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Whistleblowing in the NHS – how to best protect oneself from the costs and consequences

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The President: Good evening, everyone. Welcome to the last meeting of the current programme. I would like to extend a particular welcome to all those who are joining us remotely this evening from abroad and from around the country. We also have a number of guests with us this evening and some new members. You are all very welcome too.

Our speaker tonight is Samantha Prosser, Managing Associate at Brahams Dutt Badrick French LLP. She is an experienced employment law litigator handling financially substantial claims in the Employment Tribunal and the Employment Appeal Tribunal.

Her particular interest and expertise is in whistleblowing. She also deals with sex and disability discrimination claims and has advised senior healthcare professionals both in the NHS and in the private sector on whistleblowing and on discrimination claims. She also has considerable experience of disciplinary processes and grievance procedures including those involving bullying, harassment and contractual disputes.

She clearly enjoys a challenge because my research has revealed that she is also a bungee jumper and a sky diver. So, I hope that she will not feel too challenged tonight.

Samantha, thank you for agreeing to address us and welcome to the Medico-Legal Society. *(Applause)*

Samantha Prosser: Thank you very much, Mr President, for that lovely introduction and I am honoured to speak here this evening and particularly on a subject that's very close to my heart and an area that I focus on. I'm mindful that I've got around 40–45 minutes to speak. Whistleblowing is a huge topic legally and emotionally and it's very much in the public consciousness as we speak following high profile cases such as Lucy Letby and you may have been reading the recent *Telegraph* articles on NHS whistleblowers as well. The purpose of this talk is to provide you with information so you can recognise what may amount to a whistleblowing disclosure and to help you if you find yourself in the situation where you see wrongdoing and you feel the need to speak up and how best to go about that to try and to protect yourself.

The agenda tonight is that I'm going to provide a brief overview of whistleblowing law: who is protected, how do you gain that protection and what rights you have as a result. It's going to be a whistle-stop tour because it's a hugely complex area of law, so I'm only able to give you a high-level overview tonight. Then we'll focus on whistleblowing in the NHS, why is it so important, the common scenarios that I see in my experience of dealing with individuals in the NHS, and then how best to protect yourself if you are considering blowing the whistle or if you've already blown the whistle, and then there should be some time for questions.

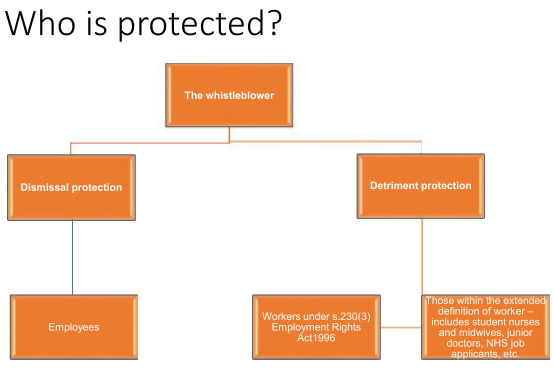
Whistleblowing law is really prescriptive and I often see a disconnect or a misunderstanding between what an ordinary person would consider to be whistleblowing and what, in fact, is actually required in law, because the term "whistleblower" is bandied about quite a lot and that can be slightly dangerous because you might not always have the protection that you think you may have. There is an awful lot that I can say about the current whistleblowing regime and its fitness for purpose and you'll be glad to know that I don't have time to do that tonight because I will get on my soapbox about it. In my view, it's not fit for purpose. It's overly complicated. You'll see as I go through my talk the number of hurdles that an individual needs to get across just to get the protection that they deserve. And, often, in my view, I think employers are held to a relatively low standard in arguing that

A meeting of the Medico-Legal Society was held at the Medical Society of London, Lettsom House, 11 Chandos Street, Cavendish Square, London, W1G 9EB on Thursday, 13 June 2024. Mr Simon Readhead was in the Chair.

their actions were not on the grounds that someone blew the whistle but because of some other non-protected reason such as the way someone said it or the way they went about it. You'll probably be thinking, yes, I would say that as I am a claimant lawyer and there is an element of truth to that, but the way I see it is that whistleblowing is a fundamental necessity for us to live and work in a safe and transparent environment, and in sectors particularly like the NHS, when there is so much at stake, people ought to have more protections not less.

Now I will go on to explain the law and get off my soapbox. As I said, I'll be focusing on the core elements of the whistleblowing framework, and due to time constraints I am not going to look at remedies or procedural issues tonight.

Slide 4



If we start with who is protected. Firstly, employees are protected. They are protected from dismissal where the reason or the principal reason for their dismissal is that they have made a protected disclosure. This protection applies to employees only and you can only bring claims against an employer. Employees also have the right for detriment protection, as do workers, and that is the right not to be subjected to any detriment on the ground that they have made a protected disclosure. "Worker" for the purposes of whistleblowing law has a special extended meaning, namely, an individual who works under a contract of employment or any other contract, who personally provides the work to the other party and who is not in business on their own account.

Case law has extended the boundaries of who is classed as a worker to gain this kind of protection and you'll see some of these on the slide – we have student nurses and midwives, junior doctors and, crucially, NHS job applicants. Job applicants in other sectors are not protected.

