EMPLOYMENT TRIBUNALS

Claimant: Dr C S Frost

Respondent: Ministry of Defence

HELD AT: Manchester **ON:** 26, 27 and 28 October 2016
31 October 2016
2 and 3 November 2016
18 January 2017
20 January 2017
1 February 2017
(in Chambers)
24 March 2017
(in Chambers)
12 June 2017
(in Chambers)

BEFORE: Employment Judge Feeney
Ms M T Dowling
Mr A J Gill

REPRESENTATION:

Claimant: Mr J Hendy, Counsel
Respondent: Mr A Serr, Counsel

JUDGMENT

The judgment of the Tribunal is that the claimant's claim that he suffered detriments as a result of making a protected disclosure fails and is dismissed.

REASONS

1. The claimant brings a claim of detriment due to whistle-blowing following the termination of his contract by the respondent on 6 September 2013.

2. The history of this case is complicated. The claimant has not been well enough to contemplate a Tribunal for some time. We set out a summary of the case management history below.

The Issues

3. The issues in this case are as follows:-

(1) Did the claimant make protected disclosures? As set out in further particulars of November 2014 and then by an amendment on 16th May 2016.

(2) Did he have a reasonable belief that they tended to show one of the matters set out in 43(B) Employment Rights Act 1996 and which of those matters did he rely on

(3) Did the claimant suffer a detriment/s because of the protected disclosures?

Witnesses

4. The Tribunal heard from the claimant himself; his son, Christopher William Frost. There was a witness statement produced by the PT on behalf of the claimant but she did not attend. For the respondent we heard from Angela Thompson, Area Manager APHS(N) DPH(N); Carole Phillips, at the time Staff Officer to Colonel Morgan-Jones at Army Primary Healthcare; Catherine Shakeshaft, Practice Nurse; Colonel (Retired) Carson Black, Regional Healthcare Director in charge of Army Primary Healthcare (North); Colonel David Morgan-Jones, Deputy Director for Army Primary Healthcare Service, and Assistant Director Clinical Services responsible for healthcare operations; Samantha Cotgrave, Regional Healthcare Governance and Nursing Lead for Defence Primary Health Care (Northern Region); Colonel John Burgess, Deputy Inspector General HQ S-G, latterly MOD responsible officer for trained doctors within the MOD who are civilians; and Brigadier Robin Simpson, Professor Military Primary Healthcare and Veterans Health, previously GP Dean, responsible for training all GPs in the Defence Medical Services ("DMS") and Deputy Responsible Officer for all trainee doctors working within DMS.

Excluded Witnesses

Mr Knott

5. The claimant sought to call Mr Knott to give evidence regarding the correct procedure for controlled drugs. We decided not to hear Mr Knott's evidence. The relevance was what the witnesses knew at the time and the matters of the correct procedures, given that the documents were in the bundle, could be put in cross examination. There was prejudice to the respondent if the statement was admitted as they had not had enough notice and would have to call another witness.

6. There was an agreed bundle.

Findings of Fact

7. The claimant is an experienced doctor and has for many years now practised as a locum mainly for the Ministry of Defence. Latterly he has worked for an agency called Castle Rock Recruitment Group ("CRG") which supplies medical staff to the Ministry of Defence under an overarching contract.

8. The claimant had a written contract with CRG who have a handbook describing many of the aspects of the claimant's work. This contract says that:

> "The employment business will endeavour to obtain suitable assignments for the locum doctor. The locum doctor is a doctor seeking work as a General Practitioner to work as a locum. The locum doctor shall not be obliged to accept any assignment offered by the employment business. The locum doctor acknowledges that the nature of temporary work means there may be periods when no suitable work is available and agrees that the suitability of the work to be offered shall be determined solely by the employment business…and that no contract shall exist between the locum doctor and the employment business during periods when the locum is not working on an assignment."

9. It goes on to say that the locum doctor was obliged to provide an invoice at the end of each week of the assignment and the employment business would pay the locum doctor in accordance with the invoice and the fees would be notified on a per assignment basis, on the basis of an hourly or daily rate.

10. Regarding termination it said:

> "The employment business or client may terminate the locum doctor's assignment at any time without prior notice or liability. The locum doctor may terminate an assignment at any time without prior notice or liability."

11. The enabling contract (between the agency and the respondent) for the provision of temporary staff required the contractor to accept responsibility for the quality of service provided by the agency worker, and at 9.7 (page 351) stated that:

> "The contractor shall maintain a written quality assurance system that covers the following procedures and practices which include receiving, investigating and resolving complaints of unsatisfactory performance or misconduct in respect of an individual agency worker."

12. The claimant began working at Weeton Barracks on the assignment in question on 22 July 2013. He had previously had an assignment there for four weeks. A number of staff welcomed him back as they had a backlog of patients waiting to see the doctor and had got on well with the claimant in his previous assignment.

13. On Tuesday 6 August 2013 the claimant was speaking to Karen Raines, the other doctor at the Practice who worked two days a week as a civilian medical practitioner, she was not employed on an agency contract as was the claimant. The Pharmacy Technician (PT) joined the conversation and she stated to the claimant that she felt the patient the claimant was about to see was a difficult patient and that

he was prescribed morphine sulphate tablets (MST)and Oramorph which is a liquid morphine solution. There was a discussion about prescribing controlled drugs in the military as the claimant said he had not prescribed this type of drug before. He was advised that they printed out prescriptions although outside of the military such prescriptions would have to be handwritten. However, no other format of prescriptions was available at Weeton Barracks.

14. The claimant advised that on arriving at the Practice that day he had seen a sports car with blacked out windows and this had heightened his concerns as he felt it was the type of car that "drug dealers used". The claimant actually said:

> "I had noticed a shiny new black sports jaguar car parked aggressively on the double yellow lines immediately outside the entrance to the medical centre…I noticed the rear windows were heavily tinted. The cliché about tinted windows passed idly through my mind at the time 'that looks like a drug dealer's car'. It turned out the jaguar car in question had belonged to patient X."

15. Mrs Cotgrave would later say to us that she felt this observation was extremely insensitive as many of their patients were young men who were amputees after being injured in Iraq or Afghanistan and would often buy sports cars with the compensation they received for their injuries.

16. It is relevant to note the patient's prescription history: that on 5 July 2013 another locum doctor, Dr Don Jose Sampedro, had prescribed 40 x 10mg morphine sulphate tablets to the patient in question, one to be taken twice a day. On 10 July Dr Susan Matthews saw the patient at Fulwood Barracks. The medical record stated that the patient used a "breakthrough" Oramorph dose of 10mg the previous evening, and she recorded:

> "Some nausea with new regime. No vomiting. Occasional myoclonic jerk as he gets off to sleep. Bowels open regularly. No nightmares."

Dr Matthews then prescribed 40x10mg MST on 24 July but as the claimant's notes stated, the patient had been unable to obtain the 10mg MST because the local pharmacy said it was a controlled drug and needed to be on a special prescription. So that prescription had never been used.

17. The claimant went ahead on 6th August saw the patient and prescribed the same amount to the patient as he had been previously prescribed, namely 40x10mg MST one twice daily. The claimant used one of the usual prescription forms as advised. He observed the patient as normal but was unaware at that point there might be any problems. The patient advised the doctor that he was feeling fine. The reason he had attended Weeton was that his usual doctor (Dr Susan Matthews) at Fulwood Barracks was on holiday.

18. A few minutes after the consultation ended he was talking to PT; she suddenly appeared to realise something and informed the claimant that she thought she had made an error following the patient's prescription of 5 July, and that she had ordered and dispensed 40x60mg MST tablets instead of 40x10mg MST tablets. The claimant said that he believed the patient had left the medical centre at that stage but he was not sure. His evidence is that he felt that this error was to be dealt with by the

pharmacy staff. With hindsight he stated that he did not think the patient could have taken 60mg MST tablets as there was no sign of that. The claimant said to PT, "Tell the truth, don't cover up and don't worry".

19. PT had spoken to the Practice Nurse, Mrs Catherine Shakeshaft, advising her that she had incorrectly ordered the tablets and then dispensed those incorrect tablets to the patient. Mrs Shakeshaft had signed the relevant documentation as correct (i.e. that the tablets being dispensed were 40 x 10mg). This was a checking security measure but obviously it had completely failed in this instance as Mrs Shakeshaft did not notice that the tablets were actually 60mg tablets.

20. The tablets were received in the pharmacy stock on 8 July and were recorded as 60 x 60mg on a document called the BMed 12. It was noted that 40 tablets x 10mg were dispensed on 8 July in the relevant transaction report. Further of relevance is that on 19th August 20x 60mg tablets of MST were recorded as transferred which accorded with 40 having beendispensed out of an order of 60.

21. Mrs Shakeshaft advised PT to raise the incident with the Regional Pharmacist and to raise a PSIR (patient safety incident report). The Regional Pharmacist was Mrs Beverley Hall. As the PT was going to Catterick on 7 August where she would see Beverley Hall, it was agreed she would raise it with her on that date.

22. The claimant says that he said to Mrs Shakeshaft at the time, that there could be illegal activity involved. She had no recollection of this and as the claimant was equivocal about this in cross examination, saying that his views about the incident were developing over the course of events, we do not accept he said this at the time. In deed his evidence that his views were evolving is completely at odds with his emphatic and detailed description of his protected disclosures as set out in November 2014.

23. On 6 August Dr Raines also knew about the error. Mrs Shakeshaft had told her that day, and also told Dr Raines that she had advised the claimant to report to Ms Hall the next day. Dr Raines did not know that PT Gould had not done this until the 20 August.

24. On 7 August PT went to Catterick and spoke to Yvonne Inkester, the Senior Pharmacist there. She asked her advice about the dispensing error, and Mrs Inkester advised her to get the patient back in front of a doctor. She also advised her to speak to the Regional Pharmacist immediately. PT met the Regional Pharmacist that day but did not raise the issue with her.

25. On 8 August Mrs Shakeshaft was aware from PT that she had not reported the error to Mrs Hall and PT agreed that she would do so when Mrs Hall was due to visit the barracks on 9 August. However, this visit was then cancelled.

26. On Friday 9 August 2013 PT delivered 40x10mg MST tablets which the patient had been prescribed on 6 August by the claimant to the patient's home. The claimant felt this was unusual. No-one is aware of whether any conversation took place or whether she told the patient at that stage about the error. PT submitted a witness statement at the behest of the claimant but did not appear as a witness and did not refer to this.

27. PT then called in sick on 12 and 13 August 2013 and on 14 August she sent a text message to Mrs Shakeshaft saying she had not reported the error and asked her to raise a PSIR. She also advised she would be off for two weeks on sick leave.

28. On 15 August 2013 Mrs Shakeshaft telephoned Mrs Samantha Cotgrave (Regional Health Care Governance Lead at Catterick) ostensibly about the procedure for reporting sickness absence initially, and asked her whether PT Gould had raised a PSIR about the dispensing error although she already knew the PT had not done this.

29. The same day Mrs Cotgrave rang the Weeton Barracks to speak to the claimant, the claimant was in the middle of a difficult consultation with a potentially suicidal patient and he was annoyed understandably that Mrs Cotgrave was put through and asked why she had been put through even though he was in the middle of a consultation. Mrs Cotgrave ordered the claimant to ring the patient and to advise him that he had taken 60mg MST and the claimant stated that he was not sure he had taken such tablets and he did not think it was appropriate to tell him over the telephone but that the patient should be called in for a consultation.

30. Mrs Cotgrave said that the claimant stated he was too busy to ring the patient and that she had spoken to him twice on the 15th and he twice refused. The Practice Manager Sergeant Kristian Smith contacted the patient instead at 16:09 and stated "patient contacted to arrange appointment for discussion that medication 20/8/13 14:00 hours, patient states has 10mg tablets only, asked to check labels as well as box for 60mg and to stop taking any if any are left, asked to bring all medication packaging to appointment, Doctor informed".

31. Beverley Hall rang the patient the same day at 17:39 and the note of this conversation states that "the patient contacted to review medication, controlled drug register shows an entry for 8th July for 60mg MST prescription was for 10mg MST. The patient stated he collected July prescription from Lloyd's Poulton Le Fylde, I have spoken to Lloyds and they have dispensed Oramorph 300 mls on 5th July but they have no record for MST prescription. Patient states has received only two prescriptions for MST in the last year and a half and is confident that the current tablets are 10mg, I discussed the colour of the tablets as MST 10mg are brown and 60mg orange, patient discussed that they are the same colour as Amitrypline 50mg brown (also mentions skin tone). I asked the patient how their pain control was and he acknowledged there was a gap in therapy between the July prescription and the August prescription and that he had to use extra Oramorph during that time, he is noticing the effects are less at the moment and considers this may be due to the gap in treatment. I have offered the patient an appointment tomorrow for 10.30 I am unable to offer an appointment at Preston but patient prepared to travel to Weeton, I will be on site then and able to show the patient the 10mg and the 60mg tablets and to see the patient's supply. The patient can be reviewed at this time by the doctor, half an hour appointment is booked, patient has to be in Preston for 12 o'clock to meet PRO. Patient had the prescription home delivered on 9th August by PT".

32. On Friday 16th August Samantha Cotgrave arrived with Beverley Hall and Angela Thompson at Weeton. The claimant clearly felt she was antagonistic as he said she said to him "why didn't you do what I told you to do yesterday" and went on to say "because of you I can't go on holiday next week". The claimant said he took

the view at the time that she was "out of control". We accept on the balance of probabilities that her manner was overbearing when she first arrived.

33. There was a conversation then between Mrs Cotgrave, and Mrs Hall and the claimant where they told the claimant that he needed to increase the patient's dosage from 10 to 20 on the basis of the telephone conversation the previous evening. On the basis it appears (although not necessarily articulated) that after having had a higher strength medication the patient would be struggling with the lower prescribed medication. The claimant again understandably refused as he says he was not convinced that the claimant had taken 60mg tablets. He was also asked to show the patient the different tablets, however again he refused and he said that Beverley Hall should do this before the consultation and he would be present.

