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18 March 2021

Dr N Acheson (Deputy Chief Inspector of Hospitals)

Care Quality Commission

Citygate

NE1 4PA

By email only; polly.gregg@cqc.org.uk

Dear Dr Acheson

Re; Dr Chris Day Whistleblowing Case

Introduction

I am writing this letter to set out the patient safety issues at the heart of my whistleblowing case so that I can be sure that the Care Quality Commission has had every opportunity to understand their significance, how they were investigated at the time in 2014 and how they have more recently been misrepresented to the press, public and MPs.

In particular, I would like to bring to the CQC's attention the actions of Dr Mike Roddis and Claire Mclaughlan of MJ Roddis Associates. MJ Roddis Associates were paid approximately £40,000 to investigate my case and a further £12,983 to attend the 2018 tribunal hearing to watch me give evidence. The former health minister, Sir Norman Lamb has expressed concerns about this in a letter to the Lewisham and Greenwich Chief Executive.

I have provided to the Care Quality Commission clear evidence showing that an employment tribunal, the press and MPs have been misled by Lewisham and Greenwich NHS Trust and Health Education England on the serious patient safety issues at the centre of my whistleblowing case. This includes grossly misrepresenting the scope of my protected disclosures, the results of an external investigation and the results of a HEE quality visit amongst other things.

Despite a longstanding dispute between me and the British Medical Association about my case, a recent British Medical Association merits assessment, dated 10 March 2021, undertaken by Edward Cooper of Slater and Gordon has found reasonable prospects of me demonstrating 9 statements released to the press and or to MPs by Lewisham and Greenwich NHS Trust and or Health Education England (former Post Graduate Dean) were untrue and misleading.

Other than expressing concern in letters to Sir Robert Francis QC about the tone and content of the various NHS public statements about my case and recording the relevant NHS Chief Executive's response to the criticisms, the Care Quality Commission has taken no action to correct the situation. This includes no action to correct the fact several MPs and public officials have been misled about my case and in particular, the serious patient safety issues and the NHS response to the safety

issues. These issues plainly affect the populations these various public officials represent and serve which makes the failure to correct the misleading statements all the more significant.

Astonishingly, Lewisham and Greenwich NHS Trust have attempted to tell the employment tribunal in court pleadings that the CQC made no such approach or criticism of their public statements. The CQC's response to me, when I made them aware of this, has been weak and defensive despite the CQC having clearly stated its position on the Trust's public statements in letters to Sir Robert Francis QC in 2019, which I have obtained from Sir Robert Francis QC;

> "*We share your concerns about the content and tone of the publicly available statements on the Trust's website and having taken up the concerns with the Trust, they have advised that they have sought the advice of their lawyers and they intend to keep the statements on the Trust website."*

The British Medical Association have sent an email challenging Lewisham and Greenwich NHS Trust on their denial to the Tribunal of the clearly stated criticism made of Lewisham and Greenwich NHS Trust by the CQC in their letters to Sir Robert Francis QC. The BMA's email was ignored by Lewisham and Greenwich.

The CQC now accepts (as it must) that it has breached General Data Protection Regulation (GDPR) by failing to provide me with the material sent between it and Lewisham and Greenwich NHS Trust and Sir Robert Francis QC as part of my Date Subject Access Request. The CQC has also failed to produce the record of the relevant meeting with the Trust where the CQC criticised the Trust's public statements and recorded the Trust's Chief Executive's response. It has provided no material whatsoever in response to my Data Subject Access Request. It has failed to indicate when (if at all) it intends to supply this information even after a further request by me made well after the relevant statutory time limit under GDPR.

It seems to me that this is yet another example of powerful people closing ranks in my case to the detriment of me, my family and to the public interest that is plainly associated with the issues contained in my 13 protected disclosures.

As you know, On 13 November 2020, Health Education England finally accepted the status of my protected disclosures made in 2014, as reasonable beliefs on patient safety and deliberate concealment. They did this after spending 6 years and vast sums of public money denying the status of my protected disclosures.

