Case Number: 3200773/2012
& 3200709/2013

YG

EMPLOYMENT TRIBUNALS

Claimant:	**Mr S G Weerasinghe**
Respondent:	**Basildon & Thurrock NHS Foundation Trust**
Heard at:	**East London Hearing Centre**
On:	**27 & 28 September 2016, 4, 5, 6, 7 October 2016, 17 & 18 October 2016 (in Chambers) 31 May 2017 (in Chambers) 9 October 2017 (in Chambers)**
Before:	**Employment Judge Russell**
Members:	**Mr G Tomey Mrs E A Colvill**
Representation	
Claimant:	**Mr A Hogarth QC (Counsel)**
Respondent:	**Ms N Ellenbogen QC (Counsel) Mr T Sheppard (Counsel)**

JUDGMENT

It is the unanimous judgment of the Employment Tribunal that:-

1. The Claimant is entitled to a basic award of £8,800 (18 years' NHS service, aged 49 at termination, at the then maximum rate of pay of £400 per week).

2. The Claimant would have been physically fit to return to work by January 2014.

3. Loss after 1 January 2014 is reduced by 35% to reflect the possibility that the Claimant would not have returned to clinical practice for reasons not caused by the Respondent's unlawful acts and the psychiatric injury suffered thereby.

4. A return to work programme would have lasted 9 months, during which time the Claimant would receive full basic pay, any Clinical Excellence Award, London weighting and on-call allowance. The Claimant would not have received any waiting list initiative payments or received any income from private practice during this period.

5. The Claimant's likely earnings included:

 5.1 12 PAs from October 2014; 50% chance of 13th PA from March 2015.

5.2 WLI payments of £17,552 per annum to the date of this Judgment, with a 75% chance of continuing at the same rate into the future;
5.3 80% chance of level 2 CEA by April 2017, 80% chance of level 5 CEA from April 2022; 20% chance of level 7 CEA from April 2027 until retirement;
5.4 Private practice of 4 operations in March 2015-16, 10 operations in March 2016-17 and 16 operations a year from March 2018. There is a 75% chance of continuing at that level until retirement.

6. The Claimant is entitled to the cost of retraining in the sum of £2,000 plus VAT.

7. The Claimant is entitled to the cost of future treatment in the sum of £6,900 as all arises out of the psychiatric injury caused by the Respondent's unlawful acts.

8. The Claimant would have retired at 67 years old (with a small chance of retirement at age 64).

9. The Claimant has not failed to mitigate his loss. His residual earning capacity is £30,000 per annum.

10. The appropriate multiplier for future loss is 12. The reduction rate on loss of earnings is 0.9 (10% reduction). On residual earning capacity, the reduction rate is 0.8 (20% reduction).

11. The discount rate for future losses is 0%.

12. The Claimant is awarded the following sums for non-financial loss:

12.1 £32,000 for injury to feelings
12.2 £18,000 for personal injury
12.3 £5,000 aggravated damages.

13. The basic award and loss of earnings for unfair dismissal (subject to the statutory maximum of £72,300 for dismissal in November 2012) shall be uplifted by 7.5% because of the Respondent's unreasonable failure to adhere to the ACAS Code.

14. The Claimant must give credit for sums received by way of Employment Support Allowance.

REASONS

1. By a Judgment sent to the parties with reasons on 23 June 2014, the Tribunal held that: (a) the Claimant had been subjected to a detriment because of a protected disclosure in respect of all detriments pleaded save for an interview on 20 September 2011; (b) he was unfairly dismissed by reason of conduct; and (c) he was subjected to unfavourable treatment arising in consequence of his disability. The Respondent successfully appealed the disability discrimination Judgment and the matter was remitted to the Employment Tribunal. By a further Judgment sent to the parties on 8 July 2016, upon remission, the Tribunal held that the Claimant had been treated unfavourably because of something arising in consequence of his disability; firstly, in respect of an allegation that he had mislead Dr Aggarwal about his ability to attend

meetings and secondly, in respect of his dismissal.

2. As at the date of this Remedy Hearing, therefore, the acts for which the Respondent has been found to be liable (and for which compensation may flow) may be summarised as

Unfair Dismissal

Protected Disclosure

(i) refusing to allow the Claimant to travel to Sri Lanka between November 2011 and his dismissal, and threats to sick pay;
(ii) subjecting the Claimant to disciplinary investigation from November 2011 onwards;
(iii) Conducting a disciplinary hearing, failing to obtain necessary medical evidence, adding an additional allegation, refusing to allow the Claimant's additional medical evidence, relying upon documents not shown to the Claimant.
(iv) Conducting the appeal as a review rather than a rehearing.

Disability Discrimination – s.15

(v) Alleging that the Claimant had mislead Dr Aggarwal about his ability to attend meetings.
(vi) Dismissal.

3. The parties have spent some time preparing for this Remedy Hearing not least as a considerable number of expert witnesses were called. The Claimant has provided a schedule of loss and the Respondent a counter-schedule. There is no dispute about the Claimant's basic salary, London weighting and on-call allowance. There is substantial dispute about the amounts which the Claimant would have earned in respect of Clinical Excellence Awards, waiting list initiative payments, additional Programmed Activity sessions ("PAs") and income which he would have earned from private practice. The disputes of principle between the parties were helpfully summarised by Mr Hogarth in his closing submissions as follows:

3.1. What is the chance that the Claimant would have been able to return to work had he been permitted to travel to Sri Lanka in the winter of 2011/2012?

3.2. Having travelled to Sri Lanka almost a year later, when was the Claimant fit to return to work as a consultant surgeon?

3.3. Having become fit to return to work, how long a return to work programme would be expected?

3.4. What would the effect of the return to work programme have been on the Claimant's income?

3.5. What were the Claimant's likely future earnings as a cardiothoracic

surgeon?

3.6. When would the Claimant have retired?

3.7. What is the Claimant’s residual earning capacity?

3.8. What age should the Tribunal use when deciding on the date of the Claimant’s retirement? (although we note that this appears to overlap with the dispute identified at paragraph 3.6)

3.9. What reduction should be made to the loss of earnings claim and the credit to be given for residual earning capacity to take account of the possibility of sickness and unemployment prior to retirement? and

3.10. What discount rate should the Tribunal use to account for accelerated receipt?

4. To these, Ms Ellenbogen added:

3.1 To what extent, if any, did the acts of discrimination or detriment as found cause loss to the Claimant?

3.2 Has any pecuniary loss been caused by any unlawful act of the Respondent?

5. We heard evidence on behalf of the Claimant from:

5.1. The Claimant;

5.2. Professor Madden (Professor of Cardiothoracic Medicine);

5.3. Ms Margaret Dale (Employment Consultant);

5.4. Dr Pollock (Consultant Actuary);

5.5. Professor Hirsch (Consultant Psychiatrist) provided a written report but was not required to attend.

6. For the Respondent we heard evidence from the following:

6.1. Dr Celia Skinner (Medical Director);

6.2. Mr Stuart Harris (Clinical Divisional Director for the Cardiothoracic Centre);

6.3. Dr Johnson (Consultant Physician, Specialist in Respiratory and General Internal Medicine);

6.4. Mr Nicoll (Employment Consultant);

6.5. Professor Wass (Labour Economist); and

6.6. Mr Rosson (Independent Financial Adviser and Head of Litigation Support);

6.7. Dr Bird (Consultant Psychiatrist) provided a written report but was not required to attend to give evidence.

7. The expert witnesses spoke with their relevant counterparts to clarify areas of agreement and/or dispute within their respective reports. Professor Madden and Dr Johnson produced an agreed statement after a telephone conversation on 30 September 2016. Professor Hirsch and Dr Bird also prepared a joint statement following a telephone conversation on the same day. A joint statement of Professor Wass and Ms Margaret Dale was produced on 5 October 2016. There was also a joint statement of Mr Nicoll and Ms Dale albeit undated. We were provided with an agreed bundle of documents and we read those pages to which we were taken during the course of evidence.

Law

8. It was common ground that the basis of damages under the Equality Act 2010 is tortious, section 124(6), and that it is intended that damages should be an effective and proportionate remedy for the Claimant. In summary, the Tribunal should consider what would have happened had the unlawful acts of discrimination not occurred.

9. The discriminator must take his victim as he finds him, **Essa v Laing Ltd** [2004] IRLR 313. The overall purpose is to award compensation to redress the wrongdoing, **Chagger v Abbey National Plc** [2010] IRLR 47).

10. Section 49 of the Employment Rights Act 1996 provides that compensation for public interest disclosure detriment shall be such as the Tribunal considers just and equitable in all the circumstances, having regard to the infringement to which the complaint relates and any loss which is attributable to that. Such compensation may include injury to feelings, expenses reasonably incurred and loss of any benefit which the Claimant might reasonably be expected to have had but for the detriment. The use of the word "attributable" suggests a broader test than "caused by", **Roberts v Wilsons Solicitors LLP & Others** UKEAT/0339/15. An award of injury to feelings is not available when assessing compensation for a dismissal where the sole or principal reason was a public interest disclosure.

11. In assessing financial loss, the Tribunal must take into account all of the circumstances including old job facts and new job facts, making allowance for the vicissitudes of life and other contingencies, see **Kingston upon Hull City Council v Dunnachie (No.3)** [2003] IRLR 843 [2003] IRLR 843 and **Wardle v Credit Agricole Corporate and Investment Bank** [2011] IRLR 604.

12. Assessing future loss carries with it a degree of speculation. As Lord Reid explained in **Davies v Taylor (No.1)** [1974] AC 207, it is not a question of whether a certain thing did or did not happen on the balance of probabilities, rather an evaluation of chance. Sometimes this may be virtually 100%, sometimes virtually nil, often it will

be somewhere in between. The Tribunal should not adopt a balance of probabilities approach, provided the chance of future loss is not too small, speculative or fanciful, the Claimant is entitled to recover damages assessed in proportion to the chance of the contingencies occurring.