34. This in fact happened and the patient did not recognise the tablets of 60mg but did recognise the 10mg tablets and he said those were the only ones he had been taking. He had brought with him 10mg MST which he had obtained recently and he denied receiving or taking 60mg tablets (he no longer had the original packaging for the tablets).

35. A second consultation with this patient then took place and the claimant noted this as follows. "Needs his Oramorph but OK for tablets - patient says he has never had any other than 10mg tablets - he also says that he has never received or taken the orange tablets shown to him by the Pharmacist - he also says he was not aware that stronger tablets than 10mg existed - says he has a very good memory and is observant and he would have noticed had he received anything other than 10mg tablets - prescribed X for itching from insect bites on R lower leg - patient happy with pain relief and does not in any way wish to increase the dosage of MST". The claimant would later rely on this as a protected disclosure. On cross examination the claimant said he thought that this would be seen if there was a police investigation, at the time he was not thinking that Mrs Cotgrave would see it. However in evidence to the tribunal it became clear she had accessed the notes and so she had seen them. However the information was no different to the information the claimant was to give in his interviews.

36. The claimant then claimed that after the consultation he told Mrs Cotgrave, Mrs Hall, Mrs Thompson and possibly others in a room where they were sitting that they needed a Police investigation because "I as the doctor suspected criminal activity involving dangerous controlled drugs, there were signs of apparent disinterest so I explained why a Police investigation was necessary, I had a strong suspicion of criminality highlighted by the diametrically opposed opposite accounts of the two main protagonists the pharmacist technician and the patient". He stated "I did have a duty to report potential criminal activity and I was trying to do this in a neutral way without directly blaming either one of the patient or PT Gould." Mrs Cotgrave denied that the claimant had said any such thing to her as did Angela Thompson. Catherine Shakeshaft said that he did say they should get legal representation before the interviews, and we think the claimant has extrapolated this into something different. We find this because the claimant made no mention of any possible criminal activities or health and safety risks in his interviews and again because he was less emphatic under cross examination about what had been said, when and to whom.

37. Mrs Cotgrave was tasked with investigating what had happened by Carson Black who was Regional Healthcare Director (North). He was in charge of Army Primary Healthcare Services North (APHSN) which became Defence Primary Healthcare North subsequently. Typed notes of the interview with the claimant confirmed that PT had told him on 6th August that she had ordered 60mg morphine tablets and she must have given them to the patient. He stated pharmacy was another world by which he meant separate and apart from the doctors. Reflecting on the 6th August consultation he said the patient did not appear to be "drugged up" which one would expect had he been taken six times the normal dose of Morphine. He thought the situation was being dealt with by Mrs Shakeshaft and PT, he did not feel as a Locum Doctor new to the practice team he should be chasing those concerns and it was not until 15th August that he became aware that the concerns had not been raised. He confirmed that the patient was adamant he had never seen or taken the orange tablets shown to him on the 16th August. The handwritten notes reflect that he said –"with hindsight he should have contacted the patient" – although this is not recorded in the typed notes..

38. He acknowledged he did not personally call the patient as requested by Mrs Cotgrave but that Sergeant Smith had offered to contact the patient because Dr Frost had an extremely busy clinic which had overrun because he was dealing with a complex potentially suicidal patient. The notes went on to say "Dr Frost said he was not sure the patient had been given the wrong dose of medication - reiterating that the patient was adamant he had never taken anything other than 10mg of Morphine and the claimant said he did not recognise the 60mg tablets. It was pointed out the patient was also adamant that he collected the drugs from Lloyds and that they were not supplied by Weeton Barracks Medical Centre". This was mentioned because it could not be the case that he had obtained such tablets from a Lloyds Chemist as they would not stock MST tablets. Dr Frost said PT was one person working alone, he said she was "a good girl who made a mistake". He said he advised PT when the error was identified on the 6th August "don't worry don't cover up and tell the truth". These statements are at odds with his original case that he raised the issue of criminal activity from the start, as here he was agreeing it was a mistake.

39. The members of staff interviewed at the time were the claimant, Mrs Shakeshaft, Sergeant Smith, Mrs Hamilton Practice Administrator. The PT was still off sick. Angela Thompson interviewed the claimant, Mrs Inkester and Mrs Cotgrave interviewed Dr Raines.

40. In Sergeant Smith's interview he said that when he spoke to the patient the patient had said "oh I know what this is about the 60's". This comment was significant in the claimant's mind as it meant the patient had some forewarning of the issue and therefore if he wished to not tell the truth he had time to consider that.

41. On 21st August there was an informal meeting regarding the progress of the investigation with Colonel Black, Beverly Hall, Mrs Cotgrave, Angela Thompson and two others. There is a record of this meeting and the proposed actions it records that advice from the Army Medical Legal Directorate should be sought in respect of the claimant.

42. Mrs Cotgrave said both Dr Frost and Mrs Shakeshaft wanted to amend and add further information to their statements and Angela Thompson met with them to

agree further notes. Dr Frost denied he had requested this however we find that he had on the basis of Angela Thompson's evidence, she was a credible witness, she was friendly towards the claimant and had no reason to lie about this.

43. In this additional statement provided on 22nd August the claimant confirmed he was not aware of the error until after the consultation. The MST tablets he had prescribed could not be dispensed that day and it was ordered but the Oramorph was dispensed, he couldn't remember if the patient was still in the building when he was made aware of the error, he declined to speak to the patient as he felt he did not have enough evidence an error had been made when he was asked to by Mrs Cotgrave. Further, that when he saw the patient on 16th, the patient denied receiving any 60mg tablets and he pointed out that the patient had said to Sergeant Smith "was it to do with the 60mg " as if he knew what it was about.

44. A statement was obtained from Dr Matthews on 22nd August which recorded that "he did not appear to her to be under the influence of an increased dose of Morphine Sulphate tablets, he did however comment that he wasn't using his Oramorph 10 mg as much as he had been and felt he was having a better control with the modified release action of the MST. Dr Matthews feel he is a good historian and on the two occasions she has seen him he has not appeared to be confused or muddled. Dr Matthews stated that having worked out his amount of MST in addition to his Oramorph that his level of pain control when she last saw him on 24th July fits with him having 60mg MST BD which she didn't know about at the time of the consultation".

45. Dr Matthews has a number of years experience with palliative care and is used to working out a patient's opiate requirements. Mrs Cotgrave's evidence was that she relied on Dr Matthews' observation which she felt did support the view he had had 60 mgs tablets. There was some discussion at the Tribunal as to how this statement had been obtained and there were contradictory versions of this, it appeared that Mrs Cotgrave had obtained this statement from Dr Matthews and written it up rather than it being Dr Matthews' own words however we feel nothing turns on this as it appeared to be a fair recollection of Dr Matthews as it was not wholly one sided and did not wholly serve Mrs Cotgrave's "case" that this was a mistake as it suggested that the patient was a reliable narrator.

46. Colonel Carson-Black also said he spoke to Dr Matthews and had gleaned from his conversation with her that the claimant had mental health issues. However, this was not apparent from any of the documentation and he had not included this in his statement.

47. It was Mrs Cotgrave's evidence that herself, Colonel Black and Mrs Thompson did consider if it was possible any criminal activity was involved but all the evidence pointed to nothing more than a dispensing error by PT. It was a serious mistake but she was satisfied that that is what it was.

48. PT Gould was on sick leave throughout the time of the interviews and the investigations were completed as far as Mrs Cotgrave could and then she provided an interim report to Major Phillips on 23rd August (however she was on holiday until 5th September). The final report was completed later in September once she had been able to interview PT but it was her opinion that her conclusion in respect of Dr

Frost would remain unaltered. It was not her responsibility to make any decisions but to simply present her report.

49. In evidence Mrs Cotgrave made clear that one of the important matters for her which was that the only tablets of MST in the pharmacy at the date the patient collected from the 5th July prescription on 8 July were 60mg ones. This had not been particularly referred to in her witness statement, neither was it apparent from her investigation report. However, there was a reference in the investigation report to documents DMICV and P2P which she said referenced the evidence that the only tablets were the 60mg ones. However, to the untrained eye this would not be apparent. In addition, of course, the claimant at the time did not have sight of this documentation or the full investigation report and therefore had no documentary evidence on which to base any suppositions or suspicions regarding criminal activity. Colonel Black also said that the Regional Pharmacist, Beverley Hall, had advised him there were no 10mg tablets in the pharmacy at the time, only 60mg. However again this was not in his witness statement.

50. It was also recorded in the investigation report that the patient was confident his current tablets were 10mg and that on the day the regional pharmacist spoke to him he gave no indication he already had knowledge of any problem regarding the tablets. The investigation report did not record that the patient had told Kristian Smith “is it about the 60s?”.

51. On the last page of the interim report under conclusions the following is set out. The report states "however some issues have become clear from the investigations so far -

> (a) although the pharm tech has not been interviewed there is evidence from the DMICP record CD register and the prescription that the dispensing error has been made by the PN, this is confirmed from the witness statements of the medical centre staff.
>
> (b) there is evidence from the P to P system and the DMICP that the wrong dose of MST was ordered by the pharm tech and receipted into dispensary against the prescription by the pharm tech and the PN.
>
> Mrs Cotgrave elaborated in evidence to the Tribunal that what she believed happened is that PT did order 60mg rather than 10mg and that when they came into the dispensary they were labelled as 10mg hence Mrs Shakeshaft confirming that they were, the patient then came in to collect the tablets on and was dispensed these tablets. She formed this belief because from the records there were no other tablets in the dispensary other than 60mg ones and therefore she concluded with the Regional Pharmacist that the patient must have taken the 60mg tablets despite his denials, they felt he was to some extent an unreliable reporter because of his reference to collecting MST from Lloyds which was not possible and also from Dr Matthews' evidence that his decreased usage of Oramorph in the relevant period could be a reflection of an increased dosage of MST.

52. Mrs Cotgrave took the view that the clinical staff had let the patient down, her other conclusions were:

(c) none of the clinical staff felt it was their responsibility to inform the patient despite two Doctors, a pharm tech and a PN (Practice Nurse) being aware for nine days this error had occurred.

(d) the PN did not report her part in the error to her Line Manager in an acceptable time frame as the HG Lead she did record an amber PSIR within acceptable time.

(e) PN concerned with raising/not raising PSIR and not the safety of the patient.

(f) neither of the doctors was prepared to accept clinical leadership within the practice or take responsibility for the duty of care of this patient.

(g) when asked to inform the patient the local doctor did not see the urgency in this request and did not carry this out.

(h) the military PN did not appreciate the seriousness of the error and did not investigation or follow up the concerns raised by the PN.

(i) due to the nature of the medicine and the admissions of duty of care from the clinicians this will result in a referral to their respective professional bodies.

53. Within the interim report Mrs Cotgrave also referred to a informal review panel on the 21st August as follows:

(a) an informal performance review was held in RHQ following interviews and fact finding investigation in order that the RHCD were aware of all the information and action plan to be formulated Annex B and

(b) advice was also sought from DBS who had an appointed case worker to advise on potential misconduct processes for the MOD civilians involved in accordance with the latest policy rules and guidance.

(c) advice has been sought via email from AMD (a reference to HR/legal advisors regarding potential disciplinary action being taken on the doctors involved.

(d) the Area Manager received the sick note from the pharm tech and contacted her regarding this but on advice from DBS not the ongoing investigation.

(e) the pharm tech, visited RHQ on the 7th August had confided in the senior pharm technician (Mrs Inkester) at GMC Catterick she made her aware of the dispensing aware, she advised the pharm tech to speak to the Regional Pharmacist immediately. She left her thinking this had been carried out and was not aware this had not happened until 22nd August.

54. Annex A of the report did record that the doctor was “not convinced the patient had overdosed, patient adamant he had not been”

55. The action plan listed the action to be taken in respect of each person involved, in respect of the Senior Nurse (Mrs Shakeshaft) formal misconduct proceedings to be undertaken, in respect of the military PN informal interview with RHCD to be held and no further action. The locum doctor i.e. the claimant AMD (Army Medical Legal Directorate) to be contacted regarding further action. The fee earning doctor, Dr Raines - AMD to be contacted regarding further action, admin no further action, Senior PT informal interview with RHCD to be held no further action, PT formal misconduct proceedings to be undertaken following disciplinary interviews on return from sickness absence.

56. Major Phillips returned from holiday on the 5th September and considered Mrs Cotgrave's report, initially with Colonel Black and then with Colonel Morgan Jones this was because they were all in the same location on the same day. Carole Phillips discussed the matter with Carson Black and then went to see Colonel Morgan Jones and presented their conclusions. Colonel Morgan Jones confirmed in evidence that Major Phillips reported the action she had agreed wit Colonel Black and he endorsed that. It was her view that Dr Frost's action like those of other staff involved had fallen well short of what was expected in that he saw no need to advise the patient of the error when he learnt of it even when specifically asked to do so by Mrs Cotgrave, further it appeared that he had not seen it as his responsibility to ensure the matter was properly reported to higher authority by means of a PSIR.

57. It was agreed action should be taken against all the staff involved and the exact nature of that action depended upon their professional roles and their involvement in the incident and how it was managed. Major Phillips stated that this was for good governance and not blame culture.

58. She stated that for the doctors normally they would face a performance review panel (“PRP”), that all doctors would have a responsible officer normally and another doctor to oversee actions and provide guidance. It was their view that as Dr Frost was a Locum Doctor the MOD had no power to hold a PRP for him however it did in the case of the Fee Earning Doctor (Dr Raines) who had a different contractual relationship with the MOD and therefore they held a PRP in respect of Dr Raines in September who admitted that she had fallen down on her duty to the patient and accepted the criticism. It was decided because they had taken the view that Dr Frost could not be given a PRP by the respondent himself that he should not be allowed to return to practice within a military establishment until this had happened. It was her understanding that his agency would deal with the PRP.

