EMPLOYMENT TRIBUNALS

Heard at:	Southampton (by video)
On:	15 to 17 November & 29 November to 3 December 2021
Claimant:	Dr Jasna Macanovic
Respondent:	Portsmouth NHS Hospitals Trust
Before:	Employment Judge Fowell
	Ms S Maidment
	Mr P Bompas
Representation:	
Claimant:	Mr Julian Allsop, instructed by Paris Smith Solicitors
Respondent:	Mr Richard Hignett, instructed by Mills & Reeve Solicitors

RESERVED JUDGMENT

ON LIABILITY

The unanimous decision of the Tribunal is as follows:

1. The claimant was unfairly dismissed for making a protected disclosure.

2. The claimant was subject to detriments for making a protected disclosure.

3. Arrangements for a remedy hearing shall be notified to the parties shortly.

REASONS

Introduction

1. Dr Macanovic worked for the Trust as a consultant nephrologist, or kidney specialist. In September 2016 a dispute arose over the use of a new technique known as buttonholing. It divided opinion among the consultants at the Wessex Kidney Centre. She was strongly opposed, and made a series of complaints about it. When that failed, she reported it to the CQC, but they were happy for it continue. The Trust also commissioned its own review, to the same effect. So, in May 2017 she reported her colleagues to the GMC.

2. Meanwhile, the Trust began its own investigation into her behaviour. They felt that she had become unmanageable. Whether as a result of her complaints (as Dr Macanovic contends) or the way in which they were fought out (as the Trust contends) relations at work were poisoned. Some of her colleagues said they could not work with her any more. A disciplinary investigation began, which led to a hearing on 28 February 2018, and her dismissal a few days later.

3. The complaints presented are therefore:

    a. unfair dismissal under section 98 Employment Rights Act 1996, alternatively under section 103A Employment Rights Act 1996 for making protected disclosures; and

    b. detriments at work, under section 47B Employment Rights Act, for making protected disclosures.

4. She first made her claim to this tribunal on 16 January 2018, while she was still employed. Later it was amended to include her dismissal. A preliminary hearing took place on 13 to 15 January 2020 when Employment Judge Gray held, with the exception of one complaint which was duplicated, that nine separate protected disclosures had been made. Hence, we are no longer concerned with whether the complaints were made, or whether Dr Macanovic reasonably believed that they placed the health and safety of patients at risk, or whether the disclosures were in the public interest. Those points have been decided in her favour. The focus of this hearing is on why Dr Macanovic was dismissed and why earlier measures were taken against her, such as excluding her from consultants meetings.

5. In this judgment we will refer to the various disclosures and detriments as we relate the events in question. Some of the alleged detriments have been withdrawn. A full list of disclosures and alleged detriments is set out in the Agreed Revised List of Issues, at page 115M-3 to 115M-7 of the bundle and there is now a separate table of detriments. In most cases the Trust accepts that the event in question occurred and that it amounted to a detriment but we will address the disputed ones as they arise. The judgment of Employment Judge Gray also details each of them.

6. The buttonholing technique itself was also explained by Employment Judge Gray as follows:

> 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.

7. It is agreed that buttonholing is a valid technique for patients with an AV Fistula, where the connection between vein and artery is constructed of tissue and can heal. The dispute is over those with an AV Graft, since the PTFE material can tear or degrade. That can cause leaks and an increased risk of infection. Patients need to be made aware of these risks to give informed consent. The probuttonholing school of thought is that using one blunt needle is better than repeated sharp needle entries, since over time these can damage the tissue and make it more difficult to find an entry site. Also, some patients prefer it to having a fresh jab each time.

8. It is not our task to decide on the merits of this dispute. The approach ultimately taken, and recorded in an agreed statement by all the consultants (p.776), was that it should not be actively encouraged and that safeguards would be applied for those patients who insisted on continuing with it.

Procedure and evidence

9. The hearing was originally listed for 12 days, but was compressed to eight days due to lack of a tribunal for the full period. Deliberations were therefore adjourned

and occupied three further days. We were provided with a bundle of 2,172 pages and heard evidence from Dr Macanovic and ten witnesses on behalf of the Trust:

a. Mr Mark Cubbon, former Chief Executive Officer;

b. Professor Theresa Murphy, former Chief Nurse, who heard the disciplinary hearing;

c. Dr John Knighton, Medical Director, who oversaw the disciplinary process;

d. Dr Matthew Wood, a Consultant Anaesthetist, who carried out the disciplinary investigation;

e. Dr Robert Lewis, head of the Renal Unit;

f. Mr Paul Gibbs, Consultant Renal Transplant Surgeon;

g. Dr Nicholas Sangala, Consultant Nephrologist

h. Dr Jacqueline Nevols, Consultant Nephrologist;

i. Mr Keith Graetz, Consultant Renal Transplant Surgeon; and

j. Ms Susie Lowe, Corporate HR Manager.

Overview

10. The reasons given by the Trust for dismissing Dr Macanovic were set out in their letter of 5 March 2018 (p.1814). One of them was, expressly, that she had reported colleagues to the GMC. That is the main protected disclosure. The other behaviours are all linked to the buttonholing dispute. In those circumstances, the plain and obvious conclusion seems to us that she was indeed dismissed for making these disclosures.

11. One of the themes of this case is the extreme anxiety and emotion caused by any referral to the GMC. When the unit head, Dr Robert Lewis, told the other consultants that he would have to attend a Fitness to Practice hearing, one of them emailed to say:

> I am completely shocked, enraged and deeply saddened to read this email. I cannot believe that one of our colleagues would sink so low but it only goes to prove what a dysfunctional and destructive individual [Dr Macanovic] is with no thought whatsoever to the impact that her actions are having, not only on individuals but also on the whole department. …
>
> I am sure the GMC will see this for what it is - a vindictive and purposeful attack on an individual colleague for no reason other than her own self satisfaction."

12. Dr Lewis himself, in his evidence to us, described her referral as frankly defamatory. Several witnesses were in tears describing these events, years later. A day-long mediation failed to resolve things, with (we find) great pressure applied to Dr Macanovic to withdraw this GMC referral. The Medical Director was summoned urgently to attend the meeting as it drew to a close. He told us that it was a scene

of total disarray. He had never seen a group of professionals so distressed. All, as far as he could see, were in tears or had been, including the external mediator. The whole process was unique in his experience.

13. But the fact that strong feelings were aroused, as they undoubtedly were, only strengthens the connection between the disclosure and the dismissal. People are less likely to be dismissed for pointing out a trifling problem, or when they cause no inconvenience to others.

14. The main plank of the respondent's case is that Dr Macanovic was not dismissed for making these disclosures but for the manner in which she did so. But that distinction was not apparent in the dismissal letter, nor to any great extent during the disciplinary proceedings, and does not seem to us to be justified in hindsight. The plain fact is that after over twenty years of excellent service in the NHS, Dr Macanovic was dismissed from her post shortly after raising a series of protected disclosures about this one issue. It is no answer to a claim of whistleblowing to say that feelings ran so high that working relationships broke down completely, and so the whistleblower had to be dismissed. The position is sufficient clear that we thought it best, unusually, to set out these views in summary form at the outset. Our detailed findings of fact and conclusions are set out below. As ever, not all points raised in evidence are dealt with, only those necessary for our conclusions.

Findings of Fact

Background

15. Dr Macanovic joined the Trust in 2001 and was made consultant in 2005. Originally from the former Yugoslavia, English is her third language. Even those she fell out with, and there were a number, agree that she is extremely gifted. In Dr Lewis's witness statement he mentions that they had a disagreement shortly after she was made consultant and she barely spoke to him for several years. Equally however, until the buttonholing controversy arose, no formal concern was raised about her conduct or about her interactions with colleagues. As with all consultants, she had to have regular 360° appraisals and these were all positive, with a good deal of praise. The view we formed was of a highly principled, dedicated, extremely forthright individual, an acknowledged expert even among her fellow consultants, proud of her standing and reputation, often impatient with or dismissive of other points of view, and not given to compromise.

16. Dr Lewis, as head of the renal unit – the Chief of Service – was her line manager. This was a role he held from 2001 to 2008, then again from 2016 when the unit was going through a difficult period. He took up the reins again to try to restore

the reputation of the Wessex Kidney Centre and rebuild some harmony among the consultants. The unit had grown in recent years from six consultants to about 20. As well as nephrologists like Dr Macanovic, it included consultant surgeons who were involved in installing the grafts and fistulae – vascular access procedures - as

well as carrying out transplants. Consultants meetings were held every week or two. Mr Lewis had responsibility for the whole unit, not just the consultants; they were led by a Clinical Director, and for most of the period in question this was Mr Paul Gibbs.

Complaint against Nursing Sister

17. In 2015 Dr Macanovic made a complaint against a nursing sister. She accused the sister of bullying and making untrue statements. This led to an investigation by the previous Clinical Director (not Mr Gibbs). Performance management steps were then put in place for the sister, an outcome which Dr Macanovic thought entirely inadequate. In fact, she felt that the Clinical Director had protected the sister and raised a further complaint about his behaviour. In the course of that grievance she questioned his probity and described his behaviour as "entirely dishonest, deliberate and unprofessional" (p.277). All that sounds very contentious, but in fact she seems to have enjoyed the support of Dr Lewis on this issue. His views appear in a conciliatory email (p.276) sent on 4 July 2016, in which he said that the sister had lost the trust of the entire consultant body. As to the Clinical Director, who had by then agreed to stand down, Dr Lewis felt that for the greater good of the unit he should not be punished any further.

18. The episode is relied on by the Trust as an example of the sort of difficult behaviour for which Dr Macanovic was dismissed, although in fact her concerns appear to have been valid, or at least to have had some real foundation. It also shows that she was no respecter of authority. She attached a high priority to honesty and integrity and where she felt this was lacking she was unafraid to say so, if necessarily loudly and publicly. Nor was she prepared to be fobbed off. Mr Lewis, on the other hand, while no less honest, was principally concerned with the reputation of the renal unit, and harmonious relations among the staff. He explained to us that the unit had gone through a difficult period and he "did not want it to spill out into the outside world." So, while Dr Macanovic was perfectly prepared to rock the boat, Dr Lewis was at the helm, trying above all to keep it steady.

Resignation from the Renal Transplant Team

19. Dr Macanovic, together with Mr Gibbs, and another surgeon colleague, Mr Graetz, was a member of a regional group, the Renal Transplant Team. She resigned in early July 2016 when she discovered that two "red incidents" – i.e. serious clinical failings - had occurred and had not been reported by either surgeon. She also felt that Mr Gibbs had misled the Trust's Medical Director over this issue. She did not however simply resign privately. She gave her reasons very publicly in a meeting. These were allegations of the most serious kind. They clearly had a major effect on her working relationship with Mr Graetz and Mr Gibbs. Both were angry and upset with her. Nevertheless, on 31 July (p.286) she raised a formal complaint about them both to Ms Susie Lowe, the head of Employee Relations team at the Trust, to ensure that her concerns were acted on. Mr Gibbs approached Mr Lewis about a right of reply, and that led to a further internal investigation, this time carried out by a Mr Simon Hunter.

The Hunter Report

20. This was a substantial exercise, enquiring into the treatment of the two patients in question. It was carried out under the Trust's whistleblowing policy. When Dr Macanovic was interviewed she was asked about any other clinical concerns she had, and took the opportunity to raise the issue of buttonholing (Disclosure 3). Although she regarded herself as a mere witness, Mr Hunter compiled a list of the 23 points raised by her in that interview before making findings on each one.

21. Buttonholing had been going on in the unit since 2014 although most of the consultants were unaware of it. It seems to have been pioneered by the vascular access nurses and surgeons in Portsmouth. Mr Gibbs was the President of the Vascular Access Society of Britain & Ireland (VASBI). They hold an annual conference each September, and in 2015 one of the Portsmouth vascular access nurse specialists, SK, gave a presentation on it. The following year she planned to give a follow-up report. Dr Sangala was keen on this new approach and suggested she present her findings at a consultants meeting on 30 August 2016, which she did.