What this extended definition means is that self-employed contractors are *not* protected. This has quite big ramifications in the healthcare sector because the majority of individuals offering services in private practice are deemed to be self-employed and they're often named as being "self-employed contractors" in the contractual documents they have with the provider, such as their practising privileges. But that is only half the story. What the courts will do is look at the reality of the situation, how does the relationship operate in practice, rather than simply looking at the label within the contract.

The key thing to note is that unless you are an employee, you are not automatically protected if you blow the whistle in private practice. What you first need to do is get over this additional hurdle to show that you are, in fact, a worker and that you do, in fact, have this protection, and then you need to go on to see if you actually meet all the various hurdles to get that protection.

If a person establishes that they fall within the whistleblowing regime there are two key questions that need to be answered. Firstly, has a "qualifying disclosure" been made and, if yes, is that also a "protected disclosure"? I will look at both in turn now.

There are four hurdles to jump in order for a qualifying disclosure to be made out. Has there been a disclosure of information? If yes, did that disclosure relate to one of six relevant types of failure? If yes, did the worker have a reasonable belief at the time that they made the disclosure that it tended to show one of the relevant failures? Finally, if yes again, did the worker have a reasonable belief, at the time, that the disclosure was made in the public interest?

Taking each of these hurdles in turn then.

First, has there been a disclosure of information? The form of a disclosure can vary and disclosures can be made orally. They can be in writing, whether that's by email or in other documents such as Datixes, or even in videos. From a claimant lawyer point of view, I would advise that you should *always* make them in writing. It is safer that way; you avoid disputes as to whether a disclosure was actually made and also about the content of the disclosure, which can often prove quite crucial in cases. If it is done orally, as is not unusual in practice, then it is always sensible to make a contemporaneous note at the time. For example, if you have a meeting where you raise a disclosure, follow up in writing to set out what was said, or at least send it to yourself so that you have that note.

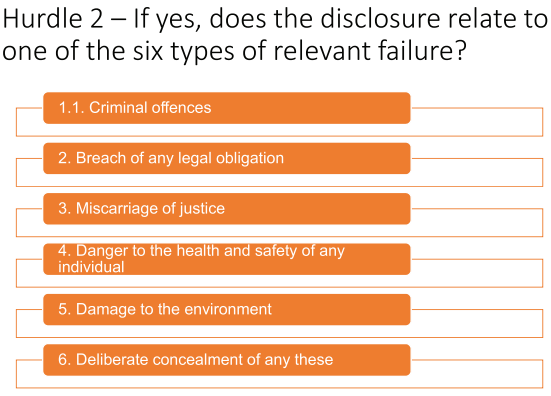
Several different communications can, cumulatively, amount to a disclosure of information even if they would not be classed as a disclosure on their own, and a disclosure can contain new information as well as old information.

What is crucial is that the disclosure must contain information, not just voice concerns or raise

allegations. You must be conveying some kind of fact. As an example, if you were to say, "The wards haven't been cleaned for the past two weeks, yesterday there were sharps lying around," that would be a disclosure of information. Contrast that with the statement, "You are not complying with health and safety requirements" – that would *not* be a disclosure of information, it is more akin to an allegation and it is not specific, it's too vague.

There is no hard and fast rule as to what is information and what is allegation. There is no rigid dichotomy and, sometimes, allegations will contain information that can amount to a disclosure of information. It all comes down to the factual content and whether what was said was sufficiently specific. The context in which a disclosure is made is also really important. So, taking the example that I just used, if you were on the ward and said, "You are not complying with health and safety requirements," but you also pointed to sharps that you could see lying around, taken together that *could* be a disclosure of information.

Slide 7



So, we have got over the first hurdle. The second hurdle is that the disclosure of information has to, in the reasonable belief of the worker, tend to show that one or more of six specified types of malpractice or failure has either taken place, is taking place, or is likely to take place. I have set out on the slide the six types of malpractice available. Typically the one that we are relying upon in the healthcare sector will be the danger to the health and safety of an individual and that includes to patients and also to colleagues or to third parties in a hospital, for example.

I also see breaches of legal obligations arise in my practice too. For example, an individual alleging that a Trust has discriminated against someone else – that could be a breach of the Equality Act 2010. What is important to know is that if you are disclosing information relating to a breach of a legal obligation you do not have to use specific legal terminology; you are not expected to be a lawyer; you are not expected to point out the specific clause of any Act of legislation; you just need to do something more than just saying, "This is wrong in law."

So, we have got over two hurdles. The third hurdle is that at the time the disclosure is made, it is also necessary for the worker to show that they had a reasonable belief that the information tended to show one of these failures. It does not matter if the information is inaccurate. You do not have to prove that the alleged misconduct did, in fact, take place, just that you had a reasonable belief that it did. It also does not matter if the information you are disclosing is capable of amounting in law to one of the categories of wrongdoing. For example, you can disclose a belief that someone is in breach of the Equality Act 2010, even if such action would not, in fact, amount to a breach of that legislation. However, you have to be mindful that if you were to deliberately disclose false information you would not acquire whistleblowing protection and are likely to face disciplinary action.

What *does* matter in this context is that the worker subjectively believes that the information tended to show a relevant failure and that the Employment Tribunal considers that belief was objectively reasonable. You also have to hold the belief at the time you raise it; you cannot retrospectively assert the belief.

