Peter Duffy: Good afternoon everybody and welcome to another one of our videos on whistle blowing and the relevance of this to healthcare. As usual, I'm joined by Helen Hughes from Patient Safety Learning and today we've got Mike Swinn joining us. Mike and I have at least a couple of things in common. We are, or in my case were, consultant urological surgeons, and of course we have in common the fact that we are whistleblowers and, in fact, we've both written books about our experiences as well. So welcome!

Mike Swinn: Thank you very much. Thank you for having me.

Peter Duffy: It'll be a pleasure I'm sure and very educational too. So I think to start off with, obviously Helen and I have both read your book, which we would heartily recommend, but obviously most people are not going to be familiar with your circumstances. Could you perhaps just start off by taking us through sort of broad strokes of what happened with your whistleblowing experience?

Mike Swinn: Yes. Well, I mean to take a step back. I first qualified as a doctor back in 1991. I qualified in London, did my junior doctor training in London and surrounding hospitals. And then my penultimate year of training was in Brisbane, Australia where I did a fellowship. And then I came back to London and was finally appointed as consultant at Surrey and Sussex Healthcare Trust in Redhill in 2004. I'd chosen Redhill because it was a friendly department. It was quite a small department, only three consultants. I'd met both the other consultants a number of times before and we got on well and I was quite happy. But fairly soon after I started, in fact in 2006, I became clinical lead and felt the burden of responsibility of making sure that standards were as high as possible. And in 2006-2007 I started to have concerns about, well a few aspects really, of my what you might call my senior colleague, so the oldest of the three of us who'd been the most longstanding member of the team.

There were some earlier concerns, but the main concerns in 2006-2007 surrounded the fact that he invested in a machine called the HIFU machine to treat prostate cancer. HIFU stands for high intensity focused ultrasound, and it's a way of treating prostate cancer. At least at that time it was called a novel treatment. It's still, I think, fair to say it's not a mainstream treatment now, but it certainly hadn't been through all the regulatory hoops and so on for it to be a standard treatment offered to all patients. And I was a bit concerned that my colleague, who by then had become cancer lead and therefore was chairing the MDTs where we discussed it, as you know Peter, I'm sure you know as well, Helen, cancer treatments for individual patients. I was concerned that HIFU might get a preferential treatment, as you might say. And indeed, in fact, before he bought the machine, he started to keep a list of patients who were not on any treatment or some who were given hormones, waiting for a business case to be approved at the hospital either for buying the machine or, in fact, the business case was for renting it in.

So because these patients couldn't have HIFU at the NHS hospital in Redhill, there then was a practice developed that the patients then would end up in the private sector where they would be given HIFU treatment against MDT recommendations. So quite quickly, 2007 now, we went from me having anxieties about a potential problem to there being an actual problem of MDT discussions being ignored, decisions overridden and patients being offered at times only one treatment, and that was HIFU for their prostate cancer, which was unauthorised, unorthodox, and they ended up paying for it in the private sector. So those were in a nutshell were the initial concerns, it then broadened out after that to other diseases, including bladder cancer, some aspects of behaviour and so on. But really it was that HIFU stuff that made me start to raise concerns in late 2006, early 2007.

Peter Duffy: Okay. And presumably you escalated these to what, senior clinicians or managers?

Mike Swinn: Well, to begin with, I tried to sort it out within the department, so I spoke to my colleagues saying that it's not just me that has these concerns, it is also the nurse specialists, it's also the middle grade staff, the associate specialist and the SPR. All had concerns over what they viewed as the lack of impartiality, the biased way that treatments were being offered. My overtures to the colleague in question were met with stiff resistance, I think you could put it mildly as, and, in fact, I realised quite quickly that it was counterproductive because the more I tried to raise concerns, the more he would dig his heels in and tell me that I was wrong and that he was right. And I came away from those conversations feeling battered and bruised and feeling that I had done nothing other than to entrench his view even more that he was right and everyone else was wrong.

I mean, the MDTs were set up, I guess about, well in the late 1990s, do you think Peter? Something like that, early 2000s, maybe. They were set up principally for situations like this; they were set up to stop bad or maverick or ill-informed or ignorant practice by an individual. But rather that important decisions, such as what type of treatment a person with cancer should get would be made by a panel of people with representatives across a range of specialties, only one of which is urology. And it includes oncologists whose remit is radiotherapy and chemotherapy and so on, but also nurse specialists. Our clinical lead nurse would be there, pathologists, radiologists and so on. And the idea is that at an MDT, a consensus view would be reached about the best treatment that we could offer a particular patient. And sometimes of course there would be disagreements and different points of view, but you'd always come to some sort of agreement in the end and sometimes you would say, well, we're not sure if it's treatment A or treatment B, but let's put it to the patient and let's offer them both.

And having been involved with MDTs twice a week now for 20 years, I can say that actually they work extremely well for the most part. And it has been shown to be an

effective way of reaching a balanced view as to the range of options or particular treatment that any patient might get. So the key problem that I was facing is that the very fundamental step, the checks and balances in which we make sure that patients are kept safe and that treatment is effective, was being completely overridden by a single person. And this goes against completely the whole reason for the existence of the MDT.

Peter Duffy: Yes, I think that's absolutely right. It's a very good summary. And so you said you got quite a lot of pushback. Did this involve counter allegations at all?

Mike Swinn: So having tried to sort it out locally, achieving nothing, I then went to my boss who at that time was called the clinical director of surgery. It's now changed its name and is called the Chief of Surgery. But either way, I went to see him in his office and presented in my capacity as clinical lead, the concerns that I and several of my colleagues, including now the oncologist, the consultant oncologist, had about the ways that MDTs were being subverted and that patients were getting a bad rap. And to begin with, he seemed shocked. He seemed a bit like a rabbit caught in the headlights. I don't think, to his credit, he just didn't know what to do. I think that was the problem. And I remember him changing the subject a number of times and I had to sort of steer it back to ‘but what are we going to do about this?’.

He said that he would look into it and get back to me. So I remember feeding that back to the clinical nurse specialists who were particularly concerned about what was going on and waited a few weeks, but nothing happened. More patients were going through the MDT and ending up having HIFU in the private sector, and some of them just seem to be bizarre decisions now. There is no way that the most passionate advocate of HIFU would say that it was a reasonable thing to give some of the patients a localised treatment to their prostate. So I'm talking about people, and Peter will know what I mean by this, with a PSA of 700. So people who stand to gain, I would argue, nothing at all by having any treatment directed at their prostate. So I came away from the meeting with the clinical director of surgery, quite upbeat I guess, that he would do something.

