EMPLOYMENT TRIBUNALS

BETWEEN

Claimant		**Respondent**
Dr J Macanovic	AND	Portsmouth Hospital NHS Trust

JUDGMENT OF THE EMPLOYMENT TRIBUNAL

HELD AT Southampton ON 13 to 15 January 2020

EMPLOYMENT JUDGE GRAY

Representation

For the Claimant: Mr J Allsop (Counsel)
For the Respondent: Mr R Hignett (Counsel)

RESERVED JUDGMENT

The judgment of the tribunal is that disclosures 1 to 5 and 10 are protected disclosures that qualify for protection pursuant to sections 43B and 43C of the Employment Rights Act 1996 and that disclosures 6 and 7 are protected disclosures that qualify for protection pursuant to sections 43B and 43F of the Employment Rights Act 1996.

Alleged disclosure 9 is not a protected disclosure.

The amendment application to include alleged disclosure 11 is refused.

REASONS

Introduction and this hearing

1. In this case the Claimant Dr Macanovic claims that she has made disclosures that qualify for protection pursuant to sections 43B and 43C or 43F of the Employment Rights Act 1996. The Respondent contests that all

of the alleged disclosures that the Claimant says she made are disclosures that qualify for protection.

2. This reserved judgment deals with the preliminary issue of whether the Claimant made disclosures of information that are protected qualifying disclosures within the meaning of the Employment Rights Act 1996.

3. It also deals with considering the Claimant's application to amend her claim to include a further alleged protected disclosure (referred to as disclosure number 10 by the parties), where the application to amend was made in February 2019 and was listed to be an issue at this hearing; and an application to amend that was made at this hearing to include a further alleged protected disclosure (referred to as disclosure number 11 by the parties).

4. For the hearing I was provided with:

    a. An agreed bundle of some 600 pages (it is not possible to confirm the exact number of pages as the bundle was a filleted version of the bundle that had been prepared for the final hearing previously listed that ran to 1942 pages);

    b. The Claimant's suggested reading list;

    c. An agreed outline chronology;

    d. An agreed cast list;

    e. A document titled "Appendix A: parties' position in respect of alleged Protected Disclosures.";

    f. Witness statement of the Claimant (which was submitted with yellow highlighting of the parts to be read and taken into account in relation to the preliminary matters to be determined at this hearing);

    g. Witness Statement of Mr Paul Gibbs;

    h. Supplemental Witness Statement of Mr Paul Gibbs;

    i. [later in the hearing] a copy of the Claimant's amended grounds of claim; and

    j. Skeleton arguments with copy case authorities from both Counsel.

5. The issues as agreed by the parties (save for the parts in square brackets) were identified as follows in relation to the questions of whether qualifying protected disclosures had been made or not:

    a. "The Claimant asserts that she made [10] protected disclosures. In respect of each alleged protected disclosure (C and R's positions outlined in … Appendix A):

        i. Did the Claimant make a disclosure which included information?

        ii. Did the Claimant reasonably believe that the disclosure was in the public interest?

        iii. Did the Claimant reasonably believe that the disclosure tended to show one or more of the categories listed in section 43B(1) Employment Rights Act 1996 ('ERA 1996')?
            1. The Claimant submits that the Respondent had failed to comply with a legal obligation in [relation to the obtaining of consent in relation to the use of Buttonholing technique on patients];
            2. The Claimant submits that the health or safety of patients had been, was being, or was likely to be endangered by the Buttonholing technique.

        iv. If so, was the disclosure made to:
            1. the employer under section 43C ERA 1996;
            2. prescribed persons under section 43F namely the:
                a. General Medical Council;
                b. Care Quality Commission."

6. For reference at the hearing and within this judgment it was agreed that the alleged disclosures would be referred to by the way they are numbered in the document provided at the commencement of the hearing titled "Appendix A: Parties' positions in respect of alleged Protected Disclosures" (i.e. 1 to 11), but would be considered in chronological order.

7. I heard from the Claimant, and I heard from Mr Paul Gibbs on behalf of the Respondent.

8. There was a degree of conflict on the evidence. I heard the witnesses give their evidence and observed their demeanour in the witness box. I found the following facts proven on the balance of probabilities after considering the whole of the evidence, both oral and documentary, and after listening to the factual and legal submissions made by and on behalf of the respective parties.

Findings of fact

9. The Respondent is an acute NHS Trust responsible for providing healthcare to the population of Portsmouth and the surrounding area from the Queen Alexandra Hospital.

10. The Renal and Transplantation Department at the Respondent is known as the Wessex Kidney Centre (WKC).

11. The Claimant worked for a period of 17 years (until 5 March 2018) for the Respondent and from October 2005 she worked there as a Consultant Nephrologist (a doctor who diagnoses and treats diseases of the kidneys). The Claimant now has a permanent position in Oxford.

12. There are outpatient nephrology clinics which are based through the Wessex region. Consultant Nephrologists in the department would attend clinics at other hospitals in the Wessex region. The Respondent provides nephrology services at 8 hospitals in the region, including the Queen Alexandra Hospital.

13. Of relevance to this case are two types of kidney dialysis process.

14. As the Claimant explains in her witness statement Kidney dialysis is used to remove toxins, excessive fluid and electrolytes from the body where the kidneys have failed. In order to undertake haemodialysis, patients need to connect to a dialysis machine that filters out toxins and excessive fluid. This connection requires insertion of needles into patient's circulation via surgically created arteriovenous fistula (AVF) or arteriovenous grafts (AVG).

15. An AVF is a surgically created connection made between an artery and a vein. An AVG is an artificial plastic tube that is placed surgically to connect an artery to a vein. Generally, the type of AV graft used is a PTFE graft.

16. Patients usually undertake the dialysis process using two sharp needles which will be inserted into the fistula or graft at different places. This technique is known as "rope laddering".

17. There is also an alternative process known as buttonholing ("BH"). As the Claimant explains, buttonholing is where patients cannulate (insert needles) using blunt needles. The blunt needles are placed in exactly the same holes in the fistula every time that the patient has to have dialysis. A track or tunnel is created through the skin to the fistula. Over time this may be less painful than using sharp needles because a patient is not making new holes on regular occasions. The buttonholing technique can be less painful and more convenient for patients.

18. The primary dispute of opinion in this case relates to the use of the buttonholing technique by those dialysing with an AVG. The differing views are presented in this case by the Claimant and the Respondent's witness Mr Paul Gibbs.

19. Mr Gibbs who gave evidence for the Respondent was at the relevant time for this case engaged by the Respondent in the role of clinical director (vascular and renal). Since April 2017 he has been the president of the vascular access Society of Britain and Ireland (VASBI).

20. Mr Gibbs describes how he carries out approximately 20 renal transplants and about 100 vascular access procedures per year. He works alongside consultant nephrologist colleagues looking after patients.

21. The Claimant and Mr Gibbs have very different views on the use of buttonholing technique by those dialysing with an AVG. It is this that forms the backbone of the Claimant's alleged disclosures in that she asserts she disclosed information that showed the Respondent had failed to comply with a legal obligation in relation to the obtaining of consent in relation to the use of the Buttonholing technique on patients with AVGs and that the health or safety of patients had been, was being, or was likely to be endangered by the Buttonholing technique being used on AVGs.

22. In her witness statement (at paragraph 338) the Claimant says, "the categories of wrongdoing that" she believed she highlighted included:

    a. (at paragraph 338.1) "Breach of a legal obligation, i.e. obligation to obtain a patient's informed consent and The Health and Social Care (Safety and Quality) Act 2015…" she then refers to paragraph 31 of her statement which reads in respect of that Act "…..The Health and Social Care (Safety and Quality) Act 2015 Section 1(2) provides that "The Secretary of State must by regulations impose requirements that the Secretary of State considers necessary to secure that services provided in the carrying on of regulated activities **cause no avoidable harm to the persons for whom the services are provided**" [Claimant's emphasis added]; and

    b. (at paragraph 338.2) "Danger to the health and safety of any individual. In this regard I believe that the Buttonholing Technique was a serious danger to the health and safety of the Respondent's patients who were undergoing the Buttonholing Technique or who might have undergone the Buttonholing Technique had I not raised my concerns…."

23. The Claimant explains why she considers her belief in the above to be reasonable at paragraphs 361 to 363 of her witness statement and why it is in the public interest at paragraph 364 of her witness statement.

24. At paragraph 361 she explains "I had no doubt whatsoever that the Buttonholing Technique was damaging and I was shocked when I was told at the start of September 2016 that the Buttonholing Technique had been introduced without the renal consultant's knowledge or agreement."

25. Paragraph 362 "All of the national and international guidelines supported my view about the Buttonholing Technique and, indeed, even a manufacturer said that the Buttonholing Technique was contraindicated."

26. Paragraph 363 "Subjectively, I felt extremely strongly that the Buttonholing Technique was a serious risk to the health and safety of patients at the Respondent. I also felt extremely strongly (as pointed out on numerous occasions) that patients had not given their informed consents. Objectively I was entirely correct, taking into account the audit data and the fact that this practice is seen as an absolute contraindication in the rest of the world."

27. Paragraph 364 "……I was not acting on my own motives, I was acting in the interests of patients at the Respondent who I felt were being subjected to an extremely risky technique without giving their informed consent (as I have described above). I always felt and still feel, that it was in the public interest to be aware of the fact that the Respondent was acting in a way that it was. The Buttonholing Technique affected existing patients at the Respondent (at the time) and any person in the region who might come under the care of the Department in the future."

28. It is clear that as a background to the differing views of the Claimant and Mr Gibbs about buttonholing there was also a difficult working relationship between them. It was the focus of a formal investigation conducted by SH the Chief of Service (Emergency Medicine) at the Respondent. The investigation outcome report is at pages 230 to 248 of the bundle and it notes in its terms of reference (page 230) "On 11 August 2016 [SH] was appointed …. in respect of a range of allegations around patient care, probity, behaviour lack of due process …made by [the Claimant] …" As acknowledged by Mr Gibbs in his witness statement (paragraph 13) the report did conclude (page 248) by identifying some governance issues within the renal unit as a whole that could be improved but it was unrelated to him as an individual.

29. At paragraph 10 of Mr Gibbs' statement he describes his view on his relationship with the Claimant, "to my knowledge the breakdown of my personal and professional relationship with [the Claimant] pre-dates the introduction of buttonholing within the WKC and is not solely related to the

differences in professional opinion we have over the buttonholing of AV grafts. The increased tension between myself and the [Claimant] was palpable from 2014 onwards, together we chaired the transplant sub-group meetings as she was the medical lead for transplantation and I was the surgical lead. It became apparent in 2014 and 2015 that on occasions when I was absent from the meetings she would make disparaging statements about me and my leadership."

30. The Claimant's position on her relationship with Mr Gibbs is articulated by her in what is referred to as her alleged disclosure number 5 which is a letter from her to SH (pages 334 to 336) – emailed at 12:54 on the 17 October 2016. The relevant part of that letter reads "……Since, I have become the subject of organized campaign to vilify me and present me as the source of problems in the unit, orchestrated by Mr Gibbs. My most genuine concerns in regard to patient safety have been manipulated into 'a private bickering'…..The timing of these events is most unfortunate as they coincided with the commencement of the investigation commissioned by [Mr H / Dr L] [(Dr L is at that time Chief of Service Renal CSC at the Respondent)] looking into concerns expressed in an email to [Dr L] that led to my resignation from the leadership role within the transplant team. I am certain that both [Dr L] and Mr Gibbs counted on my silence in regard to this matter as they thought that I would be concerned not to be seen as a 'trouble maker'. However, the use of the technique and the way it was introduced in clinical practice represented by anyone's standard the most serious breach of clinical, professional and research code of conduct, that I simply could not remain silent."

31. The Claimant was asked about her relationship with Mr Gibbs in cross examination and she accepted that she does not like him now. It was put to her that she used her opposition to buttonholing to get at Mr Gibbs. The Claimant did not accept that and it was then put to her that she was not concerned as to patient safety to which she responded she would raise the concerns even if it were against her own brother who is a doctor as well.

32. The Claimant became aware of the use of the buttonholing technique on AVGs on 31 August 2016 when the project was presented at the department meeting by Sr K a vascular access nurse specialist.

33. It was at a Consultant meeting on the 7 September 2016 chaired by Dr L as Chief of Service that the Claimant expressed concern that AVG were being buttonholed. The minutes from this meeting are at page 290 of the agreed bundle.

34. The minutes note that the Claimant "expressed concern that AV grafts were being buttonholed in contravention of accepted best practice and explicit guideline recommendations. She was also concerned that the technique

was being introduced without prior agreement or knowledge of the consultants and without informed consent of the patients." The minutes further note that three other consultants at the meeting "expressed the view that there is a dearth of evidence to support or reject the practice hence the need to innovate. After a long discussion it was agreed that:-

- All patients currently being buttonholed should be contacted by letter to ask if they wished to continue. The letter will be explicit about current practice and possible demerits of buttonholing.
- If these patients wish to continue buttonholing they can do this provided they have their consultant's explicit approval. [the Claimant and another consultant] stated that they would not give this. Other colleagues were prepared to consider it.
- Any new patient wishing to have their graft buttonholed needs to be given the facts (as they stand) and to give written consent. They will also need the explicit approval of their consultant.
- VADAR will initiate a research study into the utility of buttonholing which will be subject to standard research governance (protocol, ethics etc). Once a research study is approved by the consultant body the patients will be inducted into it on behalf of the unit."