59. On 9th September Major Phillips sent this action plan to Carson Black and Sam Cotgrave and David Morgan Jones, stating "attached to PRPs are the recommendations of this HQ and how to move forward with Weeton following the PSIR, I am happy to help recalling notice etc for the PRPs”.

60. The attached paper was headed "issue paper following patient safety incident report Weeton Medical Facility, it referred to two documents, JSP955-1-4 and JSP955-2-4.

61. It was stated that:-

Issue

"(1) A dispensing error (60mg tabs of Morphine instead of 10mg tablets), the lack of awareness of the significance of the failure to inform the patient and disclose the error to higher authority shows a clear lack of understanding of governance and assurance frameworks, not only within DMS policy but NHS and professional registration.

Recommendation

(2) Performance Review Panel to be set up to examine the performance of the Fee Earning CMP with a review by a Responsible Officer and all other health care professionals ("HCP") involved.

(3) A full report of incident and concerns to be raised to the locum agency in order for his responsible officer to undertake a performance review and as such should not be allowed back into military practice until this has been undertaken.

Timings

(4) Urgent

Background

(5) PSIR raised for wrong dosage prescribed by a Locum GP dispensed by a pharm tech and checked by RN.

(6) A failure of all staff including the Fee Earning GP to inform the patient of this discrepancy and to fully understand the implications of this omission causes great concern for overall patient safety and performance of all HCP's within this MTF.

(7) Failure to report incident to GHQN shows lack of understanding of COC (Code of Conduct) and support mechanisms available to support errors and learn from issues identified.

Recommendation 3 concerned the claimant.

62. We comment that we find this in an incredibly "scrappy" report given that it was the main instrument in the three senior officers making and recording their decision in respect of the careers, not just of the claimant but of the contract doctor Dr Raines and the Practice Nurse and the PT.

63. On 9th September at 10 o'clock Colonel Philips then emailed Carson Black and Sam Cotgrave attaching the issue paper stating "attached for the recommendations of this HQ and how to move forward with Weeton following the PSIR and how to help with the calling notes etc for the PRPs". It was headed up that it was a draft paper.

64. Major Phillips agreed the issue paper was completely incorrect where it implied that Dr Sampedro or the claimant had prescribed the wrong dosage of MST to the claimant. She believed this had been corrected before the report went out however she had no evidence of that as she could not find any other version of the report on her computer system. In her view the sanction was clear that the doctor could return once a PRP had been carried out, that was all that was required and that it was the responsibility of his agency to do that. She said she, Colonel Morgan Jones and Colonel Back were all satisfied this was a one off dispensing error and there were no grounds to believe that something different was involved such as criminal activity, blackmail, coercion, etc. If they had believed that it would have been passed to the Police.

65. Carole Phillips gave evidence that before they agreed to terminate the claimant's arrangement advice had been sought from the Army HR advisers, Anne Summerby in HR was mentioned, to confirm that his agency was expected to undertake his PRP. We were surprised and disappointed that this was not recorded anywhere, nor referred to in her witness statement given that it was a very important matter and given the importance of her actions to the claimant's career.

66. The claimant was on holiday and was due back on 9th September. The claimant received text messages telling him to urgently contact his agency on the last day of his holiday – 6th September. He was advised by his agency that the assignment was being terminated. Obviously he was incredibly shocked to receive such an abrupt message with such short notice. It was not absolutely clear how this instruction was given the respondent's evidence was that Carson Black told Mrs Cotgrave to advise the agency the claimant could not come back until the matter was resolved and that Angela Thompson contacted the agency on the day. There was nothing to suggest this was not true.

67. The PT was interviewed on 9th September also and said that the claimant had told her he would contact the patient although this recorded in the interim report that she assumed he would. Further she said that it was when she went to dispense the claimant's prescription on the 6th August to patient X that she realised that there were no 10 mg tablets there, as there should have been after the last prescription and on checking her records she realised she had ordered and dispensed 60 mg tablets. She said on delivering the 10 mg tablets to the patient at home on 9th August she had not told the patient of the dispensing error. She said it was a genuine mis pick. PT confirmed her statement on 17th September and said she believed the mistake was caused by problems in her personal life.

68. Mrs Cotgrave was in some correspondence with the DBS the Army's unit responsible for recruiting locum staff regarding the termination of the claimant's assignment on the 9th September. She stated in an email to a Lisa Powell at 11:36 as follows "whilst Dr Frost was employed as a Locum GP at Weeton Medical Centre a dispensing error of a controlled drug (40 x 60mg) tabs of Morphine instead of (40 x 10mg) tabs occurred of which he was made aware by the PT whilst the patient was still in the practice. The patient had been taking this medication for three weeks when Dr Frost was made aware of the error. He did not highlight the error to the patient and allowed him to leave the practice unaware of the error. There was no documentation with the electronic medical records commenting on the error from Dr Frost, on questioning him during the enquiry into the incident Dr Frost did not feel he

was responsible for contacting the patient to ensure that he had come to no harm and had signed a statement to this fact. The error was not raised by anyone to anyone other than members of the practice team for a further nine days. Despite prompts from the regional HG lead on the day it was highlighted from Regional HQ that Dr Frost still did not feel it was his responsibility to contact the patient therefore the Regional Pharmacist at GHQ contacted the patient to ensure the patient was safe. His lack of awareness of the significance and failure to inform the patient and to disclose the error to higher authorities showed a clear lack of understanding of governance and the assurance frameworks not only with DMS policy but NHS and professional registration. In the GMC's good medical practice guide 2013 page 18 paragraph 55 it states

> "you must be open and honest with patients if things go wrong. If the patient under your care has suffered harm or distress you should:
>
> (a) act immediately to put matters right if that is possible;
>
> (b) offer an apology;
>
> (c) explain fully and promptly to the patient what has happened and the likely short term and long term effects;
>
> The above statement is what we can reasonably expect from any doctor whether a permanent member of staff or a Locum. As such advice from Army Medical Legal Team is that there is sufficient information for us to remove the Locum from this practice until a Performance Review Panel has been undertaken by his responsible officer and a report sent to APHCS. On the advice from HQ APHCS this doctor should not be allowed back into military practice until this has been undertaken."

69. Sam Cotgrave's email was a incorrect description of events as Mrs Cotgrave stated with certainty that Dr Frost was aware the patient was in the practice whereas the evidence was that the claimant believed the patient had left the practice. It was also incorrect to imply he was working at Weeton Barracks when the dispensing error occurred, whereas he did not start until 27 July, two weeks after the dispensing error had occurred, and in any event this was an irrelevant matter as he had no involvement in the dispensing of drugs.

70. On 9th September at 11.38 a Louise Monelle from the same team replied to Sam Cotgrave "thank you for the information below. I have just received a call from CRG (the claimant's agency) asking if they are allowed to forward your email to Dr Frost, they would like clarification whether a CV can be submitted for assignments at different locations", Carol Philips replied 16.13 on 13th September to Louise Monelle copied to Mrs Cotgrave she said "I suspect that until we can identify that the doctor has had a conversation with his responsible officer and has shown learning/further training it would be difficult to employ him in a further post?". Dr Frost should have been informed of the region of their and (HQPAHCS) concerns, happy to discuss".

71. Sam Cotgrave replied to Louise Monelle at 16.22 and said "I am happy that this email is forwarded to Dr Frost, I have interviewed him on two occasions about this matter and I have a signed statement of events from him, unfortunately until we

have assurances from his responsible officer that his has been discussed and an action plan is in place we will not be able to employ him within any APHCS medical centres". DBS informed his agency that they could not accept his CV until he has spoken to his responsible officer and demonstrated learning reflection and further training. In addition it was said that the respondent would require a written statement from his responsible officer before his CV would be submitted for future bookings. This suggests to us that there was a genuine belief on the part of the respondent that the agency would be in a position to undertake the performance review.

72. The claimant contacted the Medical Defence Union who wrote to the MOD on 20th September and requested that the investigation report be disclosed, that the relevant DMS policies which had been breached should be disclosed, all statements particularly those signed by Dr Frost acknowledging any error on his part, the identity, qualifications, experience and training in undertaking such investigations of those individuals who conducted the investigation. This said "We consider it appropriate Dr Frost be given the opportunity through the MDU to respond formally to this allegation of wrongdoing rather than a conclusion being drawn and a sanction being imposed on the basis of a witness statement. Furthermore we regard the concern the fact that Dr Frost was not supported or represented during this process. It was not made clear to Dr Frost that the process being undertaken might have an impact on his employment. There was another important matter which we on behalf of Dr Frost must draw to your attention. Dr Frost was advised that the matter related to a dispensing error of a controlled drug, an unusual aspect of the case was that the patient denied ever having received a higher strength tablet than 10mg of Morphine Sulphate, that raised the important matter as to whether or not the patient indeed receive erroneously or otherwise 40 of the higher dose 60mg Morphine Sulphate tablets. If he did not do so those tablets remain unaccounted for, bearing in mind that Morphine Sulphate is a controlled drug Dr Frost expressed his concern about this at the time. We therefore seek your reassurance that this seemingly discrepancy in accounts has been properly investigation". Of course the claimant did not have any knowledge of the pharmacy records at the time and would have no idea what was in stock although he knew that the tablets he had prescribed had had to be ordered. So there were no 10 mg tablets in stock.

73. On the 9th October Mrs Cotgrave's report was finalised, as part of her recommendations she stated that a Root Cause Analysis (RCA) should take place. At Tribunal no record of this taking place could be found and the witnesses stated that as far as they were aware the matter should have been followed up under the new organisation which took the place of I Army Primary Healthcare North however no record of this could be found in the bundle. In addition some of the witnesses had changed jobs following the re-organisation or retired and were now working as civilians. On 22nd October misconduct hearings took place for the Pharmacy and Mrs Shakeshaft. Beverley Hall raised concerns re the technician to the General Pharmacy Council (GPhC). Final written warnings were issued on 25th October to the technician and Mrs Shakeshaft.

74. Another letter was sent on 30th September which was replied to on 30th October by Colonel Carson Black. He said that "I have been reviewing all aspects of this case, I am convinced that the error did indeed take place as reported. Dr Frost states there were inconsistencies in the patient's version and it is clear that the

patient's belief that Lloyds had dispensed the drug were mistaken. The signed prescription form confirmed that the drugs were dispensed at Weeton and in any case Lloyds do not dispense Morphine Sulphate for our patients. Those directly responsible for the error have been the subject of misconduct proceedings. Dr Frost was alerted to the fact that a serious dispensing error of a controlled drug had occurred and yet he did not ensure that the patient was made aware of the situation or whether or not the patient still held any of the 60mg tablets. I was not made aware of the incident until nine days later and it was only then that the patient was informed. Dr Frost appears to have assumed that others were dealing with the matter and did not take responsibility for the patient with whom he had consulted. It is very important to me that all doctors take responsibility for patients and that they do the right thing. Had Dr Frost been our employee rather than a temporary Locum I would have been able to deal with the matter in house as has been the case with a doctor in the practice who later became aware of the issue but assumed that Dr Frost had dealt with it. This involved a formal peer review of the circumstances and resulted in personal reflection, acknowledgment and assurances that this doctor would act differently if presented with similar circumstances in the future. As Dr Frost is not our employee and is employed by a locum agency we have no option other than to refer the matter to the employer for consideration. That is in accordance with GMC guidance which indicates that matters like these should be resolved at work rather than by going directly to GMC, the guidance I have received from Headquarters Army Primary Healthcare Trust was that Dr Frost should not be re-engaged in army practices until there was evidence that the matter had been considered by the agency. In doing so we tried to ensure the Locum was treated in the same manner as our own staff. Relevant information statements were collated by my Headquarter staff and considered by myself and the officer responsible for Governors at Headquarters Army Primary Healthcare Services. Copies of the statements made by Dr Frost are enclosed". So at this point Carson Black was aware of the claimant's beliefs, considered them but took a different view.

75. The MDU wrote again on 1st November citing the claimant's experience as a doctor. This was sent to Air Marshall Evans the Surgeon General. This letter said that this matter relates to a dispensing error which allegedly occurred three weeks before Dr Frost arrived at the Army Medical Centre in question. It went on to say "Dr Frost had let it be known before he went on holiday that a Police investigation was required to ascertain the truth of the matter since as far as he could judge a total of 2,400 mg of Morphine Sulphate tablets was unaccounted for. Not only was Dr Frost summarily dismissed but he was also prevented from for working HM Forces to whom he had provided loyal service since 1996 as outlined above". At this stage they had not the answer from Colonel Carson Black. A reply to his letter was received from Air Marshall Evans which said "for context it is worth explaining that we have just undergone a change of responsibility within military primary care, the incident occurred when Headquarters Army Primary Healthcare still had responsibility for the regional delivery of primary care in the North and on 30th September 2013 this responsibility moved to my Headquarters under the newly formed Defence Primary Healthcare Organisation. I will therefore command a Defence Primary Healthcare Air Vice Marshall Mozumder to investigate the circumstances surrounding this case and will ensure that he communicates with you in due course, he will inevitably involve Headquarters Army Primary Healthcare and the Regional Headquarters in this review".

76. On the 6th November the pharmacy was visited by an inspector from the GPhC. Recommendations for action were made but no suspicions of anything illegal were raised. No suggestion that the matter should be referred to the Police was made by the GPHC.

