Protecting patients

Application for a Judicial Review:

Suspension of MHPS when associated with patient safety concerns

Discussion Paper

Judicial Review:
Suspension of MHPS when associated with patient safety concerns

Executive Summary

A proposal for a judicial review to suspend the use of the disciplinary processes against doctors who have raised patient safety concerns. This is required to protect patients where whistleblowers have raised concerns about their care but have then been subject to disciplinary processes by their employers to suppress those concerns. The Secretary of State has said that legislation will be forthcoming and interim protection is required.

Core Argument

This Judicial Review will challenge the use of the MHPS Framework[1], by the Secretary of State of Health and Care acting in his role as the Minister accountable for the National Health Service. The Court will be asked to suspend the MHPS Framework where patient safety concerns have been raised by the subject of a MHPS investigation.

There is widespread recognition that whistleblowing within healthcare environments puts the individual whistleblower at risk of retribution. Either by those who are the subject of those concerns or by their organisation seeking to suppress those concerns.

This is a function of the typical organisational arrangement of NHS Trusts where patient safety concerns are assessed by the same officials who also assess concerns about the conduct, capability, and health of doctors employed by the Trust. This creates an inappropriate conflation of the two processes (HR and patient safety) which disadvantages patients.

These investigations and disciplinary sanctions, often including dismissal, have two deleterious effects: suppressing the patient safety concerns and discouraging other whistleblowers.

This has been accepted by the current Secretary of State for Health and Care, and by a series of his predecessors. For example, in 1997 Alan Milburn directed each NHS employer to give staff “maximum freedom of speech”. The Public Interest Disclosure Act (1998) followed.

Despite this legislation, other statutes which followed, and initiatives directed by the Government such as the Freedom to Speak Up, whistleblowers still face disciplinary sanction when they try to raise concerns about patient care.

The Government acknowledge this. The current Secretary of State for Health and Care has said that NHS officials who try to silence whistleblowers ‘will never work in NHS again’. He has promised further legislation, but it has not been forthcoming.

Judicial intervention is required to suspend the use of MHPS in these cases, while legislation is prepared by parliament.

The litigation vehicle is an active case of a current MHPS disciplinary investigation at [Trust] which was initiated shortly after [doctor] made a protected disclosure (under the terms of the Public Interest Disclosure Act) about the quality of care provided to [patients]. Potential interveners here, such as the British Medical Association, the Medical Defence Union, the Medical Protection Society, and Doctors Association UK would have sufficient interest.

---

[1] MHPS Framework: Maintaining High Professional Standards in the NHS. The policy guiding the investigation of doctors and dentists subject to concerns about their conduct, capability, or health. This is the process by which employers conduct investigations prior to disciplinary sanction, such as dismissal.

Purpose

There is currently a structural misalignment of the interests of patients and the interests of NHS organisations in how those organisations respond to whistleblowers. This misalignment is best illustrated where NHS bodies conflate whistleblowing with disciplinary process.

Rob Behrens, a previous Parliamentary and Health Service Ombudsman, described this situation as "defensive leadership" within a culture of "cover -ups" which "lead to inhumane things happening on a much wider scale than we had at Mid Staffs".

Similarly, Sir Robert Francis KC describes the consequences to whistleblowers as being "every bit as serious as the suffering I witnessed by patients and families who gave evidence to the Mid Staffordshire inquiries."

The effect is that concern about harm is suppressed for many years, while whistleblowers see their careers destroyed. This creates a recurring and amplifying cycle of poor care. Recurring because it keeps happening and amplifying because others are discouraged from speaking up.

Secondary effects include the costs associated with litigation in the Employment Tribunal, reputational damage to the Trusts concerned and the wider NHS, and a loss of public confidence.

A Judicial Review granting interim relief would direct the NHS to introduce a mechanism to allow disciplinary investigations to be paused in the presence of legitimate whistleblowing concerns.

Secondly, the NHS would be directed to develop an independent process to investigate those patient safety concerns externally to the organisation concerned.

These two directions would create an effective separation between the two processes - disrupting the single point of failure. This application would have no impact on legitimate, well-founded investigations into the capability, conduct, or health of doctors.

In many respects, this proposal is unapologetically ambitious in its scope and the expectations of justiciability in this area. This is to encourage discussion and refinement, to establish whether there is a) a material question which can be put the courts and b) a solution which the courts may find appealing.

Background

The National Health Service (NHS) has a range of statutory responsibilities mandated by the Health and Social Care Act (2012) and the Health and Care Act (2022). In essence, it must provide comprehensive health services, reduce health inequalities, and ensure sustainable use of resources.

Despite these statutory responsibilities, the history of the NHS is characterised by scandals where the NHS has failed in its responsibilities leading to avoidable harm including death, wasteful use of resources, and the inequitable delivery of safe, effective care.

These are almost uniformly situations where the responsible organisations have been alerted to the substandard care but have failed to act.

In many instances, the information about poor care had been provided by practitioners (doctors, nurses, and allied health professionals) working in those environments. These concerns have been raised in line with the relevant legal and regulatory frameworks, including the Public Interest Disclosure Act (1998), however there was no effective response from the healthcare organisation.

Instead of being supported in raising concerns, the practitioner typically becomes the subject of a disproportionate, vindictive, and destructive disciplinary exercise. This phenomenon has been recognised in every public inquiry following a health scandal.