So then, to the final hurdle for this part of the test. Since 25 June 2013 a qualifying disclosure has to be made in the "public interest" and, again, what matters is whether the whistleblower subjectively believed at the time of the disclosure that it was in the public interest. That belief must also be objectively reasonable. A belief in the public interest need not be the predominant motive for raising the disclosure or even form part of the motivation in doing so. However, there have been cases where the tribunal has found that a disclosure was not made in the public interest on the grounds that it was made for purely personal reasons.

So, what does amount to public interest? Unhelpfully, it is not defined in statute and the question is one to be answered by a tribunal looking at the particular facts and circumstances of a case. Previous case law has provided helpful tools and factors to help with this consideration. For example, the numbers of people whose interests the disclosure serves: the larger the number of people affected the more likely public interest is engaged. You also need to look at the nature of the interests affected and the extent to which they are affected by the wrongdoing. So, disclosure of wrongdoing directly affecting a very important interest is more likely to be in the public interest than a disclosure of trivial wrongdoing.

You also look at the nature of the wrongdoing as well. Disclosure of deliberate wrongdoing is, again, more likely to be in the public interest than inadvertent wrongdoing even if it affects the same number of people. The identity of the wrongdoer can also be quite important. The larger or the more prominent the wrongdoer, the more obviously disclosure about its activities would engage the public interest. Clearly, where disclosures are made for patient safety reasons in the NHS it should pass this test.

If someone manages to jump all of those hurdles then they have made a qualifying disclosure and they have almost unlocked the legal protection. But not quite, because, in order for the qualifying disclosure to be protected, they also need to make the disclosure to the right person and in the right way. Generally speaking, most whistleblowers will make disclosures to their employer. In the interests of time I am not going to go through each of categories of person one can disclose information to. Focusing on disclosures within the employer's organisation, statute is silent as to who within the organisation you ought to raise protected disclosures with. There may be whistleblowing policies that your employer has that designates to whom you should be raising concerns, but it is not definitive and you are unlikely to lose a legal claim simply because you do not follow the whistleblowing policy and you raise your concerns to someone else.

There is unlikely to be a dispute if you raise concerns to someone more senior than you, or someone that has implied or express authority over your actions as, generally speaking, disclosure to them would be regarded as being a disclosure to your employer. The case is not quite so clear cut if you make disclosures to junior colleagues or to someone of an equal status. In that case, the tribunal would look at the circumstances as a whole to see whether that was reasonable disclosure.

Slide 11

Is the qualifying disclosure also a "protected disclosure"?

The person	Method of disclosure
The worker's employer (and authorised third parties)	Consult whistleblowing procedure. If none, safest course is to disclose to someone senior to the worker and/or HR
The person responsible for the relevant failure	Worker must reasonably believe the malpractice relates solely, or mainly, to the conduct of the person or a matter for which the person has legal responsibility
Legal advisers	Worker must make disclosure in the course of obtaining legal advice
Government ministers	Worker must be employed by a statutory body and make the disclosure to a Minister or a member of the Scottish Executive
Prescribed persons	Worker may disclose to any "prescribed person" named in any relevant order (e.g. HMRC, FCA, PRA, ICO, MPs). Worker must also reasonably believe that: (i) the wrongdoing falls within the remit of the PP; and (ii) the information disclosed and any allegations contained in it **are substantially true**
Wider disclosure (e.g. the media)	Protection will only be available if rigorous conditions are met. These conditions are relaxed if the relevant failure is exceptionally serious.

I am going to touch briefly upon one of the other categories of persons a disclosure can be made to; Prescribed Persons. This is a list of people or organisations set out in a Government Order to whom you can blow the whistle to prior to even raising the concerns internally with your employer. So, Prescribed Persons for our purposes include NHS England, the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Care Quality Commission (CQC) and the National Guardian's Office, for example. There are additional hurdles if you are wish to disclose information to a Prescribed Person rather than your employer. A qualifying disclosure to a Prescribed Person will only be protected if the worker reasonably believes that, firstly, the wrongdoing falls within the remit of that Prescribed Person and, secondly, that the information disclosed and any allegations are substantially true. So, there is a higher threshold. That is because whistleblowing law is designed to encourage you to raise issues internally so that your employer can properly address them.

It used to be a requirement that a disclosure also had to be made in good faith. This was removed in 2013 but I reference it now because it is still relevant for whistleblowing law purposes, because if a disclosure is *not* raised in good faith, a tribunal may, if they think it is just and equitable, decide to reduce any compensation that you are awarded by up to 25%.

So, only if an individual jumps all of the hurdles that I have just taken you through do they acquire whistleblowing protection. I will now discuss what form this protection takes.

Firstly, with regards to detriment protection, as I have said, workers and employees have the right not to be subjected to a detriment on the ground that they blew the whistle. A "detriment" is something a reasonable worker would consider a disadvantage in the circumstances in which they work. Common examples of detriments that we see are failures to promote, denial of training, ostracism, bullying and harassment, failure to address concerns, suspension, disciplinary sanction and even dismissal. I will not discuss all the legal elements you would need to meet in order to win a claim for whistleblowing detriment, but I do want to pick up on a couple of key points.

An employer can be liable for its own actions as against a whistleblower and can also be vicariously liable for the actions of its employees and workers. Generally, in that situation, an employer will seek to rely upon a defence that they took all reasonable steps to prevent the detrimental treatment from taking place or occurring.