77. There was an email of 28 November was disclosed between Mozumder and Kirsten Shaw a General Medical Council (GMC) lawyer who appeared to be on the train when they were discussing the matter. This stated "I think this new outline does raise questions about the doctor's attitude and follow up of patient care. It sounds like he did not follow good medical practice and I would have expected him to be more concerned about the welfare of the patient following the accidental overdose. There is a question about whether the doctor should have checked he had the right dose before administering it to the patient so it could be argued that he should have done more. As I stated I would advise you that you pass your concerns on to the doctors RO i.e. responsible officer. In relation to the issue of whether you want to continue to employ the doctor it is a local matter for you to decide who you want to work for you and I am aware of a number of organisations including NHS Trust who will ask agencies not to place specific locums after an issue arises". It is clear that Ms Shaw did not have a completely accurate version of events when making her statements, which is likely to have arisen because of the difficulties in communicating with her while she was on the phone, as her email seems to suggest that the claimant had some part in administering the dose, which of course he did not do. However it does illustrate the respondent seeking to double check the fairness of their actions.

78. Colonel Carson Black advised Colonel Burgess who was assisting Mozumder and was Black's superior officer on 28th November copied to Mozumder that actions had been taken in relation to the other doctor (Dr Raines), ie a PRP. He said he had been thanked by the MDU for the way the PRP had been handled. Further the MDU were content with the outcome. He advised that formal disciplinary action had been taken regarding PT and Mrs Shakeshaft and they had received final written warnings. He continued, "RCD interviews had taken place with the Practice Manager (a reference to Sergeant Smith) and Mrs Inkester (the PT at Catterick) although they were very much on the fringes of the issue both could have done more and they have been appraised of that fact".

79. Air Vice Marshall Mozumder replied to the MDU on 2nd December. This letter stated that "the serious dispensing error related to the dispensing of 40 x 60mg tablets of Morphine instead of 40 x 10mg tablets. It is fully accepted that Dr Frost had no part in this dispensing error. All staff involved in this dispensing error have been investigated, recommendations made for re-training and in some cases disciplinary action taken in accordance with MOD processes for civilian staff. When the dispensing error came to light staff in the small practice at Weeton Barracks made Dr Frost aware of this error in order to ensure patient safety. At this time it was not known whether the patient had already taken these high dosage controlled drugs or still had them in his possession with the risk of potential overdose and harm. There was also a risk that the tablets could inadvertently be consumed by other members of the patient's family or children leading to potentially tragic consequences. Although Dr Frost was a Locum he had just consulted with the patient and we believe that he had a duty of care. Although it was fully understood that Dr Frost had not been responsible for the error he was made aware of the error

by the PT, we understand he declined to take appropriate safeguarding action leaving the patient and his family at considerable risk. The GMC in its 2013 updated Good Medical Practices made it very clear on the responsibilities of doctors. He then quotes the same sections as Samantha Cotgrave did. He went on to say that it was the opinion of practice staff, staff at APHCS Region and the senior clinical team at APHCS Headquarters that Dr Frost had failed to uphold his GMC standards and had failed to ensure patient safety and the safeguarding of children and vulnerable adults. There was a loss of confidence in the locum and after prolonged discussions with HQ APHCS the regional team informed the Defence Business Services (DBS) Human Resource Directorate that Dr Frost should not continue as a Locum in Weeton.

80. The respondent's policy on the management of Locums in the DMS is covered in contract CTLBC/1427 amended February 13, the appropriate paragraphs are contained in Schedule 1 paragraphs 41 to 43 and paragraph 69. The letter from Mozumder had foot notes referring to this which stated in respect of paragraphs 41 to 43 these were quoted and they said:

> "41. Unsuitability
>
> The authority's nominated representative is responsible for determining whether a Locum is suitable to deliver the services required by the authority. If a Locum is considered unsuitable for any reason including poor performance or unsatisfactory conduct the authorised demander and DBS and MST will be notified by the nominated representative as soon as reasonably possible. The authorised demander will notify the contractor promptly, the contractor will be required to remove the Locum immediately and supply a replacement, the replacement will be treated as a short notice requirement and is to be supplied within one working day in the UK … this will form part of the ongoing assignment and will not represent the initiation of a new assignment.
>
> 42. In general issues of unsatisfactory conduct, poor performance or general unsuitability of locums will be raised by the authorised demander to the contractor for resolution by the contractor with the locum. This will include notifying the contractor should the locum not attend when expected.
>
> 43. In addition the locums clinical performance is deemed to be unsatisfactory the authority reserves the right to notify an individual to the relevant professional body e.g. GMC.
>
> 69. The contractor must put in place a process to ensure that in any case where the contractor has been notified in writing by the authority that a locum has been unsuitable for assignment due to poor performance or unsatisfactory conduct this information is taken into account before any step is taken to offer that person for future authority assignments. The contractor shall require to provide evidence of remedial action that has been undertaken .e.g. additional training updated CV and that the evidence has been updated prior to being offered for a future assignment".

81. The letter went on to say that the “Healthcare Governors Lead for APHCS (this was Samantha Cotgrave) region acting on behalf of HQ informed DMS that they wished the Locum to be removed from the practice until a performance review panel had been undertaken by his responsible officer and a report sent to APHCS”. Furthermore he wrote:

> "This doctor would not be allowed back into a military practice until this had been undertaken. This statement is clear that there could well be further opportunities for Dr Frost to be placed in a military practice in future whilst employed through an agency. DPHC confirms that they would be willing to have Dr Frost placed into a military practice once notification was received that his responsible officers had investigated the incident and reach a satisfactory conclusion.
>
> Crucially Dr Frost was not an employee of the Ministry of Defence although as recorded above the MOD staff had been investigated, re-training recommended and disciplinary action taken, this option was never available to Dr Frost, a Locum. The recommendation that Dr Frost's performance is investigated by the agencies responsible officer stands as Dr Frost was not an MOD employee the questions relating to MOD regulations and processes are not relevant. Defence Primary Healthcare places patient safety and safe guarding as its top priorities, DPHC looks forward to seeing any review of performance undertaken by Dr Frost's responsible officer.
>
> On 28th November the MOD responsible officer discussed this case with the MOD GMC Employment Liaison Advisor, her advice was that DPHC as a contract holder with the locum agency are well within its rights to ask the agency not to send Dr Frost to care for MOD employees until the matter has been resolved with Dr Frost's responsible officer. In the GMC ELA's opinion the actions of Dr Frost do not demonstrate good practice by a medical practitioner in accordance with the GMC's good medical practice.
>
> On reflection it would have been better if a senior clinician had travelled to Weeton Barracks to discuss these events in person with Dr Frost. Unfortunately that option was not available at that time, DPHC will endeavour to provide such a clinician if similar circumstances were to arise in future, DPHC also reiterates its stance that once Dr Frost's RO has completed the investigation and a satisfactory conclusion forwarded to the MOD RO DPHC would consider a future engagement of Dr Frost to an agency if a locum were to be required"
>
> This was an accurate and comprehensive letter.

82. No such performance review took place with the claimant's agency, whether because the agency declined to do it, whether they disagreed and though the MOD should do it as the claimant did, whether the claimant even asked them to undertake such a review was never fully established.

83. The claimant issued a claim in the Employment Tribunal on 9th December 2013, his claim was delayed being heard by the Tribunal because of his ill health for

a considerable period of time and therefore when the events occurred which we are about to describe next the claim had not been heard.

84. The claimant issued a Tribunal claim just before Christmas, the respondent were notified of a claim form dated 9th December and after that Air Marshall Evans stated it was not appropriate for him or indeed Defence Primary Healthcare to comment any further on the case. In a disclosed email between Air Marshall Evans and Defence Medical Services of 6th January he stated that he would have been minded to try and get everyone around a table to mediate a mutually acceptable outcome but the ET proceedings now made this difficult for him.

85. The claimant in this amended particulars presented on 5th November 2014 (note the claimant was represented at this time), he stated that the following were protected disclosures:

(i) on 6th August 2013 and in subsequent conversations the claimant spoke to the Practice Nurse expressing concern that a dispensing error was highly unlikely to have been a mistake and he considered PT Gould to have been coerced into illegal activity albeit by threats or blackmail;

(ii) on or about 16th August the claimant stated to Mrs Cotgrave that he considered a Police investigation was required but it was likely that a criminal offence (blackmail/coercion/threats) had taken place to procure controlled drugs. He also stated that both Mrs G and the patient whose accounts appeared conflicting should be interviewed by the Police.

(iii) on or about 16th August the claimant expressed his concern to Mrs Cotgrave and Angela that there had been specific breaches of health and safety issues, in particular he stated that dangerous controlled drugs like Morphine Sulphate tablets should not be ordered from, stored in and dispensed from a small isolated military medical centre with no support and certainly not from a lone PT, particularly when the medication was being prescribed to someone who was not normally a patient at the medical centre.

(iv) Overall he stated he had a reasonable belief a criminal offence had been committed or was being committed and that the safety of an individual has been, is being or is likely to be endangered and that his dismissal or termination was an unlawful detriment as was the refusal to permit him to continue to work elsewhere.

Betsi Cadwaladr

86. In late March 2014 Brigadier Robin Simpson received a telephone call from Dr Fraser Campbell at Betsi Cadwaladr University Healthcare (BCUHB). Dr Campbell had become aware of a letter from the Department of Health regarding retention on the performance lists of doctors who had been working with the Armed Forces (the claimant had had difficulty with this before but had resolved it due to him persuading the relevant board he came within their criteria). The claimant was on the health

board's list of medical performers but was being considered for removal, presumably because he had done no work within Wales for a certain period of time. Dr Campbell was trying to find out what work Dr Frost had been carrying out for the MOD with a view to deciding if the claimant should be kept on the performance list.

87. The call came to Brigadier Simpson because he had replaced the Surgeon Captain Evershed who had been the previous point of contact as the GP Dean. Mr Simpson said he did not even know who Dr Frost was at that point in time. Mr Campbell wanted to know who the claimant's responsible officer was and whether he had had any appraisals. Mr Simpson's evidence was that if Dr Frost had been a civilian Medical Practitioner then the Deputy Surgeon General would have acted as his RO but as he was a Locum Doctor however his RO would have been someone nominated and put in place by the locum agency that employed him.

88. All doctors working in the UK are required to have an RO who would have carried out appraisals as required, Dr Frost's RO would be the appropriate source of information which was sought by BCUHB.

89. To be helpful Brigadier Simpson said he would try and find out more details and he emailed Colonel Black on 4th April 2014. This email stated that "I have been approached by the Medical Director of a NHS performance list in North West, a Dr Stephen Frost has been on the Welsh performance list for many years however he has indicated that he was working as a Locum at Catterick, our colleagues in Wales are keen to clarify his status to determine the "prescribed connection" with this GP. In essence who has been doing Dr Frost's appraisals etc, indeed as he been treated as a CMP and as a result comes under the DMSRO for CMP's, has he had any appraisals, is he a locum. Dr Frost is unhappy that our welsh colleagues want to remove him from their PL - he has threatened legal action and I think an MP is involved, I don't know Dr Frost at all any advice greatly received".

90. This evidence establishes that at this point Robin Simpson did in fact know nothing about the claimant including the fact that he had brought a Tribunal claim or was alleging he had whistle blown.

91. As far as Brigadier Simpson and Carson Black could remember Colonel Black telephoned him and explained about the incident at Weeton Barracks and how the doctor had been required to undergo a review panel but he had issued a claim against the MOD in the Employment Tribunal.

92. Carson Black emailed John Burgess his superior office at the time on 7 April to say: “I have been doing some research, it appears that Dr Frost is the leading light of the group of doctors who wish to re-open the case of Dr David Kelly the Government Scientist whose suicide in 2003 resulted in the Hutton enquiry. He is peripherally critical of Government in the past and on social media and one Daily Mail article (undated) describes him as a CMP working at RAA Cosford, I am not sure whether or not 11 will give access to Twitter so please check CC Stephen Frost on your private system, a number of tweets referred to "the illegal war in Iraq", his main internet vehicle is the website "Global Research" which is a "left wing" conspiracy theorist site, his colleague Dr Helpun is a believer in the New World Order theories and sees scientism, backed by Roschild Bankers, as the root of the world's ills which is a stance remarkably similar to David Icke, Dr Helpun recently

sent a very supportive letter to the Russian Ambassador with regard to their actions in Crimea. Having read widely at the weekend it is clear that Dr Frost has an axe to grind and it surprises me he has chosen to work in the MOD environment when his views are so strong, it also indicates that despite being faced with expert opinion contrary to his own he just keeps going and that is a worry".

93. There were six articles attached to that email clarification that the emails were sent by Carson Black to John Burgess on the 8th and 11th April. Carson Black denied that he sent these on the grounds of the claimant's whistle blowing or with the intention to libel the claimant. He said he had no idea that the emails he sent to John Burgess would be forwarded to Brigadier Simpson and would be used as relevant information by BCUHB. He said he had no idea how he came by those emails, he had never sent them directly to Brigadier Simpson.

94. Colonel Black on receiving Brigadier Simpson's email with its reference to legal proceedings in respect of the performers list he became curious, he had only a telephone call with Brigadier Simpson but he did some research out of his own interest given that the claimant was now threatening further legal proceedings against an NHS body, he admitted it gave him an uneasy feeling as he seemed to be heavily involved with websites spouting conspiracy theories and was a leading light in the campaign to re-open the case of Dr David Kelly and further he had suggested that military doctors might become involved in torture in Afghanistan. He felt that it could be a concern from a security point of view that he had a high level of interest and appreciation of matters Russian. He also felt it might indicate the claimant had an axe to grind against the MOD and seemed counter intuitive he was working for the MOD.

95. He considered whether he should pass it on to Army Intelligence but in the end he passed it on to his superior Colonel Burgess, Head of Clinical Operations at the Surgeon Generals HQ. It could be said Carson Black was seeking to "cover his back" by making sure he passed this information on to someone who could make a decision as to how relevant it was to anything, if it was. He said there was no malice as he had no idea that the contents of the emails would be forwarded to anyone outside of the army or the MOD, the information was solely from pages already public on the internet and therefore in the public domain. Neither did any of the matters he raised refer to the claimant's competence as a medical doctor. He was adamant the actions were not prompted by any whistle blowing, he had only seen the original claim to the Employment Tribunal where the claimant had simply ticked whistle blowing along with many other claims which did not provide any detail. He did not learn of the specific disclosures the claimant was relying on until November 2014.