35. In her witness statement the Claimant explains (at paragraph 30) that at the consultant meeting on 7 September 2016 "we had spoken about and agreed the need for patients to give their informed written consent before the buttonholing technique would continue. As a doctor, it is my responsibility to ensure that a patient has consented to his or her treatment. I've always understood this to be a legal obligation imposed on doctors. The General Medical Council provides guidelines in connection with consent and an extract from the guidelines are a page 222A [of the bundle]. As the guidelines say, before accepting the patient's consent, a doctor must consider whether the patient has been given the information they want or need or how well they understand the details and implication of what is proposed. In cases involving high risk (which is the case with the Buttonholing Technique), it is important that the doctor gets the patient's written consent, so that everyone involved, especially the patient, properly understands what was explained and what was agreed."

36. (paragraph 31) "Whilst it was agreed at the time that any patient wishing to continue with the Buttonholing Technique would need to give their written consent, as I looked into this further, my strong opinion was that the Department should not be undertaking this practice at all. I felt that it was extremely unsafe and an unacceptable risk to patients. I did not feel that any patient who was given the true facts about the Buttonholing Technique would ever give their consent to it…."

37. Following the meeting there is then an email exchange when Mr Gibbs emails the Claimant amongst others (on 7 September 2016 as seen at page 292) saying "having just read the EB PG on haemodialysis, the vascular access Society guidelines on haemodialysis, the NKF KDOQI guidelines on vascular access and the renal Association guidelines for vascular access for haemodialysis I cannot find any comment that says not to use the buttonhole technique on AV grafts. Please can you show me where in any of the guidelines it states that buttonholing AVG's is not recommended. I apologise for not being able to find it. Thanks for your help."

38. The Claimant replies to Mr Gibbs by email dated 8 September 2016 (page 292) and says "just Google it. RA guideline 6.1; EBPG 4.4; NKF/KDOQI available on website kidney.org.uk.". This email is also copied to Dr L amongst others at the Respondent.

39. In her statement the Claimant says (at paragraph 33) that guideline 6.1 says "we recommend that the rope-ladder and buttonhole techniques should be used for cannulation of AVF and rope-ladder for AVG". The Claimant says, "in other words the Buttonholing Technique is not recommended for use with AV Grafts.". The Claimant also referred to the EBPG (European Best Practice Guideline 4.4) together with the resource on the website Kidney.org.uk. which states: "The Buttonhole technique can only be used by patients with an AV fistula, and cannot be used by those with an AV Graft".

40. In her statement the Claimant says (paragraph 34) "My concern at this time (on discovering that the Buttonholing Technique was being used in the Department) was that…."

    a. "…This would cause serious harm to patients due to the fact that it was a risky and contraindicated practice. In this regard: -… "
        i. "A plastic artificial AV graft is much more prone to infections than a native fistula, and button hole needling technique at least triples that risk according to the best available medical evidence."
        ii. "Secondly, because the hole made through the AV Graft plastic cannot naturally heal, and as it is not physically possible to maintain position with needling, the holes created in the AV Graft would enlarge with time so the process becomes inherently insecure, as the risk of uncontrolled bleeding increases. Enlargement of the holes as well leads to prolonged bleeding post needle removal and need to apply pressure to stop bleeding increases the risk of graft clotting…."

41. (and Paragraph 34.2) “The patients who were being buttonholed had not given informed consent. Even if they did, the practice was introduced and run with complete disregard of the law governing introduction of ‘innovative techniques’”

42. Mr Gibbs at paragraph 7 of his supplemental statement explains why he disagrees with the Claimant’s view as to the harm the technique may cause: “[the Claimant] has stated …. that buttonholing cannot be carried out safely in patients with AV grafts. This is unsubstantiated and reflects her inability to recognise the group of the Respondents patients have now been buttonholing safely for a period of over four years. I would further deny that any results presented to date or communicated to the relevant external bodies have been misrepresented as she has alleged in her statement. The reality is that dialysis is an inherently risky process which is an unfortunate daily necessity for a significant number of renal patients. Buttonholing and rope ladder techniques on both AV grafts and fistula is dangerous and complications are inevitable because the patient is having large needles inserted around six times a week. I would like to emphasise in response to [The Claimant’s] position that there are issues with AV grafts regardless of the needling technique used. Every time a sharp needle is placed into a AV graft it makes a small hole in the graft. Over time, with at least six needles placed in the graft each week, the graft is slowly destroyed. Eventually there is little of the front wall of the AV graft left increasing the bleeding and thrombosis risk. When using the buttonhole technique this is not the case as long as the needle is placed through the same small hole in the AV graft every time. Something we have confirmed in one explanted graft and with our regular scanning of the grafts that are being cannulated using the buttonhole technique. I believe that there is less risk of enlarging the hole in the graft by using blunt needles and this is a safe technique. I would agree that repeated cannulation in the same area with a sharp needle is indeed dangerous, and should not be encouraged, but that is different to the buttonhole technique that uses exactly the same hole.”

43. At page 292a of the bundle there is an email from a nurse Sister at the Totton dialysis unit dated 8 September 2016 to the Claimant. It reads “…. [X] had had so many access problems late 2014 early 2015. Once these settled she had started to self cannulate. However she was not so much rope laddering as area puncturing which concerned me. Additionally her graft is not of great length and on her upper arm so can be a little restrictive to the ease of self needling. Hearing of the monitoring and success in QAH of buttonholing grafts I had enquired and had discussions with the Surgeons/ Access Specialist Nurse which resulted in [X] switching to Buttonholing August 2015. That you were not consulted or informed is an omission on my part that I apologise for…”

44. The Claimant replies on the 8 September 2016 (page 292a) to the nurse Sister saying "……I absolutely appreciate the decision to move to buttonhole technique was discussed with vascular access nurse specialist and my surgical colleagues and was not unilateral. If rope laddering is not possible due to the length of her graft, I would not oppose buttonhole technique but she needs to be aware of the risks and the fact that the technique used (BH) is novel not currently recommended by the Renal Association or other relevant bodies…."

45. I refer now to the alleged disclosures in chronological order by their numbers as agreed by the parties in their "Appendix A" document.

Disclosure 1

46. By email dated 9 September 2016 (timed at 10:46) the Claimant makes her first alleged disclosure (page 293). It is addressed to Dr L the Chief of Service Renal CSC. In the email she says:

> "Dear [Dr L],
>
> I did not want to engage in a protracted and in my experience often futile, email exchange with Paul about the buttonholed needling of AVG's and I do not want my concerns to be misinterpreted but would like to formally register them. If we objectively analyse the situation we have here an uncontrolled experiment, done without prior knowledge or agreement of the consultant team and without informed consent of the patients, with practice that is not in keeping with the current national and international guidelines or recommendations from the manufacturer, in which one of the participants died and that was then misreported at a national meeting.
>
> This is wrong on so many levels.
>
> As I clearly stated at the meeting, I cannot support the continuation of the project as I do not believe that the technique is suitable for AVG's and that is in line with views of the vast majority of practising clinicians worldwide reflected in the current guidelines. If patients under my care feel very strongly, I will facilitate a smooth handover of their care to [Dr S].
>
> If we manage to organise a proper study with R&D and ethics approval and scientific rigour (even if it is an observational study) I would be happy for my patients to be approached."

47. In his response dated 9 September 2016 (timed at 11:58) Dr L states that the Claimant's "concerns are duly noted" and that he has already taken action as follows:

    a. "Asked [S] to stop buttonholing unless patients (a) express a wish to try/continue it, (b) give informed consent and (c) have the approval of their nephrologist."
    b. "Asked the vascular team to prepare evidence-based document which provides unbiased information for patients and consultants. This will provide the basis of the consent process and will serve to avoid any suggestion of bias (you will see this soon and will have an opportunity to comment/amend)"
    c. "Asked the vascular team to make this innovation henceforth the subject of a proper clinical study under the umbrella of research governance as advised by the trusts R&I department"

    "We need to encourage initiative and innovation and one cannot do this without deviating from accepted practice. The key judgement is whether such deviation constitutes an unacceptable risk. Opinions on this will obviously differ, but as Paul is our expert in vascular access, I believe he should make that call and (where clear evidence is lacking as in this case) we should trust his judgement. He has accepted on reflection that he was remiss in not discussing the project more widely before its initiation. In my judgement, this was just a failure of usual professional courtesy and I don't think he intentionally disregarded his colleagues in order to avoid having to justify what he was doing.

    Thank you for voicing your concerns which I believe have brought important rigour to this subject. You have now discharged your professional duty and I hope my response reassures you (as it has our other consultant colleagues with the sole exception of MDU) that sufficient action has been taken to minimise the risk to patients and the renal unit whilst not stifling innovation."

48. In cross examination the Claimant accepted that at the point of writing the first alleged disclosure she had not reviewed any of the data of the 15 patients using the BH in AVGs. She explained though that she did meet one of her patients on the 6 September 2016 and had a telephone call with another. She says that when she spoke to her patients they did not know about infection risks so she does not believe they would have given informed consent. She also said that other consultant colleagues shared her concern and they discussed this before she sent her email on the 9 September 2016.

49. The Respondent says that the Claimant's asserted belief that there was a lack of informed consent is unreasonable as they say it was obtained for all

the patients concerned before undertaking the procedure, and their position is confirmed by reference to what is recorded the nurses say they said to the patients in the Respondent's External Review of the matter dated 28 July 2017 (at page 670 paragraph 5.3) and based on what the 4 patients interviewed are recorded as having said about risk being explained (at page 672 paragraph 6.3) in the Respondent's External Review.

50. However, I have not had any witness evidence from these nurses or patients presented to me and have not been presented with medical records of the patients by the Respondent that record any of this. As the Claimant highlighted in her replies when being cross examined she could accept that it may be the case for 4 of the patients but not the other 11 (who were not interviewed).

51. Dr L does not challenge the Claimant's statement that she makes about informed consent in his reply to her alleged first disclosure. Dr L says in his reply "Thank you for voicing your concerns which I believe have brought important rigour to this subject.". It is also of note that the minutes recording the issue on the 7 September 2016 do not go on to note that the Claimant's assertion as to informed consent must be unfounded because there is evidence of such informed consent. The Claimant's position is also consistent with what she says to the sister nurse at Totton in her email dated 8 September 2016 (as referred to in paragraph 44 above), that the patient needs to be aware of the risks.

52. Considering what the Claimant has said under oath and the Respondent not disproving this, I accept what she says about her belief about the lack of informed consent.

53. The Respondent also says it is not reasonable for the Claimant to believe that one of the participants (subsequently referred to as "MW" or "Mr W") died of infection due to BH. In her replies to this issue in cross examination the Claimant maintained that her belief could not be categorically ruled out, just as it could not be categorically ruled in as not being due to BH. It was the unknowns about the death that was the issue for her, rather than the known.

54. As to the guidelines the Respondent says the national guidelines are silent on BH AV Grafts (as can be seen at page 372B) which is correct in that it only recommends "rope-ladder for AVG" and does not expressly state BH must not be used. As already found though the Claimant had looked at guidelines and debated this point with Mr Gibbs (see paragraphs 37 to 39 above) before she made her first alleged disclosure and some do expressly state against BH AVGs.

55. The Respondent also asserts that the GMC confirmed that there is "no absolute requirement to follow guidelines" (see page 1573). The GMC does state this in its outcome report but goes on to note: "if a procedure is introduced that does not follow them there should be a justification for this and participation in a governance framework to ensure patient safety. The department acknowledged at the governance review meeting on 1 February 2017 that this had not been done and it took steps to ensure that appropriate processes would be followed in future." (pages 1573 to 1574).

56. Regarding the reference the Claimant makes to manufacturers and experts the Respondent says that manufacturers would only confirm their product can be used within its licence (and as it was not licenced for use with BH AVGs, they would not say anything differently) and the Claimant had not gathered expert opinion at that time so therefore had no evidence to support what she says.

57. It is after her first alleged disclosure that the Claimant sends an email to an expert involved in the guidelines, Dr F at Derby, on 10 September 2016 (page 295) about BH AVGs. His reply on 10 September 2016 (page 295) says "I would have to go back and check but we would never advise BH for grafts – only for AVF. The latest guideline is here [LINK] They tightened up the words from the 2011 guidance which was edited down – the text in 2011 said 'It is therefore recommended that the buttonhole technique is the preferred method for fistula cannulation'…. So, no please don't use BH for AVG.". The Claimant then forwards this to the team on the 11 September 2016 (page 299). What Dr F says is not inconsistent with what the Claimant has said.

58. This gets an acknowledgment email from Dr L on the 17 September 2016 (page 299). "Whist [Dr F's] opinions are sort of interesting, what we need are facts. He provides none – and yet presumes to tell us not to do something which our experts (who do surgery rather than preside over committees) feel is appropriate". "As long as patients are asking for a change in practice and expert clinicians can see some virtue in what they say, our duty in the renal community is to explore this in the safest possible way. I think our guys are doing this; in line with [Dr F's] oft-repeated demand for us to be more patient-centric" "As long as I am assured that this initiative is done to the highest professional standards, there is nothing that has come to light so far that induces me to ask our colleagues to stop. I hope you can support my position on this".

59. The Claimant also made an enquiry of Royal Berkshire NHS Foundation Trust (at Reading) (10 September 2016) page 297, which is then responded to by AS a Renal Vascular Access Nurse at Royal Berkshire (page 296) confirming that "We don't do any buttonholing of av grafts at RBH". The Claimant then forwards the response to Dr S of the Respondent on 14

September 2016 as he had suggested it was undertaken at the Royal Berkshire. The position at Reading is not inconsistent with the Claimant's stated position.

Disclosure 2

60. The second alleged disclosure is by an email the Claimant sends on 17 September 2016 at 16:36 (pages 298 to 299). This is addressed to what appears to be most of the consultants at the Respondent and is again to Dr L and also now Mr Gibbs.