In certain circumstances, workers who commit detrimental acts against the whistleblower can also be *personally* liable. Workers can also claim that the

termination of their engagement by reason of the protected disclosure was a detriment in and of itself and so they can claim all losses flowing from that against their colleagues and co-workers if they are named as individual respondents.

In order to win a case for detriment protection, a worker has to show the detriment was on the ground that they made a protected disclosure, i.e. there was a causative link between the disclosure made and the subsequent treatment. This means that the disclosure must have *materially influenced* the treatment they faced.

Secondly, there is protection from dismissal. This is for employees only and they will be "automatically" unfairly dismissed if the reason or the principal reason for their dismissal was that they made a protected disclosure. You do not have to have a minimum qualifying period of service in order to bring this claim, in contrast to "ordinary" unfair dismissal claims where (currently) you need to be employed for at least two years. For whistleblowing claims, you obtain the protection from day one of employment.

Whether a protected disclosure was the reason or the principal reason for the dismissal will require a tribunal to look at all of the facts and the beliefs or mental processes that caused the decision-maker to take the decision to dismiss. Note that if a person in the hierarchy of responsibility above an employee determines that they want to get rid of the employee because the employee has blown the whistle, but they give a false motive to the decision-maker and the decision-maker adopts their position and decides to dismiss, the decision-maker can still be imputed with their hidden motive, meaning the reason or principal reason for the dismissal can still be the protected disclosure.

Often, in practice, causation is a huge problem in these types of claims. It can be difficult to show what the real reason was for the treatment, and it can also be difficult to separate out the treatment faced from the whistleblowing disclosure which has been made. It is that classic case of an employer arguing that even if they did treat the worker in the way alleged, it wasn't because that individual blew the whistle, but it was because of the way they said it, or the manner in which they went about it. In some cases this is really quite clear cut. There was a case of a teacher who decided to hack into the school's IT system to prove that his concerns about security were well-founded. You will probably not be surprised to realise that he didn't win his claim in that instance. But, most of the time, the difference/the distinction is more subtle, and it can sometimes be very artificial.

I was involved in a case in the Court of Appeal last year called *Kong* v *Gulf International Bank Ltd* where this issue was in question – an issue we call "the principle of separability". I am going to talk about this case not just because it was one of my cases, but because this is the kind of defence that is used time and time and time again in whistleblowing law. In the *Kong* case, Ms Kong raised concerns about some of the contracts governing the Bank's financial products. She thought the contracts were unsuitable and they did not provide sufficient safeguards. She raised it to the Head of Legal, Ms Harding, who didn't take this kindly. Ms Harding confronted Ms Kong about it and during the course of the discussion Ms Kong questioned Ms Harding's legal knowledge.

Ms Harding felt that Ms Kong had overstepped the mark and had challenged her professional integrity, so Ms Harding told the Head of HR and the CEO about this and that she couldn't work with Ms Kong again. The CEO and Head of HR decided to dismiss Ms Kong and they created a dossier setting out this issue and the discussion that had happened plus other concerns that, strangely, had never been raised with Ms Kong before. A different decision-maker at the Bank decided to dismiss Ms Kong. The Bank claimed that this was on the basis of her behaviour, her manner and her approach and that colleagues did not want to work with her.

Ms Kong brought a claim and argued that Ms Harding's complaint about her behaviour had been motivated by the whistleblowing disclosure that she had made, and, in turn, the complaint was the principal cause of her dismissal. In other words, she had been dismissed because she blew the whistle. The Court of Appeal concluded that there was a distinction between the whistleblowing disclosure and the conduct associated with making the disclosure. They concluded that the Bank's motivation in dismissing Ms Kong was because of a lack of emotional intelligence and insensitivity in the way she conveyed her criticisms of Ms Harding and that it was not necessary for her to have behaved in this way in order for her to have made the disclosures. This was despite the fact that they agreed Ms Kong had raised legitimate concerns and she had raised them in a reasonable way.

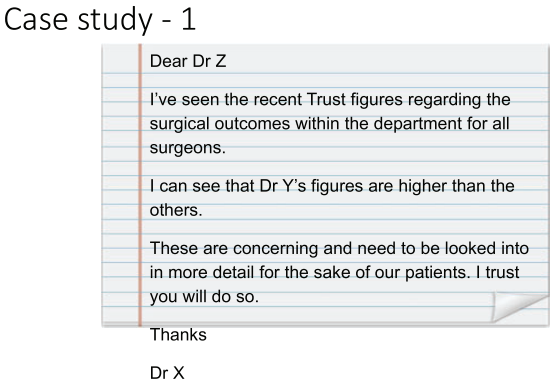
The case still rankles with me, as you can tell, because most whistleblowers will ruffle feathers. You are either expressly or impliedly criticising someone or their decisions. In my view, this case gives more scope for employers to rely upon this type of argument. Whilst it shouldn't give *carte blanche* to employers to treat whistleblowers in this way, it does allow them to dismiss someone because the relationship broke down and to say that this was separate from the disclosure made. This sends the wrong signal.

We acted on behalf of Protect, the whistleblowing charity who had intervened in this case. We tried to argue that there should be guidance offered to tribunals

in this situation. We argued that employers should only be able to rely upon this kind of argument in cases where the conduct was sufficiently unreasonable, but that was, unfortunately, rejected.

