IN THE LONDON SOUTH EMPLOYMENT TRIBUNAL **CASE NUMBER: 2300819/2019**

BETWEEN

DR CHRISTOPHER DAY

Claimant

and

LEWISHAM AND GREENWICH NHS TRUST

Respondent

WITNESS STATEMENT OF
DR SEBASTIAN HORMAECHE

I, Dr Sebastian Hormaeche of [redacted], will say as follows:

1. I am an NHS consultant anaesthetist working at [redacted] NHS Foundation Trust. I began training in anaesthesia in 2008 and gained my certificate of completion of training (CCT) in Anaesthesia 2017. My training included 12 months in ICU. After some Fellowship work, I began working as a Consultant Anaesthetist in the NHS in 2019.

2. I am currently an elected member of the British Medical Association's UK Council ("BMA Council").

3. I am aware of the issues in Dr Day's case and as a Consultant Anaesthetist, I hope to be of assistance to the Employment Tribunal in this matter. I have agreed to act as a witness in these proceedings in spite of my busy clinical duties as I feel that this in an important legal case and a matter of significant public interest.

4. Prior to what I describe below, I had never met Dr Day. I have never worked in the same NHS Trust as Dr Day.

5. I first met Dr Day at BMA House during a hustings session for the BMA North Thames Regional Junior Doctors Committee elections in late August 2016. I had by this time become aware of Dr Day's whistleblowing case against the Respondent and HEE. Both Dr Day and I were running for a place on the BMA Junior Doctors Committee ("JDC"). I heard Dr Day make a speech about his case and in particular, the arguments used by Health Education England to undermine whistleblowing law and the importance of challenging them.

6. Dr Day was duly elected, and I narrowly missed out on being elected. I do not recall having any significant conversation with Dr Day at this event, although I do recall congratulating him as we were stood next to each other as part of the election process.

7. The first proper conversation I had with Dr Day occurred around three weeks after the hustings. I first received a phone call from the then BMA North Thames Regional JDC Chair, Dr Jeeves Wijesuriya, who informed me that a decision had been made within the BMA that Dr Day could not serve on the BMA JDC because he no longer had a National Training Number and did not meet the BMA eligibility to remain the elected representative for Junior Doctors, or words to that effect.

8. I was told by Dr Wijesuriya that Dr Day had been informed of this and that the election result had been such that I would replace Dr Day on the BMA JDC, as I had gained the next highest number of votes at the North Thames Regional JDC election.

9. After the phone conversation with Dr Wijesuriya ended, I telephoned Dr Day and was expecting perhaps a difficult conversation. Our conversation in fact was very amicable and pleasant. I was struck by how calmly Dr Day seemed to have processed the news. Dr Day wished me well and we spoke about his case in more detail. This was the point at which I first became aware of the serious clinical/patient safety issues involved in the case relating to the Intensive Care Unit of Lewisham and Greenwich NHS Trust (the Trust) and the NHS's response to them and Dr Day.

10. As a practicing anaesthetist of some 13 years, and a consultant anaesthetist of 3 years, I make this statement to provide context of the disclosures made by Dr Day and how they have been represented by the Respondent

11. I will be commenting on:

a) The substance of Dr Day's Protected Disclosures made in 2013 and 2014;

b) Whether there is support for the substance of Dr Day's protected disclosures from ICU Core Standards, the Critical Care 2017 Peer Review and the findings from the 2 Serious Incidents;

c) The findings of the Trust's external investigation;

d) Whether the substance of Dr Day's protected disclosures and the findings of the external investigation have been represented accurately to the Trust's Board, to MPs and local stakeholders and to the press in a public statement dated 24 October 2018.

12. I confirm that I have read:

a) Dr Day's Grounds of Claim;
b) Dr Day's 2018 Witness Statement;
c) The Respondents Grounds of Resistance;
d) Dr Day's Further and Better Particulars;
e) Dr Day's Protected Disclosures August 2013;
f) The 2017 Critical Care Peer Review;
g) The HEE 15 October 2014 Quality Visit;
h) The Roddis Associates external investigation;
i) Coroner Papers/SUI papers for SUI 595 and 656;
j) The Trust's Public Statement date 24 October 2018;
k) Sir Norman Lambs Letter Dated 28 January 2019 enclosing Dr Day's letter dated 23 January 2019;
l) The Hansard record of Norman Lamb's speech on 3 June 2019.