13. The parties agreed that the use of Ogden tables was a relevant factor in determining future loss in this case.

14. An assessment of the chance that the Claimant would have continued in employment until retirement, but for dismissal, must be based on available evidential material which may include statistical information, although this is not determinative, **Vento v Chief Constable of West Yorkshire Police (No. 2)** [2003] ICR 318 CA. If there is a chance that the Claimant would have been dismissed or left his employment absent a discriminatory act, it must be factored into the assessment of future loss, **Abbey National Plc v Chagger**.

15. An award of lifetime career future loss is exceptional and should only be made where the Claimant has no prospect of ever finding an equivalent job, **Wardle v Credit Agricole**.

16. Ms Ellenbogen submits that the Tribunal must not adopt a slavish application of the loss of a chance methodology, particularly given the multiplicity of hypothetical scenarios in this case. She submits that the Tribunal must do our best on the available evidence to assess a reasonable figure or progression and to allow for contingencies in that assessment and in the selection of appropriate multiplier without further reducing for loss of a chance in every case. Essentially, reflecting the likelihood of any hypothetical circumstance by reducing or increasing the applicable multiplier and/or multiplicand. Mr Hogarth submitted that we should apply the loss of chance approach when assessing future loss, taking account of all of the chances of the various causes and many events to decide how great compensation should be.

17. In quantifying loss likely to have been caused by the defendant's wrongful act, the court will take into account possibilities even though they do not amount to probabilities, **Gregg v Scott** [2005] UKHL 2 at paragraphs 67 – 69. This principle applies when the extent of the loss depends upon what will happen after trial or what might have happened hypothetically before or after trial if the claimant had not been injured. In **Gregg,** Lord Hoffmann declined to adopt that approach where the damage was not found to be attributable to the wrongful act of the defendant. The House of Lords (as it then was) drew a distinction between the question of whether damage is attributable to the defendant and the quantification of damage which is found to be attributable. We understand this to mean that the assessment of a possibility or chance which is not a probability does not apply when determining causation but that it does apply when assessing damages which arise as a result of a wrong which has been found to have been caused by the defendant. This reflects the fact that causation is an essential element in establishing the tort, in other words for liability to be established the attributable cause must be established. Once it has been, the assessment of loss when calculating remedy will involve questions of loss of chance. On this point, we prefer the submissions of Mr Hogarth to those of Ms Ellenbogen.

18. Section 11 of the Damages Act 1996 provides for a discount rate of 2.5% in

personal injury damages in the courts. At the time we heard evidence and submissions, the rate was under review but the outcome had not yet been reported. The new rate of –0.75% was published in spring 2017 and we met in Chambers to consider the further submissions made by the parties. The Tribunal is not bound by s.11 but it is relevant, not least as our assessment of damage under the Equality Act is expressly stated to correspond to a similar assessment in the County Court. Mr Hogarth relies upon **Helmot v Simon** [2012] UKPC 5 and submits that we should have regard to evidence demonstrating that a different discount rate should be applied.

19. In assessing the award for injury to feelings, helpful guidance as to the bands for awards is contained in **Vento v Chief Constable of West Yorkshire Police (No. 2)**, as uprated in **Da'Bell v National Society for Prevention of Cruelty To Children** [2010] IRLR 19. The parties agreed that the **Vento** figures should be further increased by 10% to reflect the judgment in **Simmons v Castle** [2013] 1 WLR 1239. An award for injury to feelings includes compensation for loss of congenial employment, **Ministry of Defence v Cannock** [1994] ICR 918.

20. Aggravated damages are available in the Tribunal, **Commissioner of Police of the Metropolis v Shaw** [2012] IRLR 291 EAT. Such an award is still compensatory and not punitive in nature. Whilst aggravated damages may be awarded as a separate head of compensation, the Tribunal should not permit a claimant to be compensated twice for the same injury as that would be double recovery. Relevant factors in deciding whether to make an award of aggravated damages are the manner in which the defendant has committed the tort, the motive for it and the defendant's conduct subsequent to the tort but in relation to it. An alternative to making a separate award for aggravated damages is to take into account any aggravating features as part of a single award for injury to feelings.

21. The Tribunal may make a separate award in respect of personal injury arising from discrimination. The amount of an award should be determined by reference to the Judicial College guidelines. Where more than one event has caused harm, the Tribunal should consider whether the defendant's breach of duty has materially contributed to that harm and the amount of compensation is limited to that contribution, **Thaine v The London School of Economics** [2010] ICR 422). Care must be taken to ensure that the Claimant does not double recover as many of the features of personal injury may also be considered as part of an injury to feelings award.

Findings of Fact

Expert evidence

22. It was the agreed position of Professor Madden and Dr Johnson that the Claimant developed small airways obstruction secondary to respiratory infection which left him unfit for work until mid-2013. The Claimant is currently back to normal although this does not mean that there cannot be a recurrence. The Tribunal accepts their agreed evidence that the Claimant's recovery occurred largely from the combined effect of time, inhaled and oral steroids and repeat courses of antibiotics. The Claimant's symptoms improved after a visit to Sri Lanka in 2013 but, whilst both doctors agree that an earlier visit to Sri Lanka would have been reasonable, they are unable to say that this would have resolved the small airways disease at that time.

Professor Madden's evidence was that a trip to Sri Lanka in 2013 would have accelerated recovery, although he is unable to say by how much. Dr Johnson cannot refute the possibility but suspects that the length of the illness would have been the same even if the Sri Lanka trip had occurred in 2013. Neither doctor believes that the Claimant would have been fit to return to clinical duties in early 2012 and agree that the most likely outcome would have been early retirement on health grounds after submission of the form in August 2012 with a possible return to work in the event of subsequent recovery.

23. Both Professor Hirsch and Dr Bird agreed that there was no evidence that the Claimant had suffered clinical depression prior to the index actions in this case. Dr Bird accepted all the substantive points in Professor Hirsch's report. Professor Hirsch records severe depressive disorder with anxiety from the beginning of December 2011 until May 2012, with vicissitude in mood thereafter but continuing as moderate depression with anxiety disorder to the date of the hearing. The symptoms are now moderately severe. It is his opinion that the cause of the Claimant's condition was the actions of the Respondent, with effects including feelings of powerlessness and violation of his basic ethical rights to be treated as a professional employee in a fair and just manner. The Claimant's condition was exacerbated by withholding access to documents explaining the nature of the accusations and refusal to consider medical evidence about his condition. Professor Hirsch describes a profound impact on the Claimant, experiencing such fear and mistrust that he would not be able to work in a clinical environment again. Professor Hirsch makes the following statements, which we accept as accurate:

> **"331. In my view, but for the detriments found by the Tribunal he would not have developed his psychiatric condition (a Chronic Depressive Episode) that is more likely than not to have exacerbated and prolonged his recovery from his chronic lung condition. The stress induced by allegations of fraud during the Tribunal Hearing also exacerbated and prolonged his recovery from the depressive condition."**
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> **"337. I stress importance on the gradual accumulation of the detriments and events and reminders which the Claimant experienced over a protracted time, including the legal proceedings itself (especially the levelling of false charges of fraud against him by the Respondent); because it is well established that accumulated life stresses and negative experiences increase the likelihood of a depressive episode."**
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> **"356. He could have retrained as a cardiac physician, but for the fact that his psychiatric condition and experience mitigate against this as a result of the treatment he received from the Trust. He has a MRCP."**

24. Any expectation of recovery is likely to be delayed by the ongoing litigation. As for prognosis, and bearing in mind that the report was written on 30 April 2015, Professor Hirsch stated:

> **"359. With effective treatment it is more likely than not that the Claimant will recover from his depressive condition within six to twelve months following completion of the litigation. Return to work should be gradual and part time at first, possibly by doing voluntary work or working in an area where he can work part time and regain self-confidence.**

360. In my experience it is more common than not that a Claimant who has suffered in this way is unable to return to work in a similar environment. He will not be able to return to work as a Cardiothoracic surgeon for all the reasons given elsewhere in this report.

361. The Claimant will not be able to return to work in a clinical environment within a medical hierarchy. His plans to work as a lecturer may be realistic, but even that could be problematic and will have to stand the test of time. Were he to do so and find himself under criticism by his colleagues, he would have a heightened risk of relapse.

362. When he recovers, though there will be a risk of relapse, I believe he will otherwise be able to work normally, within the parameters I have outlined. Other than occasioned by relapse, or by recurrence of his respiratory problem, which appears well controlled, I believe he will be able to work normally.

363. Stated briefly, it is my opinion that the Claimant should continue treatment for one to two years after he recovers, which will reduce the risk of relapse. In general without treatment the lifetime risk is 60 to 80%, but mainly in the first five years, then diminishing to 5-6% in any one year. I do not think working will enhance the risk, unless he works within a medical environment, in which case it will be higher. I cannot envisage him returning to surgery."

25. In their discussion and joint statement, Professor Wass and Ms Dale agreed that future loss of earnings should be calculated by multiplying the formula "**annual wage x expected years of employment = lump sum**", to earnings both pre- and post-dismissal. This requires identification of the wage, the employment risks and retirement age (in order to determine the baseline multiplier) in each scenario. Beyond this, there was little if any further agreement as the application of the formula depends upon the Tribunals' findings of fact.

26. Ms Dale and Mr Nicoll were unable to agree anything of significance in their joint statement which did little more than set out their specific contentions on each disputed issue. One point of agreement emerged in oral evidence, namely that the Claimant would benefit from independent advice on outplacement and retraining and that a reasonable cost would be £2,000 plus VAT. We accept that such costs will be incurred due to the change in the Claimant's career path caused by the Respondent's unlawful acts and conclude that such sum is recoverable.

Evidence of fact

27. Broadly we found the Claimant to be a credible witness, although at times we considered that the reliability of his evidence was diminished by the emotion of his experience which led him to be overly optimistic about the prospects of his career trajectory if the unlawful treatment had not occurred. Following education in Sri Lanka, the Claimant graduated from medical school in Barbados in 1992. He came to the UK and trained at the Westminster University Hospital in London from 1994 and later at the Charing Cross Hospital. He became a member of the Royal College of Physicians (MRCP) in 1995 and a fellow of the Royal College of Surgeons (FRCS) in 1997 whilst

working at Hammersmith Hospital. Prior to joining the Respondent, the Claimant was awarded a project grant for research into endothelial disease in 1997 and obtained a PHD from Imperial College in 2003 in relation to the same area. Between 2000 and 2008 he was a specialist registrar in cardiothoracic surgery at St Bartholomew's Hospital, the Royal Brompton Hospital, Harefield Hospital, the London Chest Hospital and St Mary's Hospital. He was appointed a Cardiothoracic Consultant at the Respondent in September 2008 aged 45, four to five years later than the norm.

