful and, second, that the extent of that disclosure should be determined more by what a prudent patient would want to know, given their circumstances, rather than what a body of medical opinion might deem reasonable.[22]

Examining this more closely, one can see the advantage of focusing on consent in order to test whether care has been adequate. Consequentialist approaches, based on outcomes, can leave parties disagreeing over the data and its interpretation. As Kennedy said, in his report on Paterson, the lack of informed consent should have alerted managers to the problems in his practice, early and long before arguments began about numbers and data.[23] But another attraction of looking at informed consent is that it focuses us on the relationship between doctor and patient and the exchange of knowledge within that. In other words, it is an *epistemic* relationship, such that the great shift in consent could be seen as a move towards *epistemic justice*. From a position where doctor knows best and the patient should heed advice, we have moved to a place where the doctor can support the patient with relevant information, all in service of shared decision-making. Even if this might be considered an idealised view, I would argue that something important has happened. Rather than the failed inquiry recommendations centred around duties, outcomes and virtues, we have seen progress through measures that address a key *relationship* within healthcare, and the *epistemic injustice* therein.

Before we consider how this observation could help future inquiries, it may be useful to clarify the term *epistemic injustice,* as developed by philosopher Miranda Fricker.[24] First, she noted that the field of ethics may benefit from accounts that start with observed injustice rather than theoretical formulae for possible justice. Second, she pointed out that the field of epistemology may have neglected ethical dimensions that extend beyond fairness in the way knowledge is accessed and produced (distributive justice). In response, she defined epistemic injustice, highlighting two neglected components of this interface between ethics and epistemology. She termed these *testimonial injustice* and *hermeneutic injustice*. The former refers to a variety of situations where a speaker's credibility is unfairly downgraded by virtue of a hearer's prejudices. Fricker gives the example of black people being less believed by police. But we could also include people whose doctors believed patients had little useful to add to discussions of their own healthcare. Hermeneutic injustice refers to the wrong done to speakers who are kept without a language to conceptualise and articulate their suffering. Here, Fricker considers the struggles of women trying to voice their concerns about sexual harassment, but at a time, such as the Jane Austen era, when language for this had yet to be developed. Similarly, we could consider a time when people felt they had been insufficiently involved in their healthcare decisions but had no terms yet for medical paternalism or informed consent.

With this in mind, my thesis is that progress on informed consent has in fact been to address epistemic injustice. This has improved the relationship between clinician and patient and could improve other key relationships within healthcare too. Problems with consent were brought into focus by the development of terms like *medical paternalism*. Here, casting now more widely, I develop two further terms, *management feudalism* and *legal chokeholds*. These denote other healthcare relationships that harbour epistemic injustice that is under-scrutinised.

Let us illustrate each of these pathological relationships, starting with *management feudalism*. This is neatly depicted in the quotes below. The first is from the report of the Gosport Independent Panel as it considers how leaders' self-interest could readily give rise to appearances of conspiracy and cover up. The second quote comes from the U.K. Government's response to the inquiry report.

> First, each organisation may have acted in its own interests and those of its leaders, motivated by reputation management, career self-preservation and taking the path of least resistance. This coincidence of interests would itself lead to identical responses across organisations, without there being a conspiracy between the organisations.[6]

> The culture at Gosport was the opposite of candid. It was defensive, hierarchical and ignored the concerns of patients and families. The co-existence of closed cultures and poor and unsafe care is not a coincidence. Where a healthcare organisation lacks interest in the views and concerns of those it treats, it can quickly become lost in a cycle of excessive self-confidence, labelling problems as external attacks or threats rather than as learning opportunities. Even in the best organisations, there can be a strong temptation to seek to explain away failings in care rather than taking the harder but more rewarding road of looking deeply into what the causes of the problem really were.[25]

In other words, *management feudalism* is characterised by self-interest, defensiveness and secrecy—rather than informed consent. Feudal leaders barricade themselves in place to rebuff all comers, wielding power for self-preservation rather than the protection of patients and staff. Their palace intrigues eclipse the public good. Such leaders may conduct placatory consultations but do not really value or trust the knowledge possessed by staff and patients. They consider that theirs is the power to decide. As such, feudal leaders feel little or no obligation to be candid and upfront with staff and patients, or to include them in discussions in order to seek their consent to proceed.