Chronology

13. It appears from the evidence that the substance of Dr Day's protected disclosure made in August and September 2013 was repeated in January 2014. At this time, it was

combined with an issue with medical ward cover. Similarly, the substance was then repeated by Dr Day at his ARCP in June 2014 and then later in formal meetings in September 2014. On these occasions, the original August 2013 disclosure was combined with a complaint about an improper response to the earlier protected disclosures by the Trust that became associated in time at least with 2 Serious Untoward Incidents (SUIs).

14. Between the August 2013 and January 2014 protected disclosures, Serious Incident (SI) 595 and 656 occurred and the findings that were made from these are clearly relevant to Dr Day's protected disclosures as they all relate to the same issue to do with ICU junior doctors' level of training, experience and workload at the First Respondent.

15. On 12 November 2013 the Faculty of Intensive Care Medicine released Core Standards for Intensive Care Units set out a variety of evidence-based standards that Intensive Care Units must follow (SB p3-8).

> *"The ICU Resident/Patient ratio should not exceed 1:8"*
>
> *"The best current evidence is a Consultant/ patient ratio in excess of 1:14 is deleterious to patient care and Consultant wellbeing"*
>
> *"There must be immediate access to a practitioner who is skilled with advanced airway techniques"*

16. The Core Standards state that exceeding this staffing ratio is deleterious to patient care. The ICU cares for the sickest patients in the hospital requiring the most intense level of care and attention and when staffing levels are stretched patients may be exposed to higher degree of risk of harm. This is also impacted by the number and experience of trainees- doctors below the consultant grade, as well as the turnover of patients and the case-mix.

17. Airway skills- the skills required to secure and maintain the airway (intubation) in critically ill patients- are the core element of the anaesthetist's training and are their fundamental skillset. The sickest ICU patients (Level 3 patients) are those requiring ventilatory support in the form of a breathing tube being inserted into the airway (trachea, or windpipe) in order to help maintain their life support. Situations requiring airway intervention in the ICU typically require the presence of a practitioner with advanced airway skills. This is important because an emergency involving an airway

issue can be immediately life-threatening, therefore it is a requirement that there be immediate access to a practitioner with advanced airway skills, and in practice this is usually provided by the resident anaesthetists. It should be noted that novice anaesthetists who have not yet completed their Initial Assessment of Competency do not yet possess advanced airway skills.

18. I have seen evidence that on 15 October 2014, Health Education England carried out a quality visit at the Trust which recorded concerns from other junior doctors about staff patient ratios and the lack of ready availability of airway support. In my view, the findings of this quality visit by the HEE and the ICU Core Standards are clearly relevant to Dr Day's protected disclosures.

19. I understand an external investigation by Roddis Associates commissioned by the Trust concluded in early 2015 found the following about the substance of Dr Day's protected disclosures. Dr Day alleges that SUI 595 and 656 were excluded from this investigation despite him pointing the investigators to them. The findings were as follows (page 675-6):

> ""*. . . Dr Day . . . was expected to cover the 18 bedded ICU, ward outliers, A/E and ward ICU assessments as a resident SHO in QEH a district general hospital. In my opinion this was acceptable in light of his experience and skills at the time…The ICU core standards say that in general the consultant/patient ratio should not exceed between 1:8 and 1:15 and that anything in excess of 1:14 is deleterious to patient care and consultant well being. The core standards say that the ICU resident / patient ration should not exceed 1:8. These ratios are therefore not absolute."*

20. I was surprised to see this opinion expressed as this doesn't meet safety standards in terms of staffing levels either for doctor to patient numbers or for Dr Day's level of training at that time. In my experience this level of cover requires a senior trainee (a Registrar) with advanced airway skills and a higher level of ICU training to be resident in addition to an SHO, who is still undergoing their Core Training, as a minimum.

21. I also note that the Roddis Associates concluded in their report that *"Dr Day has immediate access to the resident anaesthetic registrar for airway management*" (Page

676). Dr Day has shown me the Roddis Associates record of the Dr Day's investigation meeting that shows him clearly stating the opposite to Roddis Associates on 18 September 2014 with some dangerous patient safety incidents that appeared to have occurred as a result (Supplementary Bundle Page 86);

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

22. This is an alarming paragraph for me to come across. It suggests an unsafe ICU environment in terms of patient safety, by way of staffing levels and access to advanced airway skills. The term intubation refers to the insertion of a breathing tube, which is a crucial element of life support for the sickest ICU patients. The term extubation refers to the removal of a breathing tube from a patient's airway.