28. The Cardiothoracic Unit ("CTC") is a specialist referral unit located at Basildon Hospital which, since 2007, has received patients from across Essex and out of the area. As a specialist cardiothoracic surgeon for the Respondent, the Claimant undertook a range of clinical duties such as outpatient clinics, ward rounds and operating sessions as well associated administrative functions such as attendance at multidisciplinary meetings and undertaking continuous professional development. Other doctors in CTC at the date of the Claimant's dismissal included Mr Aitchison, Mr Birdi, Mr Khan, Mr Ritchie and Mr Shah. Other consultants joining later included Mr Bhusari and Mr Singh.

29. As we found at paragraph 33 of our original Judgment, in a meeting with Dr Aggarwal on 19 January 2011, the Claimant expressed his career intention to combine academic work with clinical practice and develop educational, academic and research work within the CTC. His intention to develop his research work as part of his career was consistent with his job interview and his 2010/2011 appraisal goal. We found that Dr Aggarwal told the Claimant at this meeting that the CTC could not support his interests in education, academic and research work and that the Claimant indicated that he would consider applying for jobs elsewhere if there was academic potential in them. As set out in the liability Judgment, the Claimant then applied for the post at Cork University hospital, an institution with links to a major international cardiovascular research laboratory. During his employment with the Respondent, the Claimant undertook little if any research.

30. In his work at CTC, the Claimant was interested in developing minimally invasive surgical procedures known as keyhole surgery and in particular a method for treating diseases of the high aorta referred to by the acronym TEVAR. Although at interview, the Claimant discussed his interest in minimally invasive techniques, in his initial years of practice in the CTC the Claimant focused on building his reputation and developing an excellent clinical practice.

31. The Claimant is married and his wife is a community paediatrician. The Claimant has one son, born in late 2008. The Claimant and his wife intended that she would work part-time and be their son's primary carer. The Claimant and his wife have high aspirations for their son's education and intend him to go to university in 2027 when he will be aged 18 and by which date the Claimant will be 64 years old. Assuming a standard three year degree course, the Claimant's son will graduate when the Claimant is 67 years old and the Claimant anticipates will embark upon post-graduate studies for a further two to three years. We accept that this is a realistic expectation for the child of two professional parents and that the Claimant would have continued to work and to provide financial support to his son were it not for the unlawful acts of the Respondent.

32. The Claimant was greatly distressed after the meeting on 28 November 2011; we

accept his evidence that he felt that his world was turned upside down and that he experienced suicidal thoughts. The Claimant's mental health was worsened by the Respondent's refusal to permit him to fly to Sri Lanka and he was humiliated and embarrassed by the need to explain the change in plans to his parents-in-law with whom he planned to stay. The Claimant's sleep was affected and frustration and bewilderment compounded his anxiety. We accept his evidence that the significant delay in concluding the grievance and disciplinary investigations exacerbated these feelings. The Claimant had been accused of alleged misconduct in his travel whilst on sick leave and was fearful of further travel, leaving him feeling trapped and housebound. He could not get to sleep until 4am in the morning and would often wake again at 6.30am. The Claimant suffered loss of appetite and libido, the latter persists to this day. The Claimant's concentration was adversely affected; he was forgetful even on routine day to day matters. His marriage came under strain as his wife had to increase her working hours to earn income for the family, even separating for a short period but now reconciled. The Claimant felt isolated from his wife and his young son. The strain of the suspension and disciplinary procedure was the reason why he decided to apply for early retirement in April 2012.

33. Following his dismissal on 15 November 2012, the Claimant lost trust in doctors and medical ethics such that it is agreed that he cannot return to work in a clinical environment. He felt powerless and again had suicidal feelings. The Respondent's failure to have regard to the ill health retirement application which had been accepted exacerbated his distress. The Claimant's dismissal caused financial pressure to the family such that his wife now works full time and they rent out their Canary Wharf house and have moved away from friends into rented accommodation in a less congenial area of London. The Claimant no longer entertains friends and rarely socialises to avoid the need to explain the change in circumstances which he feels is humiliating. Prior to the misconduct allegations and dismissal, the Claimant was healthy and active, playing tennis with a coach once a week, swimming at the local leisure centre, enjoying scuba diving, flying, cricket, going to local restaurants at least once a month and entertaining family and friends at home. The Claimant no longer watches television or gets pleasure from it. He avoids doctors with whom he used to socialise and social occasions generally, not even going with his son and wife to school events or pubs. His hurt and anger is compounded by his sense of betrayal that a healthcare provider did not support the recovery of his health from a respiratory condition and the feeling that his fellow consultants who treated him poorly had been protected by the Respondent.

34. The Claimant's injury to feelings was aggravated in part by the discrepancies in the Birdi report (see paragraph 67 of the liability Judgment) and, most significantly, by the Respondent's allegation made in cross-examination on 18 October 2013 that the Claimant had fraudulently claimed from his insurer for his cancelled flights to Sri Lanka in December 2011. Proceedings were adjourned part-heard until 29 October 2013 during which time the Claimant was unable to speak with his legal advisors and was unaware that they had obtained evidence from his GP to refute the allegation that he had falsified the doctor's part of a medical certificate. At the resumed hearing, the Respondent retracted the allegation of fraud. We accept the Claimant's evidence that this ten-day period was particularly upsetting, feeling that he had an allegation of fraud hanging over him like a suffocating cloak and that the Respondent were again trying to ruin him.

35. After staying in Sri Lanka in 2013 the physical symptoms of his small airways obstructive disease improved to an extent where his lung function is back to normal. The Claimant has the same level of physical fitness as before his infection in 2010. The Claimant was in receipt of Employment Support Allowance awarded on the basis of his physical respiratory condition, which he voluntarily ceased on 20 May 2014.

36. The Claimant has sought to mitigate his financial loss since dismissal. He has made 21 job applications since 26 May 2014, often in clusters then separated by many months. The applications are evenly split between lecturing in universities and medical advisor jobs. The Claimant's efforts to find a job have been hampered because he has had to disclose the reason for leaving his previous employment and he can no longer work within a clinical environment. The Claimant has not found new employment to date, although he is keen to find work, initially part-time with a view to returning to full time employment in due course.

37. From August 2012, as the disciplinary process continued, the Claimant considered embarking upon a different type of career if his ill health retirement were approved. Initially, the Claimant considered moving into work as a non-interventional consultant cardiologist with some retraining, supplementing his income by writing medico-legal reports. In 2012, the Claimant began to discuss the option of undertaking an LLM with his GP and he commenced the course on 1 December 2014. The Claimant is undertaking the course by distance learning with no staff/student interaction beyond sitting exams due to his desire to avoid social contact as a result of the Respondent's acts upon his confidence.

38. On the key factual disputes to be resolved by the Tribunal, we find and conclude as follows:

Question 1: What is the chance that the Claimant would have been able to return to work if permitted to travel to Sri Lanka in the winter of 2010-2011?

39. In our liability Judgment, we found that the refusal of permission for the Claimant to travel to Sri Lanka was a detriment by reason of a protected disclosure. We accept Mr Hogarth's submission that the Claimant is entitled to compensation for any loss flowing from that wrong. In quantifying that loss, we considered the chance of a return to work bearing in mind that a chance should be ignored if it is merely speculative but evaluated if it is substantial, see per Lord Reid at page 212D in **Davies v Taylor.**

40. Both the medical experts agreed that the journey could have been beneficial, but that is not the same as suggesting that it would have been so beneficial as to have rendered possible a return to work. Professor Madden's evidence was that there are no studies or data to support a link between such a visit and recovery, at most he felt that it would have accelerated the Claimant's recovery but that there were so many uncertainties it was not possible to extrapolate from them. The Claimant's physical health improved significantly after he did visit Sri Lanka in March 2013 and his respiratory condition and lung function has returned to normal. The Claimant attributes this to the warmer climate in Sri Lanka. Both medical experts identified a number of other factors which also played a part in his recovery, including lengthy courses of steroids, antibiotics and in particular the passage of time. Neither felt that the visit

would have resolved his condition. Having regard to the medical evidence, we consider that the chance of a return to work after a visit to Sri Lanka in late 2011, although a possibility, is such a slim possibility that it may properly be described as speculative and so must be ignored.

Question 2: When was the Claimant fit to return to work ignoring his psychiatric injury?

41. In April 2012, whilst the disciplinary process was underway, Occupational Health suggested to the Claimant that he apply for ill-health retirement by reason of his physical illness. The Claimant was under great psychiatric strain by reason of a disciplinary process which he felt was unfair, such that he made it clear to Occupational Health in April 2012 that he would not consider returning to work as a surgeon, instead, at that time, he was looking to become a non-interventional cardiologist. The Claimant considered that the proposed early ill health retirement may be a desirable way of leaving the Respondent’s employment and bringing the disciplinary process to an end. Professor Madden supported such an application on physical health grounds, referring in a letter dated 18 April 2012 to the Claimant’s concern at the time about the risk of developing further respiratory infection. We accept Professor Madden’s oral evidence that he considered that continued work in a hospital environment may expose the Claimant to infection and a possible relapse. The concern about the risk to his physical health was also part of the Claimant’s concern and was part of his willingness to consider ill-health retirement. The Claimant applied for tier 1 ill health retirement in August 2012 (meaning that if he subsequently regained good health, he could return to medical work). The application was accepted and, if he had not been dismissed on 15 November 2012, the Claimant would have retired on health grounds on 3 January 2013.

42. Relying upon the joint medical evidence, the Claimant’s case is that he would have been physically fit to return to work by 1 July 2013. By contrast, the Respondent relies upon the Claimant’s continued receipt of Employment Support Allowance until May 2014 and contends for that, later, date.