I fed that back to the clinical nurse specialists that day, and they seemed reassured as well. Unfortunately, many weeks went by and nothing happened at all with the same practice continuing. So I went back to see the clinical director of surgery, and to cut a long story short, I went back time and time and time again with nothing discernible happening at all. And then at one point he said, well actually, we might just sack him. So I thought, well, okay, well if it's up to you, if that's what you want to do, that's what you want to do. But nothing happened. And I think in retrospect, that was just something to fob me off. So once I'd been to the chief of surgery, I also went to the director of operations of the Trust and said the same thing, and I went to the cancer lead of the Trust and still very little was happening, so essentially nothing.

So I then went to the medical director and told him all about it. And, eventually after a long period of time, they grudgingly arranged an internal investigation. And this was an internal investigation run by one of my colleagues, anaesthetics colleagues. So it didn't seem to me a great choice because this person didn't have any great detailed knowledge of prostate cancer or treatment options. But anyway, we had this internal investigation and frustratingly none of the contents or the results of the investigation were shared with any of us who had contributed to it apart from the person, my senior colleague. And that then led to a deterioration in relationships in the department, because for the first time, really it was in black and white, exactly what we had said, because our conversations were recorded and were there in black and white for him to read. You asked earlier incidentally Peter about counter allegations and so on.

And so by this time, in fact, within a few days of me raising concerns initially to the clinical director of surgery, it was generally known around the hospital, at least the hospital's consultant body, that I had raised concerns about this consultant. And that made life very tough for me as you can imagine; you can probably empathise with. And some of the counter allegations coming back at me was that I was new, that I didn't know what I was talking about, that prostate cancer wasn't an area of my special interest, although it kind of was, that I was a jealous colleague and that I was after his private practice. So those are the things that were fed back to me from other consultants in the hospital and from the clinical director of surgery, which was a tough one to take, but I kept going. And after the internal investigation by the anaesthetist, as I say, I wasn't told the outcome of that investigation.

I found out subsequently that it did find some fault with my senior colleague and suggested that a bigger, more in-depth investigation be carried out. Unfortunately, it wasn't, at least not at that time. So what we decided to do was, and this is now two or three years later and lots of patients have gone through the system. What we decided to do was to get together a number of patients. In fact, it was ten, who we could see had been through the MDT with prostate cancer and decisions had been made, let's say this one's for active surveillance, this one's for surgery, this one's for radiotherapy, this one's for either surgery or radiotherapy. And we knew that they had all had treatments other than had been offered at MDT. In fact, they pretty much all had HIFU or were on a waiting list for HIFU. And so we got someone called the head of clinical governance from the department of surgery and we said, we've got this problem.

No one is listening, the medical director is not listening, the chief of surgery is not listening, etc. Please will you have a look at them? And so he wrote a report. It was referred to subsequently and in the coroner's inquest as the Kemp report, and it was a fairly simple document. It said, these are the ten patients. I've looked at them all, Mr. Kemp said, and these were the treatments recommended by the MDT and these

are the actual treatments that they got. None of them have followed a traditional conventional path, certainly not according to what the MDT recommendations were. And he looked into some of them and concluded some had suffered harm. And he said the recommendations at the end were that this consultant should be suspended and that he should be referred to the GMC and that there should be a wider investigation for all of the patients. Guess what happened? Nothing. Absolutely nothing. The only thing that did happen is that Pip Kemp was asked to a meeting with the medical director and came away saying, I'm leaving the trust. And he left shortly afterwards.

Helen Hughes: That's in your book, which is excellent. I would recommend anyone to read it, but I think that was the most shocking for me. I mean, I suppose ultimately the most shocking thing is that patients weren't getting the treatment they needed and they suffered harm and some died. We'll go on to explore that and the relationship or the subsequent investigations and coroners, but the fact that here was authoritative evidence confirming what a group of professionals had been saying for years, presented to very senior leaders within the organisation, and then nothing happened. I was really quite upset when I read that in the book. I just couldn't believe it.

Mike Swinn: Yeah, well, of course you ain't seen nothing yet, as you'll know because you read the book.

But there then was another investigation once it became clear to us that nothing was going to happen. I kept going back to the medical director time and time again, but I had to get the balance right because I didn't want him to think that I was a bit mad. Do you know what I mean**?** I didn't want him to think that I was the cause of the problem after all; that fed into the narrative that the medical director was being spun from the other side, that I had this big misjudgement and I needed to go off and educate myself about prostate cancer and become "less jealous". But nevertheless, what can you do? You can't do nothing if you sit there at MDT after MDT with these decisions either being made, or what happened once we made a certain amount of progress is that the arguments at the MDT faded away. Only because the MDT had become even more sidelined and when the patient got to the clinic room, the MDT sheet wasn't even looked at.

And so it didn't matter what happened, or was decided at the MDT. Eventually there was, on the back of me going time and time again to the medical director and head of cancer and the chief executive by this stage as well, who reassured me that the medical director was very good and doing a very good job, that we eventually had an external person come from outside of the Trust. So I thought, thank goodness for this. This is now what, 2011 I think. So time has been going on. We're now talking quite large numbers of patients having been through the system. And unfortunately the terms of reference that the Trust had given to the external reviewer, who was a

well-respected urologist from the Cambridge area, and understandably he didn't want to stray into territory that was not his remit.

And so I went along for my interview. They were half hour slots, I think there were about ten of us across the department interviewed during the course of the day. Sadly, the consultant in question declared himself unable to attend. I went along for my half hour interview and the conversation was all about how many patients I saw in a clinic, what was the frequency of the on-call rota? Do we have enough nurse specialists and all this kind of stuff. And after about 20 minutes, I was looking at the clock and I said, I'm really sorry to not answer this next question, but what about the HIFU, what about all the patients in the red folder? And I pointed to this red folder on his desk, and because we didn't trust the senior managers to get it right, what we did was to get a red folder. One of the nurses bought it in Smiths for a couple of quid, and we photocopied just a few letters and a few sheets from the notes of about 25 patients, and we put it in this red folder and we made sure that this guy had it before he visited.

So I said, well, what about the patients in the red folder? I could see it on his desk. He said, oh, this. And he opened it and he said, well, they've all been mismanaged. I said, well, there you go. He said, it's not my remit to come here to talk about these, but they have all been mismanaged. Anyway, let's talk about your on-call rota. So that would turn out to be a frustrating day. And in fact, the Trust had intended no feedback at all to be given to us until I demanded it at the end of the day. And about six o'clock, someone from the management came down and said that he had given feedback verbally to the chief executive and the medical director that they had a real problem here, in other words, with HIFU and my colleague. So I thought, well, at least he's done that.