23. A breathing tube is inserted in the ICU for the sickest patients requiring the highest level of life support. Extubation is a typically a planned event which is performed when a patient's condition has improved.

24. Self-extubation, however, refers to an unplanned and serious event where a breathing tube has unexpectedly become dislodged or displaced from the airway. This can become a life-threatening event.

25. The term hypoxic refers to a low level of oxygen circulating in the blood. This will be expected to occur if a breathing tube becomes accidentally displaced. Severe hypoxia can lead to cardiac arrest and death. To prevent this outcome, immediate access to advanced airway skills is essential.

26. I have also seen evidence that was shown to the Roddis Associates from the HEE 15 October 2014 quality visit that show other junior doctors on the Intensive Care Unit expressing concerns about the immediate access to airway support for the night-time Intensive Care Unit Doctor (page 641).

"The trainees reported that the availability of an anaesthetic registrar out of hours very much depends on the emergency workload in the Trust. Very often the anaesthetic registrars were busy and unavailable to assist immediately"

27. Staffing rotas on ICUs typically include anaesthetic trainees, who are spending a block in their training in the ICU so are present there throughout the shift, so that there is usually immediate access to an anaesthetist. Where there is a shift with no anaesthetist present in the ICU, then if the need arises for one to be present one must be called from the operating theatres. If this occurs out-of-hours (evening/night/weekend) then the on-call anaesthetists will be called, however their availability cannot always be guaranteed as they may well be busy, for example in the emergency operating theatre, which often requires their presence to care for very sick, high-risk patients, and be unable to leave to come to help.

28. The Roddis Associates conclusion that the following ICU Core Standard was being met is clearly contradicted by the evidence from Dr Day and the 15 October 2014 HEE quality visit;

"There must be immediate access to a practitioner (anaesthetist) who is skilled with advanced airway techniques (breathing tubes)"(Supplementary Bundle Page 7)

29. I have seen evidence that the HEE's Post Graduate Dean, Dr Frankel stated the following in a written paper to the MP Sir Norman Lamb about the substance of Dr Day's protected disclosure in early 2019 and the HEE quality visit (page 1302-1303)

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

30. Having read Dr Frankel's comments to Sir Norman Lamb in early 2019 and the HEE Quality Visit, I am very surprised to hear that the Trust and HEE endorsed the Roddis Associates position on 15 October 2014 HEE quality visits which found: "*A recent*

Deanery Visit concluded that staffing levels (unchanged since January 2014) were safe and there were no concerns about supervision highlighted by them".(Page 677)

31. The conclusion of Roddis Associates becomes even more troubling when the papers of the 15 October 2014 Quality visit are inspected (page 634-650). I have covered the point about immediate access to airway support above at paras 16-18 above. Dr Day has shown me the findings of the Quality visit as well as the Roddis report. The following additional concerns are expressed by junior doctors in the Quality visit that clearly support the substance of Dr Day's protected disclosures and further discredit the findings of Roddis Associates:

    a) ICU night-time staffing ratios; "*Trainees felt that the ITU was well covered during in the day but at night if a patient required particular attention they could become overstretched..." (page 641)*

    "Trainees reported that there are 18 beds which are often full, but last winter this was stretched to 26" (page 642)

    b) Culture; *"Concerns raised regarding bullying and undermining, with some trainees being too scared to name consultants that were responsible for this for fear of repercussion. It was felt that this was a problem that had been seen if not experienced by most if not all trainees." (pages 634-635)*

    c) SI Reporting: "*Core ACCS Trainees indicated to the visit team that SIs have been reported on numerous occasions but no feedback has ever been received." (page 640)*

32. The concerns about night-time staffing and access to anaesthetic/airway support were known to the senior team in the ICU at the time of the 15 October 2014 Quality Visit, as the report states *"The senior team...agreed that the safety of the ITU at night did depend on the anaesthetics registrars prioritising the ITU over other work. The senior team indicated that they were working towards providing middle grade cover for the ITU out of hours". (page 641-642)* An agreed action point from this 2014 Quality Visit stated: *"Trust to provide plans for future middle grade cover in the ITU".* In other words, the Trust was aware of the safety issues around night-time staffing and airway support

in its ICU and agreed to make improvements following a Quality Visit carried out by the HEE.