96. A further email was sent on 11th April to Burgess stating "don't know how relevant it all is when it all comes together I get an uneasy feeling about his motives to be with the MOD, certainly his Facebook page uses a Moscow scene as its header, I think his love of Russia is sparked by his interest in Balian Culture in general but … we have seen this with well meaning intellectuals and idealists in the past. He appended an article written by the claimant discussing military doctors being involved in torture.

97. Following this Brigadier Simpson was on holiday and did not reply to Fraser Campbell's email, he received a further email on 11th April 2014 from a Mark Walker (BCUHB) asking him for more information, this email stated "we have had sight of a copy of a form indicating that his last appraisal took place in August 2012 but we have no clinical educational content to this form, we are concerned whether or not this individual still remains in active general practice and wonder if you could advise us of any work he has undertaken for the Army since September 2011 in any capacity akin to civilian medical practice.

98. On 15th April Brigadier Simpson replied attaching some emails strands he had received from he believed Colonel Burgess in which he stated:

> "I have attached a couple of email strands that will not answer your question but throw some light on the activities of Dr Frost, it appears Dr Frost is taking the MOD to an Employment Tribunal so I have to be careful with the information I can provide, I am however led to believe that Dr Frost has not been employed with the MOD as a Locum for more than a year.
>
> I know he was involved in an incident involving a prescription of Morphine which the patient was given excessive dose, this incident resulted in DMS no longer using Dr Frost as a Locum, I do not know all the details".

99. Brigadier Simpson assumed that Colonel Burgess had sent the information to him but he did not have an audit trail to evidence that. He was adamant that had never received any direct emails from Colonel Black. He had no evidence of that, as because he had changed roles in April 2014 his old emails had been destroyed and he could not find any records to establish how the information came to him. Brigadier Simpson took the view that the information contained raised questions about Dr Frost probity and integrity which clearly he thought might be of some relevance to BCUHB and felt it was appropriate for him to share that information. He did give information that was clearly relevant that the doctor had not worked for the MOD for more than a year (although this was incorrect) and although he felt constrained by the Employment Tribunal proceedings he felt the emails were completely unconnected to that. He felt that there was no defamation involved in providing that information as all the information came from websites and articles that the claimant had placed himself in the public domain on the internet. Brigadier Simpson stated that although he knew of the Employment Tribunal claim he did not know it was whistle blowing and knew no detail about it until being approached to provide a witness statement in respect of amended allegations which would only arise later in November. We accept his evidence on this as there was no reason why he would have seen the claimant's ET1 even if he had he would have gleamed little from it.

100. Colonel John Burgess stated that he was aware of the claimant's complaint when he raised them with Marshall Evans in November 2013 and he liaised between Colonel Black and Air Vice Marshall Mozumder whilst corresponding with the Medical Defence Unit and the claimant's MP. Colonel Burgess was responsible for Locum doctors at the time.

101. Colonel Burgess's evidence which we accept is that he became aware in early 2014 that the claimant had presented an Employment Tribunal claim although he

had no details whatsoever and did not understood it contained any reference to protected disclosure or whistle blowing. He believed that he would not have been aware of this until November 2014 when an amended Employment Tribunal claim was presented . He did not ask Colonel Black to provide the information which he sent him in April 2014, nor was he aware that Colonel Simpson had emailed Colonel Black asking him for information regarding Dr Frost nor did he know that Colonel Simpson had received enquiries from BCUHB, so the emails on 8th April were completely unexpected.

102. He realised that his response on 11th April was over infusive as he says "you are amazing, thank you so much for doing this research, very helpful". He states he was trying to boost Colonel Black's morale which was very low because of the claim and because he was doing two jobs. He was trying to be positive and ensure he felt appreciated. He said he was concerned with what he had found and felt he might even pose a security risk, not that there was any question mark over his abilities as a medical doctor. As he was responsible for locum doctors within the service he had to decide what to do with them, he had previously passed on similar things about doctors to the Army Intelligence Unit and he considered doing so now. He thad no recollection of actually passing the emails to Colonel Simpson and again could not locate an email trail but it seemed a likely explanation. He spoke to Colonel Simpson as he was at the time, he probably discovered at that point that there was an enquiry from the BCUHB, besides that he would only refer the matter to intelligence if it looked like Dr Frost was coming back to work for the MOD and he took no further action.

103. It was denied that the emails were malicious or intended to prevent him working as a doctor. If he had wanted to make things difficult he could have referred the matter to the Intelligence and Security Services. It could have affected him working as a doctor throughout the UK however he did not do so.

104. Brigadier Simpson's email of 15th April was a careless email to send as it suggested again Dr Frost was at fault in the over-prescribing incident, and also in stating that he had not worked for the respondent for a year when in fact at this stage it was only six months.

105. In the event the claimant remained on BCUHB's performance list on the basis that he could stay on that list "by virtue of his contract with the Ministry of Defence. The claimant, however, had to take his case to a first tier Tribunal in order to stay on the performer's list

Responsible Officer

106. In respect of whether the claimant had a responsible officer and whether he had had an appraisal undertaken by a responsible officer this issue had arisen in 2012, this was a letter from Shropshire County NHS to Major General Mike Bertele, Director General Army Medical Services, it was about Dr Frost being on the Medical Performers List of the PCT which meant they had duties under the National Health Service (Performance List) Regulations 2004 to manage such lists including ensuring the appropriate appraisals are undertaken and any performance issues are dealt with in accordance with the regulatory provisions, it stated "Dr Frost falls within an unusual category of practitioner who is included on the PCT's list but who is not

practising within the PCT's locality due to his full time employment as an Army Doctor for HM Armed Services at a location outside of the PCT's locality. The effect of this is that in accordance with the Medical Professional (Responsible Officers) Regulations 2010 HM Armed Forces is under an obligation to appoint a responsible officer who should be a medical practitioner and the responsible officer has a responsibility to carry out regular appraisals and to address any performance issues that arise in respect of that practitioner, I attach a copy of these regulations for your ease of reference and have highlighted the relevant sections that confirm that.

107. This letter arose because the claimant's representative at the BMA had written to Dr Jo Leahy of the Shropshire NHS on the 8th December 2011 asking why the claimant had been given notice of being removed from Shropshire County Primary Care Trust's Performance List. She had stated it was impractical for him to re-register in all the areas of the country where he worked for the military. She stated that in reply quoting Regulation 26(4) which provides that Regulation 10(6) (the provision under which his removal was being proposed) was not applicable in the case of an Armed Forces GP and therefore that status allowed the claimant to remain on Shropshire PCT's Performance List. She also raised issues of the claimant's appraisals and stated she would write to the responsible officer in the Armed Forces to highlight their obligation to undertake an appraisal.

108. The claimant had not been able to uncover any reply to this letter but following it he was approached by Lieutenant Colonel Hamer on a visit to Army Training Centre in Purbright when he was working at Deepcut and completed a military appraisal with Lieutenant Colonel Hamer in August 2012 which was produced to the Tribunal.

109. In August 2012 the NHS Medical Director Dr Bruce Keogh wrote to all SHO Medical Directors highlighting a problem regarding the situation, this said "there are a small number of non-uniform GPs (often known as Civilian Medical Practitioners "CMPS") who provide services to the Armed Forces, both here and oversees, they are not serving the uniformed defence medical services (DMS) and therefore do not benefit from the exclusion in Regulation 11(7). The United Kingdom Ministry of Defence is concerned that these GPs are likely to be removed from lists and so become unable to carry on working, this would have a negative impact on the way military personnel and their families are treated with potential knock on effects to the NHS, when you are thinking of removing a Performer from your list I would ask you to establish whether that performer is engaged in providing care for the Armed Services, where doctors are providing this important and useful service I would encourage you to use your discretion allowed in the regulations and not remove them from your list".

110. On 6th November 2013 the claimant received an email from the GMC advising that he was going to be considered for re-validation by BCUHB, he does not know how this arose, he felt he should have been allowed to remain on the Performers List in the light of Professor Keogh's letters. He also felt that the exchange above suggested that Armed Forces were responsible for providing a responsible officer and indicating his appraisal and indeed this had occurred in 2012.

111. The claimant's evidence which was not disputed was that his agency had never referred to providing a responsible officer themselves and on checking the

GMC's website he believed that the Armed Forces should have been his designated body. The claimant believed that the reason for the respondent denying that they were his designated body is because it would have made a nonsense of their decision to terminate his employment and require the agency to conduct a PRP rather than conducting this themselves.

112. However the respondent's witnesses eg Carole Phillips said they were following the advice they had been given. that they received advice i.e. that this was the correct position, that because of Dr Raines's contractual status they could deal with her but they could not with the claimant because he was a locum.

113. There were discussion and cross examination at the Tribunal regarding the regulations covering this issue and those covering the disciplining of Locum Doctors however whilst some of the wording of these documents was open to interpretation the witnesses were adamant that they acted in accordance with their understanding of the regulations and advice they had received from either AMD or HR. In particular it was put to for example to Carole Phillips that SGPLO 1/OA should apply to locum doctors would have required a more onerous and transparent procedure to be followed. Carole Phillips denied that it would apply and stated she had received advice from HR (as referred to above) as to the correct procedure to be followed in relation to the claimant. Ultimately the issue was not what was the correct interpretation of the policies but whether the respondents witnesses who were actors in these events genuinely believed at the time that the actions they were taking were in accordance with their policy.

Progress of Claim

114. In his claim form the claimant had claimed unfair dismissal, notice pay, arrears of pay and other payments. Under I am making another type of claim he put unpaid wages, breach of contract, discrimination, whistle blowing. He stated in this that prior to going on holiday he had taken part in an investigation into a dispensing area and had let it be known that a Police investigation was necessary. He was not informed his position was under scrutiny and was therefore deprived a lawful opportunity of defence and proper representation "perceived as potential whistleblower, claim of discrimination relates to different treatment of others".

115. The respondents submitted a response on 17th January and also applied for a Preliminary Hearing to consider a strike out or deposit. It was their position that the claimant was not an employee therefore his claims were misconceived. They also believed he was out of time as his effective date of termination was the 6th September and he did not file his ET1 until the 9th December. The ET3 stated that the PT became aware of an error on 6th August and brought it to the claimant's attention when the patient was still on the premises. The claimant did not highlight the error to the patient and allowed him to leave the practice unaware of the error. When questioned during the investigation the claimant stated he did not feel he was responsible for contacting the patient to ensure they had come to no harm and he provided a signed statement to this fact and then went on to state the claimant's lack of awareness of the significance of the failure to inform the patient and to disclose the error to a higher authority demonstrated a clear lack of understanding of governance and assurance frameworks. Again the GMC's practice guidance of 2013 was referred to and it was stated that the above statement is what is reasonably

expected from any doctor, whether a permanent member of staff or a locum, it is the absolute minimum which anyone in the claimant's position would be expected to do. The claimant failed to do so and therefore there was sufficient information to remove the claimant from the practice until a performance review panel was undertaken by the responsible officer within the agency and a report sent to Armoury Primary Healthcare. On advice from the headquarters at Army Primary Healthcare the claimant's agency was advised the claimant would not be allowed back to a military practice until this had been undertaken. It went on to describe what had happened to other members of staff and it also said it had been made clear to the claimant that he may undertake future assignments on the proviso that a review had been undertaken by the agency and a satisfactory conclusion reached. The claimant's allegation that he has been summarily banned from working as a doctor in the military is therefore wholly inaccurate. Because he was not an employee he could not bring an unfair dismissal claim, in respect of discrimination he failed to particularise any claims in respect of whistle blowing there was no details of any protected disclosure or any detriment suffered although the respondent denied it in any event.

116. On 4th November 2014 the claimant withdrew claims of unfair dismissal, discrimination, holiday pay, arrears of pay, notice pay and breach of contract and his remaining claims, Section 47(B) ERA detriment was noted. He submitted amended particulars of claim and in this he claimed to be a worker and therefore entitled to bring a claim under the whistle blowing provisions of the Employment Rights Act 1996. He set out the protected disclosures he relied on at this juncture as recorded above.

117. On 12th January 2015 Judge Howard agreed that the further particulars could be treated as an amendment to the claim form and an amended response was submitted stating that the claimant was not a worker and reciting the terms of the agreement with CRG. The response also included a submission that if the claimant had made protected disclosures it is unclear how such disclosures are said to have come to the attention of and influenced healthcare governors lead for APHCS region acting on behalf of HQ HPHCS who made the decision to remove the claimant from practice with the respondents. The requirement for a performance review panel to be undertaken by the responsible office was entirely explicable by the fact that the claimant was a locum and not an employee of the respondent and under the contractual arrangements in particular contract CTLBC/1427 Schedule 1 paragraphs 41 to 43 and 69 (this course of action was open to the respondent). It was agreed by the date of the hearing that the claimant could pursue his claims as a worker.

118. On 16th May 2016 Judge Porter had agreed that the claimant could amend his claim to include a further protected disclosure, as follows "on 16th August at 10.44 the claimant made a protected disclosure by making the following entry into Patient X's medical notes "needs his Oramorph but ok for tablets - patient says he has never had other than 10mg tablets - he also says that he has never received or taken the orange tablets shown to him by the pharmacist - he also says that he was not aware that stronger tablets than 10mg existed - says that he has a very good memory and is observant and he would have noticed had he received anything other than 10mg tablets … patient happy with pain relief and does not in any way wish to increase the dose of MST".

119. A further issue arose as a result of disclosure in this case and the Tribunal granted the claimant permission to amend his particulars of claim to rely on the BCUHB matters as a further detriment.