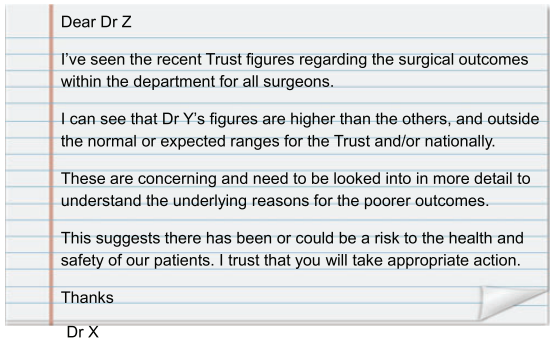
As I said, I am not going to discuss remedies such as interim relief but will now look at a case study to see how well you have all been listening.

Slide 15



Have a look at the email on this slide from Dr X. I cannot see anyone online but hands up in the room who thinks this could be a qualifying disclosure. *(Show of hands)* The majority of you are right. I think it is *unlikely* to be so in law but let's have a look at the next email which expands on the first.

Slide 16



Again, hands up who thinks this one would be a qualifying disclosure. *(Show of hands)* I think there is more consensus on this one and, yes, I think this one is *more likely* to be a qualifying disclosure. Why? Because it connects the dots. It provides information and facts and, helpfully, references objective evidence, which is always good to do in whistleblowing law, and it links those facts/that information to the potential risk to the health and safety of patients.

You may be looking at the email and thinking, "That's pretty artificial, who writes this in practice?" and I agree with you. This is one of my biggest bugbears with whistleblowing law, that, naturally, people do not have the law in mind, they do not have in mind all the various hurdles that I have just taken you through when they are flagging issues and so they can fall short of making a disclosure which is protected in law.

At the end of my talk I am going to discuss what steps you can take when you are flagging issues to try and gain that protection.

Take again, Dr X, our whistleblower, from earlier and let's assume that her email *was* a protected disclosure and she sent it off to her manager. What can and often happens next? In my experience, Dr Z, the manager she raises the concerns to, instead of looking at the patient safety concerns that had been flagged, takes no action save that they tell Dr Y about it and Dr Y naturally takes umbrage at this and then starts a campaign against Dr X, quite subtle at first, until it ratchets up quite quickly.

So, it starts off with criticising Dr X, our whistleblower, during MDTs, talking over her, disregarding her opinion. Dr Y starts asking other colleagues in the department about her – "What's her behaviour like? How do you find her?" – trying to elicit poor feedback of her. Dr X becomes more and more ostracised; she is sidelined from meetings and work, her areas of special interest. Rotas are rearranged to her detriment, and then there is a closer monitoring of her work looking for anything to criticise her – "When has she clocked in to work? What has she been doing during her PAs? Has she been doing what she ought to be doing during her PAs?" Then the Datixes start coming in, relatively minor Datixes, Datixes that wouldn't ordinarily be put in, nitpicking, and then concerns are raised about Dr X to Dr Z, or the clinical director, or the medical director about her competency, her behaviour. Others are brought on board and the department starts to become factionalised.

Then what does Dr Z do? He decides to investigate the Datixes and Dr X is subjected to a very lengthy Maintaining High Professional Standards (MHPS) process. She is placed on restricted duties in the meantime and lots of allegations are thrown into the mix. As often happens in practice with my clients, Dr X becomes unwell through the sheer stress, the anxiety, the pressure she is facing, and she goes off work sick. She then stays off work long enough that her pay starts to run out and this exacerbates the problem even more.

Then what happens? The MHPS process eventually concludes after months and months and no clinical

concerns are upheld, save one or two points are made out in respect of her behaviour or her interaction with colleagues. Dr Z thinks there is some scope for improvement and so he starts looking at remediation. Inevitably, at some point during this process, Dr X will raise a grievance against Dr Y and Dr Z, therefore, embarking on yet another very lengthy process, months and months, instead of the weeks that the Trust's policy says it ought to take. Some small issues may be upheld within it but on the whole people's heads are buried in the sand, they do not want to connect the dots between this first email and all of the behaviour that has been happening ever since, and so, for the main part, the grievance is not upheld.

Then what are we left with? We are left with a department where the relationships have broken down, where it is completely dysfunctional. There may be some attempt to mediate and then the Trust is left in a position where they cannot terminate Dr X's employment for performance reasons because no clinical issues were found, nor can they terminate her employment for conduct because it has not reached the threshold of gross misconduct, so they may start looking for "some other substantial reason" to terminate her employment such as the breakdown in working relationships. Or, they might just be hoping that things have got so bad that poor Dr X just feels like she has no option but to resign.

All of this might seem a little bit far-fetched to you, but in my experience it is really not. Some of you in the room, unfortunately, may have experienced this or you may have witnessed this with other colleagues, and, in fact, some of the treatment my clients have faced has actually been much worse. Some of my clients have had collective grievances raised against them; they've been compared to Adolf Hitler in emails; I even had a client who had covert surveillance carried out on her. We found out during an Employment Tribunal trial that photographs had been taken of her at another hospital because the individual was trying to show that she was somewhere she shouldn't have been at that particular time. If you have seen the recent *Telegraph* articles on this, they call it the "Playbook Used to Break Whistleblowers". The All-Party Parliamentary Group on Whistleblowing calls it the "Cycle of Abuse". I see these issues time and time again.