43. On the evidence available to us, both from the doctors and the Claimant himself, we find that a return to work as a consultant surgeon would have been medically possible following recovery from the respiratory condition. However, the Claimant was also suffering from cardiac problems throughout 2013 and continuing until late November 2013. Due to the Claimant’s ongoing physical ill-health and the chance that his respiratory condition had not yet resolved, he remained entitled to and in receipt of Employment Support Allowance until May 2014. In part, however, his continuing ill-health was caused by his anxiety about ongoing litigation and fear of future recurrence of his respiratory problems. The Claimant will need to give credit for sums received as Employment Support Allowance.

44. Given the multiplicity of causes, we do not accept that the date that benefits ended is the same as the date upon which the Claimant would have returned to work, were it not for the psychiatric injury. We prefer the evidence of the Claimant that if he had taken early ill health retirement in January 2013, he would have returned to employment in or around January 2014. This would have afforded him sufficient time to recover his health following his cardiac problems to have returned to work and (absent the additional anxiety caused by litigation) to be confident that his small

airways disease had sufficiently resolved.

45. Based upon our findings of fact about the Claimant's likely ill-health retirement in January 2013 and return to work in January 2014, we accept the Respondent's supplementary comment that the ill-health pension should be abated if required by the terms of the NHS pension scheme to reflect the Claimant's assumed post-return to work NHS earning insofar as they exceed the earnings margin.

Question 2a – to what extent was any loss thereafter caused by the Respondent's unlawful acts?

46. Having answered the question posed by the Claimant about the date when he would have been medically fit to return to work (absent the psychiatric injury), we must then consider the Respondent's question of the extent to which any loss thereafter was caused by its unlawful acts. In other words, to consider the chance that, without the psychiatric injury, even when physically fit and likely to return to work in January 2014, the Claimant would not have in fact returned to a clinical environment. The Respondent's case, ably advanced by Ms Ellenbogen, was that before the unlawful acts the Claimant's career aspirations clearly lay in academic and research work such that following the grant of ill-health retirement, and after a very significant period of absence, the Claimant would not have returned to a clinical environment in any event. We accept that this is a relevant consideration as, if the Claimant did not return to clinical practice, his ongoing earning capacity would be affected (for example, private practice, additional PAs and CEAs).

47. We find that the Claimant's anticipated career path had changed significantly in the period between the commencement of his sickness absence due to his respiratory condition and his dismissal in November 2012. Whereas up until November 2011, the Claimant sought to remain a cardio-thoracic surgeon, albeit possibly at another institution which could support his research and academic aspirations, from April 2012 he was considering moving out of surgery due to concerns about his physical and mental health and by November 2012 as the disciplinary process remained ongoing, he decided to look to a medico-legal and teaching future and to leave medical practice altogether. When he spoke to his GP on 5 November 2012, ten days before the disciplinary hearing, the Claimant had already begun to make enquiries about undertaking a law degree.

48. The Claimant's concerns about the possible risk of relapse posed by a clinical environment were supported by Professor Madden in April 2012 and would have applied even without the psychiatric injury, rendering it possible that he would have decided not to return to a clinical environment after January 2014 even if the unlawful acts had not occurred. Also relevant is the passage of time caused by the physical ill-health, an absence from March 2011 until January 2014, which we consider would also have affected the likelihood of the Claimant's return to a clinical environment. As set out in response to question 3 below, we accept that even without the psychiatric injury the Claimant would have become de-skilled and subject to a lengthy return to work programme. These factors, coupled with an existing desire to move into academic and research work, lead us to conclude that even without the unlawful acts of the Respondent there is a significant chance that the Claimant would not have returned to work for the Respondent, or in any clinical environment, in January 2014.

49. We accept that the Claimant is entitled to be compensated by the Respondent only to the extent that its wrongdoings caused him loss and that it is appropriate to take into account the chance that the Claimant would not have returned to clinical practice in any event. The Claimant's psychiatric injury was caused by his treatment by the Respondent starting in November 2011 with the refusal of permission to travel to Sri Lanka. The disciplinary investigation and conduct of the Respondent, as set out at paragraph 2(iii) above, and the allegation of misleading Dr Aggarwal as set out at paragraph 2(v) above were deeply distressing to the Claimant. We accept Professor Hirsch's evidence that the psychiatric injury was caused by the gradual accumulation of detriments and events and had such a profound impact that the Claimant will not be able to work in a clinical environment again, otherwise he may have retrained as a cardiac physician.

50. In summary, having found that the Claimant was physically fit to return to work by January 2014, the reasons why he did not do so were in part the psychiatric injury caused by the Respondent's unlawful acts and in part personal considerations which would have applied in any event. Assessing the extent of the contribution of each, we are satisfied that the Respondent's conduct was the main factor and assess it at 65%. The Claimant's concern about possible recurrence, his existing desire to develop his career in a different direction and the effect of the absence due to ill-health were important and material causes which we assess at 35%. It follows that any financial loss after 1 January 2014 must be reduced by 35% to reflect loss not caused by the Respondent's unlawful conduct.

51. In his comments on the draft Judgment, Mr Hogarth submitted that having found that there was a chance of two future career paths on a 65:35 likelihood, the Tribunal was required to consider the residual earning capacity in each in order to determine the Claimant's true measure of loss. In other words, that figures must be given for the likely earnings in the alternative career path. Mr Hogarth suggested what such figures may be and submitted that the Tribunal now could select an appropriate figure to apply. The Respondent's position is that these points were not included in Mr Hogarth's closing submissions, essentially they are an attempt to adduce further evidence and/or reargue the case which go beyond addressing errors and omissions.

52. At the remedy hearing, Mr Hogarth submitted that the Tribunal should not award damages for loss of earnings but for loss of earning capacity before and after the tort. In other words the consequences of the Respondent's acts insofar as they diminished the Claimant's ability to take a high-paid job in an alternative career. The point of principle is therefore not new but the analysis of the possible figures for the alternative career goes well beyond that advanced in submission at the hearing. The quantification of earning capacity in an alternative career path was not one of the questions identified by Mr Hogarth or Ms Ellenbogen explicitly and was not addressed.

53. On balance, we prefer the additional submission of the Respondent that the Tribunal's existing findings are sufficient in principle and that the calculation of their financial value in terms of lost earnings and pension benefits is for the next stage of the quantification of remedy. In summary, we have found that the alternative career which the Claimant had a 35% chance of following (absent the discrimination) would start from January 2014, would not involve any clinical environment but would be academic

or research work. The Claimant's current residual earning capacity is £30,000 per annum (see question 7 below); it does not include work as a medical lecturer for which a licence to practice is required but may include lecturing in medico-legal and medical ethics and/or pharmaceutical research.

Question 3: How long would the return to work programme have lasted

54. It was common ground that once the Claimant was fit to return to work, the duration and content of a return to work programme would have been discussed and agreed between the Claimant, Mr Birdi, Dr Skinner and the Royal College of Surgeons.

55. There is no express maximum or minimum duration for a return to work programme following sickness absence. Every case will depend upon its own particular circumstances, having regard to the duration of the absence, the reasons for the same and the nature of the work undertaken by the surgeon. During the return to work programme the Claimant would be permitted to operate, albeit under the supervision of another consultant. We bear in mind that our task is to consider and determine what the position would have been absent the psychiatric injury or damage caused by the Respondent's wrongful conduct. We consider that if the Claimant had decided to return to surgical work (and we have assessed that prospect above), then he would have been keen to return to full capacity and full earning power as swiftly as possible. Balanced against that would have been the Respondent's need to ensure patient safety.

56. In August 2011, Mr Birdi had suggested that the Claimant would require a return to work programme lasting between three and six months. This was after a period of only five months' absence and it seems inevitable to us that the duration of the return to work programme would increase materially following a three-year absence. Dr Skinner suggested that it would take a minimum of one year. We consider that the Claimant is overly optimistic when suggesting eight months and Dr Skinner overly pessimistic in suggesting over a year, not least as 12 months would be the period of requalification after the lapse of a specialist certificate (which would not have been the case for the Claimant in January 2014). Doing the best we can, we agree with Mr Hogarth that a period of nine months is reasonable.

Question 4: What would have been the effect of the return to work programme on the Claimant's income?

57. Dr Skinner accepted that the Claimant would have received full basic pay, any Clinical Excellence Awards in place, London weighting and on-call allowance during the nine month return to work programme. We accept her evidence that the Claimant would not have been permitted to participate in waiting list initiative operations during this period and that he could and would not have undertaken private work during the return to work programme as he would have had to re-apply for practising privileges at the end of the programme. Her evidence on both points is consistent with the Claimant's Schedule of Loss where, for a return to work from January 2014 he states that he would not have undertaken private practice or waiting list initiative work during the period of a phased return (albeit he suggests 8 months where we have found 9 months to be the appropriate period). Whilst the Claimant's hours may have increased during the return to work up to a full complement of 11 PAs, we conclude that no

waiting list initiative work or private practice work would have been undertaken at all during the return to work programme.

Question 5: What were the Claimant's likely future earnings as a cardiothoracic surgeon?

58. Perhaps unsurprisingly, this was the largest area of dispute between the parties, involving as it does the assessment of the Claimant's loss of earning capacity due to the unlawful acts. This inevitably requires a significant degree of speculation to re-create a future which might have, but has not in fact, otherwise existed. We approach this task by considering the factual and expert evidence before us and the findings of fact we have made in reliance upon the same. It is common ground that the Claimant will need to give credit for pension contributions which he would have made in the relevant period. We record also that the parties will need to calculate the Claimant's pension loss (subject to such credit for his contributions) on the basis of our findings about the sums which he was likely to earn as set out below.

59. The Claimant was employed by the Respondent pursuant to the terms of the standard Consultant contract. He was entitled to a basic salary dependent upon his years of service as a consultant, with annual increments and increasing salary thresholds which are not in dispute and are set out at page 5 of Mr Hogarth's written submissions. Nor was it in dispute that the Claimant also received London weighting of £149 per annum and an on-call allowance of 5% of basic salary.