I will now set out exactly how the evidence demonstrates that an employment tribunal, MPs and the press have been misled on my case. It is unacceptable for a specialist healthcare regulator like the CQC to avoid taking action on these issues. It seems to me that the CQC expects a lay employment tribunal to effectively do the job of the healthcare regulator. This is perhaps particularly unacceptable when the CQC has also decided to withhold evidence from me that I have a legal right to, in order to prevent it being put before the Employment Tribunal. The failures in this case by healthcare regulation has cost the taxpayer nearly a million pounds as the important issues have been left to the employment tribunal that still, after 6 years, has not made any findings on the way my protected disclosures have been dealt with by the NHS.

The Formal MJ Roddis Associates Investigation

The formal position from the Respondents on the response to the patient safety issues in my case came from the Lewisham and Greenwich and Health Education England's acceptance of an supposedly external investigation performed by Dr Mike Roddis and Claire McLaughlan of MJ Roddis Associates. Myself and the BMA identified a social connection between Dr Mike Roddis and the Trust's case management officer Dr Luce during a meeting on 18 September 2014. This was excluded from the formal record of the meeting.

MJ Roddis Associates concluded the following, firstly, contrary to national guidelines, secondly, contrary to clear evidence from me and other doctors, thirdly, contrary to a HEE Quality visit and fourthly, whilst excluding and making no reference to 2 Serious Untoward Incidents involving the deaths of 2 patients;

1. *"Dr Day has immediate access to the resident anaesthetic registrar for airway management"*

2. *"A recent Deanery Visit concluded that staffing levels (unchanged since January 2014) were safe and there were no concerns about supervision highlighted by them"*

3. *"Dr Day was expected to cover the 18 bedded ICU, ward outliers, A&E and ward ICU as a Resident SHO in QEH. In my opinion this was acceptable in light of his experience and skills at the time."*

I will now deal with each of these conclusions to demonstrate how dangerous they are and how evidence from multiple sources and national guidelines contradict them.

Roddis Conclusion 1 - "Dr Day has immediate access to the resident anaesthetic registrar for airway management"

At the 18 September 2014 meeting with Roddis Associates, I clearly stated that at night in the relevant ICU, airway cover for an ICU doctor, not trained as an anaesthetist, came from an anaesthetic team based outside of the ICU. I also described in the meeting, some safety issues from airway issues not being dealt with immediately. This content was initially excluded from the Roddis Associates record of the meeting. However, the below text was later included (after an initial refusal by Ms Mclaughlan) when the Roddis Associates investigators were challenged by me for false record keeping, following me sending Ms Mclaughlan my record of the 18 September 2014 meeting;

> *"Who intubates in ICU? CD answered that there is an onsite anaesthetic team who are called to ICU. CD said "on occasions the nursing ratios are not ICU for intubated patients. I have observed a number of hypoxic cardiac arrests from tubes getting displaced. The unit's self-extubation rate was high when I was there."*

Other junior doctors made similar observations to the HEE October 2014 Quality visit that were ignored and denied by Roddis Associates in their report which was repeated as the formal position of the Respondents at the Tribunal. The HEE quality visit records from other junior doctors;

> "Very often the anaesthetic registrars were busy and unavailable to assist immediately"

I and the junior doctors speaking to the HEE Quality Visit could not have been clearer but Claire McLaughlan excluded and ignored this important evidence and concluded the opposite on the airway issues and further falsely stated in her report that the Quality Visit identified no concerns. As the CQC know a key ICU Core Standard is;

> " *There must be immediate access to a practitioner who is skilled with advanced airway techniques"*

It is clear that the concerns that I and other doctors raised about the immediate access to airway support in the ICU were covered up not only by Roddis Associates but also by Lewisham and Greenwich and Health Education England. If the CQC disagree please can they explain why they hold this view referring explicitly to the above evidence. If they do not disagree, please can they set out what they intend to do about it.

Roddis Associates Conclusion 2 -"A recent Deanery Visit concluded that staffing levels (unchanged since January 2014) were safe and there were no concerns about supervision highlighted by them"

The Roddis Associate's description of the 2014 HEE Quality Visit findings are objectively false, dangerous and misled the employment tribunal. This is clearly indicated alone by what I have set out above about concerns expressed by junior doctors in the Quality Visit about airway support for the ICU. However, there were additional serious issues identified by the HEE Quality Visit that were deliberately concealed by Roddis Associates and the Respondents in order to discredit my protected disclosures. It should be noted that the lead investigator of the 2014 HEE Quality Visit was Dr Lacy who was a witness for HEE in my employment tribunal. This raises serious questions about the way this HEE Quality Visit was represented at the Tribunal.