22. Dr Macanovic had immediate concerns. Dr Sangala spoke to her afterwards and she was quite abrupt with him, telling him that it was dangerous and against national guidance. At the next meeting on 7 September she repeated this and complained that it was being introduced without the knowledge of the consultants or the informed consent of the patients. Some of her colleagues, such as Dr Uniacke, said that they would not support it. Others said that they would advise their patients to change back to the established technique. Dr Lewis was neutral on the issue, at least at that stage; his priority was to achieve a consensus if possible. Even those who supported it, principally Dr Sangala, Mr Gibbs and Mr Graetz, accepted that there was a lack of evidence about its effects but were keen to innovate. Dr Sangala noted that it was also being done in Reading. In the end they agreed (p.295) that patients would be warned about the risks and asked if they wanted to continue. They could carry on if their consultant agreed. Finally, a research study would be carried out.

23. Dr Macanovic was not content with that and put her concerns in writing to Dr Lewis (Disclosure 1). One patient, she alleged, had died as a result of buttonholing and

    this had been misreported at the VASBI conference. However, if her patients felt strongly enough about it she would arrange a smooth handover to Dr Sangala. And if a robust study was carried out, she would be happy for her patients to be approached.

24. She later sent the team the national guidelines about buttonholing. This led to further exchanges, and she emailed again on 17 September (Disclosure 2) with the results of her own research, stating that the practice was considered inappropriate by the vast majority of experts in the field and that no other renal unit in the country was doing it for AV grafts. In fact, they had been misled by Dr Sangala - she had

heard back from Reading and they were not doing it for AG grafts. Worse still, she said, patients had been told that the outcomes were excellent, whereas of the 14 patients using it, two had died, two had developed serious complications, and she had not had time to review the other ten.

25. In our view Dr Macanovic is correct that this was not being done at Reading. She emailed a colleague there about it and he passed it to a vascular access nurse who confirmed that they did not. Dr Macanovic then forwarded this to Dr Sangala to make the point. We also have some minutes of a clinical governance meeting at Reading (pp.350A and 350B) which show that the impetus for buttonholing came from Portsmouth. According to these notes, Reading used it on two patients as a research project after seeing the Portsmouth presentation at the 2015 VASBI conference; however, Renal Association Guidelines did not recommend it and so they stopped.

26. Dr Sangala's evidence was that he knew the vascular access nurse at Reading and knew she going to say this, but they were still doing buttonholing at Reading, they were just denying it to "avoid it [the controversy] spilling out to Reading". It seems to us unlikely that one hospital would mislead another in this way, and the position is confirmed by these internal minutes. If Dr Sangala knew otherwise at the time, he did not say so.

27. Disclosure 4 came on 3 October 2016 in another email to Dr Lewis (p.97). Dr Macanovic attached the powerpoint presentation given to VASBI in 2016. She felt that it was unduly positive and failed to recognise a number of complications. The death of the patient had not been attributed to buttonholing, but there had been no post-mortem. She also felt that there were multiple inconsistencies in the data. However, she ended by stating that she had fulfilled her professional obligations and would let the matter drop, although that did not prove to be the case.

28. Disclosure 5, the last one in 2016, was an email to Dr Hunter on 17 October. This was a restatement of her concerns about the outcomes for patients and the misrepresentation of data.

The initial CQC investigation

29. By then, someone had raised this with the CQC. Dr Macanovic was asked during the subsequent disciplinary investigation if it was her and she would neither confirm nor deny it. It is not one of the protected disclosures so we do not need to resolve the point, and it was not put to her at this hearing. The CQC wrote to the Trust for more information and the Trust wrote back on 16 October. That letter was drafted by Mr Gibbs, with some input from Dr Lewis. By way of overview it stated:

> "The presentation given at VASBI this year clearly states that there were two patient deaths and that a graft was removed due to infection. These details were in no way concealed."

30. It went on to explain Mr Gibbs' view that these deaths and infection were not due to buttonholing. On the issue of informed consent it stated:

> Recently, concerns have been raised about the safety of button-holing by a member of staff within renal services. Accordingly, the renal team have met with all the patients currently using the button-hole needling technique, numbering 11. They have re-iterated that the technique is outside current guidelines, have explained the theoretical increased risks of the technique and have updated them on the experience to date. The patients have signed letters to confirm their ongoing agreement and desire to continue with the button-hole technique."

31. Presented with this response the CQC did not carry out any further enquiry, and wrote back on 22 December 2016 (p.368) to say that they were satisfied that there were no safety concerns and that appropriate governance had been followed. Dr Lewis reported this to the consultants by email on 16 January 2017 (p.375) – addressing it to "Dear Jasna and Colleagues". But he did not attach the letter from the CQC, on the basis that this would then be "dissected or disputed". In fact, any request to see it would, he said, be to question his probity and that of Mr Gibbs.

32. This refusal seems to us misjudged. Opinion among consultants was divided on buttonholing, if not openly sceptical. It was being championed by Mr Gibbs, and he prepared this response to the CQC which the others were not allowed to see. Dr Macanovic was not to be deflected and asked to see a copy. Dr Lewis responded by cutting and pasting the short summary paragraph from the CQC letter saying that they were satisfied that there were no safety concerns or governance issues. This did not allay her concerns either.

The Hunter Report

33. The Hunter report followed, after several months in the pipeline. On the buttonholing issue Mr Hunter found (p.239):

> Given my limited expertise within this area and given that the response provided by the Trust addressing the anonymous has been accepted by the CQC, there is a careful monitoring process in place and all significant events which were known when the investigation commenced have been investigated and this evidence provided to the CQC, I do not think any further interpretation by myself would help in this.

34. Hence, the Hunter report rested on the CQC conclusions, which rested in turn on Mr Gibbs' letter. The Trust suggest that the Hunter report found against Dr Macanovic on most issues, and that she unreasonably refused to accept its conclusions, but in fact many of the conclusions supported her views, or found that she was right to raise them, and it called for a more detailed internal review of buttonholing.

35. Of the original allegations, there was no doubt that the red incidents had occurred and had not been reported at the time, but Mr Hunter concluded that this was the

result of failures in training, procedure and governance, rather than by individuals. Dr Macanovic, was unhappy with the guarded terms of the report while Mr Gibbs was understandably relieved and felt vindicated.

Exchange with Mr Graetz – 18 January

36. No doubt Mr Graetz felt similar emotions. Two days later Dr Macanovic was on the receiving end of an outburst from him. She was in her office at about 08.00 am when he arrived at the door and started shouting at her. He said that he was going home because he was too stressed, and that she was to blame. This was accompanied by a good deal of swearing, repeatedly telling her to 'f' off. She was left shaking and at the point of tears, and was still shaking 30 minutes later when her colleague, Dr Synodinou, came in. (This outburst is the first detriment from a chronological point of view, although it is listed as Detriment 2 in the agreed table of detriments.)

37. Dr Lewis then emailed Dr Macanovic (p.380) to tell her that Mr Graetz had gone off sick with stress. Far from sympathising with her, he went on:

> "However, it does bring to a head an issue which has been simmering for some time; namely your interaction with Paul and several other members of the consultant team. I think we should have a discussion about this — including some feedback from Simon Hunter's investigation. [emphasis added]

38. This email confirms that the outcome of the Hunter investigation was known by then. It went on to ask her to meet him the next day.

Consultants Meeting on 18 January

39. Also that day there was another consultants meeting, which turned again to the issue of buttonholing. They had avoided this topic for the last few meetings, perhaps pending the outcome Hunter report or CQC verdict, but those in favour of buttonholing were now in the ascendant. Dr Sangala had been collating his own data on patients and presented his findings. Dr Macanovic did not accept the data and said they been lied to by Dr Sangala; she then apologised, and said they had been misled. In response he complained to the others about the intimidation he was receiving.

40. The meeting clearly became heated. In the subsequent disciplinary investigation, Dr Uniacke described them as "a pack of wolves", with five consultants "going at her and she was trying to hold her ground so much that the rest of us were gob smacked at the atmosphere – it was just awful." Afterwards Dr Macanovic was shaking and in tears. The next day Dr Macanovic went to see her GP and was signed off sick for two weeks. Nevertheless, she did secure an agreement that a letter would be sent to the patients explaining the ongoing safety concerns. The use of buttonholing would also stop until there had been an in-depth review of the data. This is very

similar to the terms of the previous agreement, so it seems that little had been done to allay her concerns.

Email from Mr Gibbs

41. On 19 January, having received the Hunter report, Mr Gibbs sent an email to all of the consultants except Dr Macanovic (p.386). This is Detriment 1. His email began:

> Over the last 8 months a single colleague of ours has discussed me with the GMC and reported me to the MD [Medical Director]. As a result, several areas of my practice have been independently investigated. I have been accused of gross clinic (sic) negligence, covering up an amber SUI, threatening and physically abusive behaviour, repeatedly called a liar in one form or another, accused of being responsible for the departures of [three members of staff], deceiving the whole of the National renal community, ethical misconduct, misappropriation of funds, attempting to negatively influence the appointment of a medical colleague, covering up mistakes by both my partner and a colleague to prevent them being investigated and causing harm and putting patients lives at risk by initiating PTFE buttonholing. My leadership style has been repeatedly questioned as well. I was even accused of throwing a set of notes at a student nurse back in 2006.
>
> The button holing issues have also been anonymously reported to the CQC, which I have had to answer.
>
> This has all put a huge amount of pressure and stress on me both at work and at home. This has been while doing a full time vascular and renal transplant job.
>
> I have recently been cleared of any wrong doing on all counts. This now allows me to bring it to your attention.

42. He went on to describe how other colleagues had told him that they felt intimidated for agreeing to this method of needling; he took issue with the proposed reexamination of data for patients, and ended with an emotional appeal, essentially to take sides with him against Dr Macanovic:

> As someone who has worked tirelessly for the last 12 years in this unit and has given virtually everything I have to offer, this makes me feel so sad; that it has all been for nothing. If you question my integrity over one aspect of my work you question it over every aspect. You either trust me and think I have I professional integrity or you don't. You cannot pick and chose. (sic)
>
> The buttonhole issue follows on the back of a huge number of other unsubstantiated accusations. If you really believe the questions raised about this innovation are related to governance or concern for patient welfare, rather than a (sic) opportunistic attempt to discredit me, I believe you are being naive.
>
> I now have 10 days off to think about my future in the unit. I suggest you all do the same and take this opportunity to speak out. I fear it may be our last chance.

43. This email caused gave rise to a flurry of emotive and supportive emails, particularly from Dr Nevols to Dr Macanovic, ending:

> "Innovation is what patients need. And want. This was all done with patients' best interests at heart. No malice, lies or negligence occurred.
>
> Why you and Paul have such a deep seated personality clash, I don't want to know. But it has to stop now. Before this unit rips apart."

44. She followed this with a text to Dr Macanovic the next day, 21 January:

> "You really have done the best you can. Thank you for your reply. I will talk to Paul. I completely agree with your thoughts on BH, I really do. But I can't stand the animosity that it generates anymore. …"

45. Dr Macanovic replied on 23 January, (p.402) stating:

> I find Paul very easy to get on with, respect his surgical skills and appreciate his hard work. However, on the BH issue I wish he had some friends to offer him advice.
>
> The BH business is absolutely and totally not a private issue. It has never been. I feel so cross even that I had to spend some time looking things up. Paul should have listened to what I had to say on 7 September. The project is a lunacy and will end up in tears for all involved. I am trying to get some sense so we do not end up as headline news. I have researched the topic and sought opinions; I have reviewed our data. The data is shocking. If this gets out, all of us, doctors, nurses, interventional radiologist, vascular lab techs will be gone ..."