60. Consultants' working time is calculated by reference to the number of programmed activities ("PAs") worked. The standard consultant contract in force prior to July 2015, required 11 PAs of which 10 were pensionable. Since July 2015, the standard contract requires 11.5 PAs but still with only 10 pensionable. Consultants may also be paid for additional PAs in respect of supplementary duties, such as management or research; these PAs may reflect time actually worked or may be more in the manner of an honorarium not dependent on hours actually worked. Dr Harris accepted in his evidence that 12 PA's is the minimum currently for full-time consultants in CTC. We find that there is a 100% chance that the Claimant would also have worked 12 PAs if he had remained employed by the Respondent. The Claimant's primary focus was NHS work and he would have preferred to increase his income by expanding his NHS work. Mr Birdi, Mr Aitchison and Mr Shah either work more PAs or receive an additional responsibility payment. Mr Khan is on sabbatical. Mr Busari and Mr Singh work 12 PAs with no additional responsibility payment. Overall, we consider that there is a 50% chance that the Claimant would have worked an additional PA from March 2015, six months after his full time return to NHS work.

<u>Waiting List Initiative Payments</u>

61. The NHS is under a statutory obligation to provide commencement of consultant led treatment within a maximum of 18 weeks from referral for non-urgent conditions. This may require a clinical commissioning group to offer treatment with an alternative provider if they can treat a patient within that time. There are however financial penalties for breach of the waiting list limits and costs of referring the patient outside of the local CCG area. As such there was an incentive for CCG's and Trusts to provide additional services to meet the targets within their own area. In order to do so the

Respondent incentivises its consultants to complete additional ad hoc sessions outside of their ordinary job plan in return for a set payment referred to as a waiting list initiative payment. Waiting list initiative payments were also paid by the Respondent to surgeons in the CTC who undertook additional operating lists to cover for colleagues on leave. The payments do not form part of basic salary and are not contractual or pensionable.

62. Figures provided by the Respondent show that in the year 2011–12, the Respondent made waiting list initiative payments in the total sum of £154,190 between the six full time surgeons in the CTC. This was a year in which additional operating cover had been required by reason of the Claimant's absence. We accept that the figure for 2011-12 was high and to that extent exceptional, given that the comparable figures in other years were £118,964 for 2012-13 and £106,578 for 2013-14. The downward trend continued in 2014-15 when the total CTC payment was £92,783.

63. In March 2015, the Respondent implemented a new policy with a view to controlling expenditure by reducing the cost of waiting list initiative payments. From July 2015, the consultant surgeons' job plans included cross-cover for Friday lists whereas previously those lists attracted waiting list initiative payments. The consultant surgeons' operating lists were lengthened to include more patients and thereby reducing the number of patients who required operations on additional lists. The long-term effect of the new policy cannot yet be determined from the figures available to this Tribunal but it did not achieve any substantial reduction in 2015-16 as the level of waiting list initiative payments in CTC had increased to £104,191 (although we accept Ms Skinner's evidence that the figures may include some late payments from previous years). For 2016-17, the figure of £21,620 covered only a short part of the year and no up to date figures were available to us. Given the uncertainties involved, we did not consider it safe to attach a great deal of weight to the specific figures as set out in the table provided as an indicator of likely future payments.

64. The Respondent currently plans to recruit a seventh consultant in CTC, initially to cover annual leave and study leave with a view to a substantive appointment in the future. This would have the effect of reducing the level of waiting list initiative payments by removing the additional cover sessions, although it is not clear by how much. The recruitment process is not at an advanced stage. A business case has been drafted for approval by the relevant management committee within the financial year ending April 2017. Even if approved, time will be required to advertise, interview and appoint the new consultant. This process may take longer as there is an increasing separation between cardiac and thoracic specialities and the Respondent has yet to decide to which speciality it wishes to recruit. On balance, we consider that a seventh consultant is unlikely to be in post before January 2018 and, as such, would not have any impact upon the level of waiting list initiative payments until the financial year commencing April 2018.

65. The Claimant's case is that we should take the total level of WLI payments in CTC for the years 2012 to 2015, then divide by six to give the Claimant an average of £17,552 per annum. The Respondent's case is that whilst such a figure is reasonable for the period to July 2015, the policy change and recruitment would reduce the level of WLI payment over time.

66. Dealing first with WLIs as part of past financial loss, we have found that the Claimant would have been on a phased return to work programme until October 2014, during which time he would not have received WLIs. From October 2014, we conclude on balance that even if the desire was to reduce expenditure and even allowing for some carry forward from the previous financial year, the figures for 2015-16 do not suggest that any significant additional reduction in payments was achieved. As such, we do not accept the Respondent's case that a lower figure should apply from July 2015. The Respondent's aspiration to reduce expenditure and its assessment of its prospects of success seems to us unduly optimistic given the pressures on the service. As such, and on the balance of probabilities, we consider it more likely than not that the Claimant would have continued to receive WLI payments at the rate of £17,552 per annum to the date of this Judgment.

67. As for future loss, we accept that the effect of the changes to rotas would begin to reduce the level of WLIs from April 2017 with greater reduction apparent from April 2018 with the appointment of the seventh consultant surgeon. The chances of successful reduction are lessened by financial benefits to the Respondent of undertaking surgery from outside of the local area for which it is paid additional sums by the CCG for each operation. Over the period of future loss, we took into account the Claimant's preference to stay with NHS work and even if he may have reduced his surgical workload to some extent as he became closer to retirement, we consider that he would nevertheless have continued to receive WLI payments until the termination of his employment. Doing the best we can, we consider that there is a 75% chance that the Claimant's WLI payments would have continued to be £17,552 per annum from April 2017 despite the Respondent's best efforts to reduce the figure.

<u>Clinical Excellence Awards</u>

68. Some consultants also receive Clinical Excellence Awards. A CEA is a sum of money paid in addition to basic annual salary to recognise and reward consultants who perform to a particularly high standard. The financial value of a CEA depends upon the level of the award. A consultant seeking a CEA will make an evidence based application which is then scored on five criteria: (1) delivering high quality service; (2) developing high quality service; (3) leading and managing high quality service; (4) research and innovation; and (5) teaching and training. CEAs below bronze level are made locally by the employing Trust; CEAs at bronze level and above are awarded nationally and require Royal College accreditation.

69. Obtaining a CEA is a comparative exercise where applications are assessed and ranked against each other. In other words, it is not enough for a consultant simply to provide evidence that they meet the criteria in order to obtain a CEA. A candidate may meet the criteria yet not receive a CEA because other applications in the same round are stronger. The Claimant accepted that it is a highly competitive process where many applications do not succeed and repeat applications are often required before any CEA is made. Given the competitive nature of the process and the requirement to amass a significant body of evidence for each application to move up the levels, we find that applicants do not apply each year, rather there would be several years gap between applications even where previously successful.

70. The Respondent has a local scoring panel which applies its internal policy. This

includes a provision that a consultant cannot apply until they have been in a substantive post for at least a year. The guidance suggested that consultants with less than five years' experience would probably not have the opportunity to put together a body of evidence sufficient to meet the selection criteria. As such the local committee would not normally consider applications from consultants with less than five years' service and would expect as an absolute minimum three years with the Trust. We accept the Respondent's evidence that it did not award more than three levels of CEA in any one application and that the overall trend of the success rate of applications was downwards, in other words that it was becoming harder to obtain CEAs.

71. We were provided with statistics showing the level and number of CEAs awarded at the Respondent. The statistics relate to the whole cohort of consultants but we accept Mr Hogarth's submission that the Claimant's prospects of a CEA would have been greatly increased by the fact that he was working in the only specialist tertiary referral and income generating unit at the Respondent. As such, we consider that the appropriate comparison is with the CEAs achieved by other consultants in the CTC.

Dr Aggarwal
Commenced employment with the Respondent as a consultant on 4 January 1999. He was awarded CEA's in 2003, 2005 and 2011. His final CEA was in 2013 at level 7.

Dr Birdi
Appointed consultant at the Respondent on 18 June 2007. He obtained CEA's in 2008 and 2010 and is at level 5. The Claimant's evidence was that Dr Birdi has unique talents and an international reputation.

Mr Aitchison
Appointed consultant 18 June 2007, awarded a CEA in 2012 is at level 3.

Mr Andrew Ritchie
Appointed consultant on 1 April 2007, CEA level 2 awarded in 2008.

Mr Shah
Awarded a level 1 CEA in 2013.

72. The only consultant at the Respondent with a national CEA is Dr Stephen Morgan, the former medical director, who was appointed a consultant on 18 September 1995 and holds a silver CEA. There have been no national CEA awards for consultants at the Trust since the Claimant commenced his employment. Ms Dale, in her report, recorded the position nationally as at July 2015: of a total consultant population in England of 40,443; only 726 (1.8%) hold silver awards, 1,571 (3.9%) hold bronze awards and 1,772 (4.38%) hold level 5 awards. One of the expert witnesses, Dr Johnson, obtained a silver CEA at about age 60 in recognition of his national thoracic work, supported by the Royal College of Physicians.

73. The Claimant's case is that he had a 50% chance of obtaining a level five CEA from 1 April 2012 in respect of his work on the TEVAR programme; rising to a 100% chance by 1 April 2013. Thereafter, he would have received a bronze CEA from 1 April 2016 for organising and establishing a National Cardiothoracic Clinical-Academic Education and Training Centre of Excellence. Finally, his case is that he would have

received a silver CEA from 1 April 2020 for the Integration of Cardiothoracic and Endovascular Specialities in a Cardiovascular Research Centre of National International Standing. The Respondent's case is that the Claimant's assessment of his prospects is overly optimistic and that such awards are too speculative to be included in the assessment of his loss.

74. The Claimant's TEVAR work was important and innovative. By the date that he commenced his sickness absence, the programme was not yet up and running. The Claimant had undertaken significant training to develop the required expertise for the procedure; he had made some progress in securing commissioning funding and had seen some patients in initial outpatient assessment. The Claimant had identified a team of existing staff who could work with him to deliver the procedure and had been identified as TEVAR Lead for the Respondent. However, there was still considerable work yet to be undertaken. There was no clinical governance scheme in place, simply a mentor from the Utrecht hospital which was already a major TEVAR centre. The Claimant had prepared a business proposal in December 2009 but this still required additional work, for example an estimate of the number of anticipated procedures in order to assess the financial case and by the time he went on sick leave in 2011, the Claimant had not yet submitted to the Respondent a final business plan for approval. The Respondent had not purchased the specialist equipment which would be required to deliver the TEVAR procedure.