So I thought, well, they have to act now because you have professor so-and-so from the Cambridge area coming and saying that there's a real problem at the Trust. Unfortunately, guess what happened? Nothing. Absolutely nothing. So I went to see the medical director and the chief executive and said, well, you had this internal thing. I'd asked for an external one, but you got an internal one, which was a bit of a waste of time. By the way, if you can show me the report at some point, that would be great. Then you got the external guy in. He tells me you got the terms of reference wrong. But anyway, he told you that you've got a real problem here. And in fact, by then the chief executive and the medical director had independently used exactly those words to me when I said, how did it go when you met the professor afterwards?

And the chief exec said, yeah, but we haven't had his written report yet. I said, alright, okay, let's wait for that. Anyway, about a week later, a draft report, it had the word "draft" written across it, and it said that my colleague should be subject to a further investigation by the Royal College of Surgeons through what's called the

independent review mechanism. So I said to the chief executive, well, there you go, it's in black and white. He said, no, that's a draft report. He said, we need to wait for the full report. I said, when's that coming? And he said, well, I don't know because you see, your colleague couldn't meet the professor when he came because he was very busy at a meeting somewhere, but they're going to meet up later on. Anyway, so four months later during BAUS at the end of June, the two of them did meet, and the week after that, the final report arrived with the word "draft" removed. And instead of saying, this guy needs to be referred to the Royal College of Surgeons, it said, if you are minded to investigate this further, it should go to the Royal College of Surgeons. And that word "if" gave justification in the mind of the chief executive and the medical director not to investigate it, at least at that stage. So again, it was just another missed opportunity, which was enormously frustrating and difficult. And of course, the more investigations there are that don't conclude, this is madness, this treatment, it has to stop.

The more strength it gives, the more wind behind the sails it gives to maverick practice and poor behaviour.

Peter Duffy: And just pausing there just for a moment, Mike, what do you think was driving the sort of management and senior clinicians' attitudes? It seems perfectly clear to me there was a massive problem, and it must have been what, two years earlier there'd been a recommendation to refer to the GMC. So what was motivating people to be so hands-off?

Mike Swinn: I've pondered that a great deal, Peter, and I'm not entirely sure what the right answer is. I think as these things often are, it's a combination of different things. I think part of it is that these managers aren't bad people. They're nice people, they're hardworking people. They don't want to get things wrong. It's just that for them, they were fighting so many fires elsewhere in the Trust. That time there was the casualty wait target of, was it 95% have to be seen between four hours? And that was a great big thing. There's the finances of the hospital and there's the staffing problem in paediatrics, there's the fact the air conditioning unit doesn't work in theatre and all the rest of it

And that there are patients in corridors and someone like me comes along and says, you've really got to sort out this poor practice.

It is not really top of their agenda. So I think that's part of it. Fighting fires elsewhere. I think also they've never been in this position before. Things are relatively rare, and so they didn't really know what to do. They haven't really been trained properly in my view, in what to do in situations like this. And thirdly, I think that certainly in my situation, my senior colleague, very charming, very persuasive. It is a lot easier for them to believe that. And after all, they've known this guy a lot longer than they've known me and to my knowledge that there weren't any great concerns about his

practice before I arrived. So I think they bought the narrative that actually part of the problem is a clash of personalities or professional disagreements or whatever it was. I think it's more complicated though as you know Peter in the world of prostate cancer, it's very difficult for anyone to be dogmatic about a particular treatment being right for a particular patient. And so there was a certain amount of hiding behind that uncertainty that my colleague could do. No one really knows necessarily whether you should be treating this patient or whether it should be on active surveillance. So I think for all of those reasons, plus the Trust was struggling financially and to get someone to come in from outside costs money and a Royal College Surgeon's investigation comes with it, attached a bill for some tens of thousands of pounds. So I think there were all those reasons probably why action wasn't taken.

Helen Hughes: But if I can just highlight that those reports nevertheless were evidencing that there was patient harm at that point.

Mike Swinn: Yes.

Helen Hughes: That was undoubtedly the case.

Mike Swinn: And it just sort of went on and after the external review by the professor from the Cambridge area, poor practice continued. And in some respects, it was a bit less bad in that by then my colleague had been told that he could only see cancer patients with a clinical nurse specialist being present. His habit had been to ask them to leave the room when he was having consultations with patients and he had to run firm cancer management plans by our oncologist to ratify them. And so he did that for about six weeks. But then the poor practice went back and it went back to exactly as it was. So I then raised that as a new concern saying that letter you wrote to my colleague saying he has to do all of these things, well he did them for about six weeks. He's now not doing any of them. And that resulted in a very weak letter going from the clinical director of surgery to my colleague saying, it's come to my attention that you are not adhering to the terms set out in the previous letter from a few weeks ago. I'll be grateful if you could please do it from now on. Many thanks and signed off. And it completely lacked any teeth to my mind. And was again, another reason why poor practice continued.

Peter Duffy: And so that takes us up to about what 2012?

Mike Swinn: Yeah, yeah, that's about right.

Peter Duffy: So at that point, there's still no meaningful restriction on this consultant's practice? There are harms going on and on?

Helen Hughes: That's five years.

Mike Swinn: Yeah, five years minimum. And interestingly enough, I said that in some areas the practice was modified to some degree, but in other areas, practice became

more difficult to understand, more maverick. And in probably 2012, his management of bladder cancer patients gave cause for alarm. Particularly one patient who was a young man in his early 50s who had been a private patient previously of my colleague's with a diagnosis of CIS in his bladder. This stands for carcinoma in situ, and it's a high grade, potentially aggressive form of cancer of the bladder and it needs to be treated. And this man had been treated entirely appropriately with BCG, which is a chemical that goes into the bladder. The patient then had been transferred to the NHS where further high grade cancer, including CIS, had been found despite the fact that he'd had BCG. And the standard treatment at this stage once BCG has failed is to talk in terms of a cystectomy, so an operation to remove the bladder.

And indeed that's what our MDT said, and it was discussed at the regional MDT, which is a group of about six hospitals where we discussed all high grade bladder cancer cases. And the view of the regional MDT was indeed that this man should go straight to cystectomy. And in fact, that's exactly the words that they used. They said, go straight to cystectomy. Unfortunately, when that man saw my colleague in clinic, my colleague actively said, you don't need a cystectomy. And he sent him off for photodynamic therapy at Watford General Hospital. Well, photodynamic therapy is not a treatment for bladder cancer. It was the subject of someone's MD research when they were a junior doctor. And they had been appointed a consultant at Watford General many years later. And the letter came back from Watford after inevitably a delay saying, we don't offer PDT - photodynamic therapy and it's not a treatment for prostate cancer anyway.