46. She then went into considerable detail about the serious complications patients had, in her view experienced, with excessive bleeding, clotting and one unexpected death, ending with her own exhortation to give this issue the seriousness it deserved.

47. In fact, she had by then written to the CQC (p.393) to ask how they had reached their conclusion:

> "…I find it almost unbelievable that CQC National specialist advisor would give a green light to the technique in direct contradiction to the National and international guidelines and advise that I personally obtained from the most recent National Director for Renal Care Dr Fluck who co-authored the national guidelines in 2011 (e mail attached). This experiment was not done as a proper study, not even a pilot project and no discussion within the unit took place. So I am astonished that there is a reference to 'appropriate governance processes being followed' in the extract from your report."

48. She followed this, on 22 January, with an email to Dr Lewis and a Mr Duffield, Renal General Manager, attaching her medical certificate which signed her work off until 2 February. She added that her absence had been caused by

> "unprecedented bullying and harassment by Dr Lewis and (sic) campaign he orchestrated and directly related to my opposition to the unsafe practice in the unit …"

49. During her absence the consultants met again on 25 January and 1 February to discuss the risks around buttonholing. At the second meeting they went over Dr Sangala's data, reviewing each patient in turn, with the treating consultant describing the case in detail. The consensus was, in the words of Dr Sangala's witness statement, that no serious harm was being done to patients. It was, however, agreed that further steps were needed to address the risks. The existing letter for patients to be revised. Consultants were under no obligation to carry out buttonholing. They also planned to carry out a rigorous clinical trial and to publish their findings in a peer-reviewed journal. This confirms that Dr Macanovic was not alone in her concerns. Indeed the majority were at least sceptical about it.

50. Dr Macanovic was back for the next consultants meeting on 22 February. This time the discussion was largely about the terms of the warning letter for patients. A text was agreed and Mr Gibbs then circulated it (p.447A), describing it as a productive discussion and expressing the hope that they could all now move on.

51. Over the next two weeks Dr Lewis investigated the shouting incident. He concluded (p.461A) that:

> Your accusation about Mr Graetz is troubling on two counts. Firstly, you were clearly a source of great stress to him at the time and yet you categorically and vehemently state that you were not.
>
> You have not sought to find out why Mr Graetz felt as he did and have not considered the possibility that you might be at fault. Instead you state that the fault is entirely Mr Graetz's because he does not cope well with stress (rather unfair since you took a much longer period of stress-related leave over the same issue than he did). Secondly, and more importantly, you are clearly unable to distinguish between abuse and someone challenging you with an opinion which you find uncomfortable.

52. The last sentence has a certain irony given the way in which the Trust have put their case. The fact is that it was abuse, not Mr Graetz challenging her with an opinion. He accepted to us that his behaviour had been inexcusable and he apologised to her a few days later. He also accepted that he had not had any particular contact with Dr Macanovic for several months before this incident, so her only 'fault', in our view, was to raise allegations about him in the course of the Hunter investigation.

53. That day a letter was received from Dr Macanovic's solicitors, DMH Stallard (p.462). This is Disclosure 10. It was sent to the Trust's Chairman and Chief Executive and raised a formal complaint under the whistleblowing policy about buttonholing. It ended:

> This letter is therefore to inform you that unless my client receives confirmation by 12 noon on 21 March 2017 that:
>
> (a) the practice is to be stopped

(b) patients involved are given full written information about the nature of the practice and serious complications observed to date as outlined in the e mail to the medical director

(c) appropriate disciplinary action and referral to the professional regulator is made concerning medical practitioners involved and responsible for the practice my client will comply with her professional obligations and in accordance with the Policy, report her concerns to the GMC.

Consultants Meeting 15 March 2017

54. This was a surprising escalation. There was then a further consultants meetings on 15 March (minutes p.467) where they had another heated discussion over the data. Once again, she accused Dr Sangala of misrepresenting it and he accused her of intimidation. He recounted an incident from the previous September when he had gone into her office to discuss it. He said he felt intimidated and Dr Macanovic had responded with words to the effect "I wish I could intimidate you more".

55. In her evidence to us Dr Macanovic did not dispute the remark but attempted to put it into context: she meant that if she had been more intimidating she could have made him look more closely at the data. Some allowance has to be made for the fact that English is not her first language, and this was certainly not on a par with the abuse she had from Mr Graetz, but it was nevertheless an inappropriate remark.

56. Meanwhile, correspondence between solicitors developed. The Trust's solicitors responded within the stated deadline, on 17 March (p.469), disputing the risks of buttonholing and alleging that Dr Macanovic was not acting good faith - in fact she "could not possibly reasonably believe" what she was saying. The reply from DMH Stallard on 29 March (p.479) was equally uncompromising and demanded full details of this allegation (Disclosure 11).

Assembling the Disciplinary Evidence

57. This decided response from the Trust was, in our view, the prelude to a counteroffensive. Within the next few weeks, written complaints were assembled against Dr Macanovic from Mr Gibbs, Dr Sangala, and Dr Nevols (Detriment 3). The first two were in the form of undated Word documents. Dr Sangala's (p.811) stated:

> I am sorry to say that I am finding it increasingly difficult to function at full capacity at work due to the behaviour of Dr Macanovic towards me. This behaviour has escalated over the last few months during which, as you know, she has accused me of lying both in public in this unit, and in private.
>
> More recently she told me in private that she had "tried to teach me a lesson in a nice way" and that she "had no concerns whatsoever" about the fact I found her intimidating. I have tried, for the sake of unity within the unit, to put our differences aside. I can no longer do this as her behaviour has become increasingly aggressive and intimidating with the most extreme example being the consultant meeting on the

> 15th March 2017. Once again Dr Macanovic publicly accused me of lying, after which she re-affirmed publicly that she was not at all concerned that I found her intimidating, and openly stated that she wished she knew how to intimidate me more. Her comments about the minutes written in her own words confirm this and in this week's meeting she had an opportunity to withdraw her statement but instead chose to defend it.
>
> I should not have to came to (sic) in fear of one of my senior colleagues. This is unacceptable and I request that you do what you can immediately to rectify the situation."

58. Mr Gibbs (p.812) stated:

> "I fear opening my e-mails as I never know what she will have accused me of next. I am constantly questioning every decision I make, in and out of theatre, "Will this pass the Jasna test?" I dread on calls in case I have to discuss a patient with her for fear of being accused of further wrong doing. Operating on her patients is so stressful, "what if I have a complication?" I lie in bed most mornings not wanting to come into work. Colleagues tell me that she "wants to bring you down". My relationships with my partner, my family and my children have all been negatively impacted upon. Life is miserable."

59. The complaint from Dr Sangala was sent in on about 24 March, and Mr Gibbs' complaint followed on about 28 March. The fact that nothing was done with them for the next week or two supports the view that complaints were being assembled.

60. On 6 April 2017 Dr Lewis emailed the Medical Director, Dr Simon Holmes (p.498) and Dr John Knighton, who has about to take over that role, to tell them that he was worried about Mr Gibbs.:

> Six consultant colleagues have spoken to me in confidence in the last 2 weeks about feeling intimidated by Dr Macanovic, so clearly Paul's fears are widely shared and I think well-founded. As these consultants are recent appointees, they are understandably reluctant to lodge a formal written complaint against Dr Macanovic, which makes dealing with this issue through the recognised channels difficult. It nonetheless should go on record that I have had these conversations.
>
> I have spoken at length to Paul and he has reassured me that he remains safe to operate and does not feel a period of absence will do much to help him. He does not believe that he should reduce his current work commitments or enlist additional help from his surgical colleagues. It is my judgement that he is right, although the deep emotional distress displayed today was a cause of great concern. I will of course keep close tabs on him, supporting him through his job, plan changes etc. Nonetheless, I think you should know that one of your senior surgeons has been pushed very close to the edge by Dr Macanovic's continuing intimidation and threats.
>
> It has been reported to me by a consultant colleague that Dr Macanovic has recently stated that she will "bring the renal unit to its knees" if necessary. I guess this is how she intends to do it."

61. Concerning as this is, the reference to six colleagues being reluctant to lodge a formal written complaint indicates that their opinions had also been canvassed. Dr Nevols' email followed the next day (p.810). It is longer than the others, but the main concerns were as follows:

> "The main reason for writing is this: I now have concerns that the usual running of the renal unit has been compromised. Thus, I have potential concerns about patient care.
>
> 1. Consultant meetings — these meetings have been monopolised, on occasion, by Dr Macanovic. She has used aggressive and rude behaviour to intimidate other colleagues to get her point across. There has not been time to discuss other issues affecting patient care. There has been shouting. People have walked out. This cannot go on.
>
> 2. Fear — I have heard that colleagues are anxious about how they manage patients, in case of being accused wrong doing and other consequences.
>
> 3. Low morale and low mood amongst colleagues. This surely spreads to the rest of the unit and potentially affects patient care.
>
> 4. Highly skilled and respected colleagues (I need mention no names) have talked about resigning because of this issue."

62. There is no attempt here to disguise Dr Lewis's opposition to Dr Macanovic, with its reference to continuing intimidation and threats, and he was happy to share it with more senior management, indicating that it was common ground.

63. In summary therefore, Mr Gibbs expressed his apprehension or dread about future remarks or scrutiny from Dr Macanovic, Dr Sangala raised the fact that he had been accused of lying and that she was not concerned about him feeling intimidated, and Dr Nevols was concerned about the effect of all this on the renal unit, particularly on consultants meetings.

Report to the GMC

64. On 19 April, while these complaints were being considered by the Medical Director, Dr Macanovic carried out her threat to report matters to the GMC. She sent the same letter wrote to the CQC. (Disclosures 6 and 7 - p.499). It named Dr Lewis as the Chief of Service who "assumed full responsibility for this uncontrolled experiment" and also mentioned the Medical Director, at that time Mr Holmes. Mr Gibbs and Dr Sangala were also named as those leading the practice. She accused them of a coverup, of lying and dishonesty. It was by any standards a serious step, and might have led to them being suspended or struck off.

Disciplinary Action

65. On 2 May, Dr Holmes, the Medical Director, and Ms Susie Lowe, Head of the Employee Relations team, took some telephone advice from NCAS - the National Clinical Assessment Service. They are a division of NHS Resolution (the

replacement body for the NHS Litigation Service), and they generally advise on doctors who are perceived to be under-performing in some way. Their written response to Dr Holmes (p.572) on 4 May confirmed their discussion:

> The Trust is mindful that Dr 19339 is a whistle blower, but concerns have been expressed by her colleagues about her behaviour and you have received 3 letters of complaint alleging that she exhibits aggressive, bullying and intimidating behaviour.
>
> …
>
> The issue is, as you are aware, complicated by Dr 19339 whistle blowing status and it will be important to document carefully the preliminary information which has been received so that this is available for future scrutiny if required. Potentially it may be necessary for the Trust to be able to demonstrate that Dr 19339 is not being victimised for having raised concerns. I advised that to avoid any allegations of bias, it may also be useful for the role of Case Manager, to be delegated so that the person making any decision about how to proceed is free of any real or perceived conflict of interest. Likewise the Case Investigator should be suitably senior, experienced and independent.

66. The key principles were correctly stated in this letter – any action taken should not relate to the allegations but to her conduct, it should be investigated at a senior level, and the Case Manager should oversee things to ensure that this distinction was upheld. The letter also invited them to share their advice with Dr Macanovic, though this was not done.

67. Armed with this advice, a decision was taken to initiate disciplinary action (Detriment 4). Dr Macanovic was invited to a meeting with Dr Holmes on 15 May, and afterwards his replacement, Dr Knighton, wrote to her (p.578) to confirm that an investigation into her conduct would be carried out by Dr Matthew Wood, Chief of Service for the Anaesthetists. It was to be a Level 3 investigation, i.e. one that could lead to her dismissal. HR support would be provided by Ms Lowe and Dr Knighton was to oversee all this as the Case Manager. This must have been decided at a high level given their seniority. Dr Knighton, as Medical Director, reported directly to the Chief Executive, Mr Cubbon.