The second target, *legal chokeholds*, is illustrated first from exchanges during the statutory inquiry into the failures at Mid-Staffordshire Hospital. That investigation heard the Coroner had sought an expert report into the death of a young man in the hospital's care.[14] But the report, critical of the hospital, was not disclosed to the Coroner, even in redacted or watered down form. The inquiry criticised the lawyers involved, one of whom had since moved on to become an Assistant Coroner themselves.[26] The hospital sacked the other of the lawyers involved but then settled their case for unfair dismissal, paying them the maximum award (£103,000) and conceding they were wrongfully and unfairly dismissed.[27] This happened just as their 4-day tribunal was due to get underway, with their Queen's Counsel quoted as saying:

> An interesting issue that would have been examined in evidence [had the tribunal hearing gone ahead] is why she was dismissed for lack of openness by the same board that were trying to conceal a damning Royal College of Surgeons report on surgical standards.[27]

While the Mid-Staffs inquiry was unhappy with the lawyers' actions, it had to accept that, as things stood, the two lawyers had no legal obligation to disclose any versions of the report to the Coroner. The lawyers also argued that (1) their first duty was to their client, the hospital, and (2) non-disclosure of the report was in their client's best interests. Though the inquiry disagreed with the second of these points, it did so by arguing that disclosure was in the hospital's best interest. In that sense, the inquiry did not prioritise the alternate view that disclosure was *in the public interest* or that this should direct legal conduct in such circumstances. Despite public dismay, neither the Solicitors' Regulatory Authority nor the Crown Prosecution Service took action against the lawyers. In other words, such conduct fell within both the regulations

and the law.[28] The implications are significant. Lawyers acting for NHS institutions can still prioritise the interests of their instructing leaders rather than the wider public interest. At present, the public have no ability to consent to this legal conduct, even when public safety is at stake and despite paying for the lawyers from the public purse.

This example prompts consideration of a still different type of epistemic injustice, one neatly illustrated by the unrelated case of former MP, Ms Antoinette Sandbach.[29] She is reported as arguing that she has a right to be forgotten and that references to her should be removed from research which details her ancestor's role in the slave trade. We can recall that Fricker's landmark account is entitled 'Epistemic Injustice: Power and the Ethics of Knowing'.[24] But it seems there is something also to be said about power and the ethics of *not being known*, whether in the Sandbach case or in cases, like Mid-Staffs, where healthcare failures have occurred. This type of epistemic injustice, we could term here as *redactive injustice*. The hearer's prejudices favour those with social power, but this leads not just to relative overvaluation of their testimony (testimonial injustice), but also to a tendency to redact their testimony where it might harm said social power. In other words, the powerful benefit unfairly from their uglier truths not being aired, whether that is through judicious omissions or, for example, by negotiated financial settlements.

The legal use of public funds, potentially against the public interest, brings us to another aspect of our point on *legal chokeholds*: U.K. employment tribunals and the whistleblowing cases they hear. This area merits particular attention from the coming inquiry. Letby's killings were eventually stopped after doctors blew the whistle.[1 2] But they expressed real trepidation at doing so, feeling intimidated by management.[2] The 2004 Shipman inquiry into the GP mass murderer described a not dissimilar situation for the professionals working around him:

> The culture of the time was such that they feared that their concerns would not be taken seriously but would be dismissed as irrational. Some of them feared that they might be wrong to harbour suspicions about Shipman, and that, if they did, the consequences for them would be serious.[30]

This quote surfaces issues of epistemic injustice that confront those seeking to raise concerns in the public interest (whistleblowers). A 2020 paper from the All Party Parliamentary Group (APPG) for Whistleblowing used research funded by the University of Greenwich, the British Academy and the Leverhulme Trust to report that matters have not greatly improved. Rather, while emphasising the societal importance of whistleblowing, it also concludes that the current legal system around this still does not work:

> Whistleblowers remain the vital element of a transparent society without whose voice many more unethical activities and crimes would remain unknown, with far reaching impacts on our society and communities. Whistleblowers can help us develop policy that protects all of our citizens and they should be treasured. Unfortunately, these individuals are vulnerable to retaliation from both colleagues and employers. Whilst there are laws in place to protect them, the overwhelming evidence is that they have failed to address the principal issues.[31]

> We have identified that even where Tribunals uphold disclosures as having been made in the public interest, this recognition does not always result in a finding in favour of the whistleblowers' claim. Even worse, where a Tribunal upholds the public interest disclosure claim, the actual wrongdoing is never, or rarely investigated allowing serious crimes to continue for many years causing untold damage to society.[31]

> For those who do speak up, their future can be bleak. They face many obstacles and repeated detriment, not least navigating overly complicated legislation.[31]