Bladder cancer, indeed. And so that had wasted a lot of time, but my colleague seemed resolved that this man should not have a cystectomy and gave him more BCG. Wind the clock on about six months or so. And the nurses in fact went to the medical director and the chief executive about this one case and said, this is a clear example of bad practice that could easily end horribly wrong for this poor man, who was 53 I think. And I have an email from the medical director to me copied into lots of other people saying that he's looking into that case. But anyway, in response to your request, Mike, for another meeting about your colleague, I'm afraid we've had so many meetings about him, it's just not reasonable to have yet another meeting about him at this stage. It was a complete fob off, but at least reassured me that he was looking at this young man with recurrent high grade bladder cancer who was on the wrong treatment. Wind the clock forward, say another, probably another six months realistically.

By this time, aspects of my colleague's behaviour had deteriorated, and we were continuing to raise concerns about an increasing number of cases who had been mismanaged prostate cancer. There was a serious untoward incident review about another case of bladder cancer where my colleague had found essentially nothing in the bladder. And in fact, they had a muscle-invasive bladder cancer with bilateral

hydronephrosis, and they were on ITU with a creatinine of about 900. And he looked in the bladder and thought it was cystitis, which is a wholly inappropriate diagnosed conclusion to come to. And he came to that conclusion because he hadn't looked at the scan or read the patient's notes. So that was another, there were lots of other cases. And part of his behaviour became more challenging, more aggressive, more shouty, and eventually the hospital suspended him on behavioural grounds.

As they did that, a locum consultant came in to do the work to fill in. And at exactly that time, I, in fact, a few months early, just moved half of my sessions to Guildford. And at the time when all this was going on, I went off to Los Angeles for a few weeks to observe robotic surgery for bladder cancer. And whilst I was there in Los Angeles, I used some of the time to come to a decision about what I was going to be doing back home because by now I had had it, this is now 2013. And I had been going on about these issues for six or seven years. It had affected me greatly, stunted my career. It had made me very unhappy at times. I wasn't sleeping well. I felt unwell. I'd been in the coronary care unit with fast AF at one point, and it was taking a toll on my family.

I wasn't enjoying my holidays and it was very difficult. So when I was there, I decided in Los Angeles that I would just have to drop it. I came to the conclusion that I had done more than most people would've done, that I'd raised concerns appropriately, numerously, in person, in writing, with specific examples. In fact, dozens of examples. In fact, many dozens of examples. And yet nothing had happened. And part of me thought, have I got this wrong? Maybe he's right. Could it be that I'm a bit weird in some way and I've just misjudged it? And I sort of came to the conclusion that no, I'm right and he is wrong and my colleagues are right as well, but for the sake of my health and that of my family, really, ultimately, I suppose I thought I'll just have to drop it. So I made that decision, that deal with myself and a few days later came back from Los Angeles to England and the very first MDT back, literally the first, the case of the young man with high grade recurrent bladder cancer I mentioned a few minutes ago, was discussed.

And in my colleague's absence, the locum had looked in this man's bladder and found a tumour which was high grade and muscle invasive. And he'd arranged a scan, which very sadly had now shown metastatic disease. In other words, the high grade cancer, which hadn't been treated appropriately a year before. And which the nurses and I raised concerns about to the medical director. And the medical director had written to me saying he was looking into, he hadn't. And sadly, the disease had progressed and now spread around the body, and this man now was destined, I'm afraid to succumb to his disease. So then at that point, I literally left the MDT and went straight up to the medical director's office where I just barged straight in and he looked up and said, hello, Mike, can I help you? I said, yeah, look, I'm really sorry to just come in like this, but yet another man is going to die who shouldn't, actually like

that. He said, what do you mean? And I told him the whole story and he said, gosh, that sounds serious. Can you go and fill out a Datix? So a Datix is a online form system where you log, as you will doubtless know Helen, Peter's very familiar with it, I'm sure where you log your clinical concerns, your near misses and all the rest of it. And there are literally tens of thousands across the Trust per year, and they eventually get assigned to someone to look at who's too busy doing something else, and they halfheartedly look into it and so on. So that struck me as being a wholly inappropriate response, and I burst into tears. I could not believe it. What more do you want? It was mind-blowing.

Peter Duffy: It's worth just saying at that point that had the original MDT recommendation been followed, which was a cystectomy while the disease was still what we call superficial or confined to the bladder wall, that should have been curable?

Mike Swinn: Yes. And indeed,

Peter Duffy: And highly avoidable this, wasn't it, just for those people who aren't familiar with urological surgery?

Mike Swinn: Yes, indeed. So totally avoidable. Yeah, and it's not just you saying that or me thinking that as well, Peter. When it went to coroner's court along with nine other cases, the expert witnesses told her Majesty's coroner as she was then that there would've been a 95% cure rate if the MDT advice had been followed.

Helen Hughes: And I'm presuming that the patient would've been unaware of this, that there was a recommendation for action that could have led to that 90% cure rate. That option wasn't presented or the information wasn't shared.

Mike Swinn: No, it wasn't. In fact, the cystectomy was mentioned, but only to dismiss it. So the patient got firmly in his mind that I'm not having a cystectomy because that's the wrong thing, but look, I'm going to go for photodynamic therapy at Watford. This is brilliant, or I'm going to have some more BCG. But it was all nonsense. And sadly, the man of course, despite chemotherapy, dies a few months after that. Anyway, after my meeting with the medical director that day with the wholly unreasonable response from the medical director, the following day, which was a Friday, I finished my operating list and went to see the chief executive about six o'clock in the evening or so, and he said, come on in, how can I help? And I said, look, I've told you before, it's still going on, and I'm next week going to tell the CQC.

And he said, what do you mean? I said, you know what, I've told him all about this latest case, you know all about it. It's been going on for years. It remains unsafe. It is not a safe environment, the urology department at the moment, it hasn't been for a long time. You know that. Anyway, I've had enough. I'm going to the CQC. I don't think he said very much after that. But on the Sunday afternoon, I got a phone call

from the new clinical director of surgery saying, oh, Michael, the chief executive, has asked me to give you a call. Did you mean what you said on Friday? I said, of course, I mean, I mean about what? I mean what I say about all the patients. I mean what I say about the mismanagement, and I certainly mean what I say about going to the CQC next week.

So that was about four o'clock on the Sunday. On the Monday morning, my colleague was suspended by the medical director and the head of HR. He was told now there was going to be an invited review mechanism of his work by the Royal College of Surgeons. So that is indeed the mechanism by which the Royal College of Surgeons eventually came in, it was by this young man who I think was 53 or 54 when he died. So the Royal College of Surgeons then came in a few months later and did a comprehensive review of the department spanning several days. We were all interviewed at length, including my senior colleague, and they wrote a report saying that there had been large scale mismanagement of patients now for many years. And they said that what the Trust now had to do was to refer my senior colleague to the GMC and the hospital had to conduct a look back exercise over all the cancer cases that he had led on since 2006, I think it was, which was a big piece of work of itself.