The Law

120. Meaning of Protected Disclosure 43A of the Employment Rights Act 1996 states that "in this act a "protected disclosure" means a qualifying disclosure (as defined by Section 43B) which is made by a worker in accordance with any of Sections 43C to 43H, 43B

(i) in this part a qualifying disclosure means any disclosure of information which in the reasonable belief of the worker making the disclosure (is made in the public interest) and tends to show one or more of the following:

(a) that a criminal offence has been committed, is being committed or is likely to be committed;

(b) that a person has failed, is failing or is likely to fail to comply with any legal obligations which is subject;

(c) that a miscarriage of justice has occurred, is occurring or is likely to occur;

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

(e) that the environment has been, is being or is likely to be damaged or;

(f) that the information tends to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed. …

43C Disclosure to employer or other responsible person

(1) a qualifying disclosure is made in accordance with this section if the worker makes a disclosure -

(a) to his employer or

(b) where the worker reasonably believes that the relevant failure relates solely or mainly to

(i) the conduct of a person other than his employer or

(ii) any other matter for which the person other than his employer has legal responsibility, to that other person.

(ii) a worker who in accordance with the procedure whose use by him is authorised by his employer makes a qualifying disclosure to a person other

> than his employer is to be treated for the purposes of this part as making the qualifying disclosure to his employer.

121. It has to be established that the claimant has provided information to the respondent, whilst the information may contain allegations within it it must be sufficiently particularised to constitute information. A harsh dividing line between information and mere allegations is no longer required, in Kilraine -v- London Borough of Wandsworth EAT 2015 Langstaff J said "I will caution some care in the application of the principle arising out of Cavendish Munroe that the difference between information and allegation is not one that is made by the statute itself, it would be a pity if Tribunals were too easily seduced into asking whether it was one or the other when reality and experience suggests that very often information allegation are intertwined, the decision is not decided by whether a given phrase or paragraph is one or rather than the other but is to be determined in the light of the statute itself, the question is simply whether it is a disclosure of information, if it is also an allegation that is nothing to the point".

122. Separate disclosures can be aggregated to establish information, in Norbrook Laboratories -v- Shaw 2014 EAT quite trivial matters were involved in a series of emails which taken together constitute a disclosure about Sales Representatives driving in snow. In Babula -v- Waltham Forest 2007 Court of Appeal it was established that the information must tend to show a breach not that it is accurate. A claimant does have to establish a reasonable belief even if their belief is wrong. In Babula it was said that the word belief in Section 43B(1) is plainly subjective, "it is the particular belief held by the particular worker, equally however it must be reasonable which is an objective test. Furthermore like in Darnton I find it difficult to see how a worker can reasonably believe that an allegation tends to show there has been a relevant failure if he knows or believes that the factual basis for the belief is false".

123. A claimant also has to establish public interest following the Enterprise and Regulatory Reform Act 2013 although the requirement of good faith has been removed. In Chesterton Global -v- Nurmohamed 2015 EAT it was made clear the test of the Tribunal is not an objective one for public interest but rather whether the claimant had a reasonable belief that the disclosure was in the public interest. In this case no issue arose in respect of this if proven the disclosures were in the public interest.

Detriment

124. Section 47B of the 1996 Act states that:

> (i) a worker has the right not to be subjected to any detriment by any act or any deliberate failure to act by his employer done on the ground that the worker has made a protected disclosure;
>
> (ii) this section does not apply where:
>
> (a) the worker is an employee and
>
> (b) the detriment in question amounts to dismissal.

125. In Shamoon -v- Chief Constable of Royal Ulster Constabulary (Northern Ireland) 2003 House of Lords it was said that "a detriment will be established if a reasonable worker would or might take the view that the treatment accorded to them had, in all the circumstances, been to their detriment. In order to establish detriment is not necessary for the worker to show that there was some physical or economic consequence flowing from the matters complained of and the detriment can arise after the end of the employment relationship.

126. In order to establish that the detriment occurred because of the protected disclosure the claimant cited Feckitt -v- NHS Manchester 2012 Court of Appeal where Elias LJ held "I agree with the submissions that liability arises if the protected disclosure is a material factor in the employer's decision to subject the claimant to a detrimental act, the reason which has informed the European union analysis is that unlawful discriminatory consideration should not be tolerated and ought not to have any influence on the employers decision, in my judgment that principle is equally applicable where the objective is to perfect whistle blowers particularly given the public interest in ensuring they are not discouraged from coming forward to highlight potential wrongdoing. In my judgment the better view is that Sections 47B will be infringed if the protected disclosure materially influences (in any sense of being more than a trivial influence) the employer's treatment of the whistle blower. If Parliament had wanted the test for standard of proof in Section 47B to be the same as for unfair dismissal it could have used precisely the same language but it did not do so".

127. This raised the issue of whether the individual was responsible for the detriment but was innocent of the whistle blowing disclosures could be responsible for a whistle blowing detriment. In the Royal Mail -v- Jhuti [2006] EAT this situation was addressed where Mitton J states, "I am satisfied that as a matter of law a decision of a person made in ignorance of the true facts whose decision is manipulated by someone in a managerial position responsible for an employee who is in possession of the true facts can be attributed to the employer or both of them".

128. There is also provision for vicarious liability set out by the Enterprise and Regulatory format 2013 where a worker has been subjected to a detriment by another worker of their employer stating that that should be treated as also down by the workers employer, whether it was done with the employee's knowledge or approval.

129. In respect of establishing causation this would be decided in many cases by inferences as in a discrimination claim and it is unlikely to be positively acknowledged that whistle blowing caused the detriment.

130. For inferences the claimant relied on natural justice in respect of the notice of the charge i.e. that the claimant did not know he was under scrutiny, natural justice in respect of a defective investigation and bias, breach of protocol, inferences can be drawn from totality of the primary facts and the context of the case.

131. The respondent drew our attention to Black Bay Ventures Limited -v- Gaheer 2014 EAT which set out the steps the Tribunal should take in its reasoning in a whistle blowing case. It should:-

(1) separately identify each alleged disclosure by reference to date and contact;

(2) identify each alleged failure to comply with a legal obligation or health and safety matter;

(3) identify the basis on which it is alleged each disclosure is qualifying and protected and

(4) identify the source of the legal obligation relied upon by reference to the statute or regulation.

132. The Tribunal should then go on to consider whether the claimant held a reasonable belief as required by Section 43B(1) of the 1996 Act then the enquiry should move onto whether the disclosure was made in the public interest, following which these obstacles are surmounted a Tribunal must identify the alleged detriment, the date thereof as part of its findings and then ultimately decide whether the detriments arose because of the protected disclosures.

133. The burden of proof is on the claimant to establish a protected disclosure has been made (Goulding -v- Lands Securities Trillion Limited UKEAT 2006).

We record now the majority of the parties' submissions.

Respondent's Submissions

134. That the claimant did not make the protected disclosures he relied on – they rely on the fact that there was no recorded mention of the claimant demanding a Police investigation be initiated by the respondent, in particular in his interviews with Samantha Cotgrave and Angela Thompson, that the letter from the Medical Defence Union of the 10th September stated only that the Police should be involved but did not state that he had already said this to any of the respondents other staff, the letter of 20th September refers to him expressing concern at the time in respect of the patients denial of having received the 60 milligram dose, the first mention is in al letter of 1st November 2013 eight weeks after his termination in a letter from the MDU where it stated the claimant let it be known prior to going on holiday that a Police investigation was required. His ET1 states that he had let it be known a Police investigation was necessary without details, the ET1 included a claim of whistle blowing there was no indication of what protected disclosures were relied on, the claimant's ET1 was not amended until 5th November 2014, these were drafted on instructions, by this time the claimant's whistle blowing claim was the only remaining claim, he discontinued the rest of his claims on 4th November 2014.

135. Protected disclosures were identified as referred to above in the narrative and they were set out in some detail, there was distance between the pleaded case and the witness statement in respect of stating that between the 6th and 16th August he spoke to members of the practice including Shakeshaft, possibly Raines and Smith about possible criminal activity involving drugs, this was in contrast to his pleaded case where there was no mention of Rains and Smith.

136. In addition on 16th August he entered a room where Mrs Cotgrave, Mrs Hall and Miss Thompson were sitting and told them a Police investigation was needed

because he suspected criminal activity involving dangerous controlled drugs, the pleaded case made no mention of this disclosure being made to anyone other than Mrs Cotgrave.

137. The respondent submitted the claimant was vague, evasive and contradictory in respect of his alleged oral disclosures and it was difficult to pin down when his concerns crystallised into being articulated as a disclosure, he himself stated that his suspicions involved from the 6th August and then he conceded no oral disclosure was made before having examined the patient on the 16th August which contradicted the case he had pleaded for the past three years and his own witness statement. Therefore the respondents submitted that the way the claimant developed and the failure to support the detailed protected disclosures in the witness statement and cross examination cast doubt on the veracity of the alleged oral disclosures.

Notes of Interview

138. The respondent submitted the claimant had fabricated oral disclosures, it was alleged that an oral disclosure was made to Cotgrave and others between the consultation at 10.54 am and the interview at 11.30 but none of this is mentioned in the interview, neither was he asked any questions about this, if he had raised it in such a way immediately prior to the interview the respondents submitted it was incredible that it had not been mentioned either by the claimant or by the interviewers, further, the claimant advanced a positive case that PT Gould had made a mistake saying "G is a good girl, made a mistake, she is conscientious, her reaction to this mistake made it worse, both good Medical Centre worse off without them, mistakes happen and in way they deal with it". In cross examination the claimant alleged she was protecting the PT (need to put this in the narrative). Neither is there any mention of the breaches of health and safety (i.e. that dangerous controlled drugs should not have been administered in the circumstances) within the notes of the interview. Mrs Thompson had no recollection of him making such an allegation neither did Mrs Cotrgrave and no record of it was documented, neither was it put to Ms Cotrgrave in cross examination.

139. In the claimant's second interview which Ms Cotrgrave and Mrs Thompson both said occurred at the claimant's request to amend his original statement which he had by this time received (claimant agreed this in cross examination) although he had ample opportunity to mention this omission from his first interview he did not do so and neither was there any further disclosure regarding criminal activity, on his case he had been raising the issue for over two weeks and as far as he could see nothing had been done.

140. The respondent also submitted that the claimant truly thought there was an issue that required a whistle blowing. He could use a whistle blowing procedure and his assertions in cross examination that he knew nothing about whistle blowing procedure seemed highly unlikely given that he had worked for the NHS and the MOD for considerable periods of time and that he had been involved in political campaigns.

141. In respect of the claimant's witness evidence being unreliable in cross examination the respondent pointed out that he stated in respect of signed

handwritten notes from admitting he had signed them but not having read them to saying he could not read the writing in the Tribunal hearing itself. The respondent also submitted that Ms Cotgrave and Mrs Thompson's evidence should be accepted that none of the alleged disclosures had been made to them. The third person allegedly to whom the disclosure had been made mentioned i.e. Shakeshaft and Rains, Ms Shakeshaft denied it in evidence to the Tribunal.

142. In respect of the claimant's written disclosure where he sought to amend on 21st March 2016 the amendment read "on 16th August 2013 at 10.54 am the claimant made a protected disclosure by making the following entry into Patient X medical notes "patient says he has never had other than 10mg tablets, he also says he has never received or taken the orange tablets shown to him by the Pharmacist - he also says he was not aware stronger tablets than 10mg existed - says he has a very good memory and is observant and he would have noticed had he received anything other than 10mg tablets".

143. The respondent submitted that it had always been part of the claimant's case that the patient had denied taking the tablets and that this was recorded in his interview with Mrs Cotgrave therefore he could have relied on the interview as a disclosure, further the basis for the claimant's amendment application was it was minor and merely flushed out other protected disclosure and was not a substantial alteration, further it is submitted that an entry in the medical notes was not a qualifying disclosure as they simply recorded the patient's recollection noting the erroneous belief that tablets stronger than 10mg did not exist. It did not provide information that any criminal offence was being committed let alone identifying what offence was committed and by whom and should be viewed in the context of the claimant in his interview stating it was a dispensing error. The respondent submitted that the reason this was added in his legal team had realised that his oral disclosures case was hopeless.

144. The respondent first submitted that the claimant stated in his witness statement that he considered recording a Police investigation was required in the medical statements but he didn't, he could not give in cross examination any explanation for this, as far as he advanced the case that he was worried about being removed from the practice. At the time it would not be evident to the claimant that these notes would be read other than by the patients treating doctor.

Reasonable Belief

145. The respondents also submitted that the claimant could not have had a reasonable belief that any offence had been committed. The Pharmacist had admitted to him she had made a mistake, no one had discovered that error by 6th August and therefore there was no need for her to admit hat at that point in time. He knew that she had made errors before, that it was clear that there were reasons why the patient might not think he had got 60 milligram tablets as the box was not labelled 60 milligrams and would have indicated they were 10 milligrams. The only issue was the colour of the tablets. The claimant also relies on the demeanour of the patient during the examination on 6th August but at that point he didn't know about the overdose and therefore was not specifically checking for symptoms that might arise following an overdose. He said he did check this but there was no evidence of this whatsoever in the medical notes of this.

146. In respect of the pharmacy records the claimant did not have sight of them at the time and therefore could not be relying on these informing a reasonable belief, neither did he fully understand pharmacy records in any event. Dr Matthews was of the event that it was possible the patient could have taken 60 milligrams tablets. The claimant had a record of not being shy about publicly stating that events were suspicious, evidenced by his representations in respect of Dr David Kelly and in any event he failed to identify what crime was being committed and by whom, so in respect of the written disclosure he could not have had a reasonable belief because on the face of it there was no evidence of a criminal offence being committed or referred to and he said the exact opposite in an interview on the same day. This was not identified as a disclosure until several years after first lodging the claim, as medical records are confidential it is not a disclosure made to the claimant's employer. The notes had not been seen by Mrs Cotgrave and in any event she was not a decision maker.