I have since inspected the report of the October 2014 HEE Quality Visit. It shows the Roddis Associate's conclusion of 'no concerns highlighted' endorsed by the Respondents as untrue and dangerous. The Quality Visit recorded the following serious issues from other junior doctors that were concealed by Roddis Associates and then denied by them in their report;

- *ICU night-time staffing ratios; "Trainees felt that the ITU was well covered during in the day but at night if a patient required particular attention they could become overstretched...Trainees reported that there are 18 beds which are often full, but last winter this was stretched to 26"*

- *Culture; "Concerns raised regarding bullying and undermining, with some trainees being too scared to name consultants that were responsible for this for fear of repercussion. It was felt that this was a problem that had been seen if not experienced by most if not all trainees."*

- *SI Reporting; "Core ACCS Trainees indicated to the visit team that SIs have been reported on numerous occasions but no feedback has ever been received."*

  Airway Support "Very often the anaesthetic registrars were busy and unavailable to assist immediately"

It took until January 2019 for Dr Frankel, the relevant HEE Post Graduate Dean, to tell the truth 'on the record' about the 2014 HEE Quality visit. Dr Frankel was the most senior doctor in London for HEE at the time of my case in 2014. For whatever reason, in late 2018 (after I had been forced to settle my whistleblowing case), Dr Frankel made contact with the former health minister, Sir Norman Lamb. Dr Frankel sent an 11 page document to Sir Norman in January 2019. I have seen evidence that this was also sent to senior HEE employees including its Medical Director Prof Reid. I have also seen evidence that a senior HEE employee stated that Dr Frankel's document was "inaccurate and misleading", which I agree with. Despite knowing that a serving MP who is a former health minister had been misled about my case no action was taken by HEE to correct this.

Curiously, Dr Frankel's 11 page document does endorse the validity of my protected disclosures and the support the October 2014 HEE Quality would have given my protected disclosures had it not been misrepresented by Roddis Associates and by the Respondents at the tribunal 2018. Dr Frankel's comments to Sir Norman Lamb on the Quality Visit appear to be an attempt to give the misleading impression that this supportive position was the actual position adopted by HEE and the NHS in my case in formal reports in 2014 or at the Tribunal in 2018;

> *"the visit confirmed the issues raised by Dr Day in relation to his protected disclosures. Progress was slow and a further visit took place on 15 March 2015...the ICU was reviewed and unfortunately only limited improvement had occurred in this area."*

The actual formal view on the HEE 2014 Quality Visit represented at the Tribunal in 2018 and in formal reports in 2014 could not have been more different to what Dr Frankel stated to Sir Norman Lamb in 2019;

> *"A recent Deanery Visit concluded that staffing levels (unchanged since January 2014) were safe and there were no concerns about supervision highlighted by them"*

Roddis Conclusion 3 "<u>Dr Day was expected to cover the 18 bedded ICU, ward outliers, A&E and ward ICU as a Resident SHO in QEH. In my opinion this was acceptable in light of his experience and skills at the time."</u>

My protected disclosure in August 2013 made the point;

> *"In general I take the view that it is unfair to expect one SHO with little or no experience of critical care to be left alone at night with between 15-20 ICU patients, have outliers and be expected to admit new patients. The other deanery trainees have expressed similar concerns to me as has Dr Villar. I strongly believe that this situation is not only unfair to a cohort of inexperienced junior doctors but it is also unfair to you as consultants. I believe you deserve more experienced junior support than you have at the moment and the trust should provide you with funding for more experienced staff grades or registrars to support the SHO grades as in Bromley. I cannot understand how a smaller unit in the same trust operates with a SpR and SHO*

My position in 2013 was supported at the time by other junior and senior doctors and is completely supported by ICU Core Standards;

- *"The ICU Resident/Patient ratio should not exceed 1:8*

- *The best current evidence is a Consultant/ patient ratio in excess of 1:14 is deleterious to patient care and Consultant well being.*

- *There must be immediate access to a practitioner who is skilled with advanced airway techniques"*

The 2017 Critical Care Peer review plainly supports my protected disclosures in respect of culture and incident reporting but states specifically on staffing ratios,

> *"Staffing levels – there were 19 patients to just one consultant, which exceeded the recommended ratio of between 1;8 and 1;15. It was apparent that this is a consistent issue with no clear recognition"*

Covert audio of a formal meeting between Health Education England and the British Medical Association on 2 September 2014 records the exact words of, Dr Frankel, the most senior HEE doctor in London on the content of my protected disclosures;

> "*What you describe to me is totally unacceptable for me to have trainees in a situation that you were in. In ICU you are not trained for intubation and airway care and you're in charge 19 never mind all the other issues. The whole thing what you described is unsafe. You were clearly not the only person who had concerns about it"*

Dr Frankel did not give this view on my protected disclosure to the employment tribunal in his statement.