What's interesting following that, so my colleague who was still on suspension for behavioural grounds, his suspension was then continued on clinical grounds. So I then went back to the medical director, this is in the days following the Royal College of Surgeons investigation, where they said all of these things, you have to refer this gentleman to the General Medical Council. His suspension must continue, and you have to do this lookback exercise into all of these patients. So I said to the medical director, well, you need to do those things, but also with respect, you need to do an investigation into why it was that the Trust did not respond to concerns earlier than now. This is, and after a long delay, eventually a company called the Good Governance Institute came in and did a review of the hospital's handling of concerns raised into my senior colleague, and they concluded unequivocally that the culture was wrong, that the senior management had missed a number of key opportunities where they should have intervened earlier. And they referenced the Kemp report saying, well, it could all have been sorted out some years before if only they had listened to the previous reports, both Kemp and also the verbal feedback from the professor from Cambridge who said that you've got a real problem here, that it needs to be sorted out, which they decided to ignore because it wasn't in writing. Then following that came the coroner's inquests, which was a whole another ball game all by itself.

Peter Duffy: So that got into the national media, didn't it?

Mike Swinn: Yes.

Peter Duffy: Were you given any support over that from the Trust?

Helen Hughes: Before we go into that, because that is a fascinating story. I mean, how did you and your colleagues feel that eventually your concerns had been vindicated? But I mean, how did you feel about it all? It must have been very difficult environment for you and your consultant colleagues and your nurse colleagues. I mean, what was your response to all of this and the battles that you had?

Mike Swinn: I think one of sadness probably would be the number one emotion. It just seems such a shame and so awful that all these patients have been mismanaged for so long, and they needn't have, and particularly this young man. I'm sure I can say his name because the coroner's inquest was a public thing, so Graham Stoton was his name, a very nice man. And I just think that if there's one who stands out, I feel most sorry for him and his family because I do think that the Trust did the family a big disservice there. So it was difficult for us on a number of reasons. One, because it was an uncomfortable place to be and very sad environment in many respects. But of course, we were having to pick up the pieces clinically as well. So Mr Stoten, for example, came under my care because he had bladder cancer. I was bladder cancer lead and still am.

And relationships were of course difficult with the senior managers, but broadly speaking, I mean, apart from those things, I was sort of, I suppose, relieved to be honest, relieved that the carnage has stopped and also on a personal level, pleased that I had been vindicated because I felt that I could hold my head up around the hospital again. There were certainly still many people around the hospital I think, who were unsure about exactly what my role was in getting their friend and colleague suspended on behavioural grounds and questioning his clinical competence and so on. But no, as Peter will testify, I mean, it's a lonely, difficult, time-consuming experience, isn't it?

Peter Duffy: Yes. And dangerous as well. So I was going to actually ask you, when this was all going on and you're now heading into a coroner's inquest and so on, were you at any point afraid that you might end up losing your job or being referred to the GMC? Because as we both know, malicious referrals to the regulator are a fairly common tactic in this kind of situation.

Mike Swinn: Yes. If I'm being honest, I didn't really think too much about me being referred to the GMC, but I certainly felt very uncomfortable when there was the first set of coroner’s inquests. So this was ten cases, this is now up into October 2018. I mean, this is how time marches on.

And you asked me how the Trust prepared me for coroner's court. Well, I was asked to a meeting with the Trust lawyers called Capsticks a week before - I've read your book, Peter - literally a week before the coroner's inquest. And fortunately, I managed to get hold of a transcript of our meeting to prove that my memory of it was

correct, where they said to me that my role was to put the Trust's side and to defend the Trust and to make sure that it was to counter my colleagues' assertions and all the rest of it. Well, I didn't see that as my role at all. I saw it as my role as an independent witness in a fact-finding forum that is a coroner's inquest.

And there were two of us being prepared that day for the following week's coroner's inquest. There was me and the medical director and, in fact, the medical director was there when I arrived. And looked absolutely shell shocked, head in hands like this, like a defeated man. And I then had my conversation with him along the lines that I've just said, and I thought, well, at least the medical director's going to be there to take the flack and defend the Trust if that's what he wants to do. But I'm just a guy trying to make sure that common sense prevails and that the right conclusion is come to.

So I was then alarmed to find out that a couple of days later, the Trust insisted that I personally be the one who submits all of the summary documents about these patients before the coroner. And I say they insisted because that's the word that they used. And they said that I "need" and I "must" in a series of emails from the legal department on advice from Capsticks. Well, I could see what was happening is that I was being set up for a fall because if it's me personally submitting all of this evidence, it's me that has to be the one on the stand being cross-examined by my colleague's expensive legal team for one. And so I took informal legal advice from a friend of mine who's a criminal defence barrister and he said, well, it's nonsense just say no, it should be the medical director.

And then this, I think is the following day. They said, well now the thing is, you see, the medical director can't go to coroner's inquest. I said what? He must. And they said, no, he can't because there's a family problem, so he can't go. So that left me as the senior most employee of the Trust to go along, having been told to defend the Trust against their mismanagement over many years. The only other person that was there was the chief executive in the public gallery staring at me. It was absolutely awful. And so I stuck to my guns and said that I wouldn't be personally submitting all this material and eventually got an email from them saying, oh, it's fine, you don't have to. And I said, well, why not? And they said, oh, actually, it was submitted at one of the pre inquest hearings anyway, several months before, so you don't need to. Well, the whole thing seemed to me a ruse to try and put me in the situation of being the most exposed and being the one who'd been told to defend the Trust. I think that was wholly unreasonable.

Peter Duffy: Just so we're clear, Mike, this wasn't documentation that you yourself had written.

Mike Swinn: Some of it was. Some of it was because they were précis of patients that the Trust had asked me to do, to put before a panel to come to some sort of a

view as to the standard of care that they had received. Some of them I had had a hand in compiling; even then that was at the behest of the Trust. And to be told that I had to go and defend the Trust made me feel very uneasy.

Helen Hughes: They were looking for someone to effectively represent the Trust and to take that authoritative role, whereas that wasn't you as a senior clinician's responsibility to do that?

Mike Swinn: That was my view. And about three or four days into the inquest that were, I think due to last two or three weeks, it was very clear, not least because of the national coverage in the press that you alluded to Peter, that the Trust was coming out of this very badly indeed, all sorts of unhelpful headlines for the Trust. And at one point, one of the barristers, I think incredulous, asked, after hearing my answer to their question, how often and when did you raise concerns? And I stopped talking about 20 minutes later. He said, well, how did it feel raising your concerns for year after year after year with nothing happening? I said, it's like hitting your head against a brick wall. And that's where the title for my book comes from. But the weekend, at the end of the first few days of the coroner's inquest, the chief executive phoned me on the Sunday saying that he had written to the head of the coroner's service asking this set of inquests to be halted at this point because he didn't think that the coroner was being impartial.