However, despite abundant recommendations, guidelines, and legislation to compel the NHS to better protect whistleblowers, there has been no substantial action to address this structural, ever-present risk to patients.

Evidence is presented in the appendices in support of the context in which whistleblowing occurs and the evidential basis for any potential application to the court.

MHPS

Maintaining High Professional Standards (MHPS) is the current framework by which NHS bodies handle concerns about the conduct, clinical performance, and health of doctors and dentists.

The proposal is not that Maintaining High Professional Standards (MHPS) is unlawful, nor that the court should suspend it generally across the NHS.

The far narrower point is that, where a doctor has made a credible public-interest disclosure about patient safety, the subsequent use of MHPS may become structurally conflicted if the employing organisation is both the subject of the underlying concern and the authority deciding how the whistleblower should be managed.

In practical terms, the same senior individuals become the adjudicator for both sides of the problem.

Legal Argument

This application will be constructed on four grounds:

Illegality. Where NHS Trusts conflate patient safety and disciplinary functions, they are in breach of their statutory duties under the Health and Social Care Act 2012 and the Health and Care Act 2022. The NHS is legally required to provide safe care. A process that structurally suppresses patient safety concerns to protect institutional reputation is a breach of that duty.

Procedural Impropriety. NHS Trusts and all public bodies must act fairly. Where the same senior individuals who are implicated in, or institutionally exposed by, the patient safety concerns are controlling the disciplinary process against the person who raised them, a procedural bias emerges. A decision-maker with a material interest in the outcome cannot deliver a fair process.

Irrationality. A process contaminated by structural conflict cannot produce rational outcomes for patients. It is irrational to allow the body that is the subject of the concern to determine what happens to the person who raised it.

Legitimate expectation. Successive Secretaries of State have promised protection for whistleblowers. The government has committed to reform by 2027. The BMA, the Parliamentary Ombudsman, and two major inquiry chairs have all stated the current framework is inadequate. These repeated public commitments create a legitimate expectation of protection that has not been fulfilled, and no interim mechanism has been provided. This is required while legislation is developed.

Public Interest

Interim relief will be sought to protect patients by disentangling these processes and forcing patient safety concerns to be independently and objectively investigated.

Clearly, there will be a simultaneous benefit to whistleblowers.

This has been long promised, and protection is required while the government develops the hoped for legislation and frameworks, as described in Appendix 1 while Appendix 2 and 3 add further evidence in support of the need for this interim relief.

The public-interest dimension is central.

If the original clinical concern is delayed, diluted, or buried while attention is redirected towards the whistleblower, the clinical issue remains unresolved, perhaps indefinitely to the benefit of the organisation and the detriment of patients.

This leads to a substantial and avoidable burden of harm to patients.

If the whistleblower is isolated, excluded or professionally neutralised, colleagues observe that speaking up is dangerous. If colleagues reach that conclusion, future concerns are less likely to be raised promptly. The result is not retrospective unfairness; it is prospective and continuing risk to patients.

As such, this application engages the exceptional public interest.

Whilst the evidence before the Court would concern a single Trust and a single doctor, it would demonstrate a recurring, systemic, and evidenced pattern of patient harm caused by a structural deficiency in how the NHS responds to safety concerns raised by its own clinicians. That pattern has been identified in every major public inquiry of the past fifteen years, has been acknowledged by three successive Secretaries of State, and has been repeatedly described as playing out on a national level.

The court's intervention is sought not to resolve a private employment dispute but to address a continuing public safety risk that existing mechanisms have manifestly failed to prevent.

The court would not be asked to redesign NHS employment machinery, or indeed MHPS.

The court will be asked to put in place a nationwide mechanism to allow a pause of MHPS within NHS organisations, in applicable cases, until three legislative conditions have been met:

1. Independent triage of the patient-safety disclosure.
2. Removal of actually or apparently conflicted decision-makers.
3. Separation of the patient-safety pathway from the disciplinary pathway.

The proposed interim relief would not confer immunity on the doctor.

Limited impact

It is recognised that MHPS is required and is essential to allow the NHS to deal with doctors where there are legitimate, non-conflicted concerns about capability, conduct, or health.

Moreover, this action will not have an impact on responsible, well led organisations which do not conflate these processes. Indeed, this action may lead to improved management across the NHS, and it may never be necessary to enact the sought interim relief.

Rather, it says that where concerns about patient care and a disciplinary process are entangled, the process should be paused long enough to ensure that patient safety is examined independently and that disciplinary decisions are not being taken within a contaminated structure.

Likely objections

Judicial Review is not the natural forum for what looks, on the surface, like an employment dispute. However, the purpose of this application is to protect patients. As such, this is a legitimate challenge to an ongoing and structurally unlawful public process which has been repeatedly associated with significant and widespread risk to patients.