In a 2022 report, the APPG went further calling formally for replacement of the current whistleblowing legislation. They concluded that:

> Employment Tribunal results suggest inbuilt bias against whistleblowers and in favour of well-funded respondents.[32]

The perspective of epistemic justice is helpful in navigating the detail of what seems to be going on here. First and foremost is the evidence of testimonial injustice. Whistleblowers' concerns are not taken seriously, with it being rare for their claims to lead to investigation of the wrongdoing.[31] Poorer, female and minoritised claimants experience worse Tribunal outcomes, adding to evidence of testimonial injustice (even if more limited access to legal representation is also a factor).[31] This idea is reinforced by evidence that whistleblowing claims which also feature claims for discrimination fare worst of all. Hermeneutic injustice can also be felt.[31] We have struggled for years even to find the language to express what the present legal process does to whistleblowers, with multimodal harms that are both practical (eg, excessive complexity, delays and costs) and personal (eg, moral injury, denigration, damage to health and relationships). Wider recognition of terms like *gaslighting* and *DARVO* (Deny, Attack, Reverse Victim and Offender) is now helping to articulate negative aspects of the whistleblower's experience.[33 34] But hermeneutic injustice can also be seen in the way some institutions drown out talk of the major hazards shown by the APPG and others, filling the airwaves instead with talk of 'freedom to speak up' and glib reassurances of whistleblowers being 'protected'.

Particular concerns are that the current Public Interest Disclosure Act (PIDA) provides whistleblowers with no upfront protection or mechanism to assure that their concerns will be investigated.[8 31] The legislation may even have become a means of 'lawfare', that is, a vehicle for employers to retaliate, using the litigation process itself. The harms to whistleblowers are substantial and include financial, personal and mental impacts.[33–35] All told, meaningful redress for the whistleblower is rare. But that is not to say there are no beneficiaries of the present system. The current legislation forms the basis of lucrative work by many law firms who have honed the means to remove whistleblowers. In general, the employer's defence begins with blanket denials of any public interest (whistleblowing) disclosures or any harms to the whistleblower. Even when these defences are disproved, and even if it is proven the whistleblower was harmed *because* of their disclosures, the employer can still prevail by insisting that retaliation was the furthest *reason* from their mind.

In summary, this section has worked to demonstrate *management feudalism* and *legal chokeholds* as epistemic injustices. We can now name them properly as *harms in themselves*, rather than mere enablers of the particular physical disasters. This naming exercise forces us to consider meaningful reforms that look beyond the mechanisms of death and injury and onward to address also the need for epistemic justice. This should include informed consent that spreads beyond the narrow confines of

the clinician–patient relationship and instead requires even institutional lawyers to more often set aside the redactor's black pen. With this point in mind, I want to turn next to think about potential avenues for progress.

TOWARDS EPISTEMIC JUSTICE

To imagine a way forward, it is useful to start with a parable that rehearses Fricker's point about the relations between power and knowledge. David Wengrow and David Graeber consider how a celebrity, Kim Kardashian, might retain hold of expensive jewellery.[36] The first option, security and bodyguards, illustrates the use of force or *power*. If this were disallowed, Wengrow and Graeber argue that the next resort would be stealth or *secrecy*: that is, to hide the jewellery somehow. Disallowing that would mean Ms Kardashian would have to rely instead on *persuasion*—or as Wengrow and Graeber put it, charismatic politics—to convince others that she was entitled to hold on to the items.

As we consider reforms, this parable helps frame our problems in simpler terms: *management feudalism*, as an issue, primarily, of excessive power; *legal chokeholds*, as a problem, primarily, of excessive secrecy. Our aim instead is at greater reliance on persuasion or, better still, negotiated consent. With this in mind, we can turn to think about recommendations: first, to democratise NHS management; second, to pursue greater openness on matters of public interest via reform of legal ethics, legislation and litigation.

Democratisation of management

This serves both as a restraint on power, but also as a means of reducing the 'us-them' divide across which epistemic injustices can grow. It also accords with key recommendations from the Bristol inquiry as follows:

> 157 The involvement of the public in the NHS must be embedded in its structures: the perspectives of patients and of the public must be heard and taken into account wherever decisions affecting the provision of healthcare are made.[4]

> 162 The mechanisms for the involvement of the public in the NHS should be routinely evaluated. These mechanisms should draw on the evidence of what works.[4]

> 163 The process of public involvement must be properly supported, through for example, the provision of training and guidance.[4]

Measures to consider should include:

1. Management boards with term limits, better structured separation of powers and greater diversity of expertise

Term limits are intended to reduce the chance of board capture in the Gosport style, where a group of senior executives can barricade their position against challenges, problems and reform.[6 25] Such limits should see board members demit office and rotate back to other roles, ideally where they are again subject to the rules and procedures they once administered. For clinicians, this could see a return to frontline practice alongside other managerial options. Hopefully, this will increase the proportion of clinicians rotating through senior management, bringing their ethics training and a regulated responsibility for patient safety.