61. "Dear [Dr L] … I have some sympathy with your views and desire to promote innovation. Unfortunately I am not able to support your view in this instance as

    a. The practice is considered inappropriate by the vast majority of experts in the field of vascular access
    b. No other renal unit in the country is using button hole needling for AV grafts (we were misled last week by [Dr S] that the practice is used in Reading). Some units have abandoned the technique for AVF too due to risk of infection.
    c. National guidelines and all international guidelines indicate that the technique is only appropriate to use in native fistulas due to risk of infection, pseudo-aneurysm formation and risk of exsanguination
    d. Manufacturers do not recommend its use
    e. Patients have not been given any information regarding the experimental nature of this practice, including quite substantial risks
    f. We were misled last week that our outcomes are excellent, in fact the practice is in my view a dangerous experiment on 14 patients during which I understand"
        i. "2 patients died (I do not know the cause; 58 and 48 years of age)"
        ii. "1 patient almost died of sepsis from the infected graft that had to be removed; His clinical state was complicated by multiple septic emboli"
        iii. "1 patient developed pseudo-aneurysm"
        iv. "I did not have the time to review records of the remaining 10 patients, but considering what has happened here, that should be done as a matter of urgency"
    g. "Our 'great experience' was misreported in an abstract submitted to the national meeting and therefore this issue has become an issue for the British renal community. I am sure you will understand the implications of 'research' misreporting
    h. I cannot put lives of my patients at risk, my morality, ethics, professionalism will be destroyed if I turn a blind eye to the most

serious breaches in clinical, professional and research code of conduct.

As stated before the highest professional standards demand the proper study with R&D and ethics approval. If such is organised, I would be happy for my patients to be approached, but I suspect that you will struggle to get the ethics approval on the basis of an anecdote from a single unit in Belgium (unpublished)."

Disclosure 3

62. The Alleged disclosure 3 (dated 23 September 2016) is made during the Claimant's investigation hearing with SH Chief of Service on the 23 September 2016 and what was said by the Claimant is recorded in the investigation notes (pages 322 and 323) "SH requested a discussion regarding current unsafe practice and queried what these were. JM reported that in the last few weeks it had come to their attention that the Unit is using buttonhole technique for needling of the AV grafts for dialysis. JM explained that this only became apparent when a nurse presented the Unit's results at the departmental meeting that she was preparing for a presentation at a national meeting. JM stated that she was extremely shocked by this information, highlighting that all guidelines state that this technique is completely and totally inappropriate. JM expressed this view and detailed the risks it presented (risk of infection, pseudo-aneurysm formation and exsanguination). JM explained that when she raised this issue at a consultant meeting, it appeared no one was aware of this practice. Patients were also unaware meaning they had not given informed consent. This practice is so inappropriate that there is not a single publication in the worldwide literature supporting its use. JM noted that Paul somehow thought this would be a fun thing to do so no discussion with his colleagues who are legally responsible for patients care and their well-being; no informed consent of the patients that this is an experimental practice, no assessment of risk. Following JM escalating her concerns, Paul Gibbs proceeded to argue with JM for two hours about what the guidelines say (this technique has been established 30 years ago for use in AV fistula but is unsuitable for use with PTFE grafts. The results of the 'experiment was misrepresented to the Unit and then misrepresented in an abstract to be presented at the national meeting and JM was sure that the GMC takes this issue seriously. SH queried whether there were any other unsafe practices he should be aware of. JM confirmed that she could not think of any others."

Disclosure 4

63. The alleged disclosure 4 is an email dated 3 October 2016 (page 326) to Dr L the Chief of Service timed at 08:47 (The Respondent accepts this discloses information):

64. “Dear [Dr L],

Thank you for the email and for meeting me in person to discuss is content last Thursday.

I would like to express my deep disappointment that my most genuine concern about the introduction of untested and intuitively risky procedure without knowledge of the consultant body or the informed consent of the patients was manipulated into a ‘private bickering’. This technique is against all published guidelines and in native fistula associated with 3-4 fold increase in infective complications, and therefore wisdom of its introduction in the most vulnerable patients with AV grafts (9/14 with leg loops) has to be questioned.

I am relieved that you are taking full responsibility for its continued use as the Chief of Service and I trust that you will do what is right for the patients, the unit and in particular now - British renal community. As I stated last Thursday, the results were misreported:”

- The authors have failed to mention JKJ and the fact that she developed the most feared complication of the technique - pseudo-aneurysm, detected by angiography on 21st June. The abstract was submitted on 23rd at 12:44. From the abstract it looks that they have simply forgotten that she had been using the technique for more than 3 months.
- They failed to report that MD developed infection of the graft. They attributed graft removal (rightly or wrongly) to staphylococcal septicaemia related to ‘surgical wound’ but failed to mention that enterococcus was isolated from the tissue culture of the graft, probably the same enterococcus isolated from his needling site in early days of buttonhole technique use (19/06/15). Wisdom of the graft and buttonhole needling in someone with permanently infected arm wound I do not have the energy to discuss here.
- Death of Mr W was described as unrelated to BH, but without PM (which she should have had if she was a trial participant) no one would be able to say with certainty if her septic death with respiratory failure was related to septic pulmonary emboli (as we have seen it in 2 patients with leg loops) or infective exasperation of COPD.
- Even cursory look at the data spreadsheet is sufficient to identify multiple inconsistencies and therefore minor ‘errors’ pale into insignificance, but I attach them for your reference.

As for the letter sent to the patients that we were meant to see and amend - I feel that it will not pass external scrutiny (that is highly likely following VASBI meeting) as it does not explain the risks, experimental nature of the

practice and our experience is misrepresented. But I do not have any patients using the technique now, and I feel that I have done my best to highlight the issue and therefore I have fulfilled my professional obligations and will drop the matter now. Concealing serious professional misconduct is above my pay grade but I intend to make no further comments on this matter."

65. The acknowledgment email from Dr L on the 3 October 2016 timed at 09:54 says "Thank you Jasna. This is a very comprehensive account of your concerns. I will ask the authors of the abstract to give me the facts of each case and allow them a chance to rebut your concerns. If they cannot, then be assured further action will follow".

Disclosure 5

66. The alleged disclosure 5 is a letter to SH (pages 334 to 336) – emailed at 12:54 on the 17 October 2016 the relevant parts to the alleged disclosures are:

67. "Dear [SH],

I thought I needed to explain my concerns in regard to buttonhole technique used the needling of AV grafts for haemodialysis access in more detail as it is on your list of issues to investigate.

Mr Gibbs initiated the practice for arterio- venous grafts in haemodialysis patients without any discussion with his colleagues or informed consent of the patients.

Use of buttonhole technique for AV grafts is against all national and international guidelines due to increased risk of infection, severe consequences of infection in the presence of artificial material, risk of pseudo-aneurysm formation and exsanguination. There is no published evidence to support its use and in recent years strong calls have been made to minimise its use even for patient dialysing using native vein AV fistulas due to publication of multiple trials indicating significant increase of infective episodes with its use.

13 patients were involved so far out of which 1 has died (female, age 58), 1 patient almost died with sepsis multiple septic pulmonary emboli and required removal of the graft and one patient developed pseudo-aneurysm. He then misinterpreted the results to the unit (presentation clearly stated that there were no infective episodes and the patient with pseudo-aneurysm was not mentioned) The patient who died has been simply brushed off as a 'drop-out'. (Relevant slide from the presentation given by Sr K with comments attached) …..

……. Mr Gibbs…… proceeded to question the existing guidelines and oppose the decision of the consultant body that the patient involved should be given full explanation and asked to sign the consent if they wish to continue with buttonhole technique use. He tried to manipulate the wording of the guidelines published in 2011 that led me to seek the clarification from the co-author and the most recent National Director for renal care Dr [F]. In his reply he stated very clearly that BH should not be used for grafts ('we would never recommend…) and ask us to stop. (Dr [F] is highly regarded in the field of vascular access for dialysis and is recognised nationally and internationally for an enormous contribution in this area of renal clinical practice) ….

……. Unfortunately, despite of the concerns expressed, the practice is still continuing. I have struggled to remove the only patient under my care who was involved, but I am worried that lives of other patients are put at risk. It has been suggested that the technique is preferable to at least some of the patients, but I firmly believe that they have not been informed of the experimental nature of the practice and the 3-4 fold increase in the risk of infections that in the presence of artificial material is likely to lead to loss of vascular access.

The situation is made worse with the misrepresentation of our experience at VASBI meeting as the colleagues in other units may decide to embark up the similar path, and therefore, there is a need for urgent action…...

……. The buttonhole technique is not safe or appropriate for use with PTFE AV grafts. Dr [L]'s trust in Mr Gibbs as 'our vascular expert' is misplaced as he had to familiarise himself with the guidelines only on my prompting. Two colleagues who were aware of its use have less of 2 years of the experience at the consultant level between them and unfortunately did not research the topic before allowing its introduction.

The introduction of the techniques represents, in my view, the most serious abuse of the trust colleagues and patients place in Mr Gibbs. We trusted him to do the best for our patients, but instead, without any thought, prior research of the topic or discussion with the colleagues who are ultimately responsible for patients care he pursued the risky path for no valid clinical reasons.

This practice would be indefensible if any of the patients with developed sepsis, endocarditis, bleed to death for pseudo-aneurysm and therefore it is essential that the practice is reviewed, or at least, make sure that the patients are aware of the experimental nature of the practice and significant risks."

68. There is then a Consultants meeting on the 4 January 2017 where consultants (including the Claimant) are informed of the outcome of a Care Quality Commission (CQC) BH investigation (page 370). “PG has received feedback from the CQC following anonymous complaint about ‘unsafe practice of button holing grafts’. The CQC are happy that there is no unsafe practice case and will not stop us from continuing this practice. PG is planning to meet with the VASTECH group to see what needs to be done to prove safety weather [SIC] this is publishing are [SIC] existing data or a prospective trial. PG will feedback following this. In the mean time all existing PTFE button hole patients have been counselled and are aware that this deviates from protocol and have this clearly documented in their notes”. As already noted above The Respondent has not produced copies of such notes to support this statement.

69. Chronologically there is then an email from the manufacturer of the grafts dated 6 January 2017 (page 371) “…. The Buttonhole technique can only be used by patients with an AV fistula, and cannot be used by those with an AV Graft. Damage to the graft would be the result of attempting to buttonhole it. Infections and aneurysms are listed as a possible adverse reaction in our instructions for use, but I do not have data that shows the number of patients that developed infections or aneurysms.”.

70. Mr Gibbs on behalf of the Respondent says about the manufacturer’s email “I am unsurprised by this response. For legal reasons when manufacturers produce a device they authorise its use for (usually) quite a narrow range of treatments. However, within the medical profession I would estimate that up to 40% of medical devices and drugs are used ‘off licence’ having been initially introduced for a specific purpose. A different example of this would be the use of the Gore Viabahn Endoprothesis. This is a stent graft licensed for use in AVFs and AVGs to treat complex and persistent stenoses. On its product website there is no information on its use to treat ruptured AVFs or AVGs, or its use to treat false aneurysms in the AV access circuit. However, this is the go to stent graft in many high volume access centres in the UK, including our own and beyond. A recognised off licence use. In summary, the Tribunal should not place too much significance on the fact that the manufacturer does not recommend buttonholing AV grafts as it will not have tested this technique on its grafts and will not have a suitable licence for that purpose”.

71. On the 16 January 2017 Dr L shares an extract of the outcome of the CQC final report with the consultants by email (page 375) which acknowledges that the CQC findings (that no safety concerns arise with the use of buttonholing) is based on the information the Respondent provided to the CQC. The Claimant by email in reply requests a copy of the Respondent’s “rebuttal letter” (page 375). This is refused by Dr L (email at page 374 dated 16 January 2017).

72. At a consultants meeting on the 18 January 2017 (page 376) (which the Claimant attended) action steps are recorded:

73. "1. With regards buttonholing

    a. a letter will be composed by the Unit to be sent to patients using the technique on grafts, explaining the developments regarding ongoing safety concerns. It will contain potential risks and that we, the WKC, take the position that it stop until an in-depth review of the available data has taken place. Once that has taken place, a decision will be made as to whether it should continue and then how to move forward (process), if the use of the technique is to be explored.- ALL"

74. The Action steps then note that an internal meeting is to be set for the 1 February 2017 to review the details of the 14 patients currently using the BH AVG technique.

75. The Claimant though is signed off work sick on the 18 January 2017 for two weeks (as confirmed in the agreed chronology and the Claimant's oral evidence) and this is noted in her email dated 31 January 2017 at pages 418A and 418B. The Claimant confirmed during cross examination that it was because she was on sick leave at that time she could not take part in the review on the 1 February 2017.

76. Notes from the governance review of BH needling of grafts on the 1 February 2017 are at pages 419 and 420. The notes record "Conclusions … a. The investigation revealed no compelling evidence that BH is associated with additional harm (although, because of small sample and short duration of BH, neither did it rule this out as a possibility) b. there were no grounds for mandating that this form of needling should be completely abandoned immediately on safety grounds……. In summary:) The initiation of BH had not been handled ideally. This has been recognised. It has already been concluded that the introduction of novel techniques/practices must be discussed at the consultant meeting and submitted to governance in the future. 2) No further patients will be offered BH until the safety of BH can be firmly established. 3) Patients currently receiving BH can continue provided they give informed consent and understand the potential risks. It was decided that: a. As the existing letter of consent (September 2016) was considered inadequate by some, it will be replaced (Action PG). b. the individual's named consultant nephrologist is responsible for ensuring their patients are suitably informed about potential risks….".