To consider how the Secretary of State may respond:

> **Introduction of a new risk to patients.** The risk is that dangerous doctors could seek to shield themselves by inappropriately raising patient safety concerns.
>
> This is easily rebutted.
>
> The proposal would not shield doctors for two reasons. Legitimate disciplinary processes would only be paused, and would ultimately continue, independent of any patient safety investigation. Secondly, Trusts will always have recourse to the General Medical Council.
>
> More broadly, the response is not simply that whistleblowing should block appropriate investigation and sanction of poorly performing doctors. It is that independent triage within this interim relief should improve, not weaken, any NHS organisation’s ability to deal with genuinely dangerous practitioners. And deal with the concerns about harm to patients.
>
> A process contaminated by institutional conflict is less reliable for everyone, including patients, and exposes Trusts to litigation and costs.
>
> **There are existing remedies.** The SoS may also argue that the Employment Tribunal offers sufficient remedy. However, the ET offers only retrospective compensation, it does not protect patients at the point where harm is occurring, nor does it protect the whistleblower from detriment.
>
> The SoS may also argue that there are other remedies beyond the Court and the Employment Tribunal. As such, the court may consider whether other mechanisms provide an adequate alternative remedy.
>
> They do not.
>
> The Care Quality Commission has regulatory oversight but no power to intervene in individual MHPS processes or to protect a whistleblower from detriment in real time. The Freedom to Speak Up Guardian system, established following the Francis Review in 2015, has been assessed by the APPG for Whistleblowing as having "failed in every case investigated" and described as "beyond resurrection” and is currently being subsumed into the CQC.
>
> The National Guardian's Office is now being closed and merged into NHS England, raising further concerns about its independence.
>
> The Parliamentary and Health Service Ombudsman can investigate complaints of maladministration but cannot restrain an ongoing disciplinary process or compel a Trust to separate its patient safety and HR functions.

NHS England itself has acknowledged the problem but has no mechanism to intervene in live MHPS cases, and, in any case, is being abolished.

None of these bodies can provide the urgent, prospective protection that interim relief would deliver. They are part of the landscape that has failed, not an alternative to judicial intervention.

He can issue guidance to Trusts: Interim relief is required because successive attempts to curtail the powers to Trusts to silence whistleblowers have failed. It is not enough for the SoS to state that he will issue guidance, a direction from the court is now required to ensure patient safety.

Doctors do not have special rights: This is accurate. However, other staff groups have seen similar detriments when raising concerns and are arguably far less well protected by NHS Workforce policies. At least MHPS offers a framework which can be addressed by the court. In doing so, it will serve as a warning to Trusts in how they treat other staff groups.

The court may also consider whether the outcome for patients would have been substantially different had the conduct complained of not occurred.

The evidence is unambiguous and forms the core argument of why interim relief is required.

In every major inquiry identified in Appendix 1, the explicit finding was that patients suffered avoidable harm, including thousands of deaths, because whistleblowers were silenced rather than heard.

Had those concerns been independently investigated instead of suppressed through disciplinary processes, the outcome for patients would have been profoundly different. This is not a speculative counterfactual; it is the documented conclusion of every public inquiry into an NHS scandal in the past fifteen years.

Moreover, the harm is not confined to the patients at the Trust in question. The chilling effect of whistleblower detriment suppresses future disclosures across the NHS, meaning that the public across the country is exposed to continuing and avoidable risk, even before they become patients.

The substantially different outcome is therefore systemic, not local.

In any event, the court retains discretion to grant a remedy for reasons of exceptional public interest, even where the substantially different outcome test is arguable. Systemic patient harm across the NHS, documented across multiple Trusts, spanning decades, and involving the avoidable deaths of hundreds of patients and babies, meets that threshold.

Next steps

A whistleblower examining the landscape that emerges after concerns are raised will find it confusing, capricious, and dangerous. The conflicting and complex statutory and regulatory responsibilities of Trusts, health systems, and regulators are spread across local policies, the professional bodies, NHS England, the Care Quality Commission, the Freedom to Speak-Up Guardian, the Parliamentary Ombudsman, the criminal justice system, and other bodies.

Not only has this landscape been shown to be ineffective, but the treatment of whistleblowers now, and historically, deters potential whistleblowers while those who do speak-out become trapped at the mercy of their employers while patient safety concerns are sidelined.

There is an urgent and substantial need to address this deficiency in the mantle of safety and quality which should protect each patient.

The proposed next step is to form a working group comprising interested parties which include patient safety expertise, patient safety and whistleblowing charities and advocacy groups and individuals, the trades unions, politicians, legal experts, and others.

This group should examine the requirements of any application for judicial review and identify funding and further expertise, as required. Within that, the group will explore the availability of a costs capping order.

A proposed terms of reference for the working group is explored in Appendix 4.

Appendices

Appendix 1: Major Inquiries and Reviews

There is abundant evidence from major inquiries and reviews, the experience of individual whistleblowers, and the views expressed by Secretaries of State, Health Service leaders, patient safety charities and campaign groups, and other commentators.

This evidence is unanimous in its view that patient safety is compromised by the treatment of whistleblowers by their employers after concerns are raised. However, there has been no progress towards serious, statutory protection of whistleblowers.

Indeed, every major NHS inquiry of the past fifteen years has identified the suppression of clinical concerns as a cause of patient harm, and each has recommended better protection for those who speak up. In every case, clinicians or staff who raised concerns about patient safety were ignored, silenced, or subjected to detriment. The pattern is consistent and the scale is not in dispute.

In December 2025, the UK Government's anti-corruption strategy confirmed that it would explore reform of the whistleblowing framework by 2027. No interim protective mechanism has been announced for whistleblowers currently subject to MHPS while those reforms are developed.