68. Dr Macanovic emailed on 21 May (p.581) to make Dr Knighton aware that she had made her referral to the GMC. She claimed protection under the whistleblowing policy, entitled Freedom to Speak Up, which provides:

> Feel safe to raise your concern
>
> If you raise a genuine concern under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. We will not tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not raising any such concern. Any such behaviour is a breach of our values as an organisation and, if upheld following investigation, could result in disciplinary action.

69. She also referred him to the Trust's Dignity at Work policy, according to which a non-executive board member should have been appointed to make sure that she was not left unsupported. In due course, a non-executive director was appointed, but although she was copied in to some emails, she made no contact with Dr Macanovic.

70. The GMC referral was eventually made known to Dr Lewis. In a surprising decision, he elected to read it out in its entirety to the consultants at a meeting on 7 June (Detriment 5). Dr Macanovic was there to hear it. The exercise must have taken some time since the referral letter covers eight pages. In his evidence to us Dr Lewis said that any summary would have risked further objection from Dr Macanovic, but we see no reason why he could not just have said that she had referred him, or others, to the GMC over the buttonholing issue. In choosing to give such publicity to her complaints, he was in our view, stoking anger against her and seeking to isolate her from her colleagues. She was left shaken by this episode.

71. Dr Lewis followed this announcement with emails to colleagues who were not there. He received many messages of support, including the one quoted at the outset (paragraph 11) from Dr Armstrong, stating that she was "shocked, enraged and very saddened." Asked about this at the hearing Dr Lewis said words to the effect that Dr Macanovic had taught him well, this was how she operated, he needed a record of things and that by then "the gloves were off".

The Wood Investigation

72. Dr Nevols was interviewed on 5 June and Dr Sangala the next day. Dr Lewis was interviewed on 6 June, the day before he read out the GMC referral at the consultants meetings, and Mr Gibbs was interviewed on the day of the consultants' meeting itself. Hence, all of Dr Macanovic's opponents had their say at the outset. She was interviewed on 8 June, accompanied by her partner, Mr Heilpern; Dr Wood was accompanied by Ms Lowe, the Corporate HR Manager.
His intention was to have an initial discussion, and identify those witnesses Dr Macanovic felt that he should interview. However, it soon became a general discussion of the buttonholing issue with Dr Macanovic making various dismissive comments about her accusers.

73. On 15 June Dr Lewis went to Manchester with Mr Gibbs to attend a GMC hearing. This was an 'Interim Orders' hearing, to decide whether some interim steps such as suspension should be taken pending a final hearing. It is not clear exactly what happened that day but there was a two hour delay while the panel looked into further information, with the result that there was no time for Mr Gibbs and he had to come back a couple of weeks later. The delay was due to a phone call to Dr Macanovic. The GMC wanted to know about a table of patient complications she had sent the previous day. According to this, only one patient had not had any complications. In the course of the telephone conversation she told them that this patient had since been taken to hospital in a critical condition. It was suggested that she had deliberately timed this revelation to make things difficult for Dr Lewis at the hearing

but we see no basis for that view. She was responding to a call from them about information previously provided.

Mediation

74. This was the background to the attempt at mediation, referred to at the outset, which Dr Knighton attended at the end and found almost everyone in tears or close to tears. We were invited to disregard this episode on the basis that it involved 'without prejudice' discussions but we do not accept that. It was an attempt at workplace mediation, not to settle a legal claim between the Trust and Dr Macanovic. No solicitors were involved, or any non-clinical managers from the Trust. It was just the consultants, with an external mediator, to see if they could restore working relationships. No financial proposals were made, nor, as far as we know, was there any discussion about Dr Macanovic leaving. It is well established

that the without prejudice rule only applies once the parties are in dispute, and that raising a grievance at work does not suffice. Dr Macanovic had not raised a legal claim at this stage, and certainly not against her fellow consultants.

75. During this meeting concerted efforts were made to get Dr Macanovic to withdraw her complaint to the GMC. That was seen as the stumbling block to better relations. Dr Nevols told us that this was 'not the entire focus' of the event, but that supports the view that it was the main point under discussion. This refusal on her part must therefore have been the cause of the consternation on the part of the other consultants and even the mediator. We can only conclude that they all lost sight of the important principle that this was a protected disclosure and as such it was wrong to pressure her into withdrawing it.

Exclusion of Dr Macanovic

76. The next day Dr Knighton consulted NCAS (p.595) to update them on the position and discuss excluding Dr Macanovic. Their written response that day confirmed the discussion:

> You told me that, prior to the referrals to the GMC, the department, including Dr 19339, had requested the help of an external mediator. Everyone was keen to do this and so the Trust organised an external mediation which took place yesterday. You said you attended the start and conclusion. You described how at the end of the day everyone attending seemed stressed, anxious and some were physically shaking. One member of staff had to leave the room because he was so distressed.
>
> There appeared to be an absolute breakdown in trust between Dr 19339 and the rest of the department and the result of this led you to be concerned for the health of all in the department. You considered that the breakdown in relationships in a team who need to have confidence in each other to ensure patient safely constitutes a risk to that safety.
>
> …

> However, the Trust will wish to assure itself that any action it takes to mitigate potential safety risks within the department is not construed as being a detriment to Dr 19339 as a result of her declaration to the CQC that she is a whistle blower.
>
> …
>
> Any prolonged exclusion from clinical work can lead to de-skilling and I suggested that the Trust might wish to look for a placement in another Trust or department while the investigation is ongoing and the GMC comes to a decision as to whether it will take any action against the colleagues of Dr 19339.

77. They also suggested that the Trust take legal advice and, again, to share their advice with Dr Macanovic. Again, this was not done. Armed with this advice, and on the same day, Dr Knighton summoned Dr Macanovic to a meeting. His secretary told her to come and see him without delay (Detriment 6). She then cancelled a clinic which was due to start in 15 minutes time. It seems to us that there was some miscommunication here; Dr Knighton wanted to see her as soon as possible but not at the expense of cancelling a clinic.

78. The meeting was to decide what to do next, given the failure of the mediation. Dr Macanovic was accompanied by a colleague, Dr Christine Gast. Dr Knighton felt that exclusion was the least damaging option. Dr Macanovic said that she was the victim of bullying by Dr Lewis, but he did not accept that that was the case. Dr Gast proposed that she could simply be excluded from consultants meetings and after a pause to consider, Dr Knighton agreed that that would be a better option. After that meeting Dr Macanovic was unwell and could not resume work. She had a panic attack and spent the afternoon in the outpatients department where she had an ECG. However, she was not signed off sick.

79. Dr Knighton wrote to her recording his decision (p.598) and blaming it on the failed mediation meeting, which he described. If we are wrong in concluding that this was not a 'without prejudice' event, our view is that both parties have waived any privilege by discussing it so openly. Dr Macanovic has described it in her witness statement, and Dr Knighton has mentioned it in this open correspondence.

80. He also recorded that she felt that her working relationships generally were good and had only broken down with three of her colleagues, i.e. Dr Lewis, Dr Sangala and Mr Gibbs. The outcome was that she was to adhere to the following requirements:

- To refrain from attending MDT [Multi-disciplinary Team] and Consultant meetings
- To minimise your contact with your Consultant colleagues and limit your conversations to professional patient based discussions
- To avoid further informal discussions about buttonholing pending the external investigations that are pending

81. These restrictions comprise Detriment 7. Although stated in the letter to be an agreement, this was an alternative to being excluded (i.e. suspended) and so Dr Macanovic had no real choice in the matter. It was an imposition by Dr Knighton. (Detriment 8 was the continuation of these restrictions. In August Dr Knighton refused to lift them (p.740 to 742) but on 5 September he agreed that she could resume attending some Multi-disciplinary Training meetings.)

82. This partial exclusion was not uniformly welcomed. Four of the consultants met Dr Knighton urgently that day (26 June) to raise their concerns about buttonholing. Having heard them, Dr Knighton decided that the practice should cease immediately. The next day a consultants meeting was arranged at short notice, which he also attended. Some agreed with the decision to stop it, but Dr Borman

    and Dr Lewis put the counter case that several patients had chosen buttonholing. Mr Gibbs and Dr Sangala also emphasised that this was patient driven, and in the end Dr Knighton accepted the view that it could do more harm to reverse it immediately. So, he reversed the decision.

83. Dr Macanovic felt that Dr Wood should also look into her allegations of bullying against Mr Lewis. Dr Knighton responded to her email (p.722) agreeing that they would "include looking at all behaviours within the department that might be inappropriate or contributing to the current situation."

84. From this point onwards, the active phase of the dispute over buttonholing ended. The Woods investigation continued, but Dr Macanovic carried on with her duties without attending any meetings. Her dismissal was not to take place for another ten months, but the passage of time does not seem to have reduced any of the animosity towards her.

85. An external review was also underway. This had been commissioned by the previous Medical Director, Dr Simon Holmes, although it is not clear when. The review was led by a team of three clinicians led by a Dr Sandip Mitra, a consultant nephrologist in Manchester, and the panel came to Portsmouth on 28 July to speak to the staff, including Dr Macanovic. They also examined the patient records in detail.

Meeting with Mr Cubbon

86. In August Dr Macanovic had a meeting with the Chief Executive, Mr Cubbon, and the Trust's Chairman, Mr Nelthorpe. Also present was the 'Freedom to Speak Up Guardian' Mrs Booth. Dr Macanovic then wrote to Mr Cubbon on 26 August, summarising their discussions. She alleged, again, that she was being bullied by Dr Lewis, that the disciplinary investigation into her was an act of victimisation, and asked him to remove the restrictions to her practice. He replied on 21 September (p.760) stating that the allegations against Dr Lewis would be fully investigated by an independent investigating officer, that Dr Knighton would look into her

restrictions, but refusing to intervene in the ongoing investigation. (This delay in responding is Detriment 11a.)

87. This represented a change from the position adopted by Dr Knighton, that the Wood investigation would look into all allegations. Afterwards, Mr Cubbon had discussions with Mr Tim Powell, Director of Workforce and Organisational Development, i.e. the overall head of HR at the Trust. After that, he too changed his mind, and decided not to have a separate investigation. This decision, however, was not communicated to Dr Macanovic; Mr Cubbon thought this had been done by Mr Powell or Dr Knighton. The result was that Dr Macanovic was left under the mistaken impression that there would be a separate investigation.

88. She wrote to Mark Cubbon about this on 23 October (p.787) and made various criticisms of the Wood investigation and the continuing restrictions, but he did not respond at all (Detriment 11b). Detriment 12 is the failure to disclose Mr Powell's report, but no such report was ever prepared. Nor were any disciplinary allegations ever framed against anyone else in the course of Dr Wood's investigation. The decision to single her out in this way is Detriment 10.

89. During this time Dr Macanovic had her second interview with Dr Wood. It was on 19 September, and again she was accompanied by Mr Heilpern. (The notes are at page 948.) The questions were not confined to the 3 complaints against her but went over a wide range of matters: her earlier complaints; why her colleagues found her intimidating; whether she would retire if the GMC found against her; and the use of the phrase "being Jasna'd". This phrase had been explored in interviews with Dr Lewis and Dr Sangala, and with the previous Clinical Director who had stepped down after her earlier grievance. Dr Gast did not recognise it, nor did Dr Macanovic. It referred to being spoken over and bombarded with arguments. Mr Lewis had described it as

> "being argued at rather than with, being given a string of usually high volume or high-pressure facts which may be opinion or supported by evidence and not allowed to respond or if you do you are not listened to."

90. For her part, Dr Macanovic felt that the use of this term was bullying behaviour and she pointed to the fact that she had trained hundreds of doctors without any complaint against her.