33. I have also been shown evidence of further support for the validity of the Dr Day's protected disclosures from a Dr Umo-Etuk within the HEE in an email dated 5 December 2014 (a view I agree with):

"I did form the opinion that the hospital in question failed to provide enough support out of hours (i.e. Registrar covered more than one specialty at night and consequently may not have been readily at hand to assist). I remember that you had sole responsibility for ITU which seems to be beyond the expected competency of a CT1/2 doctor." (Supplementary Bundle Page 148-149)

34. I have also seen evidence that I understand comes from the covert audio of a formal meeting between Dr Day, the HEE and the BMA on 2 September 2014 that records Dr Frankel's view on Dr Day's protected disclosures, (which again is a view I strongly agree with):

> *"The whole thing what you described is unsafe. "*
> *"What you describe to me is totally unacceptable for me to have trainees in a situation that you were in. In ICU you are non- You are not trained for intubation and airway care and you're in charge 19 never mind all the other issues. Its totally unacceptable."* (Supplementary Bundle Page 97)

35. Dr Day informs me that he has had helpful telephone contact with the author of the 2017 Critical Care Peer Review performed by the South London Critical Care Network and was provided with a copy of it to support his case and public for his Crowdfunding campaign. Having read this Peer Review, it is apparent that it is highly relevant and supportive of Dr Day's protected disclosures.

Substance of Dr Day's Protected Disclosures

36. I wish to highlight the following statements in Dr Day's email dated 29 August 2014 to the management of the Trust :

"*In general I take the view that it is unfair to expect one SHO with little or no experience of critical care to be left alone at night with between 15-20 ICU patients, have outliers and be expected to admit new patients*. [page 167-168.....]

37. Dr Day then sets out four bullet points to set out why he thinks this. These bullets clearly relate to the significant mismatch in anaesthetic training and experience for what is required. It is also clear what is being asked would not be appropriate even for just one experienced anaesthetist or actually one consultant. This is clearly set out in ICU Core Standards.

38. The Core Standards for Intensive Care Units state that exceeding the staffing ratios as set out is deleterious to patient care, and that this is also impacted by the ratios and experience of trainees. The ICU houses the sickest and most at-risk patients in the hospital. Consequences of unsafe staffing levels to patients may include an increase in the risk of adverse outcomes.

39. Dr Day's 29 August 2013 email invites of dialogue on a very serious matter and in my view could not be viewed as confrontational. Dr Day further states ;

"*The other deanery trainees have expressed similar concerns to me as has Dr Villar. I strongly believe that this situation is not only unfair to a cohort of inexperienced junior doctors but it is also unfair to you as consultants. I believe you deserve more experienced junior support than you have at the moment and the trust should provide you with funding for more experienced staff grades or registrars to support the SHO grades as in Bromley. I cannot understand how a smaller unit in the same trust operates with a SpR and SHO. Is there any way that Deanery pressure could secure you more resources?*

I am genuinely committed to several meetings when the above issues can be discussed. I am open to you changing my opinion on all of the above." [page 167-168]

40. I note the HEE's former Post Graduate Dean, Dr Frankel summarises his understanding of Dr Day's protected disclosure in his paper to Sir Norman Lamb which I also agree with (1302)

a) "A lack of support for airway management when commencing the role as "SHO" covering the ITU at night"

b) "A lack of consultant supervision in terms of numbers of consultants per bed on the ITU"

41. I would summarise Dr Day's disclosure as raising the following:

- Inadequate/unsafe night-time resident junior doctor-to-patient staffing ratio;
- Inadequate/unsafe consultant-to-patient staffing ratio;
- Immediate access to trained airway support not guaranteed at night;
- Variation in grade/competency of junior doctor resident at night (with distant consultant supervision) leading to inadequate/unsafe out-of-hours ICU staffing;
- All the above resulting in significant patient safety issues.

42. This criticism relates to the out-of-hours staffing levels in this ICU as described and was made by more than one of the trainees. The expectation is that the consultant-to-patient ratios would be as laid out in the Core Standards. I just do not think that an SHO who is a novice to anaesthesia and ICU is adequately trained to look after an 18-bedded ICU on their own at night with distant consultant supervision and no senior trainee resident.

43. In my own experience throughout my years of training in anaesthesia and working in several ICUs, I never once found myself working in a situation where the staffing levels were as what has been described in this case, which I would consider to be unsafe.

<u>Support of Dr Day's Protected Disclosures from ICU Core Standards</u>

44. For the reasons set out above, it is clear ICU Core Standards support the validity and importance Dr Day's protected disclosures in respect of consultant-to-patient ratios,

junior doctor-to-patient ratios and airway support. I cannot understand why Roddis Associates would conclude otherwise.