77. The Claimant says at paragraph 84 of her statement that colleagues described the governance meeting as a "whitewash" and this can be seen

at pages 1327 as comments made by Dr G and also that the results were watered down and this is noted as comments by Dr U at page 1299.

78. There is an email dated 10 February 2017 from Dr U to Dr L and the consultants (page 433) about the 1 February 2017 governance meeting and it notes in relation to some of the conclusions made "we identified complications which have occurred in several patients for which button holing was an additional risk factor and therefore may or may not have contributed. This is debatable. It is on this basis that I am relieved that the consensus decision was to stop offering button holing of AV grafts in this unit until we know more from Pauls data analysis." Also, "with regard to point (3) … Patients receiving BH should continue to be offered it provided they give informed consent clearly understand the potential risks…. My own opinion on this is that buttonholing should also be stopped in existing patients as well. It doesn't make any sense to me to discontinue a procedure on safety grounds yet still offer it to certain individuals and I think the unit could remain open to criticism for doing this. I appreciate the difficulties faced by colleagues in dealing with patients already undergoing the procedure. Giving the option to continue it provided there was informed consent seem to be a reasonable compromise. However on reflection I am concerned that in continuing to provide the procedure colleagues would be assuming a clinical responsibility which would trump any type of informed consent. It strikes me that there is plenty of precedent for this in case law and perhaps the trust solicitors should be consulted to ensure that this approach is watertight in order to protect our colleagues taking it forward."

79. There is then an email from Mr Gibbs dated 11 February 2017 (page 435) that responds to Dr U on the two issues he raises:

"Having met up with a clinical trials expert on Tue, as promised from the Sept meeting, we are unable to draw any conclusions from the existing data as it is too "messy" ….."

"With regard to point 3…. I am obviously going to disagree on this point. I believe that we have stopped recruiting because of safety concerns not safety grounds - a subtle but important difference in my opinion) that are as yet unproven, and likely to remain that way for some time, if ever resolved to everyone's satisfaction… "

80. There is then an exchange of emails between the Claimant and Mr Gibbs on the 20 and 21 February 2017 (pages 441 and 442) about the drafting of an updating letter to patients and in her email at page 441 the Claimant notes "if patients are going to continue to use the technique, they deserve and need full and unbiased information so they can make an informed decision. Not anecdotes, discussions, scientific papers. Just clear and concise information in 10 sentences. The letter outlining complication

should have been sent to the patients before they were recruited. Unfortunately that has not happened and this needs to be rectified." … "I have discussed the issue with my colleagues (medical and surgical), both here and in other units and have reviewed all guidelines and publications, so I do not think there is a debate going on in regard to use of BH technique for grafts. BH use with grafts is an absolute contraindication and that is why it has not been used in the last 40 years of BH existence…."

Disclosure 10

81. We then move chronologically to alleged disclosure 10 [which the Respondent confirmed during the hearing could be allowed in pursuant to the amendment application made by the Claimant provided the parts relevant to the alleged disclosures were focused on only] which is the letter DMH Stallard (the Claimant's former solicitors) sent to IC the Chairman and TP the Chief Executive of the Respondent dated the 9 March 2017 (pages 462 to 464). In her statement the Claimant says (at paragraph 351) that "The DMH Stallard letter did not disclose anything new but, on reflection, I believe it was a protected disclosure in its own right."

82. Considering therefore the relevant parts of that letter –

83. "……. My client's concern relates to the use of button hole needling technique for haemodialysis access for patients dialysing via AV grafts, a practice that is still ongoing in a number of patients treated at the Wessex kidney Centre. This practice is contraindicated in this setting and has been introduced as an uncontrolled experiment with detrimental effect to majority of patients involved.

    I refer to clause 3.1 of the Policy. My client's concerns come within the categories of "Poor quality care", "Malpractice of Care", and "Negligence". My client's primary objectives are to stop the unsafe practice and that the Trust's legal duty of candour to the patients exposed to the unsafe practice is fulfilled, especially as the majority have experienced significant complication and detrimental effect on their vascular access for haemodialysis."

84. There are then nine bullet points that list how the Claimant has expressed her concerns, those that appear to contain details of those concerns are the fifth bullet point:

    "Verbally on 23 September 2016 to [SH] (who was running an internal investigation in regard to conduct and probity of Mr Gibbs on behalf of the Trust);"

    the seventh bullet point:

"Reporting her concerns again to [SH] in December 2016 and on 13th January 2017, when she informed him of serious complications she had observed. He assured her then that he had informed the head of HR, Medical Director of the Trust and the Trust's solicitor of her concerns…"

and the eighth bullet point:

"Sending a copy of her email outlying serious complication to the Medical Director … on 5th February 2017."

85. Then the sentence "Notwithstanding the above, the practice is still continuing and I have advised my client that it is now appropriate to consider wider disclosures…."

86. There is then an email from BB who is an associate Professor at the Department of Microbiology and Immunology, Faculty of Medicine of KU Leuben, Belgium dated 20 March 2017 (page 473) (which is referred to in paragraph 106 of the Claimant's statement) and he says, "I think buttonhole and grafts is a problem indeed".

87. There is then an email from a doctor who is a specialist nephrologist from Saint-Luc UCL in Brussels dated 22 March 2017 (page 474) (which is referred to in paragraph 112 of the Claimant's statement) "we don't use (and have never used) buttonhole needling in AV grafts in our in-center HD patients. Ideed [SIC], there is absolutely no published experience concerning this technique in AV grafts, so we prefer to be careful...".

88. There is then a further consultants meeting on 22 March 2017 (page 476 to 477) and it is noted from that (page 477) "…. A further discussion relating to buttonholing PTFE graft, seeking assurance that all patients that continue to BH must told it's against guidelines and holds safety concerns. [the Claimant] stated the patient should be told it is contraindicated and that we have observed 3/15 pseudo-aneurysms, 2/15 grafts removed and 15 times increased rate of infection, [the Claimant] feels that all complications that have arisen since September could have been prevented if her patient safety concerns had been addressed. [The Claimant] felt our results were insulting to both professional competence and practice. It was brought up that all cases were individually reviewed, that the CQC had been satisfied, NHS England were now involved. All remaining patients will receive a letter from [Mr Gibbs] and all have and will continue to be spoken to by their nephrologist. No definitive resolution beyond this was reached."

Disclosure 11

89. There is then the alleged disclosure 11 [which remains subject to an amendment application by the Claimant for it to be included but is considered chronologically here for subsequent consideration of the amendment application the Claimant has made at that start of this hearing] which is a letter from DMH Stallard to the Respondent's solicitors Mills & Reeves dated 29 March 2017 (pages 479 to 491). It is noted within that letter that "I enclose my client's comments to your letter which set out again the concerns she had previously expressed.". Although this was the subject of an amendment application to include it as a disclosure as at the start of this hearing, the Claimant did not refer to this being a disclosure in her evidence at this hearing.

90. Chronologically there is then email from Dr AD of the UCL Centre for Nephrology at the Royal Free Hospital dated 6 April 2017 (page 496) which says "as far as I am aware buttonhole cannulation has never been advocated for A-V grafts, as repeated needling in one site will risk damage to the graft material and risk pseudo-aneurysm formation, but I will check with our own surgical team (who have developed a new synthetic material with UCL). Although I was very pleased with our initial experience, we late ran into problems with infections, which have been a problem despite repeated education programs. A-V grafts are recognised to have a higher infection rate compared to A-V fistula with standard needling".

Disclosures 6 and 7

91. The alleged disclosures 6 and 7 are letters to the relevant external bodies (CQC and GMC) dated 9 March 2017 (pages 499 to 506) but they are not sent until 19 April 2017 (page 507) to CQC and submitted online to GMC at the same time (paragraph 121 of the Claimant's statement). For these disclosures the Claimant also needs to reasonably believe that the information disclosed, and any allegation contained in it, are substantially true. The Respondent says that by the time of these letters there had already been consideration by the CQC and the internal review on the 1 February 2017 (as referred to above) had concluded that the practice of BH AV Grafts was not unsafe and could continue, so the Claimant could not reasonably believe that the information disclosed, and any allegation contained in it, are substantially true.

92. The Claimant explains why she sent her letters to the CQC and GMC at that time (in paragraph 115 of her statement). "The aggressive nature of the letter from Mills and Reeves [(in response to her alleged disclosure 10)] and the way the Respondent was dealing with my concerns shocked and upset me. I felt that I had no option to report the matter further. In April 2017, therefore I wrote to both the GMC and the CQC."

93. The letter is 8 pages long – it opens:

> "I'm writing to you as a whistleblower to report severe substantial wrongdoing at the Portsmouth hospitals NHS trust; within the Wessex kidney Centre ("Centre"), during the last two years, which has unfortunately put at least 15 patients at substantial and unnecessary risk and which has resulted in serious complications for a majority of the patients involved."

94. Then under a heading "The Complaint" the Claimant sets out her concerns in particular "the use of buttonhole needling technique by the Centre for patients dialysing with AV Grafts ("Technique")".

95. The Claimant refers to the Technique being contraindicated due to health concerns. She says that the practice is continuing in a number of patients. She also says that informed consent was not obtained (page 500) "They failed to obtain the informed consent of the patients for the introduction of such an experimental practice and failed to act in this regard when concerns were expressed".

96. The letter then goes on to provide a detailed summary of the matter which the Claimant says in her letter is "the facts of what to my knowledge has so far occurred at the Centre in relation to the use of the Technique".

97. Then under a heading "Actual complications with Patients at the Centre as a result of the Technique" (page 503) the Claimant sets out in paragraphs a) to n) (pages 503 to 504) detail collected in early February 2017 about the 15 patients. She concludes by saying "Even if we had no complications at all, in my view it is unethical to put patients' lives and health at substantial risk through the use of this Technique, especially bearing in mind the risks of septicaemia, fatal bleeding and graft destruction.".

98. The Claimant then under a heading "Summary of national and international guidelines for the Technique" lists references to 8 sets of guidelines, including the International society of Haemodialysis which says that "The BH technique is not recommended for all patients and is contraindicated in patients with arteriovenous grafts (AVGs)." – there is a copy of this extract in the agreed bundle at page 1675.

99. Mr Gibbs' position in respect of these guidelines is set out in his witness statement at paragraph 7 "the national guidance on cannulation does not expressly mention buttonholing PTFE grafts. However, these guidelines also do not state that PTFE grafts cannot be buttonholed. In order to feature in these guidelines you need evidence supporting the method. In short, as I have always understood it, as the guidelines do not prohibit the use of the buttonholing method, my view is that it can be used, but for it to be

mentioned in the guidelines evidence to support the method is needed. The difference of interpretation between my own approach and that of [the Claimant] is that [she] considered that because the guidelines did not refer to buttonholing it should not be carried out. I read that as being no evidence one way or another. The progression of medical techniques and treatment relies on innovation and medical professionals applying different techniques and generally trying to improve the patient experience. As a unit the WKC are keen to progress new techniques and innovate, we recognise that dialysis is a challenging process for patients and we are continually searching for ways to improve this. For example my colleague [NS] is currently developing an app to assist with home dialysis. It is within this context that the discussions regarding buttonholing AV grafts started.". Mr Gibbs did though accept during cross examination, that the International society of Haemodialysis guidelines (as referred to at paragraph 98 above) do state that BH is contraindicated in patients with AVGs.

100. In conclusion the Claimant says in her letter (page 506) "My sole motivation in raising my concerns about the practice at the very beginning was for the welfare and safety of patients in the Centre. At that time I was not even aware of any complications. Now, 7 months and many complications later, the practice is still continuing and the Trust and its medical director have not taken any action to remedy the matter."

101. The Claimant then sends further documents to the GMC regarding her BH complaint by letter dated 13 June 2017 at page 589 to 590. This includes the "record of complications concerning every individual patient involved in the experiment together with the timing of the complications…" and "Notes from the "Governance" meeting" which is the one that took place on the 1 February 2017.

102. There was a telephone conversation between the Claimant and the GMC on the 15 June 2017 (as can be seen by the telephone note at page 591A) which records "I asked [the Claimant] about the table of instances where a problem occurred that she sent yesterday. She said she had compiled this herself using the hospital monitoring system, and the notes in italic are direct quotes from the system…. She added that previously there had only been one patient that hadn't had any complications, however on 8 June they were found in a pool of blood at their home and have now been taken to Southampton Trust and are in a critical condition. If the patient dies then this will be a direct result of the procedure…. She said she had seen the patients after the procedure and they have holes on their arms. She also added that the patients aren't being advised it's against medical advice to undergo the procedure...".

103. The GMC outcome concerning the investigation into Dr L is at pages 1564 to 1575 (dated 15 January 2018) and the outcome concerning the

investigation into Mr Gibbs is at pages 1589 to 1600 (dated 16 January 2018). In both of those outcome reports the same comments are made about the Claimant (see pages 1569 and 1594):

"We are of course mindful of the findings of the independent whistleblowers review the GMC commissioned from Sir Anthony Hooper. Having considered the correspondence disclosed to the GMC by the trust: and by Dr Macanovic, it appears Dr Macanovic first raised her concerns locally and that it was only after she concluded, in her view, that her concerns were not being adequately addressed locally that she made her complaint to the GMC. In doing so Dr Macanovic was no doubt aware, amongst other things, of the guidance at paragraph 25 of the good medical practice that doctors 'must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised'.

In the event Dr Macanovic generally considered there was a risk to patient safety, and it appears to us that she did consider such a risk existed, but she had not raised her concerns through whatever mechanism was available to her locally and/or if she deemed it necessary to GMC, she would in our view have been rightly criticised by the public and by the GMC for failing to do so.".