The External Review

91. The panel led by Dr Mitra completed its external review in early October. It made 9 recommendations, the first of which was

> 1. BH cannot be recommended as routine practice for all patients with AVG.

92. Otherwise, they concluded, it could still be used where there was a strong desire by the patient and as part of an informed decision making process, risk assessed by

MDT and the responsible clinician. This was also subject to "rigorous data collection, robust monitoring and audit of complication rates", with other recommendations about quality assurance, operating procedures, further research and, ultimately, a clinical trial to examine the long-term outcomes. All this was very similar to the internal arrangements which had been agreed.

93. Despite the safeguards proposed by this report it was the opponents of buttonholing who had most concerns with it. Dr Gast emailed on behalf of herself and three other colleagues with her objections on 3 October 2017 (p.765). They took issue with the repeated emphasis on it being patient-led, the view that monitoring and better governance was sufficient and the statement in the report that there had been no "infective complications". However, they were happy to "forgive past mistakes and move on" and set out some detailed proposals for improved patient information, in particular that it should not be promoted and that consultants could opt out it they were against it.

94. Dr Lewis was correspondingly pleased with the outcome of this review. Asked about it in his further interview with Dr Wood (p.1187) he said:

> Personally, of course I was triumphant for two reasons: first of all, because someone who had trying to destroy Paul Gibbs had pretty much been sent away with her tail between her legs and that gives you a certain satisfaction. The other thing of course is that with the GMC, I had been accused of running a study that had caused definite harm and here was a document saying it is not a study, you did not run it and it did not cause harm. So as far as I was concerned that was my defence.

95. Shortly afterwards, on 23 October, Dr Lewis had a further interview with Dr Wood. This was to examine the allegation from Dr Macanovic of a bullying culture in the unit. To this end he was asked about his control of consultants meetings but the tone was one of enquiry and no accusations of bullying were put to him. It soon tailed off into an account of the reception of the external report, which was discussed by the consultants in the absence of Dr Macanovic, given her exclusion. He described his efforts to achieve a consensus, and the difficulty posed with one group who were "vehement", (identified as Dr Sangala, Mr Gibbs and Mr Graetz) and another group were not saying very much. On the GMC referral he was asked in a roundabout way why he had read it all out at a consultants meeting, described as a meeting at which he "broke the news". He accepted that he had not discussed this with Dr Macanovic beforehand and maintained that that was the right approach – the others needed to know about these attempts to destroy people's careers. He also mentioned the solicitor's letter which had threatened this referral, which he described as blackmail. Otherwise, there was some general rumination about the cause of the personality clash between Dr Macanovic and Mr Gibbs and a discussion about the way the Trust had handled things.

96. The Wood investigation concluded the following month. It had involved interviewing all the consultant nephrologists still in post, all the consultant surgeons, haemodialysis nurse specialists, members of the renal administration team and a

junior doctor. Dr Wood also interviewed the previous Medical Director, Dr Holmes. The report (p.796) identified four allegations:

a. Accusing Dr Sangala of misleading and lying to the department about the data on buttonholing and its use in Reading at the consultants meeting on 18 January.

b. Intimidating him and others, in particular telling her in a meeting that she wished she could intimidate him more. (This was the incident he related at the consultants meeting on 15 March 2017). Other examples of intimidating conduct were found to be:

i. making threats to refer people to the GMC

ii. her behaviour in meetings, including shouting and raising her voice; dismissing Dr Sangala by telling him: 'be quiet I'm not talking to you'; iii. people leaving the meetings because of the atmosphere; iv. the results of a Happiness Survey;

v. her recording a consultants meeting;

vi. her persistent questioning of a trainee doctor about buttonholing at a memorial event where she gave a talk on it; and

vii. her 'pressure of speech' etc – a reference to the 'being Jasna'd' allegation.

c. The complaint from Dr Nevols that she monopolising these meetings to raise her concerns about button-holing despite the internal and external reviews, and in doing so, behaving in an aggressive, rude and intimidating manner.

d. The complaint from Mr Gibbs that she had made multiple, unsubstantiated claims about his personal conduct, probity, professional skills and ethics leading to him feeling bullied, intimidated and harassed.

97. There is of course a good deal of overlap in these allegations, and they centre around the two consultants meetings when tempers were raised. The first allegation about lying/misleading was upheld on the basis that it was recorded in the minutes and was admitted, although she apologised at the time for the word lying. The second allegation about the remark to Dr Sangala was upheld too as it was also admitted, although she explained that she had been trying to get him to look harder at the data. On the other particulars of intimidation, it noted that the minutes of the meeting on 15 March record her threat to refer them to the GMC and that she then actually did so. That was therefore regarded as an act of intimidation. On the other particulars of intimidation, the report simply referred to the relevant person's interview record as support for the conclusion. On the third (Dr Nevols) allegation, this overlapped with the others, but Dr Wood noted that even Dr Macanovic's supporters accepted that her manner could be aggressive and intimidating but attributed it to English not being her first language and that she felt under attack by

other colleagues on the buttonholing question. Finally, on the fourth (Gibbs) allegation, Dr Wood noted the previous investigations, her refusal to accept that her concerns were unfounded and that Mr Gibbs was innocent. He concluded that the persistence of these claims, against the opinion of the vast majority, supported the allegation.

The decision to proceed to a disciplinary hearing

98. The Trust's disciplinary policy (p.173) provides for a review of the Investigation Report before proceeding to a disciplinary hearing. Section 6.7.7 (p.184) states:

> The case manager will review the report and, through further consultation with Medical Director, Director of HR and LNC Chair, or their nominated deputies, where the Medical Director is not acting as case manager, determine whether or not there is a case to answer. Where it is determined that there is a case to answer, the case manager will consider whether restrictions on practice or exclusion from work should be considered, notwithstanding that this action may already have been taken.

99. This review took place on 6 December 2017. The LNC is the Local Negotiating Committee, a staff consultative body, and on this occasion the two co-chairs were invited, both of them consultants. Neither was able to attend that day and no consideration was given to rearranging it. Those present were Dr Knighton, Mr Powell, Dr Wood and Ms Lowe, although the policy did not provide for the last two to attend. They had been the ones engaged in producing the report and the aim of the review meeting was, to use the NCAS description, "so that the person making any decision about how to proceed is free of any real or perceived conflict of interest" (para. 65 above). Consequently, instead of the decision being taken at one remove from the investigating team, and in consultation with staff representatives, the opposite occurred. There is a record of the discussion at p.1559A. It contains no mention of any bullying of Dr Macanovic and in fact Dr Wood's view was that there was "no mitigation". Dr Knighton decided to proceed with the Level 3 hearing (Detriment 9).

The GMC Outcome

100. There followed a considerable delay. The Trust were wating for the outcome of the GMC investigation which arrived on 15 January (p.1564). It was a comprehensive exercise, reviewing all of the information provided by Dr Macanovic, the findings of the CQC and the Hunter report, and found:

> With hindsight, it could be argued that it would have been a good idea to introduce the button holing/graft access method as a research project with a formal protocol and ethical review under the research governance framework. However, because of the gradual way in which it was introduced it was not introduced in this way. As it was not conceived as a research project, the fact that it did not follow the research governance framework does not raise any serious concerns.

> The button holing/graft access method was an innovative technique, and should therefore have been introduced with appropriate controls, records and safety assurance, according to the relevant local policies.
>
> The method was introduced two years before Dr Lewis became chief of service and therefore he was not responsible its introduction. Indeed, all the governance measures that were eventually introduced were introduced as a direct or indirect result of his intervention, starting at the consultant meeting on 7 September 2016.

101. The key passage from Dr Macanovic's point of view stated:

> 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 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 genuinely 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 the GMC, she would in our view have been rightly criticised by the public and by the GMC for failing to do so.

102. In our view she did genuinely consider that there was a risk to patient safety. That is implicit in the previous finding that this referral amounted to a protected disclosure. Although it was suggested to us that this fell short of an express statement from the GMC that she was right to make this referral, that seems to us its practical effect.

The approaching hearing

103. Within a few days of this decision, which removed the threat hanging over Dr Lewis and others, Dr Macanovic was invited to a disciplinary hearing. It was to take place on 28 February. No decision-maker had been identified but the letter (p.1608) explained that Dr Knighton would be presenting the management case and Dr Wood would also be there to present the findings of the investigation. Dr Lewis (alone) would be called as a witness for the management side. The disciplinary policy does not prescribe who should attend, although there seems no reason for this duplication. Separate roles are prescribed for the Case Manager and Case Investigator and the role of the former is described (p.179) as one who "coordinates the investigation, organises its administrative support and ensures the investigation is completed to a timetable." Dr Knighton however largely took over the reins at this stage and prepared a three-page Management Statement of Case ahead of the hearing (p.1610) which recommended dismissal.

104. Dr Macanovic's solicitors wrote to Dr Knighton, attempting to deflect this process. They pointed out that there had been no difficulties at work over the many months since Dr Macanovic had been excluded from meetings and suggested Alternative Dispute Resolution (ADR), or at least a postponement. Mills & Reeve responded for the Trust on 16 February (p.1627) rejecting these proposals and responding, somewhat surprisingly:

> "First, to date your client has never articulated her specific concerns in relation to button holing to our client."

105. They also claimed that she had referred colleagues to the GMC 'with no good reason'. This response is Detriment 13.

106. Professor Theresa Murphy was appointed to hold the disciplinary hearing. She was the Trust's Chief Nurse and had recently joined the Trust at the invitation of the Chief Executive, Mr Cubbon. She was also part of the cabinet group who reported to directly to him, as did Dr Knighton and Mr Powell, and like them had offices on the same corridor, attending morning planning meetings together.

107. Dr Macanovic set about preparing in earnest for this hearing, assembling as much support as she could from colleagues. Six of them, Dr Bostock, Dr Uniacke, Dr Synodinou, Dr Dingley and Dr Gast agreed to be witnesses and attended the hearing on her behalf and many others agreed to provide character references. They included a senior nurse, who said it was a genuine pleasure to work with Dr Macanovic; a sister who described her as kind and sympathetic to patients and nurses alike; a nurse who said she was "a steady and relentless support to me"; another who described her care and empathy as exemplary; a consultant surgeon from Nottingham who spoke in glowing terms of her; and many similar comments from former colleagues in all roles and disciplines. There are 22 such references in the bundle, aside from those provided by her witnesses. She also submitted a written response to the management case (p.1641) explaining, among other things, that outside meetings she had not spoken to Dr Sangala since September 2016, nor Mr Gibbs since July 2016. Similarly, her only private communication with Dr Nevols had been the text message exchange in January 2017 after Dr Nevols had emailed her and copied in all the other consultants.

The disciplinary hearing

108. The hearing went ahead as planned on 28 February. Professor Murphy was accompanied by Ms Rebecca Kopecek, Deputy Director of Workforce plus the four-person investigation/case-management team. Once again Dr Macanovic was accompanied by her partner, Mr Heilpern. With so many witnesses the hearing was a lengthy one. It lasted over eight hours and the transcript is nearly 100 pages long (pp.1718 to 1813).

109. One concern raised by Dr Macanovic was the vagueness of the allegations. These were not confined to the original three complaints. The invitation letter did not

identify them beyond a reference to the Investigation Report and the Management Statement of Case also said "There is no need to repeat the specific allegations here, they are set out in the Report." Those allegations have been summarised already, but the management statement went on to say (p.1612):

> The concerns are her general conduct towards colleagues, not acting professionally, not working collegiately, abuse, intimidation and being wholly unreasonable in persisting with imposing her views about the use of button holing, despite no evidence to support what she says and in fact, to the contrary following both internal and external reviews. There was no justification in the threat to report colleagues to the GMC and certainly no justification for actually reporting them. Not surprisingly colleagues are not prepared to work normally with JM.