UK Government Whistleblowing Review and Anti-Corruption Strategy (2025–2027)

Context: In July 2025, the government published the results of a review of the whistleblowing framework, identifying substantial suggestions for change including a potential "Office of the Whistleblower," minimum standards for employer procedures, and extended time limits for tribunal claims.

Government commitment: The December 2025 anti-corruption strategy confirmed that the government would explore reform by 2027.

The gap: No interim protective measures have been announced for whistleblowers currently subject to MHPS while those reforms are being developed. This temporal gap is precisely what interim relief is designed to fill.

Cambridge University Hospitals NHS Foundation Trust (Verita Review 2025, ongoing)

Whistleblowing and patient safety: Clinicians raised patient safety concerns about practices within the Trust's paediatric orthopaedic services. An independent review (the Verita Report) has identified concerns about governance, the handling of those disclosures, and the relationship between whistleblowing and disciplinary processes.

Institutional acknowledgment: The Trust, NHS England, and the Secretary of State have acknowledged that patients and whistleblowers were failed due to the punitive culture towards those who raise concerns.

Countess of Chester Hospital — Thirlwall Inquiry (2023–ongoing)

Patient harm: Lucy Letby was convicted of the murder of seven babies and the attempted murder of seven more.

Whistleblowers silenced: Consultants raised concerns about the spike in neonatal deaths as early as 2015 but were ignored by Trust management. The lead whistleblower, Dr Stephen Brearey, has since been contacted by doctors across the country who report similar experiences after raising patient safety concerns.

Cost: The whistleblowing charity Protect estimates the total cost of the Letby case at approximately £40 million. This represents the cost of not listening to the clinicians who raised concerns at the earliest opportunity.

East Kent Hospitals — Kirkup, Reading the Signals (2022)

Patient harm: The investigation found that 45 baby deaths could have been avoided and that the Trust had covered up the extent of its failures in maternity care.

Concerns suppressed: Staff and families who raised concerns about the safety of maternity services were met with institutional denial. The Trust's default response was to suppress rather than investigate. Kirkup concluded that the pattern was systemic: "It is too late to pretend that this is just another one-off, isolated failure."

Significance: The same institutional dynamics; denial, blame-shifting, suppression of concern recur across Trusts, services, and time periods.

Shrewsbury and Telford Hospital NHS Trust — Ockenden Review (2022)

Patient harm: More than 200 babies and nine mothers died unnecessarily over two decades.

Whistleblowers silenced: Consultant obstetrician Bernie Bentick, who raised concerns about maternity safety, described "a climate of fear" among staff who "felt unable to speak up because of risk of victimisation." Clinical concerns were not adequately investigated, and the focus was diverted to institutional reputation.

Freedom to Speak Up Review — Francis (2015)

Context: Commissioned by the Secretary of State in response to continuing evidence that NHS staff who raised patient safety concerns were being victimised. Francis took evidence from over 600 individuals and found that their suffering was "every bit as serious as the suffering I witnessed by patients and families who gave evidence to the Mid Staffordshire inquiries."

Outcome: The review established Freedom to Speak Up Guardians across all NHS trusts but was criticised for leaving control with employers and lacking enforcement powers. The NHS Staff Survey metric on feeling secure to raise concerns has not materially improved since the Guardians were introduced. The National Guardian's Office is now being closed and merged into NHS England.

Assessment: The APPG for Whistleblowing has been told that the Guardian system has "failed in every case investigated" and is "beyond resurrection."

University Hospitals of Morecambe Bay — Kirkup Report (2015)

Patient harm: At least 12 deaths of mothers and babies between 2004 and 2012 were linked to failures in maternity services.

Whistleblowers silenced: Clinicians who raised concerns about the quality and safety of maternity care were marginalised. The investigation found a failure of governance at every level, with no effective mechanism for acting on safety disclosures.

Subsequent position: Dr Bill Kirkup has publicly endorsed proposals for a Whistleblowing Bill and stated that the NHS "urgently needs an effective early warning system."

Mid Staffordshire NHS Foundation Trust — Francis Report (2013)

Patient harm: Between 400 and 1,200 excess deaths occurred at Stafford Hospital between 2005 and 2008.

Whistleblowers silenced: The Public Inquiry found that staff who tried to raise concerns about patient safety were ignored and victimised. The culture was one in which there was an imperative not to embarrass the Trust. Gagging clauses in settlement agreements were used to prevent departing staff from speaking.

Recommendations: Francis recommended that obstruction of whistleblowing should be a criminal offence. The recommendation was not implemented. Ten years later, Francis himself stated that NHS culture “has not changed very much” and described continuing behaviour towards whistleblowers as “shocking.”

Appendix 2: Individual Cases Demonstrating Whistleblower Detriment

BMA institutional position (January 2026)

Public statement: Following the Gilby settlement (below), the BMA publicly stated that protections for whistleblowers are "woefully inadequate" and that legislation is "still not fit for purpose." The BMA council chair called for "radical change in how whistleblowers are protected and treated in the NHS" and for "the long overdue regulation of senior NHS managers."

Countess of Chester Hospital NHS Foundation Trust (Dr Susan Gilby, 2022–2026)

Disclosure: Dr Gilby, the CEO appointed weeks after Lucy Letby's arrest, raised a formal whistleblowing complaint about the Trust chairman's bullying and harassment and the board's prioritisation of reputation over patient safety.