75. During his sickness absence in 2011 due to his respiratory illness, the Claimant's colleagues continued to advance the possible TEVAR programme. The first TEVAR operation was undertaken at the Respondent in October 2013 in the newly opened hybrid theatre. Given that we have found that the Claimant would not have returned to work until January 2014, even without the unlawful acts, we find that he would not realistically have been able to apply for, far less obtain, any CEA during that period. The TEVAR programme at the commencement of sick leave was not sufficiently advanced to merit an award and whilst off sick the Claimant would not amass further evidence to support an application. There is no chance of a CEA before 1 January 2014.

76. After his return to work in January 2014, we have found that there would have been a nine month phased return. During this time, we find that the Claimant would have renewed his interest in TEVAR and would have become involved in the TEVAR procedures which the Respondent had begun to perform but that effect of the phased return and the limits upon his ability to operate independently during this time would have further delayed the point at which he could apply for a CEA. We accept the Respondent's case that the Claimant would effectively be starting from scratch in obtaining the required experience to demonstrate the five competencies in a competitive application.

77. On balance, we think that the Claimant's evidence is so optimistic about his prospects as to be unrealistic. The Claimant's absence due to his respiratory condition would have severely delayed any chance of a CEA for the reasons set out above. On the other hand, the Claimant was ambitious, appeared to be a high achiever and indeed Dr Skinner went some way towards accepting that he was likely to be driven and a high flyer. Taking all of this into account, as well as the highly competitive nature of the process and the levels of success attained by other CTC surgeons, we accept

that upon a return to full working ability, the Claimant would have striven to make up for lost time and obtain a CEA. Even if he had done so successfully, the prospects of going straight to a level 5 award are so remote as to be nil, given the Respondent's practice of awarding no more than three levels at a time and the downward trend in successful applications. Rather, we conclude that the Claimant had an 80% chance of obtaining a level 2 award in April 2017.

78. Thereafter, we consider that the Claimant's assessment of his prospects are again overly optimistic. The Claimant relies upon his intentions to develop an academic and training centre of excellence at the Respondent. However, the Respondent does not have strong research links or academic status. It runs some small local teaching programmes and has a connection with the Anglia Ruskin University. Whilst the Respondent has aspirations to improve its training and academic credentials, being realistic these are challenged by the close geographic proximity in relative terms of two major training, teaching and academic hospitals, namely Papworth and Barts. The Respondent, and in particular the CTC, currently undertakes some research and clinical trials. Unlike major research hospitals, however, these are generally commercially funded rather than blue chip research. The Respondent's research activities are nowhere near comparable to the likes of Barts or Papworth. Moreover, as Dr Aggarwal made clear to the Claimant in January 2011, research was not the Respondent's focus. The Claimant clearly understood that this was not likely to change given his decision to seek a position at a more research or academically minded hospital such as Cork. Dr Skinner, the current Medical Director, confirmed that training and research were not priorities for the Respondent. We conclude that the Claimant had no realistic prospect of developing a National Cardiothoracic Clinical Academic Educational and Training Centre of Excellence at the Respondent and, therefore, would not have been able to obtain a further CEA on the strength of the same.

79. We think it is possible that later in the Claimant's career he would have progressed beyond a level 2 by moving to another hospital, such as Cork or Barts, with greater research and training links. Such a move would enable him to continue his desire to develop his research and academic work. A hospital with an existing training, academic and research reputation would not have enabled him to set up a national training unit but it would enhance his prospects of engaging in internationally recognised research, possibly even working towards a Cardiovascular Research centre of national and international standing. Doing the best we can, we consider that there is an 80% chance that the Claimant would have progressed to a level 5 award by April 2022, by comparison with the achievements of his peers and likely career development. Whilst we would not have felt sufficiently confident to find on a balance of probabilities, we accept that there is a small chance that the Claimant might achieve a level 7 CEA before his retirement. This chance is not so small as to be fanciful or speculative given the Claimant's ambition, professional expertise and likely career path in a specialist academic or research hospital. Rather we would assess it at 20% from April 2027 until retirement.

80. In the supplementary submissions received on 3 July 2017, the Claimant asked for confirmation that where we have found an 80% chance of a level 5 CEA from April 2022 this also meant a 20% chance of a level 2 award, similarly with the 20% chance of a level 7 CEA from April 2027 there remained a 80% chance of a level 5 CEA. Once

a locally awarded CEA has been made, it is retained by the consultant. We accept the submission of the Respondent in reply to the effect that the chance of remaining at the lower level is already taken into account (as the salary of the lower award is subsumed into the higher award) and that there should be no double-counting.

Private Practice

81. NHS consultants are permitted to undertake private work as long as it does not interfere with their NHS work. The level of private work undertaken by an NHS consultant will differ according to their speciality and the time which they are prepared to devote to it. By the date of his dismissal, the Claimant had developed his own private practice, taking patient referrals from GPs within and outside of the Essex area. He tended to operate on private patients on Monday or Wednesday evenings, with outpatient consultations also undertaken outside of his working hours for the Respondent. Whilst the Claimant's primary commitment was to NHS work, he was keen to develop and maintain a successful private practice as a supplementary source of income. From 2008 onwards, the Claimant's private practice was mainly based at the Orwell Private Suite at the Respondent, although he had also registered with Nuffield Health and Spire Healthcare private practices.

82. We had regard to the table set out in the Claimant's most recent schedule of loss. This showed that he commenced private work in the year 2008/2009. In that year he had gross fees of £7,568, with a net loss of £1,498. In the year 1 August 2009 – 31 July 2010 he undertook 16 operations, generated gross fees of £44,945 and a net profit £25,870. The Claimant continued to undertake private work during 2011 until commencement of his sickness absence and anticipated that he would have undertaken again 16 operations in the full year, generating gross fees of £50,310 and net profit of £24,564.

83. Upon his return to work in January 2014, the Claimant would not have recommenced full NHS duties until October 2014. It was common ground that he would have undertaken no private work during this period and the Claimant accepted in evidence that this would have continued for a further six months thereafter. In other words, from March 2015 he would start to build up his private practice again. By this date, the Claimant would not have undertaken private practice for some four years and would then have required additional time to re-establish his private work. Taking into account Ms Dale's evidence and the Claimant's actual experience when he first started private practice, we are satisfied that it would have taken him three years to build up his practice afresh. During this three year period to the end of March 2018, we consider that the Claimant would gradually have built up to a maximum of 16 operations per year as follows: 4 operations in March 2015-16, 10 operations in March 2016-17 and 16 operations a year from March 2018

84. As for private practice income after March 2018, the Claimant's case is that he would have undertaken 40 private practice operations each year, a number he considered reasonable by comparison with Dr Birdi. Whilst Dr Birdi was registered at a number of private practice locations, neither the Claimant nor the Respondent was able to adduce evidence as to the number of operations or private practice income of Dr Birdi. The Claimant's oral evidence appeared unrealistic in his assessment of the time he would spend on private practice after accounting for time spent working for the

Respondent. At one point, the calculation of the total hours the Claimant suggested that he would work (without outpatient appointments) amounted to 70 hours a week, almost seven days a week. Whilst we accept that the Claimant was ambitious and driven, such an assessment is unreliable and not credible. There is no evidence of other surgeons spending similar amounts of time operating. Whilst Professor Madden works long hours, these were not surgical as the Claimant's hours would be. The hours estimated by the Claimant would exceed the totals done by all the other CTC surgeons operating privately in the Orwell Suite. Even with possible work through Nuffield or Spire, 40 private operations per annum seemed highly unlikely. Nor did the Claimant's assessment take into account the general reduction in the number of CTC operations being performed overall.

85. In her report, Ms Dale provided data about consultant's NHS and private income by speciality, gender and age. The data was over 10 years old and we approached it with some caution. Nevertheless, we accept that the broad trend is that the peak period for private practice is from 45 to 54 years old. Cardiothoracic surgical work is one of the more lucrative private specialities. The mean income from private practice was £47,675 in 2003/2004. The more recent BMA survey figures, also quoted in the Dale report, show a mean of 5.7 hours per week in private practice with private practice more likely for older, male consultants.

86. In assessing the likelihood of the level of the Claimant's private work, we took into account his primary desire to focus on NHS work which we have reflected in our assessment of the likely level of WLI payments to reflect additional operations for the NHS. In 2018, the Claimant will be 55 years old and his son will turn 10 years old. Before the unlawful acts by the Respondent, the Claimant's wife had her own career ambitions according to Professor Hirsch's report. The Claimant, we consider, would have wanted to continue to ensure financial solvency and security for the sake of his son's ongoing education and may have favoured private practice more in the latter years of his career. Prior to his ill-health, the Claimant appeared to have settled his private practice at 16 operations per year despite his stated intention to increase it further. Overall, having built his private practice up to a level of 16 operations per year we consider that there is a 75% chance that he would have continued at this level from March 2018 until his retirement.

Questions 6 and 8 – When would the Claimant have retired?

87. The Respondent produced statistics which appear to show that only a small percentage of consultants work beyond the age of 60 or 65. These statistics are not reliable in our view due to the changes in the pension retirement age, pension scheme and impact of the lifetime allowance tax changes. Consultants are high earning individuals who are disproportionately affected by these changes to the NHS pension and as a result we accept that a lot of consultants on the old scheme have retired early, thus skewing the statistical position.