45. The Core Standards state that exceeding these ratios is deleterious to patient care and Consultant well-being, and that this is also determined by factors including trainee numbers and levels of experience. My view is that repeated failure to comply with the Standards exposes patients to increased levels of risk, which given the already high-risk nature of the patient cohort, should not happen.

Support for Dr Day's Protected Disclosures from the October 2014 HEE Quality Visit

46. The Quality Visit clearly supports what Dr Day has stated in his protected disclosures in respect of staffing, airway support, incident reporting and culture. I find it baffling that Roddis Associates have concluded the opposite and that such a conclusion could be endorsed by Health Education England when they conducted the Quality Visit.

Support of Dr Day's Protected Disclosure from 2017 Peer Review

47. For the reasons set out above, it is clear that the 2017 Peer Review supports the validity and importance of Dr Day's protected disclosures in respect of junior doctor-to-patient ratios and consultant-to-patient ratios. In particular, it found:

"High patient to consultant ratio within the unit. On the day of the visit there were 19 patients and only 1 consultant, exceeding the recommended ratio of between 1:8 and 1:15. It was apparent that this is a consistent issue with no clear recognition of the need for extra consultant input, nor any plans to address this." (page 774…)

48. This is relevant as there was enough time in the interim to address these issues to do with staffing levels that had been raised.

Support for Dr Day's Protected Disclosures from the SI Reports

49. Dr Day's witness statement at the 2018 Tribunal states at paragraph 32 and paragraph 166 [Supplementary Bundle page 256 and 285]:

> *""32. On 7 November and 5 December 2013, two patient deaths occurred at night under the care of Intensive Care. These deaths involved two different non-anaesthetic trained doctors and were declared as Serious Untoward Incidents ("SUI") and subject to Coroner inquests (see SI 596 at page [SB page 30-58] of the supplementary bundle and SI 656 at page [SB page 59-84.] of the supplementary bundle). The SUI's involved just the kind of circumstances that I had been concerned to avoid when I raised concerns about patients safety in August and September 2013.*
>
> *166. Ms McLaughlan's investigation was also incomplete. She had failed to investigate two Serious Untoward Incidents: SI 596 on 8 November 2013 and SI 656 on 5 December 2013 (see page [SB page 58-84.] of the supplementary bundle), which occurred between my August 2013 and January 2014 protected disclosures. These incidents involved the deaths of two ICU patients. They involved just the kind of circumstances which my August and September 2013 protected disclosures sought to avoid. Their reports make important recommendations and criticisms of the critical care service in Woolwich."*

50. It seems to me that the findings of both these SIs fully support Dr Day's warning in his August 2013 protected disclosures about the training and experience of the grade of doctors used by the Trust to cover the night shift in the Intensive Care Unit under distant supervision.

SI 656

I have seen an email dated to 5 December 2014 sent to the Trusts external investigation referring to the incident SUI 656. It is described in a few sentences, but I understand that no reference was made to it in the Trust's external investigation which I find very surprising. [SB page 151]

"the Incident occurred on 05/12/13 - involved insertion of a chest drain which was incorrectly sited and pierced the liver. The patient died from haemorrhage (coroner's PM report)"

51. The SI 656 made the following observations and recommendation*;*

*""**3b – misinterpretation of cause of blood in the chest drain tube following insertion**. It was not appreciated at the time by senior staff that the clinical fellow was too inexperienced (i.e.: lacked exposure to other similar type situations such as complications of other procedures to be able to broaden the differential diagnosis of the unexpected bleeding (as possible misplacement of the drain). Consequently he communicated incomplete information to the (off site) on call consultant and surgeon who was subsequently called to attend" [SB page 73]*

"3. It is vital that senior doctor staff implement proactive supervision of more junior staff. To minimize the chance of any complication a consultant must authorize procedures associated with excess risk and either perform them him/herself or be fully confident of the competency of anyone else directed to perform the procedure." [SB page 76]

52. I have seen the Coroner witness statements from the relevant consultant and junior doctor for SUI 596 which occurred on 8 November 2014 and the Corner Inquest Report that states, *"The failures to first investigate the cause of hypertension on 07/11 and to admit in a timely manner to ICU contributed to his death."* I find that this SUI also supports what Dr Day is saying about the training and experience of the doctor used to cover the intensive Care Unit under distant supervision.