Better separation of powers and greater diversity of expertise is also intended to improve the chance that the non-executives have the expertise to hold the executives accountable. For example, medically qualified non-executives may be better placed to scrutinise a Medical Director in their powerful role as GMC Responsible Officer. Boards should retain financial expertise, as at present, but should recruit a more diverse group of experts, including from science, ethics and humanities and from younger demographics than typical at present.

Expertise could be tested, not just in subjecspecific areas, but also in terms of epistemic justice. Skills with testimonial justice could examined, for example, by looking at how well the board candidate, as hearer, was able to listen to, reflect back and *put on record (to the speaker's satisfaction*), the experiences of patients, families and staff. Another key test would be to see whether leaders can, as far as possible, do their work by seeking informed consent from relevant stakeholders.

2. Meaningful board representation of staff and patients

This is intended to see that crucial decision making, including on whistleblowing concerns and legal disputes, is more inclusive, robustly informed and better overseen. Again, it is hoped that this would act against testimonial injustice by defusing the social power differences that arise within 'us and them' structures. It may also assist with hermeneutic injustice by helping boards to listen better to the experiences of patients, families and staff—and then, together and more quickly, develop the language needed for its fair articulation

3. Reinforcement of local democratic oversight (via e.g. elected community health councils, or similar) so boards are more answerable to local people on these same issues too

These community structures could also benefit, as above, from term limits, separation of powers and a diversity of tested expertise. This again would be hoped to reduce epistemic injustice for reasons already given.

With these three measures in place, it may be possible to improve on the patterns of repeated failure noted by Kirkup.[5] In that context, measures touched on previously, like professional regulation of managers, may also reap more public benefit. The yield may be greater still if attention to epistemic justice is regularly appraised. Leaders and managers could be regularly evaluated by patients, families and staff for their ability to listen, reflect and accurately put on record their various voices rather than just delivering closed off and legalistic responses.

Loosening legal chokeholds

The further hope is that the management measures above might see a measurable reduction in resort to legal proceedings. But given these will not disappear altogether, we should turn next to recommendations in response to the challenge of *legal chokeholds*. Measures to consider should include:

1. Independent review of existing inquiry reports, starting with an analysis of the evidence of lawyers advising public institutions

A number of areas of public life have been the focus of public inquiries, ranging from medicine and the military to the Post Office and policing.[37] It is striking therefore that the legal profession seems often to have escaped similar scrutiny, despite institutional lawyers and their advice featuring as evidence in most if not all such inquiries. With that in mind, the review should examine, in particular, wherever legal advice impeded timely disclosure of information about material risks that a prudent public would want to have known.

As part of the review, ethicists and jurisprudential scholars should be engaged to examine how lawyers acting for public institutions might better balance duties of client confidentiality against disclosure of material risks in the interests of a prudent public. This might, for example, lead to the development of a *prudent public test* for the materiality of risks that should be disclosed. The threshold for materiality could be informed by public consultations such as citizen juries. Consideration could be given to making the materiality threshold especially low for situations where the public user has no choice but to rely on the institution for a vital service (eg, where the institution is a public monopoly provider like the NHS provision of neonatal care).

Alongside this, the review should bring forward recommendations to address the observation made by the Institute of Government (IoG): that between 1990 and 2017, more public inquires were chaired by people called Anthony or William than by women.[38] Brians were at level pegging with all women, with Johns, Michaels and Peters not far behind.[38] We need to move beyond an approach redolent of Plato's Guardians, to one that allows greater inclusion from a wider pool of talent. On these lines, the IoG observed separately that non-judicial Chairs may bring subject specific expertise, greater familiarity with making policy recommendations and more willingness to advocate on the issues once the inquiry is concluded.[37] They also advised that inquiries may be improved by interim reports to offset lengthy delays, expert witnesses to improve the drafting of recommendations and a permanent unit in the Cabinet Office to host inquiry administration.[37]

2. New whistleblowing legislation

The current PIDA dates back to 1998 and is widely considered to be well past its sell by date, including by the APPG and others. Several groups have suggested avenues for reform.[8 32] My suggestion is that, as part of developing new legislation, an independent review should attend to epistemic injustice and seek out the less heard evidence of whistleblowers and their families. Against *redactive injustice*, this process should also seek information that tends to keep a lower profile and which is therefore less scrutinised. For example, this would include the NHS spend on whistleblowing litigation, by Trust and law firm, and the rates at which each Trust enters such litigation, broken down by protected group, safety concerns raised and settlements paid. Likewise, the review could exploit new information from item 3 below, testing the fidelity of sample tribunal judgements against the transcribed oral evidence. Along with public consultations, this could all then inform the consideration of alternatives.