In addition to Roddis Associates, both the BMA and Health Education England need to explain why they have attempted to conceal this supportive view on the substance of my important protected disclosures and consume public money advancing the opposite position;

> *"Dr Day was expected to cover the 18 bedded ICU, ward outliers, A&E and ward ICU as a Resident SHO in QEH. In my opinion this was acceptable in light of his experience and skills at the time."*

Serious Untoward Incidents

On 18 September 2014, I asked Roddis Associates to investigate and take account of two Serious Untoward Incidents that I said supported my protected disclosures. Like my stated concerns about airway support this content was excluded from the initial Roddis Associates record of the 18 September 2014 meeting but later included when Claire McLaughlan was challenged on false record keeping;

> "*Some of the other Residents have found themselves in the middle of serious incidents (SIs). CD suggested that he was lucky that none of what he described applies to him. He said "what I have described shows an inadequate night time ICU situation."*

I stated the following in my statement to the Employment Tribunal in October 2018;

> "*On 7 November and 5 December 2013, two patient deaths occurred at night under the care of Intensive Care. These deaths involved two different non-anaesthetic trained doctors and were declared as Serious Untoward Incidents ("SUI") and subject to Coroner inquests (see SI 596 at page […….] of the supplementary bundle and SI 656 at page […….] of the supplementary bundle). The SUI's involved just the kind of circumstances that I had been concerned to avoid when I raised concerns about patients safety in August and September 2013.*
>
> *Ms McLaughlan's investigation was also incomplete. She had failed to investigate two Serious Untoward Incidents: SI 596 on 8 November 2013 and SI 656 on 5 December 2013 (see page […….] of the supplementary bundle), which occurred between my August 2013 and January 2014 protected disclosures. These incidents involved the deaths of two ICU patients. They involved just the kind of circumstances which my August and September 2013 protected disclosures sought to avoid. Their reports make important recommendations and criticisms of the critical care service in Woolwich."*

An email dated 3 December 2014 was sent to Roddis Associates from Trust administration referring to the incident SUI 656. This email was not acted on or referred to but is likely to have come as a result of Roddis Associates making enquiries about Serious Incidents in the ICU. The email described in a few sentences a dramatic serious incident.

> *"The Incident occurred on 5/12/13. It involved the insertion of a chest drain which was incorrectly sited and pierced the liver. The patient died from Haemorrhage"*

The SUI report plainly supports my protected disclosure about the grade, experience and workload of the doctor used to cover the ICU at night. I have sent the report of SUI 656 to the CQC but I now highlight the following observations and recommendations in the SUI report that clearly support my protected disclosures.

> "*It was not appreciated at the time by senior staff that the clinical fellow was too inexperienced (ie: lacked exposure to other similar type situations such as complications of other procedures to be able to broaden the differential diagnosis of the unexpected bleeding (as possible misplacement of the drain). Consequently he communicated incomplete information to the (off site) on call consultant and surgeon who was subsequently called to attend.*
>
> *It is vital that senior staff implement proactive supervision of more junior staff. To minimise the chance of any complication a consultant must authorise procedures associated with excess risk and either perform them him/herself or be fully confident of the competencies of anyone else directed to perform the procedure".*

I was able to obtain the Coroner witness statements for the relevant consultant and junior doctor for the second Serious Untoward Incident ignored by Roddis Associates. SUI 596 occurred on 8 November 2014 and the Corner Inquest Report that states;

"*The failures to first investigate the cause of hypertension on 07/11 and to admit in a timely manner to ICU contributed to his death.*"

The SUI report makes the following observations that clearly support my protected disclosures;

"- The ICU resident discussed the patient by telephone with his consultant. However, as the resident failed to appreciate the severity of Mr As condition, the communication failed to result in an escalation of care. This is something that could be made mandatory if a standardised referral format was introduced.