110. Dr Lewis gave his evidence first. Professor Murphy explained to us that she saw him as a representative of the three complainants. He went over the history of the dispute, giving his views about the atmosphere in the department, how shocked people were at the referral to the GMC, the failed mediation, and how her exclusion had been welcomed. The questions were led by Dr Knighton, who then summarised things as follows:

> JK - So in summary I think Dr Lewis has described some of the atmosphere that has been pervasive over the course of the last year. I think that in conjunction with some of the witness statements and testimony investigation does describe a pervading culture of fear and intimidation resulting in a reluctance to speak up and defensive changes in clinical practice resulted from that because people are fearful of the way that practice may be changed, an inability to discuss serious and important clinical as well as non-clinical issues relating to the service and its development. I think sadly there is significant evidence Jasna that you have not worked actively with your colleagues, that you haven't respected their skills or treated them fairly or with respect and also that you have shown a lack of insight and indeed reflection on how your behaviour may have affected others and the working of the team. Potentially at least given the appearance that you don't care about those things as well. I think I am afraid therefore that in summary I have to say that I believe your behaviour has caused irreparable damage to the function of the renal service and to the Trust within the consultant body and therefore the management case is that unless you wish to reconsider your position and resign to pursue a career elsewhere the management case would be that the Trust must seek your dismissal, with great regret. [Emphasis added]

111. This extensive summary of the management case came at an early stage. It shows that the focus was not on particular behaviours on particular days or at particular meetings, but on working relationships generally, in the context of this dispute. It culminated in this offer to resign. Professor Murphy told us that she knew that this offer would be made by Dr Knighton, so clearly they had discussed things in advance.

112. There were questions to Dr Lewis interspersed with some long statements from Dr Macanovic, but in the absence of any more specific allegations these served a

limited purpose. The six witnesses for Dr Macanovic were then called in turn. Some more focus was applied to the consultants meetings in question, of which the main ones were on 7 September 2016 and 18 January 2017. On the first of these, the technique had only just been revealed whereas at the second there was a general and heated discussion of the data. As may be expected, Dr Bostock was supportive. Dr Samson, not one of Dr Macanovic's group of supporters, said that there were heated exchanges on every side. Dr Uniacke said that anything she said was met with anger and aggression, and gave his evidence about there

being a pack of wolves. Dr Synodinou and Dr Dingley did not believe that Dr Macanovic was louder or more aggressive than the others. Dr Gast said that after other consultants meetings, when Dr Macanovic was not there, she was left crying afterwards, with the pro-buttonholers denying that there were guidelines and ignoring patient safety concerns. Having heard this evidence, and towards the end of the hearing, Dr Knighton referred again to his suggestion of resigning with a good reference.

113. So matters rested for a few days while the outcome was awaited. In that period, on 2 March, Dr Bostock, Dr Uniacke, Dr Synodinou, and Dr Gast emailed Mr Cubbon, to ask him to step in to prevent her dismissal (p.1716). Dr Gast was the author. She said that these complaints were from a minority of staff, and were an attempt to silence and discredit Dr Macanovic as a whistleblower. He declined to intervene (Detriment 20).

114. The hearing resumed on 5 March 2018 when Professor Murphy gave her decision. At the outset, she also reminded Dr Macanovic that she could instead choose to resign with a good reference. The main passages from the dismissal letter (p.1814) are as follows:

> The general thrust of the Management case was that the behaviours complained of were witnessed by others, were your usual way of interacting when challenged and that you had an 'I'm right, you're wrong' attitude. Things were either done your way or they were not being done correctly.
>
> I then heard you case. It became very evident that you interpreted the Management case as "colleagues won't work with you"; despite Mr John Knighton repeatedly making the point that colleagues find it difficult to work with you due to your behaviour, making them very anxious and that as a result good patient care is threatened.
>
> In fact, it was noteworthy that all of the witnesses who appeared at the hearing, including yours, agreed that the atmosphere in the Renal Unit has become very difficult and, in your words, "dreadful".
>
> Throughout the hearing you asserted that all your behaviour was as a result of your opposition to button holing. I do not intend to go into great detail about button holing in this letter. It is however very clear to me that the Trust had no concerns with the fact that you raised concerns and indeed it has gone to great lengths to investigate the use of button holing a number of times, resulting in an internal review and three

external reviews to try to resolve the concerns. Despite the internal and external reviews, it was evident at the hearing, which was dominated by your assertion that button holing is a patient safety issue, that this remained your focus rather than your behaviour and how it had impacted on your colleagues, which was the focus of Management concerns.

You produced a list of patients and on questioning you confirmed that although they were not your patients, you were nevertheless continuing to monitor them in relation to button holing. This is not appropriate and a further example of your continuing focus on button holing as an issue despite the Unit Position statement on button holing being agreed last October and which you have signed and subsequently stated dealt with your concerns. As you are aware you have no right to look at patient data not pertaining to your own patients without patient consent. This is a breach of information governance and confidentiality, which the Trust has every right to take very seriously.

Your witnesses were supportive to your position and spoke about your clinical excellence and support as a peer and mentor. For clarity the Trust has never doubted your clinical skills and has no concerns in that regard. …

I have made a number of key findings in this case, which are, in summary:

- The behaviours complained of by Dr Nick Sangala, Dr Jacqui Nevols and Mr Paul Gibbs did occur;
- Whilst you make a point of saying that you did not call a colleague a 'liar' you accept that you have accused a colleague of lying and to my mind this is a distinction without a difference;
- You are aware of the fact that you intimidate people and have stated that you wished you were more intimidating;
- Despite internal and external confirmation that button holing is not contraindicated and carries no specific risks, and despite you not being an expert in vascular access, you not only continue to disagree with its use, but you also referred colleagues to the GMC for using/supporting its use and I do not feel you acted professionally in this regard;
- Relationships between you and a number of consultants in the Renal Unit have broken beyond repair as a result of your behaviour. [Emphasis added]

115. So, as noted at the outset, the misconduct included the fact that she made the GMC referral. Other contentious points in this letter include the statement that the Trust had "no concerns with the fact that you raised concerns" and the dismissal of the evidence of her supporters as only relevant to her clinical competence.

116. Dr Macanovic was found guilty of 'serious misconduct' rather than gross misconduct and paid in lieu of notice. There was a right of appeal to Mr Powell, who had appointed Professor Murphy, but Dr Macanovic chose not to press her case any further, and so her employment ended.

117. A number of further detriments have been alleged arising from this disciplinary process, each of them an argument about the fairness of the process. Of those remaining:

    a. Detriment 14 involves various alleged failures to follow the Trust's policies, considered further below.

    b. Detriment 16 was the alleged failure to consider alternatives to dismissal.

    c. Detriment 18 is an allegation of pre-judging the outcome.

    d. Detriment 19 is an allegation of failing to consider ADR.

Applicable Law

118. The primary claim here is of unfair dismissal. Although reference is often made to 'ordinary unfair dismissal' and 'automatically unfair dismissal' there is just a single right, provided by section 94 Employment Rights Act 1996, not to be unfairly dismissed. Section 103A provides that:

> "An employee who is dismissed shall be regarded … as unfairly dismissed if the reason (or, if more than one, the principal reason) for the dismissal is that the employee made a protected disclosure."

119. For such an 'automatically unfair dismissal' it is not necessary to have two years' qualifying service. Those without two years' service have the burden of proving this principal reason. As explained by the Court of Appeal in Kuzel v Roche Products Ltd [2008] IRLR 530, those with two years' service (as here) just have to provide some evidence to show that it was for a different reason – i.e. whistleblowing. The tribunal may agree, or find that it was for another reason altogether. Here, there are two clear alternatives – whistleblowing or behaviour. (Section 98 of the Act sets out the potentially fair reasons for dismissal, including conduct, capability and 'some other substantial reason'. These are relied on by the Trust but we use the term 'behaviour' for convenience.)

120. Conduct etc are merely the relevant categories or headings. The principal reason is the reason that "operated on the employer's mind at the time of the dismissal": per Lord Denning MR in Abernethy v Mott, Hay and Anderson 1974 ICR 323, CA. So, for example, in Kuzel, the tribunal found that the principal reason was simply that the line manager lost his temper. We therefore need to address the reason that operated on the mind of the employer, i.e. on the mind of Professor Murphy.

121. If the reason was a fair reason (behaviour) we then need to consider whether the dismissal was fair under the ordinary principles relating to unfair dismissal, i.e., applying the established principles, in a case of alleged gross misconduct it depends on whether the decision-maker had a genuine belief in her guilt, based on reasonable grounds, formed after as much investigation as was reasonable in the

circumstances, and whether dismissal was within what is known as the range of reasonable responses.

122. As to the alleged detriments, section 47B Employment Rights Act 1996 provides:

> (1) A worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure. [Emphasis added]

123. Again, there was little disagreement over the applicable legal principles. As decided by the Court of Appeal in Fecitt v NHS Manchester [2012] IRLR, this test was held to mean that the disclosure must have had a 'material influence' on the detriment. That is an easier test to meet than for a dismissal.

Time Limits

124. Finally, time limits have to be considered in relation to the detriment claim. Section 48 Employment Rights Act 1996 provides that a detriment complaint must be presented within three months of act or failure to act in question, "or, where that act or failure is part of a series of similar acts or failures, the last of them."

125. That three month period is now extended by section 207B to allow for time spent in early conciliation. That period can be further extended where the claim form is submitted within one month of the end of early conciliation (known as Day B), but that did not happen here. Day B was on 1 November 2017 but the claim form was not submitted until 16 January 2018.

126. The period of early conciliation lasted a month, from 1 October to 1 November 2017, so the three month time period was extended to exactly four months. Hence, any act which took place more than four months before the claim being lodged on 16 January 2018 is potentially out of time, i.e. on or before 17 September 2017. That includes the first eight detriments. The only way around this for the claimant is if it was not reasonably practicable for her to bring her claim sooner, which has not been alleged, or that the detriments are part of a series, and the last act of that series was in time.

Conclusions

127. We will start with the dismissal claim, and the reason operating on the mind of Professor Murphy. That is a question of fact. It does not depend on the way in which the case is now presented. As already described, the allegation has been cast in various forms in the course of the disciplinary process. The letter inviting her to the disciplinary hearing (para. 67) stated that three complaints had been received and:

> "they have cited; aggression, fear and intimidation, accusations of lying and threats of being reported to the GMC."

128. The Wood report (p.796) opened with an introductory paragraph in almost identical terms, referring to the three complaints and adding:

> "They referred to aggression, fear and intimidation. They said that JM had made accusations of lying and threats of referral to the General Medical Council."

129. The Wood report broke this down into four allegations, set out at para. 96 above. Those four allegations were also summarised at the review meeting on 6 December 2017. Again, the main points are her conduct at consultants meetings (in the context of the buttonholing dispute), the accusations that Dr Sangala lied to or misled them, and the threat to refer people to the GMC. This is borne out by the wording in the management statement of case set out at paragraph 109 above. At the risk of repetition, this was about:

> "her general conduct towards colleagues, not acting professionally, not working collegiately, abuse, intimidation and being wholly unreasonable in persisting with imposing her views about the use of button holing, despite no evidence to support what she says and in fact, to the contrary following both internal and external reviews. There was no justification in the threat to report colleagues to the GMC and certainly no justification for actually reporting them. Not surprisingly colleagues are not prepared to work normally with JM.

130. If anything, this further highlights the buttonholing issue and the concern over any involvement by the GMC. The invitation to the disciplinary hearing (p.1608) repeated the original wording:

> The purpose of the hearing is for us to formally discuss your conduct in relation to allegations made by senior members of the Renal Department with regard to conduct towards them and intimidating behaviour (citing aggression, fear and intimidation, accusations of lying and threats of being reported to the GMC).

131. Finally, the outcome letter itself has just been quoted. It upheld the allegations and also referred to the GMC expressly.