Detriment: The chairman and three directors created "Project Countess" to force her out. She was told it was "time for you to go." The group constructed what the tribunal called a "sham case" and suspended her on unspecified allegations. Documents including favourable appraisals were deleted or destroyed.

Outcome: The tribunal found constructive unfair dismissal for making a protected disclosure. The Trust paid £1.4 million; total costs to the taxpayer estimated at £3 million.

North Tees and Hartlepool NHS Foundation Trust (Mr Manuf Kassem, 2017–2024)

Disclosure: Mr Kassem, an associate specialist surgeon, raised concerns about 25 patients who he alleged had suffered complications, negligence, delayed treatment and avoidable deaths. The Trust accepted this constituted a protected disclosure.

Detriment: His identity as a whistleblower was revealed to the very doctors he had complained about. He was removed from the emergency on-call rota and subjected to a retaliatory disciplinary investigation lasting 17 months, involving allegations the tribunal found "not particularly weighty." Colleagues about whom he had raised concerns filed retaliatory Datix incident reports.

Outcome: The tribunal found whistleblowing detriment and racial discrimination. He was awarded £431,768 in total compensation. Notably, he won the liability hearing while representing himself. The same Trust had previously been found to have victimised a senior nurse, Linda Fairhall, for raising safe staffing concerns—demonstrating recidivist institutional behaviour.

HCSA survey evidence and the "Employers' Playbook" (systemic, 2023–2026)

Survey findings: A 2023 HCSA survey of 526 hospital doctors found that more than 70% believed it was impossible to raise patient safety concerns without risking career detriment. 93% of those who had spoken up were dissatisfied with the management response. Two-thirds reported impacts including effects on mental health, lost promotion, and disciplinary proceedings.

The pattern: The HCSA describes a recognisable "employers' playbook": clinicians who raise patient safety concerns are recast as a reputational risk, followed by MHPS initiation, heightened scrutiny of clinical work, restrictions on practice, and professional isolation. The original safety concerns are not fully investigated.

Quantitative context: Written evidence to the Health and Social Care Committee identified approximately 10,000 Some Other Substantial Reason (SOSR) dismissals in the NHS between 2010 and 2018. The success rate of whistleblowing litigation under PIDA is approximately 3%.

Portsmouth Hospitals University Trust (Dr Jasna Macanovic, 2022)

Disclosure: Dr Macanovic, a consultant nephrologist, raised patient safety concerns through whistleblowing channels.

Detriment: She was subjected to detrimental treatment following her disclosures.

Outcome: A tribunal awarded £220,000 in compensation. The Trust spent nearly £680,000 on legal fees fighting the case—three times the eventual award—illustrating the institutional willingness to use public money to defeat a whistleblower rather than address the underlying patient safety concern.

Care Quality Commission (Shyam Kumar, 2022)

Disclosure: Mr Kumar, a surgeon working as a CQC inspector, repeatedly raised patient safety concerns about services he was reviewing—concerns directed at the NHS's own regulator.

Detriment: The Manchester Employment Tribunal found he was unfairly dismissed and subjected to detrimental treatment, concluding that his raising of safety concerns materially influenced the decision to remove him. He described being perceived as "a troublemaker."

Outcome: He was awarded £23,000 in compensation for injury to feelings. The case demonstrates that the problem extends to the regulatory bodies meant to protect patients.

West Suffolk NHS Foundation Trust (Dr Patricia Mills, 2021)

Disclosure: Dr Mills raised concerns about a doctor injecting himself with drugs while on duty.

Detriment: Rather than acting on the patient safety concern, the Trust subjected the whistleblower to a disciplinary investigation. An NHS England review found that the investigation verged on "victimisation."

Outcome: Dr Mills was completely exonerated. The case was highlighted by the National Guardian's Office as evidence that the Freedom to Speak-Up system was failing.

Croydon Health Services NHS Trust (Dr Kevin Beatt, 2014)

Disclosure: Dr Beatt, a cardiologist, raised concerns that staffing decisions, including the suspension of a head nurse, contributed to a patient's death during cardiac surgery.

Detriment: He was dismissed for making those disclosures. During the process, trust managers physically restrained him while he was carrying out his contractual duties. The GMC took three years to investigate allegations made against him before closing its file.

Outcome: The tribunal found automatic unfair dismissal for making protected disclosures, with Dr Beatt found to have contributed nothing to the dispute. The Court of Appeal established that an employer cannot defeat a whistleblowing claim by arguing they did not believe the disclosure was protected.

Lewisham and Greenwich NHS Trust / Health Education England (Dr Chris Day, 2014–ongoing)

Disclosure: In January 2014, Dr Day raised concerns about acute understaffing in an ICU linked to patient deaths.

Detriment: He was dismissed and Health Education England removed his training number. HEE then argued that it bore no legal liability for detriment to a whistleblower, seeking to strip protection from approximately 54,000 junior doctors. A Trust director deleted up to 90,000 emails during tribunal proceedings.

Outcome: Over a decade of litigation, still unresolved. A judge described Day's patient safety disclosures as of "the utmost importance" and ordered full disclosure.