"Within the statement provided by the Outreach nurse, (who overheard this conversation), they stated that the discussion between the ICU resident and consultant hadn't resulted in the appropriate outcome for Mr A, but did not feel able to revisit this decision with the Consultant."

"Despite an arrangement made at 08:20 hrs being in place for Mr A to be reviewed by the ICU consultant this did not happen before his cardiac arrest at 12;40. This was because the ICU was busy and occupied the consultant for longer than anticipated and there is no separate consultant assigned to the Outreach service"

Roddis Associates decision to exclude the 2 SUIs from their investigation has no justification and combined with their other actions amounts to public money being paid to private investigators (that are also a registered doctor and nurse) to cover up serious issues in order to discredit a junior doctor raising serious concerns in the public interest. If the CQC disagree please can they explain why with reference to the above evidence.

False Record Keeping from MJ Roddis Associates

Dr Mike Roddis and Claire McLaughlan were forced to apologise when I accused them of making a false and detrimental record of my formal investigation meeting with them on 18 September 2014. After reading their false and detrimental 3 page record of the meeting, I provided my own 16 page note of the meeting that was clearly from covert audio. It was stated that my record would be incorporated in full but in the final report significant content was yet again excluded including Dr Roddis' social link to the Trust's senior doctor appointed as case manager to my case. The incorporation of my record of the meeting came after an initial refusal to change the record when I made the request verbally over the phone to Claire Mclaughlan. Roddis Associates eventually changed their record and apologised because they had no choice once they had received my record of the meeting.

My Grounds of Claim that I was forced to settle in 2018 stated in respect of my meeting with Roddis Associates on 18 September 2014;

"The Claimant attended an interview on 18 September 2014 with the independent investigators, MJ Roddis Associates, who had been appointed by the Trust to investigate the Claimant's concerns and complaints about safety at Woolwich Hospital ICU. The investigators' record of that meeting failed to record much of what the Claimant had said

regarding patient safety at Woolwich Hospital, for instance hypoxic cardiac arrests from displaced ETT as a result of staffing issues on the ICU. The investigators' report also distorted what he had said and attributed statements to him which had not been said.

On 27 September 2014, the Claimant wrote to Dr Roddis of MJ Roddis Associates with his record of the meeting, correcting the factual inaccuracies in the investigators' record of the meeting. MJ Roddis Associates responded by email on 7 October to the Claimant's concerns. They offered written apologies for their record of the meeting and accepted the Claimant's written account as representing "the full content of the meeting." The Email was sent by Claire Mclaughlan, one of the investigators."

Nothing was pleaded in the Lewisham and Greenwich NHS Trust's Grounds of Resistance to resist this content.

At my meeting with MJ Roddis Associates on 18 September 2014, I was represented by the BMA. As you would expect a formal trade union record of the meeting was produced. Shortly after the Roddis meeting I was denied a copy of the BMA record of the meeting and my BMA IRO became uncontactable. I have since learnt from an audio of a BMA Council meeting on 16 November 2016 that the (then) BMA Chair, Dr Mark Porter stated that the BMA Senior Industrial Relations Officer present in the Roddis meeting was dismissed for gross misconduct. The audio records another BMA Council member stating that the relevant BMA officer had been gagged and his trade union record of the meeting had been lost/destroyed by the BMA. This was at a similar time to the BMA withdrawing legal support from my case (5 days before a legal deadline).

Astonishingly, the audio shows that BMA Council were falsely told that the Legal Ombudsman had investigated the alleged dismissal and gagging of my BMA representative and exonerated the BMA. This was an entirely false statement. The Legal Ombudsman has categorically denied investigating and exonerating the BMA on these issues or at all. They further stated that they had no knowledge of the allegation. It appears a BMA Council member was so concerned about what had been said in 16 November 2016 meeting that they leaked the audio outside of the BMA.

Following this, a Professor on BMA Council attempted to challenge the BMA on the false account given to BMA Council about these serious issues. The Professor ended up being subject to a BMA disciplinary process chaired by the same Barrister representing Lewisham and Greenwich in my whistleblowing case. The Professor has been removed from the BMA Council.