104. The GMC outcome also notes (at page 1571) "… it appears in light of these results that the contention that there have been 'no infections is no longer sustainable. There have now been several infections, one of which was unequivocally identified as having been a buttonhole infection…."

105. The GMC outcome further notes (at page 1574) "…. The buttonholing technique was not consistent with professional guidelines and some of the patients developed complications. However the evidence indicates the Dr [L] took safety concerns into account, and there is no evidence in our view of any actions or omissions in this regard that would be considered to be serious enough to warrant action on his registration. The realistic prospect test is not satisfied"

106. Matters against Dr L and Mr Gibbs are not upheld as the GMC found that there was insufficient evidence of misconduct for a warning to be appropriate. The cases against them were closed with no further action.

107. The Claimant describes at paragraph 168 of her witness statement that four of her consultant colleagues (Dr B, Dr U, Dr G and Dr Sy) met with Dr K (the new medical director) and TP the acting CEO on the 26 June 2017. The discussion they had is documented in a letter dated 4 July 2017 at pages 604 to 605 of the bundle. The letter records:

"As you are aware, there are both clinical and manufacturer guidelines against this practice. We have had concerns about the introduction of a contraindicated practice into our Unit without a research governance structure in place, i.e.

- Due consideration of the available guidelines,
- Design of a methodical research proposal to introduce the technique,
- Ethical approval to commence this technique in patients and
- Fully informed patient consent regarding the risks, in accordance with Good Clinical Practice guidelines……

……. Since February, we have had continuing concerns about observed clinical events in this group of patients. We have not yet received a formal departmental update on these patients by the Vascular Group; to reassure us this practice is safe to continue.

Therefore, we have verbally expressed to you on Monday 26th June, our concerns about the ongoing use of this technique and queried whether consideration should be given to suspending this practice, pending the proposed external review……

…. We remain of the opinion the practice should cease, though do understand this would be unpopular with patients involved and the Vascular Group…Our primary concerns are with regard to patient safety…We respect our colleagues and do not seek to conflict with them; we would like to re-iterate that we have no concerns regarding their clinical skills. We simply feel that judgement on the practice of BH-AVG has been misguided."

Disclosure 8

108. The next alleged disclosure (alleged disclosure number 8) dated the 18 August 2017 is no longer relied upon by the Claimant.

109. There is then an external review report dated 28 July 2017 at pages 665 to 720. Within the Executive Summary of that review report (page 667) it is noted "….. The practice appears to have been initiated through a patient driven need to self-cannulate, avoid area puncture and use dull needles for ease of pain and cannulation. Patients we met expressed a strong preference for BH technique for AVG due to a number of factors including previous positive experience with BH, ease of cannulation and less pain, being able to self-cannulate and be at home and concern about inadvertent area puncture instead of rope-ladder used in difficult circumstances with its associated complications. These patients were fully aware about risks and complications of BH in AVG and had recently signed consent forms to continue with BH for AVG. All the interviewed patients expressed strong feelings in relation to how this practice had transformed their lives. They

expressed full confidence and trust in the team and their overall care. Most of these patients have had kidney failure over several years……. There has been extensive work done within the Department with available documentation on patient information, consent, BH practice protocols and Standard Operating Procedure [SOP] and guidance within the unit. An internal review of all 15 patients who had AVG cannulation using BH technique concluded that there was no additional harm to patients that was above and beyond expected in the clinical circumstances, from analysis of recorded complication rates from a button hole cannulation"

110. This external review report was then circulated to Consultants on the 26 September 2017 (this is referred to in the email at page 753).

111. There is then an email dated 3 October 2017 sent by four of the consultants (not including the Claimant) to the Medical director at the Respondent about this external report (pages 764 to 765). It notes:

"You were asking us to tell you our concerns regarding the external report on buttonholing of AV grafts. We completely agree that we need to move forward as a unit and heal. Therefore our focus is on how we do that, rather than on arguing about errors in the report. We agree that the external team did their best to provide a fair report with the information they were given, and we do not think that asking them further questions is likely to be helpful. We would like to point out the following:

> 1) The repeated statement that this was a patient led initiative and was a response to an unmet patient need is factually incorrect. It is true for the index patient who started the technique, but it is not the case for the majority of the other 15 patients. This group included patients who were not self needling and who had had no problems with their grafts being rope laddered, and patients starting out on dialysis who would not have been familiar with the concept of buttonholing.
> 2) The report states that no harm was done if robust governance and monitoring was in place. There was no governance or monitoring in place until this year, and this was only initiated in response to the patient safety concerns raised. The report indirectly acknowledges this by citing "recent consent".
> 3) The interpretation of the observed complications being no higher than expected for a similar patient cohort not buttonholing is problematic, as this comparison was never attempted in our unit, despite our insistence during the internal review subsequently that excess harm could only be established in this way……

Having highlighted these issues we are sure you will understand why we are uncomfortable from a professional point of view with accepting the entire

content of the report. However, for the purposes of moving our unit forward we agree with the clinical conclusions reached in the executive summary."

112. On the 18 October 2017 a position statement is signed as agreed by the relevant medical professionals at the Respondent in connection with BH of AVG (pages 776 to 779). This position statement confirms that BH technique "should not be actively encouraged or promoted outside of a formal clinical trial". The Claimant signs this position statement and says in her statement that she was content to sign it so that from October 2017 there was an agreement amongst all the renal consultants about the BH technique (paragraph 202).

Disclosure 9

113. The alleged disclosure 9 is a repeat of the alleged disclosure 5 in that a copy of the letter that had been sent to SH is sent to the Corporate HR Manager by email dated 3 November 2017 (page 784) as an "FYI". So, the purpose of the communication does not appear to be to disclose information about the issues the Claimant was originally concerned about (as the position statement on BH was agreed in October 2017), but to relay that she had (in her view) made disclosures. At paragraph 350 of her witness statement the Claimant states about this alleged disclosure "I sent a copy of my previous disclosure made on the 17 October 2016 to [SH]".

114. In evidence I was directed to a letter of Professor M, a Professor of Medicine and Epidemiology at the Western University, London Ontario, Associate Chair, Division of Nephrology at pages 1630 to 1630B of the bundle dated 21 February 2018. Her opinion as expressed at page 1630B notes "1. The use of BHC in AV-fistula has been proven to increase the risk of infection and provides minimal patient benefit….2. The PTFE graft is not approved for BHC. In fact the manufacturer recommends against the use of a cannulation method that does not rotate the sites…… Based on the literature review above and the manufacturers recommendations for use, any use of BHC in grafts renders significant patient risk and safety concerns. In vitro testing of the integrity and safety of the PTFE graft material with repeat cannulation should be a first step before considering its use patients. Any proposed "innovative" use of BHC of AV grafts must be approached with significant caution, with full disclosure to the patient regarding the increased risk and off label use. The reporting of outcomes of BHC in AV grafts must meet the highest level of surveillance and reporting of risk and harm. This should be a set intention at the start of use. The steps above do not appear to have been met in the renal unit in question.".

115. Although this view from Professor M is presented after the Claimant's alleged disclosures have been made, and after the internal and external reviews and the agreed position statement on practice has been put in

place, the Claimant asserts that as the view of Professor M is the same as hers it shows objectively that what she believed she disclosed to the Respondent, CQC and GMC was reasonable.

The amendment application

116. As to the amendment application as already said the Respondent has now consented to the alleged disclosure 10 being considered as an "alleged disclosure". It opposed the application for alleged disclosure 11 to be included. It was explained to me that the amendment was raised with Respondent's Counsel on the 10 January 2020 and the application was then made at the beginning of this hearing. Claimant's counsel confirmed that the reason for it being made now was because the Respondent continued to object to the Claimant's amendment to include the alleged disclosure 10. The assertion by the Respondent that the Claimant's solicitors, who made the application to amend in February 2019 to include disclosure 10, would have known about disclosure 11 at that time also, was not challenged by the Claimant. It could therefore have been included then as part of that application.

The Law

117. Under section 43A of the Employment Rights Act 1996 a protected disclosure is a qualifying disclosure (as defined by section 43B) which is made by a worker in accordance with any of sections 43C to 43H.

118. Section 43B(1) provides that a qualifying disclosure means any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show one or more of the following – (a) that a criminal offence has been committed, is being committed or is likely to be committed, (b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject, (c) that a miscarriage of justice has occurred, is occurring or is likely to occur, (d) that the health or safety of any individual has been, is being or is likely to be endangered, (e) that the environment has been, is being or is likely to be damaged, or (f) that information tending to show any matter falling within any one of the preceding paragraphs has been, or is likely to be deliberately concealed.

119. Under Section 43C(1) a qualifying disclosure becomes a protected disclosure if it is made in accordance with this section if the worker makes the disclosure – (a) to his employer, or (b) where the worker reasonably believes that the relevant failure relates solely or mainly to – (i) the conduct of a person other than his employer, or (ii) any other matter for which a person other than his employer has legal responsibility, to that other person.

120. Under Section 43F(1) of the Act a qualifying disclosure becomes a protected disclosure if it is made in accordance with this section if the worker – (a) makes the disclosure …to a person prescribed by an order made by the Secretary of State for the purposes of this section, and (b) reasonably believes – (i) that the relevant failure falls within any description of matters in respect of which that person is so prescribed, and (ii) that the information disclosed, and any allegation contained in it, are substantially true. Both the Care Quality Commission ("the CQC") and the General Medical Council (GMC) are "prescribed persons" for matters relating to the provision of health and social care.

121. I was presented with helpful skeleton arguments by both Counsel in this matter and they referred to the following case authorities within their submissions:

a. Kilraine v London Borough of Wandsworth [2018] IRLR 846
b. Cavendish Munro Professional Risks Management Ltd v Geduld
c. Simpson v Cantor Fitzgerald Europe [2019] UKEAT 0016 18 2016
d. Babula v Waltham Forest College [2007] EWCA Civ 174
e. Korashi v Abertawe Bro Morgannwg University Health Board [2012] IRLR 4
f. Darnton v University of Surrey [2002] UKEAT 882 01 1112
g. Nese v Airbus Operations Ltd [2015] UKEAT 0477 13 2701
h. Chesterton Global Ltd and Anor v Nurmohamed UKEAT/2015 (and as discussed in Parsons v Airplus International Ltd UKEAT 0111 17
i. Montgomery v Lanarkshire Health Board
j. Blackboy Ventures Ltd v Gahir [2014] IRLR 416
k. Dr Y-A-Soh v Imperial College UKEAT/0350/14/DM
l. Eiger Securities LLP -v- Korshunova [2017] IRLR 115
m. Selkent Bus Co Ltd -v- Moore [1996] ICR 836 EAT

122. Both Counsel in their submissions identified three separate elements to be considered when determining if a qualifying protected disclosure has been made:

a. Did the Claimant disclose any information?

b. If so did she reasonably believe the information tended to show at least one of the relevant failures? Plus, for the alleged disclosures 6 and 7 did she reasonably believe the information disclosed, and any allegation contained in it, are substantially true?

c. If so did she reasonably believe that the disclosure was made in the public interest?

Disclosure of Information

123. As noted by the EAT in Kilraine, tribunals should be careful when applying the EAT's ruling in Cavendish that, to be protected, a disclosure must involve information and not simply voice a concern or raise an allegation. The legislation does not distinguish between "information" and "allegations". The question is simply whether the disclosure imparts information, and the fact that it is also an allegation is irrelevant.

124. On this matter Claimant's counsel referred me to Eiger – paragraphs 32 and 35:

125. "32. Mr Cordrey, counsel for the Claimant, submitted that the decision as to whether the Claimant had disclosed information to the Respondent was a straightforward issue of fact. The ET had correctly considered Cavendish Munro and Kilraine and reached a permissible conclusion on the facts. Mr Cordrey contended that, applying Kilraine , a statement by an employee that "your treatment of me is disgusting" would not be a disclosure of information. However saying "your treatment of me in locking me out of the office is disgusting" would be a disclosure of information. In Kilraine Mr Justice Langstaff held:

> "that the words in issue in that case said nothing that was specific. They were 'there have been numerous incidents of inappropriate behaviour towards me'."

The Judge had no difficulty in concluding that the ET had not erred in holding that the Claimant had not conveyed information within the meaning of the ERA . However it was said that the Claimant's words to Mr Ashton were specific and went beyond what he already knew. She told him that clients did not like him communicating from her computer without identifying himself.

"35. The Claimant stated to Mr Ashton that it was wrong for him to trade from her personally designated computer without making it clear that she is not the person making the trade and identifying himself. If the statement had stopped there it may have been no more than an allegation of wrongdoing. However the Claimant went on to tell Mr Ashton what her clients thought of his behaviour. This was new information given to Mr Ashton. The two sentences should be read together and considered in their context. This is an example of the situation envisaged by Mr Justice Langstaff in Kilraine in which allegation and information are intertwined. Whether such words are to be regarded as "disclosure of information" within the meanings of ERA section 43B(1) depends on the context and the circumstances in which they are spoken. The decision as to whether such words which include some allegations cross the statutory threshold of disclosure of information is

essentially a question of fact for the Employment Tribunal which has heard evidence."