132. Taking all this together, we conclude that the reason for dismissal was the breakdown in working relationships caused by the buttonholing controversy. This is turn resulted mainly from fear that Dr Macanovic would report colleagues to the GMC and a sense of outrage that she actually did so. That is the only context in which we can make any sense of the sense of fear and intimidation which is repeatedly mentioned. They were afraid of the GMC. Dr Wood made this connection between intimidation and the GMC in his findings on allegation 2. That was the cause of the stress and outrage, not fear of personal violence or even of a verbal tirade from Dr Macanovic. This outrage was particularly stressed in the management statement of case, emphasising that she had no justification for this referral, although the GMC view was different.

133. At this hearing the Trust's case was rather different. They argued that it was all about the manner in which she raised her allegations. Hence, they accept that this

was really all in the context of buttonholing. The extent to which the Trust's case rests on this distinction is seen from Mr Hignett's closing written submissions:

> Distinction between the disclosure and other separable matters evidenced by it
>
> 12. Whistleblowing law has long recognised a distinction between a person making disclosures and their conduct in making those disclosures. This distinction is at heart of [the respondent's] defence to the claims in these proceedings.
>
> 13. This central idea is discussed in Whistleblowing Law and Practice, Second Edition, Bowers & Others at Chapters 7.68 – 7.72 and 7.79 – 7.100 and in IDS Employment Law Handbook Whistleblowing at work Dec 2018 5.52 – 5.54 (relating to detriment) and 6.17 – 6.20 (in relation to dismissal). Bowers summarises it in this way:
>
> > PIDA protects disclosures but it does not protect other conduct by the employee even if that other conduct is connected in some way to the disclosure.
>
> 14. From the highlighted passages above the following cases are worthy of mention.
>
> Bolton v Evans
>
> 15. An early example of the distinction being drawn is Bolton School v Evans 2006 EWCA 1653 [2007] IRLR 140. This case concerned a technology teacher who hacked into the school's IT system in an attempt to prove it was insecure. A distinction was drawn by the [Employment Appeal Tribunal (EAT)] and the [Court of Appeal] between the making of the disclosure that the system was vulnerable and the misconduct involved in hacking into the system. Mr Evans was dismissed for his misconduct in hacking into the system not for making his disclosure that the system was vulnerable. His claims for detriment and dismissal both failed on this reasoning. Importantly, the Court of Appeal rejected the suggestion that 'a special purposive meaning' should be given to the term disclosure so as not to encompass Mr Evans' act of hacking into the system.
>
> Panayiotu v Chief Constable of Hampshire Police
>
> 16. Now regarded as the lead case on the distinction is Panayiotu v Chief Constable of Hampshire Police and Another 2014 IRLR 500. Here the EAT upheld the ET's decision that the reason for dismissal and detriments was not the fact that P, a police officer, made protected disclosures but the manner in which he pursued his complaints. The Tribunal found that whilst his employer took action in relation to his concerns, P would then relentlessly campaign if dissatisfied with the action taken by the employer following his disclosures; further that he would strive to ensure that all complaints were dealt with in a way that he considered appropriate. He continued to press his concerns resulting in the employer having to devote a great deal of time to his correspondence.
>
> 17. In Panayiotou the EAT emphasized that a tribunal must be astute to ensure that the factors relied on (a) are genuinely separable from the fact of making the protected disclosures, and (b) are in fact the reasons why the employer acted as it did. These were held to be issues of fact for the Tribunal.

18. The distinction between the making of a disclosure and the manner in which a disclosure is made continues to be approved of in a plethora of appellate cases: Barton v Royal Borough of Greenwich EAT 0041/14 B, Parsons v Airplus International Limited EAT 0111/17, Gibson v Hounslow LBC and others UKEAT/0033/18BA; Beatt v Croydon Health Services NHS Trust v [2017] IRLR 748; Robinson v His Highness Sheikh Khalid Bin Saqr Al Qasim 2020 IRLR 345.

19. The distinction has been maintained.

20. The Panayiotou distinction was applied in Parsons v Airplus International UKEAT/0111/17/JOJ, 13 October 2017. Ms Parsons, a qualified non-practising barrister, was employed by the respondent as its Legal and Compliance Officer, subject to a six-month probationary period. From early in her employment she raised numerous concerns. Her managers became increasingly concerned as to the way in which she was raising matters, her inability to work with others and her rudeness. After attempting to reassure Ms Parsons and to remove some of the pressure on her, the respondent was unable to see any improvement and decided she should be dismissed. The EAT upheld the ET's judgment that the reason for dismissal was not her disclosures but her reaction thereafter; her inability to explain her concerns, her failure to listen to others and her rudeness, which were genuinely separable factors.

21. The Panayiotou distinction was applied in Fertsch v Schultz ET Case No.2602017/16 (discussed IDS HB page 199). An ET found that F had not been dismissed for the disclosures he made concerning racist and sexist comments made to him but the manner in which he sort (sic) to complain about such matters to his manager. The ET accepted the manner in which the disclosure had been conveyed, F had acted in an intimidating and threatening manner.

22. Mr Alsop contends that it is only 'conceptually possible' for a distinction to be drawn between a protected disclosure and the manner in which it is pursued (JA skeleton para 21) but the case law shows that the Panayiotou distinction is much more than a mere concept. It is used over and over again to draw the boundary line between the protection afforded to whistleblowers and the commission of misconduct.

23. Contrary to the submissions by JA in his skeleton argument (JA 21), the Panayiotou distinction has been applied, made and approved of in a number of in cases involving NHS whistleblowers.

24. For example, Idu v Ipswich Hospitals NHS Trust Case 3400400/16 (discussed IDS HB page 198). This case involved a consultant who made disclosures about patient safety and the clinical competence of her colleagues that lay behind it. She was dismissed for misconduct when the Trust concluded that she had become unmanageable because of the deliberate tone and style of her communications with colleagues, her clear challenges to any attempt to exert authority, her refusal to accept any alternative innocent explanations for events and her refusal to adjust her behaviour when she was provided with a clear explanation as to why it was unacceptable and how it affected those around her. The Tribunal accepted that the reason for dismissal was connected to one of the disclosures but that the manner of the disclosure was separable. The Tribunal noted in that case it was important to recognise that the Trust was not hostile to Ms Idu's disclosures.

25. By way of further example, LJ Underhill approved of the Panayiotou distinction in the NHS whistleblowing case of Beatt v Croydon Health Services NHS Trust v [2017] IRLR 748 para 94:

> Employers should proceed to the dismissal of a whistleblower only where they are as confident as they reasonably can be that the disclosures in question are not protected (or, in a case where Panayiotou is in play, that a distinction can clearly be made between the fact of the disclosures and the manner in which they are made).

134. This passage from Beatt was also quoted by Mr Allsop. It highlights the key point for us to decide, which is whether the distinction can "clearly be made" between the fact of the disclosures and the manner in which they were made. More generally, this section shows that there was little difference between the parties on the legal principles, only differences of emphasis as to how ready we should be to draw this distinction. We shall compare and contrast these other cases with Dr Macanovic's situation below, but the question of whether this distinction can clearly be made is one of fact, after an assessment of all the circumstances of the case.

135. In Bolton School v Evans, Mr Evans went further than simply raising the disclosure; he hacked into the schools computer system to prove that it was vulnerable. To do that he had to decode the passwords, which he did with the help of a former student. He then told the headmaster what he had done, but failed to tell ICT. When they discovered the intrusion the whole system was shut down, causing a loss of £1,000. The headmaster concluded that he had hacked into the system without authority and issued him with a written warning, at which point Mr Evans resigned claiming that he had been constructively dismissed for making a protective disclosure. The employment tribunal agreed, and felt that his hacking was part and parcel of the disclosure. At the Court of Appeal it was argued on behalf of the claimant that a broad meaning should be given to the word disclosure in the Act, to ensure protection for whistleblowers. Lord Justice Buxton disagreed. "Disclosure" should be given its normal meaning. He was satisfied that Mr Evans was disciplined for the physical act of accessing the computer system, and hence that was the principal reason for his dismissal, rather than the disclosure itself. He added:

> "While I agree that the tribunal should look with care at arguments that say that the dismissal was because of acts related to the disclosure rather than because of the disclosure itself, in this case there is no reason to attribute ulterior motives to the employer."

136. Hence, it will be a relatively rare case when the actions of an employee in making a disclosure can genuinely be separated from the disclosure itself, but this is one case where that distinction can clearly be made, given the commission of an offence.

137. For Panayiotou itself, the headnote sets out the relevant facts:

> Mr Panayiotou was a police officer on the Isle of Wight, where his wife had established hospitality businesses. There were rules governing police officers having business

> interests and Mr Panayiotou applied for and was granted permission to be associated with his wife's businesses. In around 2000, Mr Panayiotou made disclosures to senior officers concerning the attitude of certain officers in respect of the treatment of race and the treatment of victims of rape, child abuse and domestic violence. There was an investigation and he was found to be largely correct in his concerns. However, he was not happy with the outcome and began to campaign for the force to take actions that he believed were appropriate. When the force did not take that action, he believed that matters were being covered up and this made him more determined to try other channels to secure redress. For example, he sought support from officers in representative bodies and made many lengthy complaints. He made other disclosures, including a complaint in October 2005 that there had not been a proper investigation of a racially motivated attack on a Lithuanian national. From about October 2006, the police force revoked, refused, or would not consider Mr Panayiotou's applications for permission to be involved in his wife's businesses. In that month, Mr Panayiotou was at home on sick leave when he was arrested at his home, the alleged offence being that he was receiving sick pay whilst working without authorisation in his wife's business. A specific police operation involving a huge amount of work was set up to investigate him. The relevant officers in the force decided to recommend that he be dismissed on the basis that he had an incompatible business interest.

138. Both parties in this case took fairly extreme steps. The campaigning activities by Mr Panayiotou covered a period of several years, and included elaborate conspiracy theories that senior officers had been bought off with honours to stop helping him. At the same time the actions of the Police Service were heavily criticised. After his arrest, two officers carried out surveillance on his wife's market stall in their own time to try to catch him helping her. However, ultimately the Tribunal concluded that the main reason for dismissal was exasperation that Mr Panayiotou had worked so little in the years that he had been with them, while being paid, and while seeking to be involved with the family business. The judgment noted:

> 52. Those authorities demonstrate that, in certain circumstances, it will be permissible to separate out factors or consequences following from the making of a protected disclosure from the making of the protected disclosure itself. The employment tribunal will, however, need to ensure that the factors relied upon are genuinely separable from the fact of making the protected disclosure and are in fact the reasons why the employer acted as it did. [Emphasis added]

139. In Parsons v Airplus International Ltd EAT 0111/17 the distinction was again upheld. The Tribunal held that Ms Parsons was fairly dismissed for her conduct rather than the content of her disclosure. The claimant there worked for the company in Compliance, and the conduct in question was her rude and confrontational behaviour. The Employment Appeal Tribunal observed, at paragraph 45, that:

> "The Respondent was, rather, concerned with what the Claimant did after she had made her disclosure; with her unresearched assumptions and demands; her conduct at meetings and failure to give rational, cogent reasons for her beliefs; her irrational fixation on her personal liability; and her inability to listen or take on board what her colleagues had to say. Of course, all of this was in the context of the Claimant's role

> in compliance, but the ET was clear: it was not what the Claimant was raising in that respect, but the way in which she was raising it and then, thereafter, conducting herself.