University Hospitals Coventry and Warwickshire NHS Trust (Dr Raj Mattu, 2001–2016)

Disclosure: Dr Mattu, a cardiologist, raised concerns in 2001 about overcrowding on cardiac wards after patient deaths linked to a dangerous “five-in-four” bed policy. The regulator subsequently confirmed a 60% excess mortality rate at the Trust.

Detriment: He was suspended for over five years, subjected to approximately 200 fabricated allegations to the GMC (all rejected), and dismissed in 2010. The Trust’s Chief Executive was found to have threatened to “get him off the road completely.” His patient safety concerns were recast as employment disputes.

Outcome: After a tribunal lasting over four months and producing a 400-page judgment, the Birmingham Employment Tribunal found detriment on more than 25 occasions and awarded £2.5 million. The Trust spent an estimated £14 million fighting the case. NHS Improvement took no meaningful action in response.

Appendix 3: Political and Institutional Statements on Whistleblower Protection

The following statements are public acknowledgments, by those with responsibility for the system, that existing protections are inadequate. Taken together, they demonstrate that the problem is not contested.

Across three Secretaries of State, two major inquiry chairs, the Parliamentary Ombudsman, the BMA, the HCSA, an independent reviewer, and both Houses of Parliament, there is broad consensus that whistleblower protections in the NHS are inadequate.

The gap between that rhetoric and any protective mechanism for clinicians currently subject to MHPS is the space within which the proposed application sits.

Dr Sasha Burns, HCSA Medical Employment Adviser (March 2026)

"What essentially happens is trusts will try to find a way to get rid of doctors who they view as being a problem, all to protect their reputation." On MHPS: "They will look for any excuse to trigger an MHPS, and it can be for ludicrous reasons. Some of the MHPS processes that are triggered are absolutely crazy." (Medscape News UK)

Dr Tom Dolphin, BMA Council Chair (January 2026)

"It remains clear that the protections afforded to doctors raising concerns are woefully inadequate and legislation in this area is still not fit for purpose. We need to see radical change in how whistleblowers are protected and treated in the NHS." (BMA press release)

Note: The BMA co-designed the MHPS framework. Its public declaration that the system is not fit for purpose is an admission by one of the framework's own architects.

Sir Robert Francis KC (July 2025)

Described the behaviour of NHS leaders towards whistleblowers as continuing to be "shocking." (Health Service Journal)

Wes Streeting, Secretary of State for Health and Social Care (July 2025)

"If you silence whistleblowers, you will never work in the NHS again. Protecting the reputation of the NHS should never be put before protecting patient safety." (GOV.UK)

Note: Legislation to implement a statutory disbarring regime has been committed to but not yet introduced. No interim mechanism exists to protect whistleblowers currently subject to MHPS.

Tom Kark KC (July 2025)

"A positive move to strengthen management in the NHS by weeding out poor leadership. This is good news for whistleblowers and those looking for accountability in senior management which has long been lacking." (GOV.UK)

Wes Streeting, Secretary of State for Health and Social Care (November 2024)

Launched a public consultation on regulation of NHS managers, designed to "tackle a culture of cover up which has been found to be present in several patient safety scandals in recent years." (GOV.UK)

Wes Streeting (June 2024, pre-election)

“I’m deadly serious when I say NHS managers who silence whistleblowers will be out and will never work in the NHS again. It is the number one priority for the system.” (The Guardian)

Rob Behrens, Parliamentary and Health Service Ombudsman (March 2024)

Reflecting on seven years in office, Behrens described confronting “a cover-up culture, including the altering of care plans and the disappearance of crucial documents after patients have died and robust denial in the face of documentary evidence.” Asked whether care was safer: “There are still too many examples of care not being safe. It shows we haven’t got to the root of the problem yet.” (The Guardian)

Rob Behrens, Parliamentary and Health Service Ombudsman (February 2024)

“Cultures of blame and cover-ups cost lives. Never has the importance of learning from mistakes at all levels been so pivotal to the future of the NHS.” (PHSO statement on the Times Health Commission Report)

Rob Behrens, Parliamentary and Health Service Ombudsman (December 2023)

At the WhistleblowersUK/APPG event, Behrens described the NHS as “command and control” and spoke of the “persecution and character assassination of whistleblowing doctors and nurses who report patient safety issues.” He called for “fundamental change” in NHS leadership. (Westminster Confidential)

Rob Behrens, Parliamentary and Health Service Ombudsman (2023)

Following the Lucy Letby trial, warned that more babies would be harmed unless “systemic changes” were made to end “defensive leadership” and the unacceptable treatment of whistleblowers. In a separate interview: “I get lots of doctors… because when they’ve drawn safety matters to the attention of the management in the NHS, the tables have been turned on them and they’ve been hounded out of work and sometimes out of their careers. To me, there is no sign that that has improved in the last five years.” (Radio Ombudsman; The Lowdown)

Sir Robert Francis KC (March 2023)

“The culture within NHS England has not changed very much over the years.” He feared the pressure on staff meant “inhumane things are bound to start happening and are happening on a much wider scale than we had at Mid Staffs.” (Nuffield Trust)

Rob Behrens and Sir Robert Francis (January 2023)

In a joint letter to the Secretary of State for Health: “What we are witnessing across the NHS is the Mid Staffordshire scandal playing out on a national level.” (Letter to Steve Barclay)

Dr Bill Kirkup CBE (2022)