126. Both counsel referred to Kilraine and in particular:

"28. The EAT in Cavendish Munro correctly noted at [20] that in section 43F , set out above, the ERA recognises that there can be a distinction between "information" (the word used in section 43B(1)) and an "allegation". Both words are used in section 43F . At [24]-[26] the EAT said this:

> "24. Further, the ordinary meaning of giving "information" is conveying facts. In the course of the hearing before us, a hypothetical was advanced regarding communicating information about the state of a hospital. Communicating "information" would be "The wards have not been cleaned for the past two weeks. Yesterday, sharps were left lying around". Contrasted with that would be a statement that "you are not complying with Health and Safety requirements". In our view this would be an allegation not information.
>
> 25. In the employment context, an employee may be dissatisfied, as here, with the way he is being treated. He or his solicitor may complain to the employer that if they are not going to be treated better, they will resign and claim constructive dismissal. Assume that the employer, having received that outline of the employee's position from him or from his solicitor, then dismisses the employee. In our judgment, that dismissal does not follow from any disclosure of information. It follows a statement of the employee's position. In our judgment, that situation would not fall within the scope of the Employment Rights Act section 43 .
>
> 26. The Tribunal based its conclusion that Mr Geduld was dismissed because, through his solicitor's letter of 4 February 2008, he made a protected disclosure. In our judgment the letter sets out a statement of the position of Mr Geduld. In order to fall within the statutory definition of protected disclosure there must be disclosure of information. In our judgment, the letter of 4 February 2008 does not convey information as contemplated by the legislation let alone disclose information. It is a statement of position quite naturally and properly communicated in the course of negotiations between the parties."…..

> 31. On the other hand, although sometimes a statement which can be characterised as an allegation will also constitute "information" and amount to a qualifying disclosure within section 43B(1) , not every statement involving an allegation will do so. Whether a particular allegation amounts to a qualifying disclosure under section 43B(1) will depend on whether it falls within the language used in that provision. …….
>
> 35. The question in each case in relation to section 43B(1) (as it stood prior to amendment in 2013) is whether a particular statement or disclosure is a "disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the [matters set out in sub-paragraphs (a) to (f)]". Grammatically, the word "information" has to be read with the qualifying phrase, "which tends to show [etc]" (as, for example, in the present case, information which tends to show "that a person has failed or is likely to fail to comply with any legal obligation to which he is subject"). In order for a statement or disclosure to be a qualifying disclosure according to this language, it has to have a sufficient factual content and specificity such as is capable of tending to show one of the matters listed in subsection (1). The statements in the solicitors' letter in Cavendish Munro did not meet that standard.
>
> 36. Whether an identified statement or disclosure in any particular case does meet that standard will be a matter for evaluative judgment by a tribunal in the light of all the facts of the case. It is a question which is likely to be closely aligned with the other requirement set out in section 43B(1) , namely that the worker making the disclosure should have the reasonable belief that the information he discloses does tend to show one of the listed matters. As explained by Underhill LJ in Chesterton Global at [8], this has both a subjective and an objective element. If the worker subjectively believes that the information he discloses does tend to show one of the listed matters and the statement or disclosure he makes has a sufficient factual content and specificity such that it is capable of tending to show that listed matter, it is likely that his belief will be a reasonable belief."

127. Respondent's counsel highlighted from Simpson that disclosures which are speculative or are based on assumptions are unlikely to have the required level of specific content (paragraph 70).

Reasonable belief

128. Claimant's counsel again referred to Eiger and paragraph 46

"46. In my judgment it is not obvious that not informing a client of the identity of the person whom they are dealing if the employee is trading from another person's computer is, as in Bolton , plainly a breach of a legal obligation. That being so, in order to fall within ERA section 43 B(1)(b) , as explained in Blackbay the ET should have identified the source of the legal obligation to which the Claimant believed Mr Ashton or the Respondent were subject and how they had failed to comply with it. The identification of the obligation does not have to be detailed or precise but it must be more that a belief that certain actions are wrong. Actions may be considered to be wrong because they are immoral, undesirable or in breach of guidance without being in breach of a legal obligation. However, in my judgment the ET failed to decide whether and if so what legal obligation the Claimant believed to have been breached."

129. Respondent's counsel highlighted that reasonable belief is both objective and subjective. I must be satisfied that the Claimant subjectively believed that informed consent was required but not obtained before undertaking BH on AVGs and/or that BH endangered patient safety but also that it was reasonable for her to hold those beliefs. It is not enough for the Claimant to rely on an assertion as to her subjective belief (as per Simpson – paragraph 69).

"69. The Tribunal is thus bound to consider the content of the disclosure to see if it meets the threshold level of sufficiency in terms of factual content and specificity before it could conclude that the belief was a reasonable one. That is another way of stating that the belief must be based on reasonable grounds. As already stated above, it is not enough merely for the employee to rely upon an assertion of his subjective belief that the information tends to show a breach."

130. The reasonableness of Claimant's belief is to be judged by the information that would be available to a consultant nephrologist at the time of her disclosure and her ability (given her qualification and experience) to assess the information and reach reasoned conclusions about it (paragraph 9 of the Respondent's skeleton and also referred to at paragraph 40 of the Claimant's Skeleton). Reference is made to paragraph 62 of Korashi:

"62. This filter appears in many areas of the law. It requires consideration of the personal circumstances facing the relevant person at the time. Bringing it into our own case, it requires consideration of what a staff grade O&G doctor knows and ought to know about the circumstances of the matters disclosed. To take a simple example: a healthy young man who is taken into hospital for an orthopaedic athletic injury should not die on the operating table. A whistleblower who says that that tends to show a breach of duty is required to demonstrate that such belief is reasonable. On the other hand, a surgeon who knows the risk of such procedure and possibly

the results of meta-analysis of such procedure is in a good position to evaluate whether there has been such a breach. While it might be reasonable for our lay observer to believe that such death from a simple procedure was the product of a breach of duty, an experienced surgeon might take an entirely different view of what was reasonable given what further information he or she knows about what happened at the table. So in our judgment what is reasonable in s43B involves of course an objective standard — that is the whole point of the use of the adjective reasonable – and its application to the personal circumstances of the discloser. It works both ways. Our lay observer must expect to be tested on the reasonableness of his belief that some surgical procedure has gone wrong is a breach of duty. Our consultant surgeon is entitled to respect for his view, knowing what he does from his experience and training, but is expected to look at all the material including the records before making such a disclosure. To bring this back to our own case, many whistleblowers are insiders. That means that they are so much more informed about the goings-on of the organisation of which they make complaint than outsiders, and that that insight entitles their views to respect. Since the test is their "reasonable" belief, that belief must be subject to what a person in their position would reasonably believe to be wrong-doing."

131. Determining the factual accuracy of the information in the disclosures is an important tool for determining whether Claimant had a reasonable belief or not (Darnton paragraphs 28 and 29):

"28. In our opinion, it is essential to keep the words of the statute firmly in mind; a qualifying disclosure is defined, as we have noted on a number of occasions, as meaning any disclosure of information which in the reasonable belief of the worker making the disclosure tends to show a relevant failure. It is not helpful if these simple words become encrusted with a great deal of authority. We are unable to accept Mr Kallipetis's submission that the worker's belief in the truth of the factual allegations he makes, as opposed to what the allegations "tend to show", is always irrelevant to the issue of reasonable belief, but is only relevant as to whether the disclosure is made in good faith. We are equally unable to accept Mr Sutton's submission that the worker must believe in the accuracy of the factual basis of the disclosure on reasonable grounds. Circumstances that give rise to a worker reporting a protected disclosure will vary enormously from case to case. The circumstances will range from cases in which a worker reports matters which he claims are within his own knowledge, or have been seen or heard by him. At the other extreme will be cases where the worker passes on what has been reported to him, or what he believes has been observed by other persons."

"29. In our opinion, the determination of the factual accuracy of the disclosure by the tribunal will, in many cases, be an important tool in

determining whether the worker held the reasonable belief that the disclosure tended to show a relevant failure. Thus, if an employment tribunal find that an employee's factual allegation of something he claims to have seen himself is false, that will be highly relevant to the question of the worker's reasonable belief. It is extremely difficult to see how a worker can reasonably believe that an allegation tends to show that there has been a relevant failure if he knew or believed that the factual basis was false, unless there may somehow have been an honest mistake on his part. The relevance and extent of the employment tribunal's inquiry into the factual accuracy of the disclosure will, therefore, necessarily depend on the circumstances of each case. In many cases, it will be an important tool to decide whether the worker held the reasonable belief that is required by section 43B(1) . We cannot accept Mr Kallipetis's submission that reasonable belief applies only to the question of whether the alleged facts tend to disclose a relevant failure. We consider that as a matter of both law and common sense all circumstances must be considered together in determining whether the worker holds the reasonable belief. The circumstances will include his belief in the factual basis of the information disclosed as well as what those facts tend to show. The more the worker claims to have direct knowledge of the matters which are the subject of the disclosure, the more relevant will be his belief in the truth of what he says in determining whether he holds that reasonable belief."

132. The Respondent asserts that it would be reasonable to expect the Claimant to look at all the patient records and data pertaining to the 15 patients (as per paragraph 62 in Korashi) and also referred to the comment from paragraph 76 "…if the Claimant had not examined the patient's records, the Tribunal was entitled to form the view that the Claimant acted without objectively reasonable belief in the truth of his allegations."

133. Respondent's counsel submits that where others with equivalent or greater knowledge and expertise would not regard the information as showing that BH was unsafe, then that would be relevant in determining whether the Claimant's belief was reasonable – paragraph 55 Simpson "55. Thus, the Claimant's 'insider status' means that respect is to be afforded to his view that there is or is likely to be a breach of some regulatory obligation, but that status also means that the Claimant can be expected to apply his knowledge and expertise in properly considering all the material available to him before making the disclosure. The views of others in the organization are not irrelevant for the purposes of determining whether the Claimant's belief is reasonable. If the evidence suggests that others with equivalent or greater knowledge and expertise of the industry would not regard the information as tending to show a breach, then that would be relevant in determining whether the Claimant's belief was reasonable. Insider status does not mean that the whistle-blower's subjective view that the information tends to show a breach is sufficient; the test remains an objective one.

However, one only gets to the stage of applying the objective test if the employee establishes that the belief was genuinely held. If the employee did not actually believe that the information tends to show a breach then the claim that there was a protected disclosure will not get off the ground."

Reasonable belief in public interest

134. The "public interest test" was considered by the EAT in Chesterton. The test is not whether the disclosure per se was in the public interest, but whether the worker making the disclosure had a reasonable belief that it was. The language of "reasonable belief" pre-dated the June 2013 amendment to the statutory provisions and had remained the same since. Cases such as Babula remain relevant. The workers' belief that the disclosure was made in the public interest has to be objectively reasonable.

135. Respondent's Counsel referred me to discussion of Chesteron in Parsons – paragraph 25 as quoted below (and which also includes the references made to Chesterton by Claimant's counsel):

136. "25. More generally, in Chesterton , Underhill LJ offered the following guidance. First, as to the approach that has to be taken in general:

> "27. First, and at the risk of stating the obvious, the words added by the 2013 Act fit into the structure of s.43B as expounded in Babula (see paragraph 8 above). The tribunal thus has to ask (a) whether the worker believed, at the time that he was making it, that the disclosure was in the public interest and (b) whether, if so, that belief was reasonable.
>
> 28. Second, and hardly moving much further from the obvious, element (b) in that exercise requires the tribunal to recognise, as in the case of any other reasonableness review, that there may be more than one reasonable view as to whether a particular disclosure was in the public interest; and that is perhaps particularly so given that that question is of its nature so broad-textured. The parties in their oral submissions referred both to the 'range of reasonable responses' approach applied in considering whether a dismissal is unfair under Part X of the 1996 Act and to 'the Wednesbury approach' employed in (some) public law cases. Of course we are in essentially the same territory, but I do not believe that resort to tests formulated in different contexts is helpful. All that matters is that the tribunal should be careful not to substitute its own view of whether the disclosure was in the public interest for that of the worker. That does not mean that it is illegitimate for the tribunal to form its own view on that question, as part of its thinking - that is indeed often difficult to avoid - but only that that view is not as such determinative.

29. Third, the necessary belief is simply that the disclosure is in the public interest. The particular reasons why the worker believes that to be so are not of the essence. That means that a disclosure does not cease to qualify simply because the worker seeks, as not uncommonly happens, to justify it after the event by reference to specific matters which the tribunal finds were not in his head at the time he made it. Of course, if he cannot give credible reasons for why he thought at the time that the disclosure was in the public interest, that may cast doubt on whether he really thought so at all; but the significance is evidential not substantive. Likewise, in principle a tribunal might find that the particular reasons why the worker believed the disclosure to be in the public interest did not reasonably justify his belief, but nevertheless find it to have been reasonable for different reasons which he had not articulated to himself at the time: all that matters is that his (subjective) belief was (objectively) reasonable.

30. Fourth, while the worker must have a genuine (and reasonable) belief that the disclosure is in the public interest, that does not have to be his or her predominant motive in making it: otherwise, as pointed out at paragraph 17 above, the new ss.49(6A) and 103(6A) would have no role. I am inclined to think that the belief does not in fact have to form any part of the worker's motivation - the phrase ' in the belief' is not the same as 'motivated by the belief'; but it is hard to see that the point will arise in practice, since where a worker believes that a disclosure is in the public interest it would be odd if that did not form at least some part of their motivation in making it.""

Law concerning the amendment application

137. As confirmed in Selkent when determining whether to grant an application to amend, the Employment Tribunal must always carry out a careful balancing exercise of all the relevant factors, having regard to the interests of justice and to the relative hardship that would be caused to the parties by granting or refusing the amendment. Relevant factors include:

a. The tribunal has to decide whether the amendment sought is a minor matter or a substantial alteration pleading a new cause of action; and

b. if a new claim or cause of action is proposed to be added by way of amendment, it may be necessary for the tribunal to consider whether that claim or cause of action is out of time and, if so, whether the time limit should be extended; and

c. an application should not be refused solely because there has been a delay in making it as amendments may be made at any stage of the proceedings. Delay in making the application is, however, a discretionary factor. It is relevant to consider why the application was not made earlier and why it is now being made: for example, the discovery of new facts or new information appearing from documents disclosed on discovery.