53. I cannot understand why Roddis Associates were to exclude these two highly relevant SIs from their investigation.

Datix Incident Reporting

54. I can gather from the pleadings that Dr Day submitted a Datix incident report with his protected disclosures. I note from the Dr Day's Further and Better Particulars that the Trust made the following findings on how that was handled [page 695 and 712-713…]:

a) "*the Datix report was not formally followed up and logged on the system as would be expected*";

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

c) *"Dr Day then shares his experience with Dr Harding who involves Dr Ward who then copies his response to a wide and senior audience which is undermining and could be perceived as bullying"*.

55. This is an inappropriate manner in which to handle and process an Incident Report, and in my view, it is also unprofessional.

56. Incident reporting is an important part of the NHS safety culture, which is a matter that is taken seriously at Board and Governance level. Datix is one of the Incident Reporting systems currently in use in the NHS. The Care Quality Commission when inspecting healthcare services, uses key lines of enquiry according to its framework which looks closely at Safety as one of five major domains. NHS organisations that have high numbers of Incident Reports are those which are fostering a positive reporting culture in an environment of transparency and seeking to continually learn and improve, whereas those with low numbers of incident reports may not be engaging with the safety culture in the way that is encouraged. NHS trusts throughout the UK understand the importance of Incident Reporting and are keen to show firstly that they encourage members of staff to feel safe and free to report matters as they arise, and secondly that they handle and process these Incident Reports in a transparent and professional manner. This in turn leads to public confidence.

57. The 2017 Critical Care Peer Review, refers to the incident reporting culture within the Trust's Woolwich Intensive Care Unit, it identifies a "*poor incident reporting culture*". It further states:

"Two members of staff were approached by their managers after reporting incidents with one being told "she had created a lot of work" while another was told she should have said something verbally rather than submitting a formal incident form." [page775 ...]

58. There are obvious parallels with these 2017 Peer Review comments to the findings made by the Roddis external investigation in respect of how Dr Day's Datix incident report was handled. I cannot understand how the Trust can firstly conclude that the Roddis external investigation found that they handled Dr Day's Datix report in the right way or secondly that the Peer Review doesn't support and expand on the criticisms made by the Trust's external investigations into Dr Day's case concerning Datix incident reporting culture in the relevant Intensive Care Unit.

24 October 2018 Trust Public Statement

59. I understand a public statement about Dr Day's case was published on the Trust's website on 24 October 2018, used to brief the Board of the First Respondent on 30 October 2018 and then used in several letters to local MPs in South London to ensure they were "*fully briefed*" on the case.

60. Given what I have set out above, I find the statements below that were released by the Trust on 24 October 2018 and were shared with MPs and the press, to be false and misleading. In my view, they clearly misrepresent the substance of the Dr Day's important protected disclosures and the findings of their external investigation as set out in his Grounds of Claim:

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

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

61. In fact, the external investigation made several criticisms of the way the Trust responded to Dr Day's incident reporting. These included, but were not limited to, failing to deal with the formally raised concerns through routine governance processes, and addressing the issues raised in an informal and uncoordinated way, as well as comments made in the report that refer to the way the concerns were handled as being bullying and undermining towards Dr Day. The report goes on to say that there "is evidence that Dr Day feels bullied" and that matters should have been handled differently. I would say this all goes strongly against any assertion that the Trust responded to Dr Day's concerns "in the right way".

62. I should also make clear that the findings of the external investigation in respect of the validity of Dr Day's protected disclosure, in my view are dangerous and troubling as they are contradicted by the evidence and national guidelines:

> "*Dr Day was expected to cover the 18 bedded ICU, ward outliers, A&E and ward ICU as a Resident SHO in QEH. In my opinion this was acceptable in light of his experience and skills at the time.*
>
> *"A recent Deanery Visit concluded that staffing levels (unchanged since January 2014) were safe and there were no concerns about supervision highlighted by them."*

63. They are even more troubling in light of what the HEE' Dr Frankel stated to Sir Norman Lamb about the substance of Dr Day's protected disclosure in early 2019:

> *"the visit confirmed the issues raised by Dr Day in relation to his protected disclosures.. Progress was slow and a further visit took place on 15 March 2015. The ICU was reviewed and unfortunately only limited improvement had occurred in this area*". [page 1302-1303.....]

I confirm that this statement is true to the best of my knowledge and belief.

Signed .....

Name **DR SEBASTIAN HORMAECHE**

Dated .....