As a core principle, my proposal would be that we enshrine a strong duty to investigate whistleblowing concerns, developed as follows. We argue that informed consent requires that material risks, where uninvestigated or unresolved, have to be disclosed by the institution to a prudent public reliant on its services. For materiality, we would use the prudent public standard developed under item 1 above. Failure to comply would be an epistemic harm in itself and constitute professional, even criminal negligence on the part of leaders and managers. In other words, if whistleblowing identifies material risk, leaders and managers have a choice to investigate and resolve the matter or otherwise a strong duty to disclose it to a prudent public.

Consideration would also have to be given to ways to protect whistleblowers from the point of disclosure. Of these, perhaps the greatest protection would accrue from prompt and independent investigation of their concerns, directed by a more diverse and democratic management whose term limits might focus them on the job at hand rather than preservation of power and position. Such management might also direct themselves better if under professional obligations that included the need to seek the informed consent of a prudent public.

In this model, whistleblowing cases might be moved into specialist courts that recognise the vulnerability of whistleblowing witnesses, feature specialist judges and, where needed, use juries to help determine facts and/or the public interest. In certain cases of particular importance, public funding of the whistleblower's case could be considered.

Finally, it may help if whistleblowing law adopted the standard used in discrimination cases, where it is sufficient to show causation rather than needing to peer into employers' heads to divine their *reasons* for adverse treatment.

3. Recording and transcription of employment tribunal proceedings

The APPG has documented the concerning failure of tribunals to provide justice for so many whistleblowers, particularly those who are poorer, female or minoritised.[31] Reform is hobbled by the idiosyncratic way in which employment tribunals, unlike many other legal proceedings, are not recorded.[39] This makes it hard to investigate for injustices, leaving us reliant on the judge's account in their own judgement with no opportunity to cross check this against the evidence actually presented.[40] It is already an epistemic injustice if judges fail accurately to record a whistleblower's evidence or misrepresent the same. But it is a further injustice, if as is common, whistleblowers lack the resources to pay for their own transcription. This prejudices their ability to appeal even highly flawed tribunal decisions. Recording can improve on this and afford much needed scrutiny of the quality of justice when matters of public interest are at stake.

Helpfully, some tribunals already share premises with higher courts where recording and transcription are routine, meaning the technology is in situ and this step could be achieved at speed and relatively low cost. Indeed, the move to online hearings during the pandemic illustrated the means by which, in time, automated transcripts could be generated for checking, saving further on time and costs.

CONCLUSION

The Countess of Chester cases will be examined by an inquiry, and recommendations brought forward. But these may repeat those of previous inquiries and again go un(der)implemented. The IoG report that just 6 of the 68 public inquiries established between 1990 and 2017 have been followed up by Select Committee hearings to check on implementation.[37] They have suggested that *post hoc* scrutiny should form a core task of the U.K. Parliament's Liaison Committee. However, the risk remains that the chief lesson learnt from the Letby inquiry will be that *lessons are not being learnt*. In this paper, I have offered some practical measures to challenge that dismal prospect and, in particular, to change culture by focusing on the character of ethical relationships, not only within institutions, but beyond them, with a prudent public. These are also epistemic relationships that should be made fairer and more just by widening the ambit of informed consent and thereby placing stronger obligations around disclosure upon health leaders and their lawyers. Material risks would have to be promptly investigated and resolved or else disclosed to a prudent public. The call to democratise NHS management is also grounded in political philosophy and the long-understood point that unaccountable and unified power retains little virtue. The call to study the legal and judicial processes stems from recognition that while lawyers have duties towards client confidentiality and judges have to exercise power

without undue interference, further analysis and oversight may help the public better protect its own highly significant interests. For a start, it may want to examine whether tribunals originally designed to wrangle pay and conditions, are really the best place to weigh children's lives and the reasonableness of speaking up for them.

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