And I don't know all of the ins and outs of that, but I was told that they would all have to be reheard on another occasion. And a year later, October 2019 was when they were subsequently reheard. And between the two coroner's inquests, shortly after that first set of inquests in October 2018, information started filtering back to me that the hospital were going to be defending themselves by saying that you didn't make yourself clear enough in raising concerns. And I also was told at the very senior level in the Trust that the chief executive and the medical director were both concerned about corporate reputational damage, a possible corporate manslaughter charge. And even that they could be held personally responsible in some way for some of these deaths. So they were very, very anxious about things. And as soon as I heard that they were going to try and turn their fire power back onto me, that made me feel very uncomfortable indeed.

So I went to see the chief executive and said that I felt very uncomfortable about what I'm hearing. And he said, well, I mean he became very aggressive and shouty and pointy, but he said, well get your medical indemnity then if you feel that you need to be defended. And I said, well, my medical indemnity is something that I pay for to indemnify or insure me in my private practice, not NHS. And anyway, I'm a witness, so I shouldn't need any legal support. And about three weeks after that, I got a letter from the Trust saying that given the views that I had expressed, it wouldn't be appropriate for the Trust or its legal representatives Capsticks to support me through the next set of coroner's inquests. So what that meant is that I had been cut further

adrift, if you like, and that I was more isolated, squashed in a narrow gap between my colleague and his legal representatives on the one side, and the Trust and their legal representatives on the other side.

So I took legal advice myself, and I employed a lawyer for a bit who accompanied me to a few meetings at the Trust and so on. I stopped employing her when my bills were about £27,000 and it wasn't really affordable, so I decided to go it alone after that. But one thing which I hadn't really realised at the time is that by not having any support as they put it from Capsticks, the Trust lawyers, what it meant is that I didn't have access to the legal bundle, which is the boxes and boxes of papers that all interested parties in the coroner's inquest have access to. Had I had access to it before the coroner's inquest, I would've been able to read the statements of the chief executive and the medical director. And many of their statements were difficult to say that they were 100% true, shall we say. And because I wasn't legally represented and didn't have the Trust's support, it meant that I had no means of cross-examining them, saying things which well, which some things were untrue. I can demonstrate they're untrue. So a very difficult, horrible process from start to finish. But I think that is the lot of the whistleblower in modern day NHS, it seems, sadly.

Peter Duffy: And just zooming back and looking at the broad view of that, that just comes across to me as a complete perversion almost of what a coroner's inquest should be. It is not actually really supposed to be about blame, is it? It's supposed to be about determining if there are risks to patients and sorting out any potential future risks.

Helen Hughes: Yes, establishing the cause of death, and then they're under a statutory duty to put in the public domain their concerns of the Section 28 Prevention of Future Deaths report if they feel that those risks are still potentially going to cause harm to patients.

Peter Duffy: The corporate duty of candour; there should not be all this legal confrontational stuff should there?

Mike Swinn: I think the reality though is that, I mean, I'd naively thought that a coroner's inquest would be the impartial, cool, calm environment where we're here to find out the facts of the who, where, when, how questions. But I think increasingly in recent years, it's become an adversarial forum where interested parties do bring their lawyers along and ask some probing questions. So I hadn't anticipated that at all, but that's how it was I'm afraid. And I know that many of the families of the bereaved have been given compensation, and had they not had a lawyer going along attacking the Trust, maybe their level of compensation would've been less high. I don't know. But the coroner's inquests concluded that three deaths had been contributed to by neglect, which is an unusual, rare thing. Normally neglect means it's withholding the fundamentals to sustain life, food and water and so on. But in this case, it was

withholding standard treatments and a further three cases had had their deaths brought forward by mismanagement.

Peter Duffy: And presumably after all this fallout and bad publicity and so on and so on that you've just described, you then have to go back to work in this organisation.

Mike Swinn: Yeah. Well, very difficult. After the second set of coroner's inquest in October 2019, I was very tired apart from anything else. I had the prospect of a GMC hearing in Manchester in a few weeks' time. In order to attend as much of the coroner's inquests as I could, I took annual leave. So I was short of a break anyway. I'd used much of my time off in preparing myself for what I would say on the stand at the coroner's inquests. There are a few other elements of it that I had invested time myself in getting to grips with, such as the fact that my senior colleague had submitted false literature before the coroner. So there was a fabricated letter in the documents which he put forward, and how do I know it's fabricated? Well, it was supposedly a letter to me, which I'd never received.

It was supposed to have gone to the widow of one of the men who was a subject of - well, Mr Stoton, who I mentioned earlier. And Debbie, his wife hadn't received the letter. So I took it to a secretary in the department and said, can you just have a look at this letter? Tell me what you think. And the secretary looked at it and within five seconds said, well, it hasn't come from here. And I said, well, why do you say that? And she said, well, because where it says "private and confidential" on the letter wouldn't come out in the window, so we would never put that. And she said, oh, the secretary's initials are missing. And I think the logo was slightly wrong or something, but this was a letter purporting to have come from the department of urology, but which clearly hadn't. And so I raised it at the time as a concern to the medical director and the Trust's legal team saying, there's this fabricated piece of evidence about to be submitted before the coroner.

Is this a police matter? I said; surely it's perverting the course of justice or something? The medical director responded by saying that he hadn't seen it and he was off today, but he would look at it potentially the following week. The legal team didn't want anything to do with it. And so I raised it as a separate thing through one of the widows of someone who had died, the subjects of the inquest, and they got their lawyer to cross-examine me about it on the stand. And that's how it came out that there was this fabricated letter, and in fact, that became part of the GMC Fitness To Practise hearing that happened now another year later, because that was delayed many times. And they concluded that that letter had in fact been fabricated, not least of all because when I was looking at it before taking the stand, I could see that the fax number was wrong by one digit and so there's no way that a standard letter with a standard format would have the phone number or fax number wrong on it.

So all of these things, preparing for these internal investigations, the GGI investigation I mentioned about looking at into issues of how the Trust had handled itself, the coroner's inquests, two sets of them, I went to some of the pre inquest hearings as well. All of this was massively time-consuming and tiring and pretty much did me in. So the answer to your question, how did it feel going back to work after it? It's a bit of a blur, to be honest, because I was so tired, but relieved that I felt that finally there had been justice for the families, too late of course for the patients. And just moving on perhaps to the GMC investigation, that itself took about a year for the whole investigation to run its course and finish with a fitness to practise hearing at the end of which they concluded that my colleague should be struck off. So he was at the end struck off, and by then the Trust had dismissed him on disciplinary grounds.