The decision

138. Before addressing the three questions posed by respective Counsel (see paragraph 122 above) I can record that (as is accepted by the parties and apparent from the submissions they made both in writing and orally and with reference to the Appendix A document) the alleged disclosures 1 to 5, 9 and 10 were made to her employer so fall under Section 43C(1)(a). Alleged disclosures 6 and 7 were made to prescribed persons (the CQC and GMC) so fall under Section 47F and they are the correct "prescribed persons" for matters relating to the provision of health and social care, but have the additional requirement that the Claimant reasonably believes the information to be substantially true.

139. The alleged disclosure 11 (which is subject to the Claimant's amendment application) was a letter to the Respondent's solicitors and is addressed further in my decision on the Claimant's amendment application below.

140. It is accepted by the Claimant that disclosure 8 is no longer relied upon so I will not address that one further.

141. So, reminding myself of the relevant wording of Section 43B relevant to this claim "a "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show one or more of the following –

… ***(b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject….***

(d) that the health or safety of any individual has been, is being or is likely to be endangered….".

142. **Information -** The Claimant says that all her alleged disclosures tend to show:

a. Breach of a legal obligation:

i. (Paragraph 338.1) an "obligation to obtain a patient's informed consent". Then further the Claimant explains in her witness statement (at paragraph 30) "… As a doctor, it is my responsibility to ensure that a patient has consented to his or her treatment. I've always understood this to be a legal obligation imposed on doctors. The General Medical Council provides guidelines in connection with consent and an extract from the guidelines are a page 222A [of the bundle]. As the guidelines say, before accepting the patient's consent, a doctor must consider whether the patient has been given the information they want or need or how well they understand the details and implication of what is proposed. In cases involving high risk (which is the case with the Buttonholing Technique), it is important that the doctor gets the patient's written consent, so that everyone involved, especially the patient, properly understands what was explained and what was agreed."; and

ii. (Paragraph 338.1) The Health and Social Care (Safety and Quality) Act 2015…" which then refers to paragraph 31 of her statement which reads in respect of that Act "…..The Health and Social Care (Safety and Quality) Act 2015 Section 1(2) provides that "The Secretary of State must by regulations impose requirements that the Secretary of State considers necessary to secure that services provided in the carrying on of regulated activities **cause no avoidable harm to the persons for whom the services are provided**" [Claimant's emphasis added];

b. Health and Safety (at paragraph 338.2) "Danger to the health and safety of any individual. In this regard I believe that the Buttonholing Technique was a serious danger to the health and safety of the Respondent's patients who were undergoing the Buttonholing Technique or who might have undergone the Buttonholing Technique had I not raised my concerns…."

143. So, did the Claimant disclose information that tended to show the above?

144. As noted in Eigar (paragraph 35) I can consider the context and the circumstances in which the words are conveyed and the "decision as to whether such words which include some allegations cross the statutory threshold of disclosure of information is essentially a question of fact for the Employment Tribunal which has heard evidence."

145. As noted in Kilraine - “28. The EAT in Cavendish Munro correctly noted at [20] that in section 43F, set out above, the ERA recognises that there can be a distinction between "information" (the word used in section 43B(1)) and an "allegation". Both words are used in section 43F”.

146. However, the question to consider is simply whether the disclosure imparts information, and the fact that it is also an allegation is irrelevant.

147. Paragraph 35 of Kilraine - “35. …. In order for a statement or disclosure to be a qualifying disclosure according to this language, it has to have a sufficient factual content and specificity such as is capable of tending to show one of the matters listed in subsection (1). ….”

148. The Respondent asserts that disclosures 1, 2 and 3 are allegations without substance and so do not disclose information that has sufficient factual content and specificity such as is capable of tending to show that:

a. a person has failed to comply with any legal obligation to which he is subject - where one of the legal obligations is to get informed consent and the other is to not undertake activities that cause avoidable harm;

b. that the health or safety of any individual (in this case the patients) has been, is being or is likely to be endangered.

149. Alleged disclosure 1 does in my view appear to be more than just an allegation. It does link back to what was discussed at the meeting on the 7 September 2016 to put what is said in context and states “If we objectively analyse the situation we have here an uncontrolled experiment, done without prior knowledge or agreement of the consultant team and without informed consent of the patients, with practice that is not in keeping with the current national and international guidelines or recommendations from the manufacturer….”.

150. It is in the context of the “uncontrolled experiment”, that is the BH of AVG grafts, that the Claimant says there has not been the informed consent of the patients, so in my view this is information tending to show that a legal obligation has failed to be complied with (i.e. the need to obtain informed consent from patients). It is also said to be counter to national and international guidelines and the recommendations from the manufacturer which in my view would be information tending to show the health or safety of the patients has been, is being or is likely to be endangered.

151. This is clearly more than the Claimant just saying, for example, you are not complying with Health and Safety requirements. It is also of note that a lack of information is not something that is raised by Dr L in his

response to the Claimant's first alleged disclosure and that actions have been taken about the matters, as confirmed in his response to what the Claimant says. To say actions have been taken in response to what the Claimant says would require an understanding of what the Claimant was informing the Respondent about.

152. Alleged disclosure 2 does also in my view appear to be more than just an allegation. It says "National guidelines and all international guidelines indicate that the technique is only appropriate to use in native fistulas due to risk of infection, pseudo-aneurysm formation and risk of exsanguination …. Manufacturers do not recommend its use …. Patients have not been given any information regarding the experimental nature of this practice, including quite substantial risks.". The Claimant then goes on to describe what she says she understands has happened to the 14 patients.

153. Alleged disclosure 3 does also in my view appear to be more than just an allegation. "…. all guidelines state that this technique is completely and totally inappropriate. JM expressed this view and detailed the risks it presented (risk of infection, pseudo-aneurysm formation and exsanguination). JM explained that when she raised this issue at a consultant meeting, it appeared no one was aware of this practice. Patients were also unaware meaning they had not given informed consent. This practice is so inappropriate that there is not a single publication in the worldwide literature supporting its use…... no informed consent of the patients that this is an experimental practice, no assessment of risk……."

154. The Respondent accepts that alleged disclosure 4 is a disclosure of information.

155. As to alleged disclosures 5, 6, 7 and 9 they clearly contain more information than 1, 2, and 3 and are at a level of content like, or greater than, that in alleged disclosure 4 about informed consent and the health and safety of patients when considered against various guidelines. Further, the Respondent does not appear to assert in Appendix A that those alleged disclosures do not disclose any information. It is my view that those disclosures do have sufficient factual content and specificity such as is capable of being information tending to show the matters the Claimant relies upon from subsection 1 of section 43B, that is the legal obligation to obtain informed consent and health and safety endangerment.

156. The alleged disclosure 10 contains similar information to alleged disclosures 1, 2 and 3 plus in addition also confirms that there has been a continuation of BH AVGs. With that additional information it is in my view also of sufficient factual content and specificity to be information tending to

show the health or safety of the patients has been, is being or is likely to be endangered.

157. As to the other legal obligation referred to by the Claimant in her witness statement (as to avoidable harm as detailed in paragraph 31 of her statement) information about that is not apparent from the words the Claimant has used in the information she discloses, which does seem to focus on the legal obligation to obtain informed consent and the health and safety concerns about the patients. Therefore, the disclosures do not appear to disclose information tending to show that the Respondent is in breach of the Health and Social Care (Safety and Quality) Act 2015 causing avoidable harm in breach of regulations as the Claimant has referred to in paragraph 31 of her statement. I have also noted that this legal obligation is not expressly referred to in the issues presented to me at the start of this hearing, or the Claimant's oral evidence at this hearing. Further, her statement at paragraph 363 confirms her subjective position as being concerned about the health and safety of patients and the need for informed consent.

158. **Reasonable belief** - Did the Claimant reasonably believe that the disclosures tended to show one or more of the categories listed in section 43B(1) of the Employment Rights Act 1996? Again, in reminding myself on what the Claimant says the information she disclosed tends to show, that the:

a. Respondent had failed to comply with a legal obligation in relation to the obtaining of informed consent in relation to the use of Buttonholing technique on patients;

b. health or safety of patients had been, was being, or was likely to be endangered by the Buttonholing technique.

159. I must be satisfied that the Claimant subjectively believed that informed consent was required but not obtained before undertaking BH on AVGs and/or that BH AVGs endangered patient safety but also that it was reasonable for her to hold those beliefs. It is not enough for the Claimant to rely on an assertion as to her subjective belief (as per Simpson – paragraph 69).

160. Then considering Korashi – "Since the test is their "reasonable" belief, that belief must be subject to what a person in their position would reasonably believe to be wrong-doing." The Claimant's belief is therefore to be judged by looking at her as a consultant nephrologist.

161. Then considering Darnton - did the Claimant know or believe that the factual basis was false?

162. The Claimant accepts that she had not looked at all the patient records, but what she did do before her first alleged disclosure was see one of her patients and speak to another on the phone. She also spoke to colleagues after the meeting on the 7 September 2016. I have not been presented with any witness evidence from the patients or their medical records that record they gave informed consent before they started to BH with AVGs.

163. Dr L does not challenge the Claimant's statement that she makes about informed consent in his reply to her alleged first disclosure. Dr L says in his reply "Thank you for voicing your concerns which I believe have brought important rigour to this subject.". It is also of note that the minutes recording the issue on the 7 September 2016 do not go on to note that the Claimant's assertion as to informed consent must be unfounded because there is evidence of such informed consent. The Claimant's position is also consistent with what she says to the sister nurse at Totton in her email dated 8 September 2016, that the patient needs to be aware of the risks.

164. Considering what the Claimant has said under oath and the Respondent not disproving this, as stated in my findings of fact, I accept what she says about her belief about the lack of informed consent and as a consequence of my factual findings conclude that this belief is reasonable both subjectively and objectively.

165. As to her concerns as to patient health and safety this appears to have been informed before her first alleged disclosure by her research of the guidelines. The Claimant by email dated 8 September 2016 (page 292) directs Mr Gibbs to "just Google it. RA guideline 6.1; EBPG 4.4; NKF/KDOQI available on website kidney.org.uk.". In her statement the Claimant says (at paragraph 33) that guideline 6.1 says "we recommend that the rope-ladder and buttonhole techniques should be used for cannulation of AVF and rope-ladder for AVG". The Claimant says, "in other words the Buttonholing Technique is not recommended for use with AV Grafts.". The Claimant also referred to the EBPG (European Best Practice Guideline 4.4) together with the resource on the website Kidney.org.uk. which states: "The Buttonhole technique can only be used by patients with an AV fistula, and cannot be used by those with an AV Graft".

166. It is after her first alleged disclosure that the Claimant sends an email to Dr F an expert involved in the guidelines on 10 September 2016 (page 295) about BH AVGs. His reply on 10 September 2016 (page 295) says "I would have to go back and check but we would never advise BH for grafts – only for AVF. The latest guideline is here [LINK] They tightened up the words from the 2011 guidance which was edited down – the text in 2011 said 'It is therefore recommended that the buttonhole technique is the

preferred method for fistula cannulation'….. So, no please don't use BH for AVG.".

167. Mr Gibbs' view in respect of these guidelines is that because the national guidelines do not prohibit the use of the buttonholing method, it can be used. As noted within my findings of fact the International society of Haemodialysis guidelines state that "The BH technique is not recommended for all patients and is contraindicated in patients with arteriovenous grafts (AVGs)." Mr Gibbs did accept during cross-examination that these guidelines do state BH is contraindicated in patients with AVGs. In my view having national guidelines that are silent on BH AVGs (so they have not expressly stated it can be used) and with other guidelines expressly confirming it is contraindicated, the belief of the Claimant that using BH in AVGs is counter to guidelines is reasonable both subjectively and objectively.

168. In relation to the guidance from the Manufacturer. There is an email from the manufacturer of the grafts dated 6 January 2017 (so after disclosures 1 to 5) (at page 371) "…. The Buttonhole technique can only be used by patients with an AV fistula, and cannot be used by those with an AV Graft. Damage to the graft would be the result of attempting to buttonhole it. Infections and aneurysms are listed as a possible adverse reaction in our instructions for use, but I do not have data that shows the number of patients that developed infections or aneurysms.". Although this email post-dates the Claimant's first disclosure it does support her position.

169. Mr Gibbs' view about the manufactures position is that it would not approve its device for use outside of its licence and that it is common for the medical profession to use medical devices beyond that recommended by a manufacturer. He refers to the use of the Gore Viabahn Endoprothesis as an example, in that it "is a stent graft licensed for use in AVFs and AVGs to treat complex and persistent stenoses, but on its product website there is no information on its use to treat ruptured AVFs or AVGs, or its use to treat false aneurysms in the AV access circuit. However, this is the go to stent graft in many high volume access centres in the UK, including our own and beyond. A recognised off licence use. In summary, the Tribunal should not place too much significance on the fact that the manufacturer does not recommend buttonholing AV grafts as it will not have tested this technique on its grafts and will not have a suitable licence for that purpose". In my view I do not think the manufacturers email can be dismissed in this way as it specifically states that the buttonholing technique would damage the graft. This is not being silent on the matter as is the case with the uses of the Gore Viabahn Endoprothesis.

170. As to the belief of the Claimant in this information tending to show that patients had been, were being, or were likely to be endangered by the

Buttonholing technique, this the Respondent says could not be objectively held because of the findings of the CQC in January 2017, which said that no safety concerns arise with the use of buttonholing, and based on the findings of the internal review on the 1 February 2017 and of the external review on the 28 July 2017.