Why is it such a big deal in the NHS? The clear and obvious reasons are patient safety; the harm that can be caused if concerns are not raised or if lessons aren't learned, the use of public money and the unique position that the NHS holds in our society. Also, the obligations that come with being a medical professional. There is an added complexity in this area because as regulated professionals you are under a positive obligation to raise concerns. I won't go into the history of the "Freedom to Speak Up" regime and all the reports and inquiries that have created and emphasised these obligations, but put simply, if you know about patient safety concerns, then your own regulatory position could be in jeopardy if you do not raise them. If you are sufficiently senior within the organisation, it may also bring into question whether you are a fit and proper person to perform that role. So, because of this, and because of the nature of the work done within the NHS, it gives rise to lots of potential to spot and raise concerns.

It may be a generalisation, and it will not be everyone's experience, but I have acted for enough clients to form the view that unfortunately I believe there is a systemic cultural issue about how the NHS treats whistleblowers. I have to try and take this with a pinch of salt because I am an employment lawyer, I see things when they go wrong. There are likely to be thousands of people who raise concerns, and those concerns will have been looked at, they will have been addressed and the parties move on. In those situations, they wouldn't necessarily class themselves as a whistleblower, because you only tend to class yourself as a whistleblower once bad things start happening to you as a result. But this is based on the number of people I have acted for, and the similarity of the events that occur. As I highlighted in reference to Dr X in our case study, which was an amalgamation of most of my clients' experiences one way or another, and the fact that my clients can often point to one, two or three other individuals who they say have also faced this treatment and, as I've set out, it is also played out in the news. There is probably not a week that goes by when we do not see a negative story in the press about whistleblowing in the NHS.

I have thought long and hard when acting for clients about why this is such an issue in the NHS. Why do I see these issues arising time and time again? You all may have a much better insight than I do. You work in the NHS, and you may have your own thoughts as to why but, in my experience, I think there are a number of factors. Quite often it can be the personalities involved. Again, it may be a generalisation, but in some specialities you can have really big personalities, you are making big and difficult decisions, you are needing to be assertive and decisive, and that can be a double-edged sword although we all know it shouldn't be. I also find there is an element of saving face, of professional embarrassment. It feels like there is a culture of blame rather than it being seen as a learning experience. I often think that reputational risks can be at the forefront of the mind of management. This appeared to be the case reading some of the stories in the Lucy Letby case. There are also issues of protecting private practice work. I had a case where a client raised concerns about the number of patients

who were being put forward for biopsies and this was because the Trust was outsourcing those operations to the private practice because of the huge waiting lists they had on the NHS list. The consultant who was putting forward these patients for biopsies had a financial incentive for doing so because they were doing the work as part of their private practice.

I think in the NHS other elements such as pressure of workload, lack of resources and huge waiting lists are also relevant. As an outsider, it seems, unfortunately, that the NHS is in pretty dire straits at the moment despite your incredible efforts, and you are operating in such an intensely pressurised environment which can heighten emotions. That also means there is a lack of management time and lack of management and HR incentive to address issues properly at the outset as well. I see time and time again that issues are just left to fester, to worsen and to blow out of all proportion and, believe me, out of all proportion compared to any other sector that I advise clients in.

What I find difficult from a claimant lawyer point of view is that there are so many different ways that an individual can be backed into a corner. It is not like other sectors where you can just find another role if you do not like the environment or if your concerns are not being addressed. That is not easy to do when you are training, or you are in a specialised position or where you are constrained to live within a certain distance of where you work. I think the regulatory position also plays a part in this because allegations, Datixes, they can all be weaponised against a whistleblower and the threat of a referral to the GMC is a powerful deterrent. It also means that you can sometimes feel stuck. You cannot leave when you have lots of internal investigations ongoing and those processes can take months and months.

Some of the other issues I see is that what happens in a Trust may also have an impact in private practice. Some hospitals have a kind of symbiotic relationship between the NHS Trust and the private hospital and so what happens at the Trust has a knock-on effect on private practice and that can have really severe financial consequences for that individual. When issues do blow up, unlike in the private sector where commerciality plays more of a part, in the public sector there are huge difficulties in resolving issues or resolving claims because of the financial constraints that Trusts are under. You either have to apply for HM Treasury approval which is very difficult to get and can take months, or the Trust cannot settle unless and until they have a judgment made against them. So, it means that more often than not you are either looking to settle claims for contractual payments due to you, or in respect of packages that do not require HM Treasury approval, or, if you end up having to bring an Employment Tribunal claim, particularly if you are clinical staff, you are likely to have to pursue it all the way to the trial.

What I find so sad, and I know that my clients particularly find sad, is that the focus is on these employment issues rather than the patient safety concerns; that first email from Dr X, in our example, gets forgotten about and lost. I have a case at the moment that is going to trial in three weeks' time and, two years on, we know that the issues that she raised are still happening.

I am conscious that seemed a lot of doom and gloom and I really do not wish to put you off from raising genuine concerns you have; that is paramount. The fact is, I have enormous respect for whistleblowers. It takes a huge amount of courage to put your head above the parapet.