88. The Claimant was a late entrant to the NHS pension scheme, was ambitious and passionate about his work. He has one son, born in 2008 and who will turn 18 years old when the Claimant is 64 and 21 years old when the Claimant is 67. The Claimant is committed to providing his son with a good education and would have worked to generate the income to do so. Whilst there is a small, but realistic chance, that the

Claimant might have retired at 64 years old given the physical pressures of surgical work, we consider that it was far more likely that he would retire at 67 years old. This would enable him to fund his son's undergraduate studies, would be the age at which he could draw his NHS pension and his state pension. In reaching this conclusion, we accepted Professor Wass' evidence that by the time an individual gets to 64 years old, they are more likely to stay until retirement. Whilst her analysis concerned the previous retirement age of 65 years, we consider that the same is likely to hold true of the new pension retirement age of 67 years old.

89. Rather than attaching a particular percentage chance to each possible retirement age, 64 and 67 years, we accept the approach preferred by the parties of applying the Ogden tables and the multiplier/multiplicand approach. Therefore, we find that the starting point in calculating future loss is a retirement age of 67 years old. We have dealt with the reduction factors below.

90. As set out above, we do not consider that the Claimant's earnings would have reduced significantly over the period to retirement. By the time the Claimant returned to full time NHS practice and in a position to start rebuilding his private practice again from March 2015, he would be almost 52 years old. Due to ill-health the Claimant would have lost lucrative earning years and would be likely to want to ensure maximum earning capacity for the remainder of his career. We considered that the level of his estimated work is not excessive insofar as it amounted to 12 programmed activities on the NHS, a 50% chance of an additional PA, some waiting list initiatives and 16 private operations per annum.

Question 7: What is the Claimant's residual earning capacity?

91. The Claimant has limited options. Professor Hirsch and Dr Bird agree that the unlawful activity has had such a profound impact on the Claimant that he cannot work in a clinical environment again. Contrary to the Respondent's submissions, we do not think it unreasonable that the Claimant let his license to practice lapse in such circumstances. Nevertheless, the inability to work not only as a surgeon but in any clinical capacity is such that the Claimant's experience in his professional career to date is no longer directly applicable in the workplace. Whilst the Claimant's mental health will improve with the resolution of this litigation, it will not improve to such extent that he could undertake work in a surgical or clinical environment in future.

92. The Respondent relied upon a report by Mr Nicoll which identified a number of roles which the Claimant might reasonably be expected to undertake in an attempt to mitigate his losses. Mr Nicoll was not a persuasive witness; his evidence appeared to us more designed to minimise the Respondent's financial exposure than to give a realistic assessment of what the Claimant could or could not reasonably do by way of residual earning capacity. For example, Mr Nicoll's report suggested that the Claimant could find employment as a lecturer. In order to be a lecturer in a medical subject, the Claimant would require a licence to practice which he no longer holds. Even if this were not obstacle enough, the Claimant would not be a strong candidate for such a position due to the period of time that he has been out of a clinical or medical environment. The Claimant has in fact applied sporadically for academic roles and has not been successful. Two possible opportunities identified by Mr Nicoll demonstrate his unrealistic approach. The Kings College course is designed for those currently

undertaking clinical practice and we accept the Claimant's evidence that he would not be suitable for the course, far less that he would be an attractive candidate even if he applied. The one advertisement relied upon by the Respondent, to teach medical students at the University of Leicester, clearly required such a licence. Mr Nicholl's only response was that the Claimant should have applied and tried to persuade them otherwise.

93. Mr Nicoll also identifies possible work as a benefits assessor for Maximus. Notwithstanding that the Claimant does not have a licence to practice, we also consider this totally unsuitable work for the Claimant given the effect of the unlawful acts of the Respondent upon his mental health. The psychiatric evidence is that the Claimant is not able to work in a clinical environment within a medical hierarchy because he has a real fear of conflict between his duties as a clinician and management pressure given his experience at the Respondent. This sort of conflict is very likely to occur in the pressurised environment of assessing applicants for disability related benefits. Mr Nicoll's evidence about the suitability of such a job was particularly poor and showed a complete failure to understand the effect of the Claimant's condition. Indicative of Mr Nicoll's lack of understanding of the pressures of benefits assessments work for doctors, we noted his inappropriate reference to people being assessed as "units". We preferred without hesitation the Claimant's evidence that such work was not possible as it would exacerbate his fear of conflict.

94. As for what is left available to the Claimant, realistically his opportunities lie in writing, charitable work, volunteering and pharmaceutical research studies. There are jobs available in each of these areas but they do not pay well. The period for which the Claimant has been out of a clinical environment counts against him in the search for medical or pharmaceutical research work, both of which we accept are competitive markets. The Claimant is highly qualified but possibly overly so for lesser roles and we accept Mr Hogarth's submission that his age is against him when seeking to start his career essentially afresh. Whilst a law degree may not have been an obvious choice for retraining, it does provide medicolegal and medical ethics possibilities for future work and we are not satisfied that it was unreasonable for the Claimant to embark upon such a course of study to improve his confidence and with a view to improving his prospects in lecturing. We reject the Respondent's submissions that the Claimant failed to mitigate his loss in choosing this course or in engaging an outplacement consultant.

95. Once the litigation is concluded, the Claimant's psychiatric health will improve and we accept Ms Dale's evidence that he will gradually build up to full time work. The Claimant concedes residual earning capacity in the sum of £30,000 per annum. The Respondent has not persuaded us on the evidence which it has adduced that a failure to obtain higher paid work would be an unreasonable failure to mitigate loss.

Question 9: What reduction should be made to the loss of earnings claim to take account of possibility of sickness and unemployment prior to retirement

96. We confess that we have not found the application of the Ogden tables and the nature of the adjustments for the various reduction factors easy, despite the many attempts by Professor Wass to explain them. At times, it seemed to us that even Professor Wass appeared fazed by the adjustments required to the Tables to reflect

the change in state retirement age to 67 years old.

97. Doing the best we can, we accept Ms Ellenbogen’s submission that the Claimant is to be treated as a 53 year old man with a high level of qualification. The Claimant should be treated as non-disabled by reason of his respiratory condition given that we have found that he would have returned to work from January 2014. On the evidence available to us, we consider that both at that date and the date of this hearing, he was not disabled due to his respiratory condition by reason of the significant and sustained improvement which he has enjoyed.

98. We considered that the appropriate approach was to look at Table 9 (age 65, male) which gives a multiplier of 11.59 and Table 11 (age 70, male) which gives a multiplier of 16.06; applying a 0% rate of return. Professor Wass accepted that if we found a 50% chance of retirement at 63 and a 50% chance of retirement at 67, the appropriate approach would be to take the midpoint between the two and apply the tables for retirement at age 65. We have adopted the same approach to the Ogden Tables, taking a figure between the two proposed multipliers but not taking the mid-point as we have found that the likely retirement age was 67 (lower than the mid-point of 67.5) and to reflect the small chance that the Claimant would have retired at age 64. In other words, we conclude that the multiplier should be higher than in Table 9 but significantly lower than in Table 11.

99. Since reaching the above conclusion on our approach to determining the multiplier, the Claimant turned 54 years old on 25 April 2017. Although the Tables refer to age at the date of trial, we agree with Ms Ellenbogen’s supplementary submission that the Claimant’s age should be adjusted in the application of the Tables. Reflecting this, we considered the revised figures of 10.63 (Table 9) and 15.12 (Table 11). Applying our preferred approach, and bearing in mind that we have taken the Ogden Tables as our starting point but are not required to apply them slavishly, we have settled upon a multiplier of **12** as appropriate in this case.

100. Determining the multiplier as above is not sufficient as we must also consider what discount to apply to take into account contingencies that employment may have terminated sooner. The prospect of early death is already taken into account in the tables and the contingency of early retirement is dealt with in the tables, subject to the above approach which Professor Wass suggested at one point in her evidence, and which we accepted. We must also consider any additional factors to be taken into account in the circumstances of this case, the so-called vicissitudes of life.

101. There was a chance that the Claimant may have left the Respondent in any event because he was not going to be able to pursue his academic and research goals at the Respondent. This risk was material as can be seen from his unsuccessful application to Cork. The Claimant made no other applications to other hospitals prior to commencement of the disciplinary investigation. Thereafter, the effect of the Respondent’s unlawful acts deprived him of the ability to pursue his intended career elsewhere. There was no realistic prospect of the Claimant otherwise losing his job, for example by reason of redundancy. As for the prospect of ill-health, we do not consider any further reduction appropriate in respect of relapse on the respiratory condition. On the medical evidence available to us, we consider the risk of relapse to be no more than the normal chances of a person falling ill and accept that the provisions of a

consultant contract would have afforded the Claimant six months full pay and six months half pay, in other words a year to improve his health and consider medical termination if necessary.

102. The starting point for reduction factors in the Ogden Tables is a factor of 0.8 (a 20% reduction), a figure adopted by Professor Wass in her report. Mr Hogarth, by contrast, submits that only a 5% reduction would be appropriate. Taking into account the matters set out above, we consider that the appropriate reduction is 10% as this adequately accounts for the chance of the Claimant seeking employment elsewhere for unrelated reasons and the security of employment for a consultant, both against redundancy and ill-health termination due to relapse on the respiratory condition. This reduction applies to the "old job" figures.

103. As for the reduction factor upon the Claimant's residual earnings capacity, the principal risk factor is his psychiatric injury. Despite the anticipated improvement in his mental health once the litigation has concluded, we accept the medical evidence of Professor Hirsch that there is a 60% risk of subsequent mental health relapse, mainly in the first five years and diminishing to 5-6% in any one year thereafter. This 60% risk will be reduced by continued treatment after recovery. Furthermore, we conclude that even if there were a relapse, it would be unlikely to be of such a degree of severity as to require the Claimant to stop work to such an extent that his earning capacity would be reduced further. We reach this conclusion largely because the nature of the work which the Claimant will be able to do, such as writing, volunteering or charitable work with possibly some lecturing, will enable him to avoid hierarchical management structures and permit a large degree of independent and flexible working which, combined with treatment, will be less critically affected by mental health relapse.

104. Given the delay caused to the Claimant's career to date and the need to provide financial support to his family, we consider that the risk of early retirement for other reasons is so small as to be discounted.

105. The starting point in the tables for a disabled person is 0.63, however having regard to the nature of work that the Claimant is likely to undertake and the anticipated improvement in his mental health, we consider that the figure should be adjusted to 0.8, in other words a 20% reduction on future earnings capacity (the "new job" figures).