147. In summary the respondent submitted the claimant by his own conduct did not consider the entries to be a disclosure due to the delay in identifying it, he had the medical records for eight months before the amendment was sought.

Causation

148. In causation the respondents submitted that the decision to treat the claimant as they did i.e. ending his placement and requiring him to attend a PRP all arose from the fact that he was a Locum Doctor engaged with third party agency which was terminable at will on either side without notice, see RG contract dated 16th June 2010, pages 337 to 338. It was counter intuitive that the respondent would consider submitting the claimant to a detriment as a result of the alleged whistle blowing when they themselves had prompted the investigation for the dispensing error, even though the staff involved had dragged their heels and that Mrs Cotgrave had insisted PSIR was raised and that Carson Black had instructed Mrs Cotgrave to undertake an investigation as a matter of urgency and indeed the investigation was begun immediately, that Mrs G and Mrs Shakeshaft were both subjected to formal disciplinary action resulting in a final written warning which were indications that the respondent did not wish to conceal anything, it was illogical to suggest that they would want to conceal the possibility of a criminal offence if it had been raised in the currency of the enquiry as there was no reason why they would not have called the Police in to investigate, neither was it properly put to any of the respondent's witnesses that they stood to benefit in a material way by concealing the possibility of a crime by not calling the Police, there was no costs to the respondent, it would not have been administered inconvenient in fact the opposite, there was no reputational impact, there was no explanation as to why the claimant did not call the Police and removal of the claimant from his post would not have prevented a Police investigation as he could have reported the matter at any time to the Police whether working for the respondent or not but it made more likely he would articulate the concerns by removing him from his employment and no satisfactory explanation was given in cross examination why the claimant never at any time reported the matter to the Police.

149. Further it was also illogical that if they wished to victimise C for his alleged disclosures they would have done so in such an opaque fashion, indeed they could contrary to their own regulations conducted their own performance review, been

dissatisfied with the outcome and permanently excluded him from placements or even reported the claimant to the GMC as it reported PT to the General Pharmaceutical Council, what they required was very simple and insubstantial a PRP to be undertaken externally and to be satisfied with the results of that PRP.

150. The respondents submitted that this was a low level act against the claimant and it was wholly inappropriate to suggest that there should have been no PRP conducted with the claimant as Dr Raines who had no clinical involvement with the patient was required to undertake a PRP, the fact that this was done by the respondent was because she was not engaged through a third party. The respondent submitted the claimant's case was contradictory on this point, he was adamant he had done nothing wrong but contends that the PRP should have been undertaken by the respondent. The respondents submitted that at the time it was decided that the PRP should be undertaken by the agency, this was in accordance with the contract and the respondents understanding of the regulations that they could not undertake this rather than being motivated by any victimisation relating to his whistle blowing.

151. The respondent also submitted the claimant had not explained the mechanics of how he saw the disclosure leading to the detriment, is it assumed that C made his disclosures to Mrs Cotgrave and others who suppressed them from the report at the time if this was the case there would have been no case to answer, on the basis of case law prior to Jhuti, if the decision makers were unaware of the disclosure it cannot have influenced them. The respondent has put forward cogent reasons why they decided a PRP was required (see paragraph 43 of the respondent's submissions) and that these were the reasons for the ending of the claimant's contract. Whether the factual basis for the ending of that contract were true is not required to be established by the employer only that they were genuine as they may have been in error as to some or all of the factual basis unless an inference is drawn from that that they are not the real reason but if they are true it undermines any argument that they are a sham.

152. The reasons given were all correct and which are:

(i) failure to re-examine the patient having been alerted to a potential overdose of morphine;

(ii) failure to notify the patient at any material time of the overdose;

(iii) failure to record the potential overdose of the patient medical records or in any other appropriate records;

(iv) failure to alert appropriate colleagues of the potential overdose;

(v) failed to satisfy himself that action had been taken by others to alert appropriate colleagues/take other action;

(vi) showed a total lack of insight into the above failings.

153. They are all true, the only time that the claimant made a note was following the consultation with the patient on 16th August which was arranged by the respondent at its insistence. The respondent submitted that they were correct as far

as it was relevant in saying that they could not deal with the issues and it must be resolved by the agency (bearing in mind that the test was whether they genuinely believed this or not)

154. Schedule 1 paragraph 42 and paragraph 69 of the contract were referred to and it was reasonable to conclude the claimant was guilty of poor performance or unsatisfactory conduct as referred to in the service level agreement. This was their honestly held view at the time, this was a view formed by Colonel Philips and Co and not by Samantha Cotgrave who the disclosures were made to. The respondent also pointed out that it was only recently that the claimant had asserted the respondent should have assigned him the responsible officer based on the documentation with Shropshire PCT in January and February 2012. This was made on the erroneous basis that the claimant was in full time employment when he was not employed but was a Locum worker employed through an agency and that no context or analyst is given to ascertain what was being taken into account, further appraisals were done by Shropshire PCT between 2007 and 2009, the appraisal undertaken by Lieutenant Colonel Haymen on 9th August 2012 the respondent submitted was done in error and was not repeated, again at the time it was honestly believed by the respondent this was the correct procedure. The fact that BCUHB agreed to keep him on the performers list also appeared to be on the basis of an erroneous belief he was an employee of the MOD. The respondent also points to the fact that they had been consistent in their reasoning for their action throughout the conduct of proceedings and contemporaneously and whilst Major Phillip's draft issue paper dated 9th September did contain some errors the central issues were properly identified and it was in respect of those that action was taken, i.e. the failure to inform the patient and accept clinical leadership, as late as 2nd December the same reasons were set out by Air Vice Marshall A K Mozunder including the assertion on which the respondent had acted in good faith as a Locum R could not review his performance once this was done he could return to R. This was never challenged by the claimant's professional body at the time of the correspondence.

Detriment

155. It is accepted that the threshold for what constitutes a detriment is low, the respondent submitted that having to undertake a PRP was not a detriment as it is not a disciplinary process allowing a Clinician to reflect on an incident and identify any further training requirements, also did the detriment arise in any event because of anything the respondent did or because the claimant failed to pursue this matter with his agency, there was no evidence whatsoever he had been given for large bundles that he ever contacted them and asked whether they could provide this service or not. He didn't complain to the MOD in terms that CRG would not do it. He submitted it was not a detriment for CRG to undertake the PRP rather than R as this simply reflected the contractual arrangements between these two parties. Nor was it a detriment to require them to leave the service of the respondent in the interim, he was not precluded from working for other entities in the interim as other NHS Trusts.

2014 Emails

156. The respondent submitted:

(i) there was no evidence Brigadier Simpson who forwarded the emails was aware of any disclosures, this is evident from the correspondence. The amended claim was not served until November 2014 and the email to the Trust was sent on 15th April 2014. Until then no one knew of the claimant's disclosures putting his evidence at the highest only he leisurely disclosed to at the base knew. There were genuine cause for concern in the material.

(ii) no detriment arose in any event as the claimant was not removed from the performance list and the reason he was taken off the performers list in the first place was entirely unrelated to the emails. The claimant did not explain whether he had effectively been removed from the list, therefore what is left is the derogatory comment by itself sufficient, if it is the matter reverts to causation.

Claimant's Submissions

157. The claimant submitted we should accept his evidence of the earlier protected disclosures between the 6th and 16th August. In respect of the entry in the medical records it was asserted that the information that was being disclosed was that the patient denied receiving 60 milligram tablets. This information was also of course in his interview statements, it was contended this was the information which tended to show a criminal offence had been committed or the health and safety of someone had been endangered, it is not necessary to show criminal offences had been committed still less who did it or when, it has to be information which tends to show that its clear that she had dispensed controlled drugs in excess of the prescribed amount and therefore she had committed a criminal offence under the Medicines Act 1968 or if the patients account was correct and he had not received more than the prescribed amount 2000 milligrams of Morphine was missing and one or several criminal offences were likely to have been committed.

158. The claimant did not have to identify the criminal offences, he simply had to have a reasonable belief, it was also submitted that the disclosure was properly made to another person i.e. the MOD who were not the claimant's employers in accordance with 43C (1)(b).

159. In respect of the medical notes not being disclosed because they are confidential Mrs Cotgrave had been deputed to investigate and she did access the notes in the course of that investigation Dr Frost said he knew they would be accessed if there was an investigation. In any event the information was equally disclosed in his interview notes.

Detriment

160. The claimant relies on the termination of his contract and the BCUHB events.

Other matters referred to in submissions

161. The manner in which the investigation was conducted, decisions taken about him, decisions taken while he was on holiday and communicated without reason by text and email whilst on holiday, the later secret malicious emails and the attempt to prevent a return to practice. These were said to demonstrate the respondent's animosity towards the claimant. That there was no logic to treating Dr Frost differently from Dr Raines and the fact that he wasn't suggested an undisclosed motive namely that the respondent wished to remove a whistle blower.

162. The claimant contended that the MOD's belief that they had to terminate his contract and that they could not undertake the performance review or provide a responsible officer was disingenuous and unsustainable in the light of the correspondence from Jo Leahy to Major General Von Bertalay (no reply was ever received and therefore it is not clear that this was accepted albeit in 2012 an appraisal was undertaken by Hamen).

163. The claimant contended that Jo Leahy's analysis was correct on the basis of the Health and Social Care Act 2008 and the Medical Profession (Responsible Officers) Regulations 2010. He admitted the Army was Dr Frost's designated body and were required to provide the responsible officer. Neither did Brigadier Simpson assert the Army had no responsibility for undertaking Dr Frost's appraisal. The MDU also challenged this on 28th November 2013 in response to a letter from Colonel Black. Likewise it was refuted in response to the Surgeon General's asserting the same matter.

164. In respect of the emails which damaged his reputation the claimant submitted that Brigadier's Simpson's action on 15th April in sending the damaging email stating that “they threw some light on to the activities of Dr Frost” and asserting that “he had not been employed for more than a year” when in fact he had only ceased his employment on 6th September 2013 which was by then six months and also the erroneous description of the incident suggesting that he had been responsible for the excessive dose was detrimental. This was the cause of his non-employment (query whether in fact it’s the email attachments that do the reputational damage rather than the implication that the claimant was responsible for the excessive dose) and what the claimant actually relied on in his claim.

Causation

165. The claimant relied on the fact that some relevant witnesses were not called the patient, the PT (although the claimant had a witness statement for her and she did not appear), Beverley Hall the Chief Pharmacist, Susan Matthews, the patient’s doctor. In respect of the witnesses he submitted Mrs Cotgrave was not a credible witness. The claimant relied on that she did not refer to Dr Matthews in her interim report and initially denied knowing that Dr Matthews had seen the patient on 10th July or 24th July and yet she had taken a statement from her on 22nd August and that she had accessed the medical notes for a second time without recording she had done so. Neither were the original notes of the statement of Dr Matthews produced and different explanations were given for this, neither did her report record that the Regional Pharmacist had interviewed the patient and been told that he did not recognise 60 milligram tablets that were shown to him and that that demonstrated that the report was unbalanced and seeking to down play the possibility of a alternative explanation for events. Mrs Cotgrave suggested she told

Colonel Black orally but this is not documented in any witness statement. Neither did she point out that mislabelling and mis dispensing a drug was an offence under the Medicines Act 1968, that she came to her conclusion without interviewing the Pharmacist Technician who had allegedly made the mistake and was clearly materially influenced by the fact Dr Frost was stressing the conflict of evidence which led whether he said or not to the necessity of a proper investigation on what had happened to the drugs, and we should draw an inference of that from the fact that she suppressed the following evidence from her interim report:-

(a) the patient's unequivocal denial that he had ever seen let alone taken the distinctive orange 60 milligram tablet when interviewed by Mrs Hall;

(b) the fact that the patient himself did not describe any symptoms whatsoever of an overdose;

(c) the fact that Dr Matthews has seen the patient on 10th July two days after the patient had received the massive overdose of 120 milligrams of Morphine per day and she noticed no problems;

(d) the fact that Dr Matthews had seen the patient on 24th July and he did not appear to be under the influence of an increased dosage of MST;

(e) the fact that Dr Frost had seen the patient on 6th August and he showed no sign and made no complaint of having had an overdose;

(f) the patient's statement that he knew about the “60s” when phoned by Sergeant Smith;

(g) the fact that the report contained thirty references to the incident having been a dispensing error but only one mention tucked away in an annex suggested that there was any contrary narrative that the patient had not received the 60 milligram tablets where there were two references to Dr Frost's statement that he wasn't sure an error had been made and that he wasn't convinced that the patient had overdosed as he was adamant that he had not been.

166. The claimant submitted that the report was biased to protect PT Gould from a wider and deeper investigation in which the Police would also inevitably have looked at why a lone pharmacist was dispensing Morphine on base especially in the light of critical CQC report on MOD's management of controlled drugs and that Cotgrave had agreed in evidence that an unresolved discrepancy would have had to have become a Police matter (Cotgrave said that the reason she didn't include it was because she believed there was overwhelming evidence the patient had received the MST "she said there was no other medication, no 10mg or 20mg tablets in the building"). (Another possibility raised in cross examination was that he had received them but he hadn't taken them, Mrs Cotgrave didn't believe there was anything the MOD could do about that and that could be done at any point with any tablets with whatever strength). The claimant submitted that the decision makers may claim ignorance of the claimant's PIDs but the investigator knew when she manipulated the Decision Maker to actual ignorance of them, the failure to provide her with a hearing and the failure to investigate is a loss of drugs (not sure what this means).

167. The Tribunal should also draw an inference from the form of the procedure of the investigation and decision making hearing. No disciplinary allegation was put to him, that he had no knowledge he was being investigated, that he had no chance of considering his position or defend himself, he had no opportunity to be accompanied by his defence organisation. That the investigation report was not disclosed by him, he had no chance to take issue with him, that he was kept in the dark about the process being followed and what the outcome might be, he knew nothing about the meeting on the 22nd August, he was not invited to a meeting on 6th September when the decision to terminate it was taken and he was given no chance to prepare a defence for it.