“It is too late to pretend that this is just another one-off, isolated failure, a freak event that ‘will never happen again.’” (Reading the Signals). “I support the proposals set out in the Whistleblowing Bill because the NHS urgently needs an effective early warning system.” (WhistleblowersUK/APPG)

House of Commons, Westminster Hall debate (July 2018)

The success rate of whistleblowing litigation under PIDA was described as 3%—“appalling” and demonstrating “how utterly weak the law is.” It was argued that “it is critical that whistleblowers are protected from detriment from the moment of speaking up.” (Hansard)

Sir Robert Francis KC (February 2015)

The pain and distress of whistleblowers was “every bit as serious as the suffering I witnessed by patients and families who gave evidence to the Mid Staffordshire inquiries.” The suggestion that whistleblowers have ulterior motives had “for too long been used as an excuse for avoiding a rigorous examination of safety and other public interest concerns.” (Freedom to Speak Up Report)

Sir Jeremy Hunt, Secretary of State for Health (February 2015)

“The message that must go out is that we are calling time on bullying, intimidation and victimisation, which has no place in our NHS.” (GOV.UK)

Note: The protections introduced during Hunt’s tenure have been widely assessed as ineffective. The NHS Staff Survey metric on feeling secure to raise concerns did not improve.

Sir Jeremy Hunt, Secretary of State for Health (June 2014)

“Still today too many staff in the NHS feel they can’t speak up or that nothing will happen if they do.” (GOV.UK)

House of Commons debate on the Francis Report (February 2013)

It was acknowledged across the House that the Public Interest Disclosure Act 1998 had “failed” when confronted with NHS culture. (Hansard)

Sir Robert Francis KC (February 2013)

In the Mid Staffordshire Public Inquiry, Francis found that staff who raised concerns were ignored and victimised. He recommended that obstruction of whistleblowing should be a criminal offence. (Final Report)

All-Party Parliamentary Group for Whistleblowing

The APPG has described the “Cycle of Abuse” suffered by whistleblowers: isolation, intimidation, heightened scrutiny, counter-accusations, and character assassination. It has been told that both the Freedom to Speak Up Guardian system and the Duty of Candour are “beyond resurrection.” Evidence to the APPG identified approximately 10,000 SOSR dismissals in the NHS between 2010 and 2018.

Appendix 4: Draft Terms of Reference

These terms of reference are focused, disciplined, evidence-led, and explicitly framed to test viability rather than assume litigation is the answer.

They reflect the paper's central concern that patient safety concerns and MHPS processes may become structurally entangled, and that any working group should examine whether there is a justiciable and properly evidenced route to targeted public law relief.

Terms of Reference

Working Group on Patient Safety, Whistleblowing, and MHPS

1. Purpose

The Working Group is established to examine whether there is a viable, evidence-based and properly arguable public law response to cases in which a doctor who has made a protected or arguably protected disclosure concerning patient safety becomes subject to MHPS or related disciplinary measures within the same organisational structure.

Its purpose is not to promote litigation at all costs, nor to advance a general attack on MHPS as a framework, but to determine whether there exists a narrowly framed and justiciable route to protect patient safety, secure procedural fairness, and address actual or apparent structural conflict in decision-making.

2. Objectives

The Working Group shall:

- Identify whether the problem under consideration is properly characterised as a public law issue, an employment issue, a patient safety issue, or a combination of those matters.
- Assess whether there is sufficient evidence of a recurrent structural problem, namely the conflation of patient safety concerns with workforce or disciplinary processes, such that an individual case may illuminate a wider public law defect.
- Evaluate the potential legal bases for challenge, including unfairness, apparent bias, conflict of interest, failure to take relevant considerations into account, illegality, irrationality, and any arguable legitimate expectation.
- Determine the proper defendant or defendants in any proposed claim, including whether any challenge should be directed to an NHS trust, the Secretary of State, NHS England functions, or a combination thereof.
- Consider what forms of relief are realistically obtainable, with particular emphasis on claimant-specific and operationally workable relief rather than abstract or system-wide redesign by the court.
- Examine whether interim relief is capable of being framed in a way that protects patient safety and preserves fairness without conferring impunity on unsafe practitioners.
- Review the adequacy, or inadequacy, of alternative remedies including internal processes, regulators, and the Employment Tribunal, recognising that tribunal remedies are often retrospective and individualised.
- Identify an appropriate litigation vehicle, if one exists, including the factual pattern, evidential threshold, claimant profile, and timing requirements most likely to withstand permission scrutiny.

Explore non-litigation or parallel options, including protocol correspondence, policy advocacy, independent review proposals, regulatory engagement, and model safeguards capable of adoption without proceedings.

3. Scope

The Working Group shall confine itself to the following question:

Whether, and if so in what circumstances, the use of MHPS or cognate disciplinary mechanisms following the raising of patient safety concerns creates a sufficiently arguable public law wrong to justify pre-action steps or judicial review.

The Group's remit includes:

Cases involving doctors and dentists subject to MHPS or equivalent trust procedures.

The relationship between protected disclosures, patient safety concerns, exclusion, restriction, suspension, investigation, and disciplinary escalation.

The institutional separation, or lack of separation, between clinical governance, patient safety review, medical staffing, HR, and disciplinary decision-making.