Peter Duffy: And this is a very straightforward question, really. You are obviously resoundingly proved to be in the right here. You absolutely did your job and your sort of clinical professional duty, and you saved an awful lot of other patients from similar adverse outcomes. Has anybody at the Trust ever thanked you?

Mike Swinn: After enough time had elapsed, so the time limit had elapsed that meant that my colleague couldn't, he'd run out of time to appeal against being struck off by the GMC. Literally the day after, I was emailed by the new medical director, invited to a meeting with some of my colleagues with the new chief executive. So by now a new chief executive, new medical director, who knew very little of what we've been discussing this afternoon. And I gave them a potted summary and they were shocked, absolutely shocked. And they did say sorry and said that it won't happen again, and so on. And about six weeks after that, six weeks, I presume, because their letter had to go through Capsticks for vetting, I suspect, there was a less fulsome apology saying that we're happy to confirm that you did the right thing. And it's always important that people do the right thing. And I'm sorry you've had a tough time.

So I'm not sure that I could say that they've ever really put their hands up and say that they got it all wrong from start to finish. And thank you so much. I mean, certainly nothing along the lines of what would've been appropriate. And by contrast, I do have letters from them, not the current set of senior managers, but from the previous set saying the exact opposite. In other words, saying we are confident that, and I'm quoting now, we are confident that at all times we did what we could to address concerns raised around Mr.Miller. And it goes on to say, once concerns had been raised to a sufficient level or sufficiently clearly at that point we acted very promptly. Again, implying that it was a question of how clearly the concerns had been raised and that's where the fault lies, not in them.

Helen Hughes: But Mike, as you said about the senior management's response, variable response, was any of this, to your knowledge, ever shared with the Board?

Because the Board overall has the governance of the organisation and this went on from 2007 to 2018 or 2019 for the GMC. So this was a long time in the making. Was there any oversight by the Board on this, do you think? The Quality and Safety committees, the full Board, the medical director, non-exec?

Mike Swinn: The answer to that is that the GGI report, the report that looked into how the Trust behaved when concerns were raised, criticised the Board for lack of oversight. But I have a little bit of insight to the behaviour of the Board myself because once I had, if you like, fallen out with my chief executive and he told me to get my own lawyer and wrote me a letter saying, we're removing legal support for you. I made an appointment to see the senior independent director of the Board and I went along and she was very nice, very concerned. I remember she gave me a bottle of water and said, sit down. How can I help? She was relatively new in the Trust. And again, I told her the whole story pretty much from start to finish about all the times concerns had been raised, all of the patients, all of these duff inquiries, the wrong terms of reference, the wrong people doing these reviews, the times we'd been ignored.

I mentioned the fact that the chief of surgery in his statements to the Royal College of Surgeons claimed never to have received any clinical concerns about the man in question. Black and white untruth. And she was very concerned. She said, oh, this is awful. God, I'm so sorry for what you've been through, is exactly what she said. And I said, and now they've removed legal support for me. I'm isolated. I find myself in a very difficult position. I'm very scared that I'm going to be attacked by the Trust in the next set of coroner's inquests. And she said, I'll do some finding out. Why don't we have a meeting in two or three weeks time? We got our diaries out. We made an appointment for two and a half weeks' time at which I was sure that she would come in as the senior independent director of the Board and say, you're absolutely right, and I'm so sorry and I'm going to do X, Y and Z, A, B, C and all the rest of it.

I'm so sure that she would be of that mindset that I took my wife Lesley along because she'd struggled through this issue with me now for many, many years. And I just thought it'd be really nice for her perhaps to get some sort of closure and for someone who' is senior in the Trust to say thank you very much and we got it wrong. Anyway, so we walked in, my wife and I, and the same woman said, come in, take a seat. And I said, everything all right? Because she looked perturbed. She said, look, the thing is that when we say something, when any of us says something, we don't always get the message across that we are thinking we are getting across. Do you see what I mean? I said, no, what do you mean? She said, well, when you were raising, well, what you thought was raising concerns, I mean that's not really what you were doing.

And I said, can I ask who you've spoken to since we last met? She said, how do you mean? And I said, have you been talking to our chief executive? She said, well, yes.

And I said, have you been speaking to anyone else on this issue? She said, no. And I said, have you read the Good Governance Institute criticising the Trust's handling? She said, no. And that was it. And I said, I'm sorry, but this is, if you are now parroting what the chief executive is saying, what is the point of being a senior independent director?

Helen Hughes: What did Lesley think of it?

Mike Swinn: Oh, she burst into tears.

Peter Duffy: And that does lead me on to, I was just about to ask, what sort of impact has this had on your immediate family?

Mike Swinn: Kids are resilient, don't really remember much of it, probably Dad being a bit grumpy, a bit detached on some holidays now, many years ago. It hasn't put off my eldest daughter from pursuing a career in medicine. She's fourth year medicine at Manchester at the moment. I'm still scarred. As we discussed, I think just before we started recording, I think issues like this and experiences that you go through that are such a big part of your life for so long, and they're so traumatising on every aspect of your life, your social life, your ability to relax, your professional life, your feeling of self-worth, this feeling of self-loathing creeps in every now and again, the lack of sleep, the tablets you have to take from time to time, to calm your heart down, all the rest of it.

Even once you've got to the end of an issue like this and you've been vindicated and been shown to be right all along, you still can't shake it off. At least I can't. And I did actually start to go and see a counsellor for a bit, and I saw about her three or four times, but I didn't really, see much point to be honest. And I think it's a bit like a bereavement in the sense that a close family member dies and then someone might say to you a couple of years later, have you got over it all now? Well, the answer is no. Thank you for asking. But no, but the thing is you never do, you adjust. Your life is a bit different afterwards. And my guess is that it probably will be forever, but it is what it is. None of us chooses to be in these positions, do we? And we just have to be resilient and try to do the right thing, keep plugging away and eventually get there. But it takes its toll and probably takes its toll in the long term and possibly even forever.

Peter Duffy: Yes, I think that's all absolutely right. And it is astonishing just how closely your own experiences parallel, not just mine, but so many other whistleblowers as well. So I think we're probably coming towards the end of this now, but I think we ought to try and wrap it up just with what sort of lessons we can learn from this, what sort of conclusions we can draw. Because there will be other people who are going through exactly this sort of cascade of events right now. And there'll certainly be others who I think are probably so traumatised by what they've been through that they don't feel they can speak out about what's happened.

Can we draw anything positive out of this? Can we draw any lessons out of it? And how would you set about advising somebody who's perhaps just embarking on the sort of horrendous journey, ten-year journey that you've been through?