168. The record taken by Colonel Phillips was untruthful and damaging and the chance of having the performance review was denied to him on false and spurious grounds. They disputed Major Phillips' evidence that SGPLO1/08 does not apply to a Locum and her spontaneous evidence that she had been told by somebody in HR, there was nothing to prevent this procedure applying to Dr Frost.

169. The claimant also relied on the flawed decision by Phillips Morgan Jones and Black based on the erroneous issue paper. In addition it was submitted that the MOD also failed to follow their own protocols in relation to discrepancies involving controlled drugs. He also referred to Major Philips' issue paper where this protocol was asserted to actually not apply to the Army at the relevant time. The respondent also failed to do a root cause analysis even though Mrs Cotgrave suggested they should do.

170. The claimant submitted that Mrs Cotgrave wanted a decision on 6th September that barred him returning to the premises on the 9th and the reason for that was he was the only person who was asserting the significance of information tending to show a statutory failure. The claimant submitted that the respondents' failure to be open with disclosure was a matter that inference should be drawn from in addition.

Respondent's Reply

171. Following the end of the claimant's submission the respondents reply submitted that relying on a breach of the Medicines Act 1968 was in fact contradiction to the claimant's pleaded case which throughout insinuated some sort of blackmail of the PT or that the patient was selling the drug elsewhere and that a police investigation was required.

172. It was submitted it was incredible to suggest that the claimant had this breach of the Medicines Act 1968 or the Controlled Drugs Act in mind at the time of making his alleged disclosures.

173. It was also incredible that the claimant had abandoned his oral disclosures which had been the bedrock of his case for four years and sought to rely only on the patient records of 16 August. It was also in contradiction of the claimant's seeking of an amendment to now say that the information that was the subject of the protected disclosure had been raised in any event in the interviews, if this was his case he could just have relied on the interviews. He did not need the amendment.

174. Further, if this was the disclosure it was freely recorded everywhere throughout the interview, it was a remarkable change of tack from the claimant.

175. The respondent reiterated that the decisions made about whether or not the respondent could undertake a performance review etc were taken in good faith based on the interpretation of their own regulations, that the issue did not require calling patient X, it was not a re-run of the enquiry, neither was it necessary to call the PT. The respondent did not have to prove that the report was correct and in any event the claimant was going to call the PT, and had submitted a witness statement but did not call her.

176. The respondent could equally say in respect of the claimant why has he not now called the PT? Further, that although Beverley Hall was not called as a witness it was no secret she was part of the investigation but as she was not involved in the chain leading up to the claimant's termination there appeared to be no reason to call her, again she could give relevant evidence as part of the investigation but not relevant to the Tribunal case.

177. The respondent pointed out again that Mrs Cotgrave on behalf of the MOD had insisted on a PSIR being raised and these were not the actions of someone trying to cover something up.

178. Further Dr Raines was in a different position as she was not employed by a third party, she was employed directly with no intermediary and her treatment was intended to be the same as the claimant's.

179. The PT and PN were disciplined quite severely and they were treated the same during the fact finding investigation as the claimant in respect of all the matters the claimant seeks to rely upon from drawing an inference. The claimant was not treated more harshly or more differently during the investigation than any of the other staff including the other doctor.

180. Regarding the patient's medical records they did not want to disclose those without an order due to their confidential nature. The Betsi Cadwaladr emails were not disclosed as they had no relevance to the claimant's pleaded case (add the submission regarding the CQC).

Conclusions

181. We have considered both parties submissions in full although we do not refer in our conclusions to every single one of those submissions.

Protected Disclosure

182. Did the claimant make protected disclosures? In relation the claimant's pleaded case we find that the claimant did not make protected disclosures he initially relied on. We find this because the claimant has changed his position in cross examination saying that there was a developing situation rather than being positive about it, that it was inconceivable that he would have clearly stated there was a need for a Police investigation immediately before going into a meeting and then not mentioning in the meeting. Further Angela Thompson gave convincing evidence that this was never mentioned as did Catherine Shakeshaft. There was no reason why

he could not have mentioned this in his interviews. Accordingly these original three protected disclosures we find did not factually occur.

183. Regarding the patients notes my colleagues find this was a protected disclosure I find it was not. I find it was not in the view of the fact that the claimant is now relying on simply information being provided that the patient was denying he had taken the medication. It was information but in my view it had no meaning other than as a record of what the patient had said, there was no hint of allegation of wrongdoing in terms of Section 43B. Also, there was no disclosure as no information was actually being given to anybody at the time, the claimant did not know that Samantha Cotgrave would look at these notes in the course of conducting her investigation. Further it was information Samantha Cotgrave already had from the interview with the claimant and yet the claimant chose not to rely on those interviews as protected disclosures. Accordingly the information would remain confidential and only be seen by another treating physician who would be required to keep them confidential and would have no power or obligation to act on them. In fact the most that could be said which is what the claimant said under cross examination was that the reason he put them there was in case there was a Police investigation in the future so in my view there was no actual disclosure of information to anyone and no allegation of any wrongdoing. In my view it would require a leap of imagination to imply anything from the information provided.

184. My colleagues take a different view and feel that the words used were sufficient given the context of healthcare professionals and in view of the fact that Mrs Cotgrave actually did access those notes.

Reasonable Belief

185. Did the claimant have a reasonable belief that that the information in the notes tended to show criminal activity or a health and safety risk?.

186. Subjectively we agree that the claimant did believe by the time after his termination that some type of criminal activity was a possibility – that the patient was selling MST tablets or those tablets in particular or the PT was involved in similar activity or had been 'blackmailed' into obtaining higher strengthen tablets. I find that this was not a reasonable belief. I have taken into account the claimant's perspective and his personality and individual circumstances as required however I find this is not a wholly subjective test and given the claimant's professional standing would have expected him to have had more information before forming a belief in respect of criminal activity. For example he appears to have extrapolated his suspicions from the type of car the patient drove as well as his denials of taking the drugs. He has relied too on an examination of the patient by himself when he had no idea the patient may have taken an overdose and so was not looking for relevant signs. He had no knowledge of what the pharmacy records said. I find further that he could not have had a reasonable belief in criminal activity as he says in his interviews that the PT has made a mistake.

187. My colleagues on the contrary find the information in the notes sufficient to meet the test of tends to show in respect of criminal activity in the context of healthcare professionals.

188. In respect of the breaches of the law regarding storage etc of controlled drugs which the claimant argued were criminal offences we find the claimant had no idea about this legislation at the time he made his disclosure and therefore that was not a matter he had in his mind at all when he made the patient notes.

189. In respect of health and safety we all agree that there was no reasonable belief here - whilst this may have been an issue in relation to the third of his original disclosures it is not an issue in relation to the note as the claimant clearly believes as reflected in the notes that there was no health and safety risk because the patient had not taken these drugs.

Detriment

Termination

We find that the claimant did suffer a detriment in being terminated, the respondent states this was because he was a Locum however that does not alter the fact that he suffered a detriment rather it goes to causation. This was not a detriment on the grounds of being required to undertake a performance review, as Dr Raines had been treated in the same way. However, Dr Raines had been allowed to carry on working pending the performance review, whereas the claimant was terminated and did not work again.

BCUHB

190. The detriment claimed here is a malicious libelling to make sure he did not practice. There was a detriment here in how the information was presented to the hospital board by Brigadier Simpson, but in particular in implying that he had been terminated by the respondent because he had prescribed an overdose to a patient and suggesting that he had not been employed by the respondent for one year .In respect of the articles as they were in the public domain I find this aspect of the detriment was not a matter which could be said to be detrimental as the claimant himself had placed the articles in the public domain and they were open to be BCUHB to access at any time. My colleagues think that they still constitute a detriment as they were sent with a view to suggesting that the claimant's integrity and probity was at issue and therefore that was sufficient to be a detriment.

Causation

191. The question then arises whether either of the two detriments arose because of the one protected disclosure of the notes in the medical records.

A. The detriment of being terminated

192. We find that the respondent terminated the claimant as explained by David Morgan Jones because he felt that that was the correct position under the Army's

protocol and procedures pending the claimant undergoing a PRP and because they genuinely believed he had failed in his duty of care,as had Dr Raines. We accept his evidence that it was expected by all those involved in the decision that this would happen through his agency and that consequently he would be back at work and there was no idea that this situation would be prolonged at that stage.

193. We accept the evidence of the Mrs Cotgrave that the investigators were convinced that this was a dispensing error. The investigators were convinced that this was a dispensing error because there was a genuine view the evidence was overwhelming, this became clear in Tribunal when Mrs Cotgrave was cross-examined and stated that there were no other tablets in the pharmacy at that time, this was a crucial consideration although it had not been spelt out in the report or in the witness statement as she felt it was clear. There is a reference in the report to this but it is a technical one and was not understood either at the time of reading by the panel or by the doctors representatives that this is what this reference meant. However we were not her audience at that time and therefore we do not read anything into that.

194. In addition Mrs Cotgrave had all the information the claimant relies on for his protected disclosure as he had provided this information in his interviews. When Mrs Cotgrave saw the entry in the patient records it is inherently improbable she would have considered this was a disclosure of any sort of information raising a whistle-blowing allegation, and on the balance of probabilities it is unlikely she would have been influenced by such information as she had already received that information from elsewhere. Therefore if it was a whistle-blowing disclosure when he put it in the notes, it was one when he raised it in the interviews. She also knew this information from Beverley Hall,the Regional pharmacist.

195. The reference in the patient notes to this information whilst its of some concern the reason it was discounted by the respondent's witnesses was genuine i.e. that they felt that the patient was an unreliable narrator and that the pharmacy records showed that 60 x 60mg had been ordered and that there were no 10mg tablets in the pharmacy.

196. In respect of the argument that Mrs Cotgrave set up a report which would lead to the claimant being terminated (the Jhuti argument)this is a fallacious logic, the claimant was terminated because he was a Locum and the Army believed that is what they should do. He was required to do a PRP and the reason for the PRP and the termination (what was envisaged to be a temporary termination) was because there was a perceived failure by the claimant (which he agreed to himself in one of his interviews) that he should have followed the matter up more quickly and ensured that it was reported. This was the same situation as with Dr Raines. This was the matter which led to the detriment, this is clearly evidenced throughout the documentation and there is no evidence that this was a sham. Further it was irrelevant to the reason the respondent wanted the claimant to have the PRP whether he had made protected disclosures or not this would not have altered the fact that the claimant did not follow up the situation with the patient when he first knew about it, neither did Dr Raines who had not made a protected disclosure and who also received a similar if not entirely equivalent "punishment". Further he himself admitted in the handwritten notes that with hindsight he should have done more. The fact that the same contention was made in respect of Dr Raines shows

that the claimant was not singled out. The difference in treatment was due to the difference in status. Therefore the reasons for his treatment were entirely to do with the perceived failing and his status and had no connection with any alleged whistle blowing. It may have been an erroneous belief that the respondent could not have conducted his PRP but it was a genuine one.

197. In addition it has been clearly established as far as we are concerned that the three decision makers (Black,Philips and Morgan-Jones) had no knowledge of any whistle-blowing allegations at the time of their decision, and the fact that the issues paper was incorrect in a number of aspects has not lead us to draw an inference having heard the witnesses.

The Betsi Cadwaladr Emails

198. There are two strands to this, the actual production of the emails themselves which we accept Carson Black's evidence that he pursued these out of interest and had no intention of forwarding them to Brigadier Simpson and was unaware that Burgess had done so.

199. Far more damaging was the loose way in which Brigadier Simpson after saying he did not know much about the Tribunal case implied that the claimant had been negligent, which he clearly had not been, in terms of the prescribing, rather than that it was a dispensing error.

200. However we have found that Simpson had no knowledge that the claimant was bringing a whistle blowing claim or what the alleged disclosures were about at all and therefore when he chose to write his careless and damaging email it could not have been motivated by any whistle blowing. These events occurred before the claimant particularised his disclosures and certainly before he added the patient notes as a disclosure.

201. At the time the most anyone knew of the claimant's claim that he had ticked the whistle blowing box on his ET1 along within several other claims and had expressed the factual basis of his claims none too clearly.

202. In reaching our conclusions on causation we have ofcourse considered whether we should draw inferences from the matters raised by the claimant however as is evident we have declined to do so finding that for eg deficiencies in procedure, record keeping and disclosure arose from genuine reasons unconnected with any whistleblowing allegations.

203. In summary the majority have found that the claimant did make a protected disclosure in making a note in the patient's records of the information that the patient was denying he had received the tablets and that it did in the reasonable belief of the claimant tend to show as follows that a criminal offence had been committed. However we unanimously find that the detriments suffered by the claimant did not arise from that protected disclosure accordingly the claimant's claim fails and is dismissed.

204. However we would say that we are very concerned at the way the claimant's termination was handled by the respondent. The rushed way the decision was made, the terse issues papers which despite its terseness still was wrong in a number of respects, that such a short paper should be the basis of the decision making. The sudden termination of the claimant's employment with no or little consideration for alternative ways of handling this , the failure to discuss with his agency initially whether they could do a PRP and provide a responsible officer. In addition the Betsi Cadwaladr incident shows the respondent in a poor light, over reacting to the information about the claimant's activities and the very careless way in which Brigadier Simpson replied to Besti Cadwaladr.

205. The respondent's record keeping was poor and whilst we understand there was a major reorganisation at the time the respondent should give some consideration in the future in similar circumstances to the need to preserve documentation,for litigation purposes at least.

Employment Judge Feeney

Date 7th July 2017

RESERVED JUDGMENT AND REASONS
SENT TO THE PARTIES ON

7 July 2017

FOR THE TRIBUNAL OFFICE