Misleading the Press, the Public and MPs

Lewisham and Greenwich on several occasions have misled the public, the press and MPs about the serious safety issues in my case.

On 22 February 2016 Lewisham and Greenwich stated to the Evening Standard;

> "We identified the need to increase medical staffing numbers for the intensive care unit at Queen Elizabeth hospital. The unit is now fully compliant with quality standards."

It was clear at the time the Intensive Care Unit was not compliant with national consultant staffing ratios, junior doctor ratios or immediate airway support. MJ Roddis Associates denied some of the

issues and explained away others including breaches of national ICU Core Standards but Roddis Associates never said the unit was "fully compliant" with ICU Core Standards (despite misleading on immediate access to airway support). This false claim to be fully be "fully compliant" with quality standards made in 2016 to the Evening Standard was exposed by a Critical Peer Peer Review in 2017,

> "*Staffing levels – there were 19 patients to just one consultant, which exceeded the recommended ratio of between 1;8 and 1;15. It was apparent that this is a consistent issue with no clear recognition"*

Once my whistleblowing case settled on 15 October 2018, Lewisham Greenwich NHS Trust released various further false claims in public internet statements dated 24 October 2018 and 5 December 2018. They sent the statements to the national press and also to multiple MPs and public officials. The key misleading statements from Lewisham and Greenwich are as follows (see Grounds of claim for the others);

a) "Some of the publicity around this case has incorrectly made a link to the findings of a peer review of the critical care unit at QEH undertaken by the South London Critical Care Network in February 2017…It is important to be clear that these were not the same issues that Dr Day had raised in January 2014, which related to junior doctor cover on the medical wards;

b) "The external investigation found it had been appropriate for Dr Day to raise his concerns and that <u>the Trust had responded in the right way".</u>

c) "he claims that the Trust threatened him with the prospect of paying our legal costs. All of this is simply untrue"

As stated a merits assessment commissioned by the British Medical Association undertaken by Slater and Gordon has found the above statements with 5 others statements from Health Education England to have reasonable prospects of success of me showing them as untrue and misleading statements. The basis for such assertions have been clearly set out in my Grounds of Claim and Further and Better Particulars that have been sent to the CQC and I note you have confirmed that you have read these documents.

Notwithstanding the flaws and quite frankly blatant cover up in the MJ Roddis Investigation even MJ Roddis Associates did not conclude that Lewisham and Greenwich NHS Trust "responded in the right way" to my protected disclosures. They made the following criticisms as set out in in my Grounds of Claim that I now repeat;

- "the Datix report was not formally followed up and logged on the system as would be expected."

- “When a Datix report was submitted on 15 January 2014 it was not dealt with through routine governance processes. The responses to the clinical issues Dr Day raised were addressed in an informal and uncoordinated way.”

- “In my opinion, the manner of Dr Ward's dealing with him by email, in effect dressing him down in front of seven people was ill judged. The matter should have remained confidential between Drs Ward, Harding and Day and/or a face-to-face meeting could have been convened to deal with the matter.”

- “Dr Day then shares his experience with Dr Harding who involves Dr Ward who then copies his response to a wide and senior audience which is undermining and could be perceived as bullying”

- “Dr Harding's reaction that given the opportunity he would not employ Dr Day again also suggests that Dr Harding found Dr Day an irritation rather than a worried colleague who needed support.” (In reference to Dr Harding’s 7 May 2014 email to Dr Brooke, the HEE Training Programme Director, that included the words, "His inability to let these issues go is starting to worry me. I would consider not employing him again as a result")

- “Dr Harding's response was more considered and he lets his feelings known which was ill advised given his position in the Trust. Despite his assertions to the contrary he holds influence and power, certainly when compared with a CT2.”

- “Although Dr Day's concerns were informally investigated by Dr Ward, there was confusion and ambiguity about the consequent 'report'. Unfortunately the ambiguity was not clarified immediately when it would have been easy to do so.”

- “*Dr Roberts passing on this to Dr Day in fact escalated the problem, allowing Dr Day to believe that Ms Jarrett had tried to undermine him”*

- “There has been no input that I can see from HR until after Dr Day's letter of complaint to Mr Higginson when this independent investigation began. Those trying to deal with the situation have therefore been unsupported which has meant that they were not advised about process or policy.”