Mike Swinn: Yes. Well, I think there are a few learning lessons, which probably is the most practical outcome from this. I think if someone were to embark upon this process now and ask for my advice, I would say, first of all, do it. Because people often say to me, well, would you do it again? And I thought about that for a while, but you have to, don't you? Because if you don't, you're complicit. And that's not a great place to be either. And we are mandated. It is a mandatory thing in the GMC that you have to raise concerns. So first of all, first piece of advice is yes, do it. Remember that you're doing it for the right reasons. Remember that you are not the bad person here. You are the good person.

Do take lots of notes. You go to a meeting, come out, take notes, you're in the meeting.
Take contemporaneous notes, date them, time them, make a list of exactly who was there, the emails of meetings and things are easy to print off. But there are lots of conversations that I had with people, there are even sets of notes that I gave to the medical director, which he then denied any knowledge of afterwards. There are eight sets of notes that we gave him that we had printed out on an A4 thing, the list of concerns, a list of the summary of the care, and then a bullet point of concerns, one to five. We stapled that to the front of the notes so that he didn't even have to open the notes. We took them to his study, we put them on his office floor by his chair, but he claims never to have seen them. Take a photograph of that and speak to the non-executive branch of the Trust sooner rather than later.

I think I did that too late. And by then they'd already been nobbled by the executive. Get the BMA on board. I didn't do that and I only sort of thought about it relatively late in the piece. And by then I was dealing with this investigation, that investigation, the coroner's inquest, the GGI report, the GMC, all that, the Trust having a go at me, dealing with all the clinical fallout as well, that someone said to me, well get the BMA, but the thought of phoning up the BMA and going through everything from start to finish, I just didn't have the time or the inclination. If I were to embark upon this process now, or were to advise someone else, that's what I would tell them to do. I think you did use the BMA. I think you found that helpful?

Peter Duffy: I did. Although I was very late in the process, I'd pretty much been managed out of my job by the time I phoned them up. And they themselves said, well, there's nothing we can do. We'd have to go to an employment tribunal, there's a two-year wait.

Make sure you are a member of the BMA and go to them sooner rather than later.

Helen Hughes: One of the things that you've said, Peter, and many others that we've had the privilege of interviewing have said, is don't do it alone. Mike, you were very open that it was not just yourself, but it was your clinical colleagues and your nurse colleagues, so that actually you did that at a very early stage. You were taking that mantle on behalf of the MDT really?

Mike Swinn: Yes. I think that's a very good point, Helen. And one thing that we used to do, the clinical nurse specialists, a doctor or two, and I used to sit down and say, let's just go through this again. Why is the hospital not acting? Is it possible that they're right and we are wrong? And maybe it's just that our threshold of what's acceptable and not acceptable is a bit wrong, and maybe it is acceptable to behave like this. So we would examine things over and over and again, and always comes to the conclusion that we''re right here. It is just that they're wrong. And we thought, well, is there some weird dynamic going on between us that we're all just sort of egging each other on or something? Am I a jealous colleague? Am I after someone's private practice? So we tested all these hypotheses time and time again, and it's important to do that, but it's important as you suggest, to have a raft of people that you can bounce things off.

But as long as you don't whip yourselves up; but you need colleagues to share the burden with. And I certainly had that. In fact, I'm giving a talk at BAUN, the British Association of Urological Nurses, later on in the year in Edinburgh, talking about the importance of a collaborative team approach in raising concerns. I think it's fundamental. The other team that's important is your friends and family. You don't want to bore them rigid, but at the same time, you don't want to bottle these things up afterwards. So that's another important thing is not just your colleagues at work, but your non-medical friends and family.

Helen Hughes: If you are being gaslit, the classic response is to doubt yourself, to believe that in your case, that you didn't make your case clearly enough and it was you were culpable because you weren't enabling them to take the action that they would've done had you behaved differently.

So turning it on yourself, and we've seen that, haven't we, Peter, with all the other people we've spoken to, pushing it back on the responsibility of the person that's raising the concerns and making them out to be the problem?

Mike Swinn: Yes, yes. There are sort of classic tactics aren't there here, and that's certainly one of them, is just to turn it back on the person who's brave enough to raise concerns. Which when you think about it, is despicable because the person raising concerns has to, we are duty-bound from our professional code of conduct to do so in difficult circumstances. The NHS systems are imperfect when it comes to arranging meetings, recording meetings, putting into action, various outputs from meetings. It is classically bad at all of that stuff. So it's always difficult in the NHS. It's

less hard, I hear from friends of mine in the finance industry. It's not perfect either, but I do have friends who are bankers and so on where it's a much more rigid - and friends who are pilots, that might even be a better example where it's much more rigidly adhered to. And when you raise concerns, they are listened to. That's another tactic is that they always say, don't they? We're working hard to create the right environment for people to feel safe to raise concerns. Well, the problem is very often not with raising concerns. I raised concerns. The nurses raised concerns. My other consultant colleague raised concerns. The oncologist raised, we all raised concerns repeatedly, in person, in writing, with specific examples, dozens. It's just that they weren't listened to, or at least not listened to enough or acted upon enough.

Peter Duffy: Indeed. And well, let's hope that the lessons that we can learn from this series of videos is going to bring some sort of change in that will make that easier.

So I think we've probably rather overshot our time, but I think it's been more than worth it because that has just been, it's been both fascinating and appalling and quite emotional as well, just listening to what you've been through, just realising just how similar your treatment has been to mine and to so many others.

There will, I'm sure, be an awful lot of people out there who will identify with your story. So thank you so much. Is there anything else you wanted to ask Helen?

Helen Hughes: Well, I just wanted to say a huge thank you and exactly the same. I was reading your book, Mike, I was reflecting your story. Peter and I were kind of ticking them off, the kind of approach.

We are doing something. We're going to be promoting some of the themes that are coming out of these interviews and describing them as a playbook about how organisations respond. And when you see it in one set of circumstances and you hear of others' experience and you go, that's the same. That's the same. It's almost like there's a checklist here. I mean, I'm sure it's not the case for everyone that raises a concern, but these very, very serious issues where there have been allegations of avoidable deaths that have been evidenced. It does seem like there's a playbook.

(So I just wanted to thank you so much for your tenacity in keeping going and your absolute core faith in doing the right thing and for patient safety and taking the time today is amazing. Taking the time to write the book. I am not going to get any reward for this, but it's a compelling read. I read it in, I think it was two days, one weekend. My husband just didn't see sight or sound of me. It was like reading a thriller, a horrible thriller, but it was a brilliantly written book. So I would commend people to that.

Mike Swinn: That's very kind. Thank you.

Helen Hughes: Thank you. Thank you for your time, Mike.

Mike Swinn: Absolute pleasure. Nice to see you again, Peter. Nice to meet you, Helen. And thank you for everything that you're doing.