What I want to look at now is what you can do to try and minimise risks if you feel that you do need to blow the whistle. There are a number of practical steps that you can take to try and bolster your position.

The first is to try to understand what amounts to a whistleblowing disclosure before raising concerns. This will enable you to properly identify whether your concerns are about wrongdoing/malpractice and so you gain protection, or whether they fall outside the scope of whistleblowing protection. In addition to that, understanding the law means that you are better able to formulate your concerns in a manner that is more likely to gain that protection. As I tried to show in the case study, you should always try to seek to relate the activity you are concerned about to one of the examples of malpractice provided in whistleblowing law, to connect the dots for someone.

It is also important to look at the whistleblowing policy that may be in place so that you are raising concerns in the right forum in the right way and to the right people, although sometimes that is just not possible. One of the crucial things to do is to behave reasonably and responsibly at all times because, as I've shown, employers will try to argue that the treatment meted out was not on the grounds that you blew the whistle but because of what you said, or the way you went about it. If you are measured and proportionate, it makes it harder for employers to adopt those kinds of arguments.

One way to do that is to set out your concerns factually, without unnecessarily apportioning blame or throwing around accusations or making things personal or directed at one particular person. That may also help minimise fallout with colleagues. It will also look better when a judge looks at your disclosure in a year/18 months' time if a claim is brought.

One important thing to note is that you do not have to conduct your own investigation into the

wrongdoing. You can simply flag the issues and leave it to your employer to investigate. Sometimes they are not investigated, or they are dismissed out of hand or, when they are looked at, the findings are unfair or unreasonable and, in that case, you can obviously escalate the matter if necessary. I recommend that you are careful to whom you escalate and, generally speaking, it is better to try and keep things in-house, but there will be certain times where you may have to go outside your employer, to a Prescribed Person for instance. Just be careful about how you escalate it and how often you escalate it. Otherwise you are in danger of providing the employer with the kind of defence I have just discussed – i.e. it's not what you said, it's the way you said it, the way you went about it, etc.

It is also helpful to understand the protections afforded by whistleblowing law as well. That will help you identify when you have been treated detrimentally and to pick out those detriments or to connect the dots and realise why you have been dismissed. I recommend that you are realistic and don't adopt a "kitchen sink" approach. Focus only on the detriments that are really important and meaningful to you because not everything that happens once you blow the whistle will be because you blew the whistle and, in fact, you have actually a better chance of winning an Employment Tribunal claim if you can present a clear, clean and simple case that is easy to understand.

Speaking about cases, research time limits so you are not out of time to bring claims. Generally speaking, you have three months less one day from the date of the dismissal to bring a claim if you have been dismissed or, if you remain in employment, three months less one day from the act that you're complaining of, or if there have been a series of detriments, the last of those.

Another key step, as I have said before, is to keep records. It is so important to evidence the protected disclosures made and it is better to raise issues in writing. However, that is not always practicable and it is not always going to go down quite so well as well. Therefore, ensure you keep a record of any meetings at which disclosures are made, send a summary to yourself or send a summary to the person that you have spoken to.

I also recommend that you err on the side of caution and do not covertly record meetings. A few of my clients have done this and I can see the justification for it when you feel like you have been gaslit and are denying that things were said. However, you have to tread very carefully when recording meetings because there is often a section in the disciplinary policy stating that covertly recording meetings is an example of misconduct and you do not want to give your employer the means to dismiss you fairly.

Finally, get support. It can give you the confidence to raise issues in the first place, but particularly if you are facing detriments having blown the whistle, as it can take an enormous toll. You may want to seek advice and support from your trade union, from Practitioner Health, in Scotland they have now the Independent National Whistleblowing Officer, and there are also free helplines such as Protect to help support you. Unfortunately, when things do get really bad, you may need to seek specialist legal advice.

I hope you have found this talk helpful in understanding the law in this area better and to use it to better your chances of a favourable outcome for you and for your patients. Yes, whistleblowing law is complex and if you bring a claim you are likely to be in for a long slog in pursuing it, but I do not want this to put you off. Whistleblowing is vital, particularly in healthcare. Without whistleblowers we wouldn't have known about unavoidable deaths in Morecambe Bay courtesy of Dr Peter Duffy; we wouldn't have known about medical neglect on the Isle of Man courtesy of Dr Rosalind Ranson; Lucy Letby could have harmed more babies; and even Harold Shipman was brought to justice through a whistleblower raising concerns.

What I would say is that you do a wonderful job in very difficult circumstances. Use the power that you have to turn whistleblowing into being seen as a positive thing, as a learning experience, and that can only better the profession, can only better the outcomes for your patients, and to speak truth to power. *(Applause)*

The President: Thank you very much, Samantha, for a very clear and very comprehensive presentation. Samantha has agreed to take some questions and the usual rules, please. Shall we take the question on the chat first? Can you report concerns anonymously is the question from Dr Yogesh Patel.

Samantha Prosser: Yes, you can. Most Trusts will have their own Freedom to Speak Up Guardian; there may also be hotlines that you can use to raise concerns anonymously. I would always be reluctant to say, "Of course it's going to be confidential; your name will never come out," because there may be issues about whether the concerns you have raised can be investigated properly if they can't go to you and request information or if you can't engage in the process. It depends upon the severity of the issues that you are reporting as well. I know, from a regulatory point of view, the GMC cannot guarantee anonymity if you are raising serious concerns to them for that very reason.