171. When considering the Claimant's belief it can be seen from when the second alleged disclosure is read in the context of what was being communicated at the time (particularly the response from Dr L dated 9 September 2016 in response to the Claimant's alleged first disclosure) that the Claimant does not accept the reassurances given by Dr L, maintaining that she is still concerned that patients are not adequately informed and BH AVG poses a risk to patient health and is contrary to guidelines. This is made clear by the way she opens her second alleged disclosure addressed to Dr L. So, do the findings of the CQC in January 2017, the internal review on the 1 February 2017 and the external review on the 28 July 2017 mean that the Claimant's continued asserted beliefs are objectively unreasonable?

172. As to the CQC review on the 16 January 2017 Dr L shares an extract of the outcome of the CQC final report with the consultants by email (page 375) which acknowledges that the CQC findings (that no safety concerns arise with the use of buttonholing) is based on the information the Respondent provided to the CQC. The Claimant by email in reply requests a copy of the Respondent's "rebuttal letter" (page 375). This is refused by Dr L (email at page 374 dated 16 January 2017). The Claimant's request for the "rebuttal letter" is based on her not accepting the basis of the CQC's conclusion. As Dr L did not provide her with the "rebuttal letter" the Claimant has no evidential basis to suggest she cannot continue to reasonably believe her position.

173. The conclusions of the Governance Review on the 1 Feb 2017 do not rule out the Claimant's position and therefore suggest it is unreasonable. It reads "Conclusions … a. The investigation revealed no compelling evidence that BH is associated with additional harm (***although, because of small sample and short duration of BH, neither did it rule this out as a possibility***) [emphasis added].

174. The external review process concludes on the 28 July 2017, after all the alleged disclosures have been made, save for disclosure number 9. The findings of that review are not universally accepted as can be seen by the email dated 3 October 2017 sent by four of the consultants (not including the Claimant) to the Medical director at the Respondent (pages 764 to 765). It notes having highlighted a number of issues with certain findings of the external review that "….Having highlighted these issues we are sure you

will understand why we are uncomfortable from a professional point of view with accepting the entire content of the report.".

175. Despite the apparent difficult working relationship between the Claimant and Mr Gibbs it is not suggested when the Claimant's alleged disclosures are responded to at the time they are made, that she is only saying what she is saying because of her dislike for Mr Gibbs.

176. Dr L acknowledges the Claimant's first alleged disclosure by saying "Thank you for voicing your concerns which I believe have brought important rigour to this subject. You have now discharged your professional duty and I hope my response reassures you (as it has our other consultant colleagues with the sole exception of MDU) that sufficient action has been taken to minimise the risk to patients and the renal unit whilst not stifling innovation".

177. As already referred to in relation to the findings on informed consent the Respondent does not challenge the Claimant's statement about informed consent at the time by recording it is unfounded, either in the responses of Dr L to her disclosures, or in the minutes recording the issue on the 7 September 2016. The consistency in what the Claimant says about BH AVGs and the reasons for that do appear to transcend what she may personally feel about Mr Gibbs as she confirmed in her responses to cross-examination about this matter.

178. Considering paragraph 55 of Simpson – "The views of others in the organization are not irrelevant for the purposes of determining whether the Claimant's belief is reasonable. If the evidence suggests that others with equivalent or greater knowledge and expertise of the industry would not regard the information as tending to show a breach, then that would be relevant in determining whether the Claimant's belief was reasonable."

179. Clearly the position of the Claimant and Mr Gibbs as to the risks of using BH in AVGs, is different. But, there is not a unanimous view one way or the other within the Respondent and it certainly cannot be said that the other consultants are unanimously behind Mr Gibbs.

180. As found as fact the Claimant's views are consistent with a number of her consultant colleagues (please see paragraphs 78 (about the internal review), 107 (generally), and 111 (about the external review) above). The position is also not definitively agreed within the Respondent until the position statement is signed on 18 October 2017.

181. The Claimant has highlighted that not all of her consultant colleagues felt the governance meeting on the 1 February 2017 was a fair review process of BH AVGs, as she says at paragraph 84 of her statement one

colleague described the governance meeting as a "whitewash" and this can be seen at page 1327 as comments made by Dr G and another that the results were watered down and this is noted as comments by Dr U at page 1299.

182. Mr Gibbs himself acknowledges in his email dated 11 February 2017 (at page 435) where he responds to Dr U on the two issues he raised about the internal review:

183. "Having met up with a clinical trials expert on Tue, as promised from the Sept meeting, we are unable to draw any conclusions from the existing data as it is too "messy" ….."

184. "With regard to point 3…. I am obviously going to disagree on this point. I believe that we have stopped recruiting because of safety concerns not safety grounds - a subtle but important difference in my opinion) that are as yet unproven, and likely to remain that way for some time, if ever resolved to everyone's satisfaction… "

185. It recognises that his own data is "messy" and that patient "safety" is at the heart of why the BH of AVGs has been stopped, which does objectively justify the Claimant's position.

186. There is then a further consultants meeting on 22 March 2017 (page 476 to 477) and it is noted from that (page 477) "…. A further discussion relating to buttonholing PTFE graft, seeking assurance that all patients that continue to BH must told it's against guidelines and holds safety concerns. [the Claimant] stated the patient should be told it is contraindicated and that we have observed 3/15 pseudo-aneurysms, 2/15 grafts removed and 15 times increased rate of infection, [the Claimant] feels that all complications that have arisen since September could have been prevented if her patient safety concerns had been addressed. [The Claimant] felt our results were insulting to both professional competence and practice. It was brought up that all cases were individually reviewed, that the CQC had been satisfied, NHS England were now involved. All remaining patients will receive a letter from [Mr Gibbs] and all have and will continue to be spoken to by their nephrologist. ***No definitive resolution beyond this was reached***." [emphasis added].

187. If the Claimant's beliefs were unreasonable and therefore her position on this matter unreasonable then it would be logical to think that a definitive resolution would have been reached in favour of BH AVGs at this consultants' meeting.

188. There are also external colleagues and bodies that agree with the Claimant, such as:

a. An expert involved in the guidelines (as per paragraph 57 above);

b. A Renal Vascular Access Nurse at Royal Berkshire NHS Foundation Trust (as per paragraph 59 above);

c. An associate Professor at the Department of Microbiology and Immunology in Belgium (as per paragraph 86 above);

d. A specialist nephrologist from Saint-Luc UCL in Brussels (as per paragraph 87 above);

e. A doctor at the UCL Centre for Nephrology at the Royal Free Hospital (as per paragraph 90 above).

189. There is also Professor M's email, albeit after all the alleged disclosures had been made, but she also agrees with the Claimant's position.

190. Of significance are the findings of the GMC about the Claimant's alleged disclosures. Both GMC outcome reports make the same comments about the Claimant (see pages 1569 and 1594):

191. "We are of course mindful of the findings of the independent whistleblowers review the GMC commissioned from Sir Anthony Hooper. Having considered the correspondence disclosed to the GMC by the trust: and by Dr Macanovic, it appears Dr Macanovic first raised her concerns locally and that it was only after she concluded, in her view, that her concerns were not being adequately addressed locally that she made her complaint to the GMC. In doing so Dr Macanovic was no doubt aware, amongst other things, of the guidance at paragraph 25 of the good medical practice that doctors 'must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised'.

192. In the event Dr Macanovic generally considered there was a risk to patient safety, ***and it appears to us that she did consider such a risk existed***, but she had not raised her concerns through whatever mechanism was available to her locally and/or if she deemed it necessary to GMC, she would in our view have been rightly criticised by the public and by the GMC for failing to do so.".[Emphasis added]

193. The GMC outcome also notes (at page 1571) "… it appears in light of these results that the contention that there have been 'no infections is no longer sustainable. ***There have now been several infections, one of which was unequivocally identified as having been a buttonhole infection***…." [Emphasis added]

194. The GMC outcome further notes (at page 1574) "…. ***The buttonholing technique was not consistent with professional guidelines and some of the patients developed complications***. However the evidence indicates the Dr [L] took safety concerns into account, and there is no evidence in our view of any actions or omissions in this regard that would be considered to be serious enough to warrant action on his registration. The realistic prospect test is not satisfied." [Emphasis added]

195. This all supports the position that both subjectively and objectively the belief of the Claimant that she had disclosed information in alleged disclosures 1 to 5 and 10 that was tending to show the Respondent had failed to comply with a legal obligation in relation to the obtaining of informed consent in relation to the use of Buttonholing technique on patients and the health or safety of patients had been, was being, or was likely to be endangered by the Buttonholing technique was reasonable.

196. Further, it also shows that what she informs the GMC and CQC (in alleged disclosures 6 and 7) about, she reasonably believed the information to be substantially true. The GMC in its investigation into the matter notes it appeared to them that the Claimant did consider there to be a risk to patient safety and she would have been criticised for not raising it. This does not support the Respondent's position that the Claimant could not reasonably believe matters.

197. The ninth alleged disclosure is after the Respondent's position statement had been agreed and signed by the consultants (including the Claimant) on the 18 October 2017. Objectively therefore the Respondent's practice regarding BH AVGs moving forward had been settled. This alleged disclosure is a repeat of the alleged disclosure 5 in that a copy of the letter that had been sent to SH is sent to the Corporate HR Manager by email dated 3 November 2017 (page 784) as an "FYI". It does appear that the purpose of the communication is not to disclose information about the issues the Claimant was originally concerned about (as the position statement on BH AVGs was agreed in October 2017), but to relay that she had (in her view) made disclosures. At paragraph 350 of her witness statement the Claimant states about this alleged disclosure "I sent a copy of my previous disclosure made on the 17 October 2016 to [SH]". The Claimant does not herself refer to it as a protected disclosure at that point, so does not appear to hold a reasonable belief that this is a disclosure tending to show one of the matters listed in subsection (1) of 43B.

198. **Reasonable belief in public interest** - Did the Claimant reasonably believe that the disclosure was in the public interest?

199. Chesterton – "The tribunal thus has to ask (a) whether the worker believed, at the time that he was making it, that the disclosure was in the public interest and (b) whether, if so, that belief was reasonable."

200. The Claimant's subjective belief as to why she says it was in the public interest is articulated in paragraph 364 of her statement "……I was not acting on my own motives, I was acting in the interests of patients at the Respondent who I felt were being subjected to an extremely risky technique without giving their informed consent (as I have described above). I always felt and still feel, that it was in the public interest to be aware of the fact that the Respondent was acting in a way that it was. The Buttonholing Technique affected existing patients at the Respondent (at the time) and any person in the region who might come under the care of the Department in the future.".

201. The findings as to why the Claimant could maintain her belief in the disclosures as detailed above are also relevant here, but of significance as to whether that belief was in the public interest was reasonable is that it was not until the 18 October 2017 that a position statement was agreed about BH AVGs at the Respondent, this was after all the disclosures the Claimant alleges, save for disclosure 9. Until that position statement is in place it does seem reasonable for the Claimant to hold her belief that it is in the public interest for patients to be aware of the risks the Claimant believed BH AVGs posed and that the process needed informed consent. Further, there is nothing to suggest in the findings of the GMC that it would not be in the public interest as noted in its report if "…. she had not raised her concerns through whatever mechanism was available to her locally and/or if she deemed it necessary to GMC, she would in our view have been ***rightly criticised by the public*** and by the GMC for failing to do so" [emphasis added].

202. Therefore, her subjective belief it was in the public interest does appear to be objectively reasonable.

203. For these reasons I find that disclosures 1 to 5 and 10 are protected disclosures that qualify for protection pursuant to sections 43B and 43C and that disclosures 6 and 7 are protected disclosures that qualify for protection pursuant to sections 43B and 43F. I do not find that disclosure 9 is a protected disclosure.

204. **The amendment application** - Dealing then with the amendment application. It was agreed by the Respondent during this hearing that disclosure 10 could be included as an alleged disclosure. The Respondent maintained its objection to the amendment to include disclosure 11 saying that it was more prejudicial to it to allow it in, as the application was late and the basis of asserting the alleged disclosure was a qualifying protected

disclosure was unclear, so it could not properly challenge the position as to its status at this hearing and was therefore prejudiced.

205. It is unclear on what basis disclosure 11 is asserted by the Claimant to be a qualifying protected disclosure. It is a letter to the Respondent's solicitors from the Claimant's then solicitors and is not evidentially described as a protected disclosure by the Claimant. The amendment does not appear to be introducing a new head of claim. The amended grounds of claim that were presented to me at this hearing record the amendment as being to refer to disclosures 10 and 11 as qualifying protected disclosures. On this basis the amendment sought would not appear to raise a time limit issue.

206. However, as part of balancing exercise of all the relevant factors, having regard to the interests of justice and to the relative hardship that would be caused to the parties by granting or refusing the amendment, I need to consider why the application was not made earlier and why it is now being made. The reason for this, as presented by the Claimant, is that as the Respondent had continued to object to the amendment to include disclosure 10 before this hearing, it was decided to argue that disclosure 11 should be included by amendment. It is clear that alleged disclosure 11 would have been known of when the application to include disclosure 10 was made (so in February 2019). So, now making a late application without clarity as to why evidentially it is asserted as being a qualifying protected disclosure does in my view cause more hardship for the Respondent at this hearing than it does to the Claimant by not allowing it, and therefore it is not in the interest of justice to allow the amendment.

207. For the purposes of Rule 62(5) of the Employment Tribunals Rules of Procedure 2013, the issues which the tribunal determined are at paragraphs 1 and 3; the findings of fact made in relation to those issues are at paragraphs 9 to 116; a concise identification of the relevant law is at paragraphs 117 to 137; how that law has been applied to those findings in order to decide the issues is at paragraphs 138 to 206.

_____
Employment Judge Gray
Dated 5 February 2020