MJ Roddis Associates have made no attempt to correct the public record or the account given to MPs and other public officials of their investigation. They, the Trust and Health Education allowed MPs and public officials to believe that my protected disclosures amounted to a ‘fuss about nothing’ about medical ward cover on one night in January. All along, the Respondents were aware that the truth was that my 13 protected disclosures (now accepted as such) involved serious issues relating to an Intensive Care Unit’s night time resourcing that were associated with 2 deaths and further allegations of deliberate concealment.

CQC's Failure to Correct MPs

On 28 January 2021 I wrote to you (Dr Acheson Deputy Chief Inspector of Hospitals) to inform you that it had come to my attention that on 5 December 2018, the Lewisham and Greenwich Chief Executive wrote 19 letters to local MPs, council officials and stakeholders. The letters enclosed the October 2018 and December 2018 public statements about my case which the Trust Chief Executive stated would leave the relevant MPs/public officials "fully briefed "on it . In reality the statements misled them in the ways set out above in this letter which the CQC appear to support my position on (in their letter to Sir Robert Francis QC).

The Trust Chief Executive decided to leave these letters out of the disclosure process to the Tribunal. I only found out about the letters when Health Education England inadvertently referred to them in an internal email that they did disclose in the Tribunal process. This is in itself an extremely serious matter.

I provided evidence to the CQC that the following named public officials had been misled about the scope of my protected disclosures, the results of the external investigations in my case and the use of cost threats to settle the case (which are now supported by a BMA merits assessment). The public officials were as follows;

- Cllr Averil Lekau, Cabinet Member for Adult Social Care, Health and Anti-Poverty, Royal Borough of Greenwich
  .
- Mr Simon Pearce, Director of health and adult services, Royal Borough of Greenwich
- Mayor Damian Egan, London Borough of Lewisham
- Cllr Chris Best, Deputy Mayor of Lewisham and Cabinet Member for Health and Adult Social Care, London Borough of Lewisham
- Aileen Buckton, Director of Community Services, London Borough of Lewisham
- Cllr Teresa O'Neill OBE, Leader, London Borough of Bexley
- Cllr Brad Smith, Cabinet member for Adults' Services, London Borough of Bexley
- Andrew Bland, Single Accountable Officer, Bexley, Bromley, Greenwich, Lewishamand Southwark CCGs
- Martin Wilkinson, Managing Director, NHS Lewisham, NHS Lewisham Clinical Commissioning Group
- Neil Kennett-Brown, Managing Director, NHS Greenwich, NHS Greenwich Clinical Commissioning Group
- Dr Sid Deshmukh, Chair, NHS Bexley, NHS Bexley Clinical Commissioning Group
- Janet Daby, MP for Lewisham East

- Clive Efford, MP for Eltham
- David Evennett, MP for Bexleyheath and Crayford
- Vicky Foxcroft, MP for Lewisham and Deptford
- Teresa Pearce, MP for Erith and Thamesmead
- Matthew Pennycook, MP for Greenwich and Woolwich
- Ellie Reeves, MP for Lewisham West and Penge

Despite the CQC's stated concerns about the tone and content of what has been reported publicly about my case, it has taken no steps to correct these public officials on serious issues affecting the local populations that they serve. Please can I ask that the CQC ensure these public officials receive a letter from the CQC correcting the misinformation released by Lewisham and Greenwich.

Separately, it has come to my attention from a blog by the journalist David Hecke that public money is being used to fund Claire McLaughlan of MJ Roddis Associates in an investigation process involving a consultant, namely Dr Usha Prasad. I understand Dr Prasad is involved in a whistleblowing case against Epsom and St Helier NHS Trust. I am deeply concerned by Claire McLaughlan's involvement in this process given what is set out in this letter as I trust you will be. I will be providing this letter to Dr Prasad and her legal team.

https://davidhencke.com/2021/03/10/exclusive-general-medical-council-investigation-exonerates-dr-usha-prasad-of-any-medical-failings/?fbclid=IwAR08McCzoTHu17aX5VUu9i87A-m_4l0ZRiHwe35VQ623XjaegqjfZ3yKxXQ

I have made several requests to the CQC for a meeting so that these important issues can be explored but this request has not been responded in addition to my Date Subject Access Request that has also not been responded to. Please can I be advised of a way forward.

Yours sincerely,

Dr Chris Day

Cc

Sir Robert Francis QC