James Pattison: James Pattison; I'm a Consultant Physician. I read those *Telegraph* articles regarding referring whistleblowers to the GMC. Do you think it's the same across the NHS or do you think it

varies to the different Trusts and organisations, because there was the *Newsnight* programme about a particular Trust, wasn't there, and they had a particularly high referral rate? I suspect it's something to do with the culture of the management of these Trusts but what's your view on that?

Samantha Prosser: From my point of view, it does seem to be an issue across the board. I act for consultants in a variety of Trusts, not just in London but everywhere across the UK. I think in certain Trusts there does seem to be a high number of whistleblowers. I did a talk a couple of months ago with Sue Allison who blew the whistle at Morecambe, and she was very good friends with Peter Duffy, and there were a few other people who had issues having blown the whistle, and I think some of the board members there resigned because of the way whistleblowers had been treated. So, I think there are issues in particular hospitals but I do think it is across the NHS as well.

The President: Shall we take another remote question from Dr Yogesh Patel? Can you expand on any support there is before reporting concerns?

Samantha Prosser: What I would say is research properly beforehand, look at the policies and maybe speak to the Freedom to Speak Up Guardian. I take that with a pinch of salt sometimes because in all the cases that I have dealt with I don't think the Freedom to Speak Up Guardian has ever played a role in any of them, but they are meant to be there to offer that support. I would speak to your BMA rep if you have one just to get your ducks in a row because if you start out on the right foot by formulating your concerns in the right way to gain that protection you are starting the protection for yourself earlier on. As I said, there are other hotlines you can use as well such as Protect who can answer concerns about whether what you are proposing to say will amount to a whistleblowing concern and what you can do in the circumstances.

Danny Allen: Danny Allen, Consultant Psychiatrist. Do you think that perhaps the first person a doctor should go to is their defence organisations?

Samantha Prosser: To be honest, in all the cases I have dealt with there has only been one client that was actually referred to the GMC and my client needed their defence union onside. There are often quite a lot of threats about referrals being made; it's kind of this issue hanging over you but it does not always lead to referrals actually being made. Generally speaking, the BMA represents my clients at internal meetings. If matters start unravelling and issues are starting to be raised against you, you may want to speak to them then.

Rob Mortell: My name's Rob Mortell; I was a barrister and I will be an FY1 doctor next month. I just want to know if people search you out for pre-disclosure advice or does your role often come in after the event?

Samantha Prosser: It's always after the event. Quite often, I would like some of my clients to have come to me in the first place because, like I said earlier, you don't have the law in mind when you are raising concerns, so you may be saying things that do not amount to a protected disclosure. Then, things fall out three or four months down the line and we are having to try to argue that what you said, if you put it altogether and read between the lines, actually does amount to a protected disclosure. In my view – I'm not just saying this because I am a lawyer – I think it is better to get that advice upfront so you can properly protect yourself from the beginning.

Rizwaan Baig: Rizwaan Baig; I'm a second-year medical student. You mentioned the double jeopardy of on the one hand you might want to keep your head below the parapet and on the other hand you do have a duty of candour/a duty to raise issues. If someone looking at all of this were a little bit scared of whistleblowing, how would you advise making sure that you did do things so that someone couldn't come back to you later and say you should have raised concerns at this point, why didn't you?

Samantha Prosser: I think that depends upon the concern that you are raising. If it is a very serious concern, I would be reporting it as a Datix or going to a line manager to raise it. If you have that inkling that something is not right or you are starting to see a pattern of behaviour, I recommend you look at the relationships you have around you. If you have a good relationship with your mentor or line manager such that you can seek their advice in the first instance, speak with them and they can then support you through the process if you do end up having to report concerns more formally.

Miranda Stotesbury: Miranda Stotesbury, Deputy General Counsel at the NMC. I was just thinking about this from a slightly different perspective from management accountability. What are the ramifications for managers and employers who fail to act on protected disclosures and, at worst, then go on to cause detriment to individuals?

Samantha Prosser: There is not much from what I see. Firstly, if a claim is brought, that individual could be named as an individual respondent, so they could be personally liable for any compensation, etc. awarded. One deterrent is that you could be named as a respondent and have to defend yourself during an Employment Tribunal with the reputational risks involved. If the individual is sufficiently senior, then another deterrent can be to raise concerns about whether they are a fit and proper person to perform that role and if they were to move elsewhere whether

they would be assessed at that stage as being qualified to do that role. In whistleblowing law generally speaking there is no real deterrent. There are no external organisations looking into this to address the aftermath of the employment fallout. I know that there have been rumblings in the press about this and, again referring to the Lucy Letby case, about whether managers/non-clinicians ought to be subjected to the same or a similar regulatory regime as clinical staff. I think there is some merit in that kind of argument. Doctors talk about the double jeopardy, you know that you have this regulatory obligation to raise concerns and you may feel obligated to do so given the potential regulatory consequences if you do not, and I wonder whether if a manager was concerned about their career being on the line, or that their regulator could look at this, if they don't address this issue, whether that would help to address the cultural issues I see.

The President: Thank you very much indeed again. It's clear from the number of questions you had the interest that it's raised, so may we show again our appreciation. *(Applause)*

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