Question 10: What discount rate should the Tribunal use?

106. We take as our starting point the Damages (Personal Injury) Order 2001 which fixes a discount on personal injury damages at the rate of 2.5%. Although it has been suggested that it may be good practice to adopt it, the Order is not directly applicable in the Employment Tribunal where we retain a discretion to apply a different rate as we think appropriate. The Respondent contends that 2.5% is the appropriate rate here as compensation for discrimination is awarded on the same basis as the County Court, where the rate would be applicable. Mr Rosson, on behalf of the Respondent, gave evidence suggesting that investment in a mixed portfolio of gilts, bonds and equities would generate a healthy return of 3.91% after inflation and charges. As such, it is said that the Claimant would receive an unjust windfall if we declined to discount his future losses by the rate of 2.5% as the award would fail to take into account the additional financial benefit generated by a substantial lump sum payment representing

many years of future loss.

107. By contrast, the Claimant submits that the 2.5% is no longer appropriate. It was set some years ago by reference to the investment return on government gilts which now, due to the economic downturn, perform far less well and may, indeed, lead to a reduction in value of the investment over time after deduction of management charges. Mr Hogarth drew our attention to the decision of an Employment Tribunal in **Michalak v Mid Yorkshire Hospitals NHS Trust** Case No. 1810815/2008 where Employment Judge Burton set out the correct approach to deciding the discount rate at paragraphs 101 to 109. **Michalak** was not overturned on appeal and, whilst not binding, is relied upon as strongly persuasive. We heard evidence from Dr Pollock about the review of the discount rate current at the time of the hearing and the likelihood that a lower rate would henceforth be prescribed in personal injury cases. His evidence was that a positive return on investment was not realistic unless the portfolio was substantially risk bearing.

108. We preferred the evidence of Dr Pollock to Mr Rosson, the latter's evidence being rather overly optimistic given the sustained period of economic downturn which persists. In order to provide the Claimant with an effective and proportionate remedy, and mindful that the choice of the gilt rate in setting the Lord Chancellor's rate was to avoid penalising a risk averse claimant, we consider it appropriate that there should be a 0% discount rate. This takes into account that the Claimant may prudently invest his award, without undue risk, and yet generate a return which covers only inflation and management charges.

109. In the time taken from hearing submissions to promulgation of this Judgment, the Lord Chancellor has indeed prescribed a new rate of -0.75% as the discount rate in personal injury claims to reflect changing economic conditions. In other words, that instead of reducing awards they should be increased by 0.75% in the County Court. We invited further submissions from the parties in light of this change and met again in Chambers to discuss whether and to what extent it affected the provisional view which we had already reached on a 0% discount. We concluded that it did not. The Lord Chancellor's rate is not binding on this Tribunal. The award which we are making covers lost earnings until 2029, a very considerable way into the future. Whilst the investment market has been depressed, there have been some more recent improvements but not so large as to generate a return after inflation and management charges. For these reasons, we maintain that a 0% discount rate is appropriate.

Non-financial Loss

110. Dealing first with injury to feelings, we consider that this case is a top band **Vento** case, falling towards the middle of the band having regard to the length, severity and effect of the Respondent's conduct as set out in our findings of fact at the outset of this Judgment. We took into account that the Claimant had complained about a number of other matters where he was not successful. These will undoubtedly have caused some injury to his feelings but overall we consider that it was not great. The principal source of the Claimant's distress was and still is the refusal of permission to travel to Sri Lanka and the conduct of the disciplinary process culminating in dismissal, issues where he did succeed. Taking all of this into account, we consider it appropriate to award the Claimant the sum of £32,000 for injury to feelings. We decline to make any

separate award for loss of congenial employment as that is part of the injury to feelings suffered by the Claimant and which we have already taken into account. To award separately for the Claimant's upset at his lost career would be double recovery.

111. As for personal injury, we are satisfied that a separate award is appropriate as there is no dispute that the Claimant suffered a discrete psychiatric injury in addition to the injury to feelings. The psychiatric injury was severe, it is now moderate and is expected to resolve in 18 months. There was no psychiatric ill health prior to the Respondent's unlawful actions nor is it suggested that there were any other causes for the injury for which discount should be made. The Judicial College guidelines gives a range of between £15,950 and £45,840. Given the prospects of recovery, the extent to which many factors have already been addressed in injury to feelings and the risk of overlap, we are satisfied that the personal injury award should be £18,000.

112. As for aggravated damages, a separate award may be made where the conduct of the Respondent merits it because of the manner in which the tort was committed, the motive for it and the conduct subsequent to the tort, but in relation to it. Aggravated damages are compensatory in nature, not punitive, and will to some extent overlap to such an extent with injury to feelings that a separate award may not be appropriate. In the circumstances of this case, we had particular regard to the very serious allegations of fraud made against the Claimant during the course of these proceedings. This was conduct which was in relation to the tort insofar as it related to the Sri Lanka travel and was an attack upon the credibility of the Claimant in these proceedings. As such, the additional upset caused to the Claimant has not been reflected in the existing injury to feelings award nor fully in the personal injury award. We assess the value of this award at a £5,000.

113. The other matters relied upon by Mr Hogarth are, in our view, already adequately compensated for in the injury to feelings and personal injury awards. Furthermore, we are not satisfied that the changes to the Birdi report and the EAT appeal and the failure to pay the Claimant to date are all matters which fall properly within the limited categories of aggravating features in any event. The Respondent was entitled to pursue an appeal to the EAT which was successful and there is no obligation to pay remedy until the same has been determined.

114. We make no separate award for stigma damages as this has already been taken account of in the loss of earnings and the assessment of the residual earning capacity and likely future prospects of employment and also to some extent the injury to feelings and the Claimant's isolation from his former professional and social circles.

Remedy specific to unfair dismissal

15. In addition to compensation for his financial and non-financial losses, the Claimant is entitled to a basic award. The basic award is calculated according to section 119 of the Employment Rights Act 1996 by determining the period of continuous service, applying the appropriate age-related factor and multiplying by a week's gross pay (up to the statutory maximum in force). Section 218(8) treats all service in the NHS as continuous, notwithstanding that the employee worked in different health authorities. In the supplementary submissions made in response to our draft Judgment sent to the parties on 5 June 2017, the Respondent contended that the

basic award should be limited to the sum of £1,935 as agreed between the parties in the closing submissions at the remedy hearing. Whilst it is surprising that the provision was overlooked by Mr Hogarth in his initial submissions, we conclude that we must apply the statute and are not limited by the agreement in the closing submissions. As a result, we are satisfied that the Claimant is entitled to a basic award of £8,800 (18 years' NHS service, aged 49 at termination, at the then maximum rate of pay of £400 per week).

115. With regard to ACAS, we are satisfied that the Code applies to this dismissal which was for conduct reasons (albeit not well founded in our view). We refer back to paragraph 167 of our Liability Judgment which sets out the procedural failings found, most seriously the failure by Dr Karunaratne to admit relevant additional medical evidence, his canvassing of the opinions of others and finding the Claimant to have committed a fraud when this was not the allegation put to him. We are satisfied that these are unreasonable breaches given the high level of HR support and active involvement from the early stages of the process. We are not satisfied that the delay in concluding the disciplinary process was an unreasonable failure to follow the Code. In our experience, it was not of an order of magnitude unusual in the NHS or other large public bodies.

116. The possible range of uplift is up to 25% but we need to consider not only the effect of the failures but also, in line with cases decided under the previous statutory dispute disciplinary procedures, we need to consider the overall value of the award to the Claimant. To award for example a 25% uplift would be to give the Claimant a considerable windfall bearing in mind the sums involved in this case. Taking all of that into account, including the substantial effect to which the Respondent did comply with the ACAS Code, we are satisfied that a 7.5% uplift is appropriate. The ACAS uplift will apply to the basic award and to the compensatory award calculated under section 123 Employment Rights Act 1996 (which shall not exceed £72,300 for a dismissal in November 2012).

Next Steps

117. With the agreement of the parties, a Judgment was issued in draft form on 5 June 2017 and the parties asked to notify the Tribunal within 28 days of any material errors or omissions. Both parties responded and the Tribunal met again in Chambers to consider those points. The draft Judgment made clear that after corrections the Judgment would be promulgated as a series of declarations without figures attached. It is common ground that expert accounting or actuarial evidence will be required to calculate the precise amounts due and the grossing up required. In their additional representations sent on 3 July 2017, the Respondent asked that this corrected Judgment also be issued in draft form so that the parties could calculate the financial consequences before considering their position on any possible appeal (against this Judgment or the subsequent Judgment with the figures included).

118. The promulgation of the Judgment to date has taken far longer than initially anticipated due to pressure upon judicial resources and the complexity of the issues which has required a great deal of thought and deliberation. Two further Chambers days have been listed for deliberation which has increased the time taken significantly due to difficulties in finding dates convenient for all members of the Tribunal. Expert

evidence to calculate figures will inevitably take some time and, with a further Chamber's day required to consider any points arising, means that the final Judgment with figures would not be promulgated until 2018. The full merits hearing of this case was in October 2013, already some four years ago. If there is to be an appeal (and indeed cross-appeal) against the conclusions of principle set out in this Judgment, we consider that it is in accordance with the overriding objective that it be lodged now rather than later. Whilst there is merit in the Respondent's suggestion, we do not agree that a further draft Judgment is an appropriate course of action due to the additional delay which it would cause.

119. The Tribunal are grateful for the careful and detailed analysis of the evidence by Mr Hogarth and Ms Ellenbogen. Where we have not explicitly addressed a point of evidence explored in cross-examination or submission made, it should not be thought that we have ignored or forgotten it. Rather, to have addressed each and every point made would have added considerably to this already lengthy and delayed Judgment. As such, we have contented ourselves with resolving only those disputes which we considered necessary properly to resolve the issues placed before us.

120. Finally, we record that the Claimant was ordered to pay to the Respondent fees of £1,600 in the EAT appeal, which sum is to be set off against the award due to the Claimant arising from this Judgment.

Employment Judge Russell

10 October 2017