The practical design of any proposed interim safeguard, including independent triage, removal of conflicted decision-makers, and separation of patient safety assessment from disciplinary management.

The Group's remit excludes:

A general campaign to abolish MHPS.

The merits of individual employment claims except insofar as they inform the public law analysis.

Findings of professional misconduct, capability, or patient harm in any individual case unless necessary to assess litigation risk or interim safeguards.

4. Core questions

The Working Group shall in particular address the following questions:

Is there a coherent and justiciable public law claim capable of being pleaded on concrete facts rather than general systemic criticism?

What is the strongest juridical formulation: procedural unfairness, apparent bias, unlawful conflict, failure to separate functions, unlawful policy, breach of statutory duty context, or some narrower combination?

What evidence is required to distinguish a true public law challenge from an ordinary employment dispute?

Can the public interest in patient safety be demonstrated in a way that is immediate, concrete, and not merely rhetorical?

What relief could realistically be granted by the Administrative Court: pause, reconsideration, independent review, removal of conflicted decision-makers, declaratory relief, or mandatory interim directions in a specific case?

What would be the defendant's best objections, including alternative remedy, prematurity, delay, standing, causation, practicality, and risk to patients, and how could those objections be answered?

Is there a litigation vehicle that is sufficiently strong on facts, timing, documents, and witness evidence to justify counsel's involvement and external funding efforts?

5. Deliverables

The Working Group shall produce the following outputs:

A concise merits assessment identifying the strongest and weakest features of any proposed judicial review.

A litigation options paper setting out at least three routes: no claim; a narrow claimant-specific claim; and any broader strategic claim, with risks and prospects stated candidly.

An evidence schedule identifying what documents, witness accounts, expert input, and comparator material would be required before any pre-action step.

A draft framework for interim relief, limited to measures that are practically workable and defensible on patient safety grounds.

A funding and costs note addressing solicitors, counsel team shape, protective costs or costs-capping issues, and litigation risk management.

A recommendation to proceed, pause, or stop.

6. Membership

The Working Group should be deliberately small, expert, and decision-capable. It should include:

A chair independent of any proposed claimant, preferably a senior lawyer, former judge, or respected public law figure.

Public law counsel.

Employment law counsel with whistleblowing expertise.

A solicitor team experienced in judicial review, disclosure strategy, and urgent interim applications.

One or more senior clinicians with credibility in patient safety and clinical governance.

A patient safety specialist with inquiry or systems expertise.

Representatives of relevant professional or representative bodies only where their involvement assists evidence, standing, or implementation. The paper identifies bodies such as the BMA, MDU, MPS, and Doctors Association UK as potential interested parties or interveners.

A person responsible for witness coordination, document management, and confidentiality governance.

7. Principles of operation

The Working Group shall operate on the following principles:

Independence: membership does not imply support for litigation, only willingness to test the issue rigorously.

Candour: the Group must identify defects in the proposed case theory as readily as its attractions.

Narrowness: preference shall be given to fact-specific and legally orthodox routes over ambitious systemic claims unlikely to survive permission. This reflects the paper’s own emphasis that the narrower issue is structural conflict where the employer is both the subject of the concern and the manager of the whistleblower.

Patient safety first: any proposal must protect patients and must not create a shelter for genuinely unsafe practice. The paper itself recognises that MHPS remains necessary and that Trusts retain recourse to the GMC.

Evidence before rhetoric: inquiry findings, tribunal materials, internal documents, chronology, and witness evidence shall drive conclusions. The discussion paper relies heavily on inquiry material, tribunal outcomes, and systemic examples, which should be organised into admissible and analytically useful form.

Practicality: any proposed relief must be capable of implementation by a court and by NHS bodies.

8. Work programme

The Working Group shall proceed in four stages:

Scoping stage: identify the candidate case or cases, the immediate procedural posture, limitation or urgency issues, and any live risks to patients or claimant.

Merits stage: test the legal theory against the facts, defendants, alternative remedies, and likely objections; identify whether the case is truly arguable.

Remedy stage: settle the narrowest tenable form of pre-action ask and, only if justified, the narrowest defensible form of interim relief. The paper's proposed mechanisms of independent triage, removal of conflicted decision-makers, and separation of pathways should be tested here as possible relief models rather than assumed conclusions.

Decision stage: advise whether to send a pre-action letter, pursue urgent interim relief, seek a negotiated protocol outcome, develop a broader evidence base, or cease the project.

9. Governance and confidentiality

The Group shall maintain a confidential register of members, conflicts, and case connections. Any member with involvement in a candidate case, relevant trust, regulator, or prospective defendant shall declare that interest at the outset and withdraw from decisions where appropriate.

No public statement shall be made in the name of the Group unless approved by the chair. The Group's role is evaluative and strategic, not campaigning, unless and until a separate decision is taken.

10. Counsel engagement

Any invitation to a KC should make clear that the Group is seeking disciplined forensic leadership, not endorsement of a pre-formed claim. The KC would be asked to assist in identifying the strongest legally orthodox route, the weakest assumptions in the present proposal, the realistic shape of relief, and the threshold that must be met before any formal opinion or pleading exercise is justified.

That framing is likely to be more attractive to senior counsel than an invitation to front a campaign. It offers a chance to shape a serious piece of strategic public law work around a plainly important patient safety issue, while preserving professional independence and forensic realism.