140. Again, these are distinct and severable features of the case. Some of those features are present in the present case, but to a much lesser degree. Concerns were of course raised about the conduct of Dr Macanovic at meetings, and perhaps also failure to take on board what colleagues had to say, but the outcome of the dispute was largely to accept and agree that her concerns were valid. She did not fail to give cogent or rational explanations for her beliefs although there was a dispute over the data. More importantly, the case of Ms Parsons involved a succession of compliance issues: Dr Macanovic was concerned with one main issue, potentially a matter of life and death. She raised her concerns against a dominant management group and at two meetings there were heated exchanges. Tempers were raised on both sides. The findings of the disciplinary process were, in our view, very one-sided, reflecting a determination to remove Dr Macanovic as the source of the problem, but that is very different from one individual making a disproportionate fuss about things that concern them. Regard must be had to the scale of the issues at stake in deciding between the message and the method used.

141. Fertsch v Schultz is an unreported decision of an employment tribunal. According to the report in the IDS brief:

> The disclosure concerned racist and sexual comments made to F, a Polish national, by non-Polish colleagues. F had gone into W's office to complain about these incidents and, in doing so, stood very close to W, stared directly at him and stated that he knew how to 'handle himself'. The tribunal accepted that W found F's behaviour to be menacing, intimidating and threatening and found that this this, rather than the disclosure itself, was the principal reason for dismissal.

142. Again, that conclusion seems uncontroversial. Idu v Ipswich Hospitals NHS Trust is also a first instance decision, described in IDS. Ms Idu - also a hospital consultant –

> "was dismissed for gross misconduct when the Trust concluded that she had become unmanageable because of the deliberate tone and style of her communications with colleagues, her clear challenges to any attempt to exert authority, her refusal to accept any alternative innocent explanation for events, and her refusal to adjust her behaviour even when she was provided with a clear explanation as to why it was unacceptable and how it affected those around her. The employment tribunal accepted that this was the real principal reason for dismissal and rejected I's assertion that her protected disclosures about patient safety and the clinical competence of her colleagues lay behind it. The tribunal accepted that part of the reason for dismissal was connected to one of the disclosures — namely, I raising patient safety issues by email to colleagues rather than through the proper channels — but found that the subject matter of the disclosure and the manner in which I had raised it were properly separable. [She] had been expressly asked not to cause unnecessary disruption by disclosing her concerns to all and sundry but to make disclosures to her line manager

> who would then deal with it appropriately. That was a reasonable request, given I's tendency to cause upset by her widespread and often inaccurate communication to colleagues. The tribunal noted that it was important to recognise that the Trust was not hostile to I's disclosures — indeed, on occasion, it thanked her for them, told her that it had investigated or was doing so, and indicated that her concerns for patient safety were shared by others.

143. Again, there are some similarities here, but again the main missing element is the very serious and single concern pursued by Dr Macanovic over buttonholing. It was not a case of her raising concerns to all and sundry. She escalated them, but only when she felt that no appropriate action was being taken, i.e. that the Trust was simply carrying on regardless. We note too unlike Ms Idu, Dr Macanovic encountered clear hostility, as shown by the conduct of the mediation meeting and the plethora of highly emotional and critical emails about her.

144. A case on the other side of the line, already referred to, is Croydon Health Services NHS Trust v Beatt. In that case the claimant was dismissed by a letter setting out the charges found proved, three of which related directly to making unsubstantiated allegations of unsafe staffing levels, so there was little doubt about the reason for dismissal. At paragraph 94, Underhill LJ stated:

> "I wish to add this. It comes through very clearly from the papers that the trust regarded the claimant as a trouble-maker, who had unfairly and unreasonably taken against colleagues and managers who were doing their best to do their own jobs properly. I do not read the tribunal as having found that that belief was anything other than sincere, even though it found that it was unreasonable. But it is all too easy for an employer to allow its view of a whistleblower as a difficult colleague or an awkward personality (as whistleblowers sometimes are) to cloud its judgment about whether the disclosures in question do in fact have a reasonable basis or are made (under the old law) in good faith or (under the new law) in the public interest.

145. Those comments apply with equal force in this case. And this is the nub of the matter. Although some valid concerns were raised in the disciplinary process, particularly about her accusing Dr Sangala of lying or misleading them, she apologised at the time and there was no comment or complaint about this at the time. The context of lying about Reading is also important and was not considered

at all in the investigation or disciplinary hearing. It was only when the buttonholing issue came to a head that disciplinary steps were taken over these points. The complaints were raised in March 2017, long after the consultants meetings in September 2016 and January 2017, suggesting that this allegation and the remark about intimidation, were not a spontaneous response. She did, we accept, make reference on occasion to making a referral to the GMC. That was not in our view an attempt to intimidate, only to demonstrate the seriousness of the situation. It has to be remembered that this was an innovative procedure and a substantial number of others shared her concerns.

146. It is true that in the course of the referral to the GMC and in the previous whistleblowing complaints she did make quite scathing personal criticisms of Mr Gibbs and Dr Lewis and was often dismissive of other people's views or expertise. She was never an easy colleague. But it is artificial to try to distinguish between the manner of raising the concerns from the concerns themselves, and that was not how it was seen at the time. The email from Dr Armstrong, quoted at the outset, expresses simple outrage at the GMC referral. It is not qualified by any suggestion that this was of course her right to do so, perhaps coupled with a statement that it was the manner or wording of the referral which was outrageous. That sort of sentiment is not to be found in any of the three complaints raised against her, or anywhere in the evidence we have seen.

147. This view is supported by the degree of co-ordination shown in the assembly of evidence against Dr Macanovic and the subsequent departures from their policies. Straightforward concerns about her behaviour would not have required any such departure or the bypassing of the various safeguards. And had the concerns about her behaviour been the overriding concern it is surprising that the Trust was willing to make repeated offers of a favourable reference.

148. One particular point raised on behalf of the Trust was that they took the buttonholing issue seriously, indicating that it was a separate matter. In fact, our view is that the consultant body in the renal unit were led by Mr Gibbs as Clinical Director, and he was a strong proponent. Dr Lewis gave Mr Gibbs his backing on this issue, and so Mr Gibbs was the one in a position to respond to the CQC. That is not so much treating her concerns seriously as attempting to resist or deflect them. It does not affect our view of the main reason for dismissal or the concern generated by the GMC referral.

149. Reliance was also placed on the pattern of previous behaviour, particularly over the nursing sister and the Hunter investigation. We have made our findings on those points, and would just add that they did not feature to any real extent at the dismissal stage.

150. Given our view that the Trust have not shown a potentially fair reason for dismissal, there is no basis for a reduction on the basis that a fairer process would

    have led to the same result (a Polkey deduction) or to contributory fault on her part.

    'Ordinary unfair dismissal'

151. If we are wrong that the principal reason for dismissal was the protected disclosures, particularly the GMC referral, we consider that the dismissal was unfair under ordinary principles. There were a number of serious failings in the process adopted here, the most conspicuous is the fact that she was offered the opportunity to resign during the disciplinary hearing itself. This was done by Dr Knighton with the knowledge and (we presume) prior approval of Professor Murphy. That follows from

the fact that it was then repeated by Professor Murphy on the day of the outcome itself. That offer can only mean that the outcome was a foregone conclusion.

152. A number of procedural errors were identified on behalf of Dr Macanovic, all of which seem to us valid:

    a. The scope of the investigation was confined to her behaviour, and there was no separate investigation into her complaints of bullying, contrary to the policy on Freedom to Speak Up.

    b. The review meeting involved Dr Wood and did not involve the LNC representatives, so this safeguard was bypassed.

    c. Dr Knighton took over the conduct of the disciplinary hearing, a senior manager at the same level as Professor Murphy.

    d. The decision should have been taken by a 'panel' and although not defined in the policy, it is in our view implicit that this should have been more than one person. Again, this was a safeguard which was bypassed.

    e. The weight of evidence at the hearing was all in Dr Macanovic's favour. Although numbers are not decisive, none of the three complainants attended to answer questions about their relatively short complaints. By contrast, no consideration appears to have been given to the supporting evidence for Dr Macanovic, which was not confined to her clinical competence.

    f. A number of aspects were not fully considered, or considered at all. These include her length of service; the fact it was a first 'offence'; that the disputes arose in the buttonholing context, when tempers were raised on both sides and where real concerns existed about patient safety; the context of the accusation of lying over its use in Reading; the length period since the consultants meetings in question, during which there had been no further disagreements; and whether there were any alternatives to dismissal. (Given the fact that the outcome was one of serious rather than gross misconduct we are not satisfied that Professor Murphy felt that it was sufficiently serious by itself to justify dismissal.)

153. Other indications of a predetermined decision, which cannot have been confined to Professor Murphy given her late involvement, are the fact that the three complaints were assembled by or for Dr Lewis in the way described, after an interval of weeks or months. There is also the fact that her exclusion began hard on the heels of the failed mediation, i.e. her refusal to withdraw the GMC referral. All this combines to show that a decision had been taken to solve the problem caused by the dreadful atmosphere in the unit by removing Dr Macanovic.

Detriments

154. It follows that the various detriments are also upheld, since it is only necessary to show that they were 'materially influenced' by the disclosures. Reviewing them briefly, the first five disclosures were all in late 2016 – the emails to Dr Lewis on 9 September, 17 September, and 3 October, and the allegations made to Mr Hunter, both in interview and later in writing on 17 October. By then the dispute was already highly contentious. We accept therefore that the subsequent detriments – the incident with Mr Graetz and the emotional email from Mr Gibbs the following January – were connected. The latter was expressly about her and her complaints.

155. The further disclosures comprised the letters to the CQC and GMC, on 9 March 2017, together with her solicitors' letter that day and on 29 March. All this was shortly before the three allegations of misconduct were assembled against her (Detriment 3), then the decision to initiate disciplinary proceedings (4) and Dr Lewis reading the terms of the GMC referral out at the consultants meeting (5). We accept that there was no need for her to cancel her clinic at short notice (6) but that was followed by the decision to exclude her from meetings (7) and later continue those restrictions (8). They followed the failed mediation and so were in the context of her refusing to withdraw her GMC referral.

156. Given that the disciplinary hearing and process were in our view designed to remove her for making these disclosures, it follows that the various shortcomings were also materially influenced by them. That includes the review meeting in favour of proceeding to a disciplinary hearing (9), the failure to investigate allegations against her, i.e. singling her out (10), and the response by the Trust 's solicitors stating that her allegations were not made in good faith.

157. In other respects the net has been cast too wide. Delays by Mark Cubbon do not seem to us attributable to the allegations. More likely it was simply a very difficult situation and there was some miscommunication (11 a and b). As already noted, there was no Powell Investigation Report (12) to disclose. The failure to resort to ADR (19) is also a difficult claim. A refusal to seek agreement is difficult to describe as a detriment, however desirable that might have been. Similarly we can understand why Mark Cubbon failed or declined to intervene in the disciplinary policy at the 11th hour, as requested (20).

158. However there were then various departures from policy (14), including the lack of any real investigation into incident with Mr Graetz and the consultants meetings that day, which led to her being signed off sick for two weeks, the failure to consider alternatives to dismissal (16), the pre-judgment (18), and the offer to resign (21), all of which are in our view made out.

159. Those are essentially housekeeping matters given our findings in relation to the dismissal. In closing, we repeat that the broad lines of this case were apparent at the outset and emerge clearly from the dismissal letter. The attempt to distinguish

Dr Macanovic's conduct from the subject matter of her complaints was not apparent at the time, and cannot now be sustained. There is no doubt that Dr Macanovic could have raised her concerns more diplomatically and less personally. The terms of her referral to the GMC were bound to offend her colleagues, regardless of her justification or perceived justification. Nevertheless, it was established before this hearing started that she was entitled to take those complaints to the GMC and that, we are satisfied, was the main reason for her dismissal, not the manner in which she did so.

160. Notice will be sent to the parties shortly of a case management preliminary hearing to give directions for a hearing on remedy. The outstanding costs application relating to a previous adjourned hearing can also be considered at that hearing.

Employment Judge Fowell

Date: 17 January 2022

Judgment sent to parties: 20 January 2022

FOR THE TRIBUNAL OFFICE