EMPLOYMENT TRIBUNALS

Claimant: Dr S R Krishna Thalagavara

Respondents: 1.The General Medical Council
2.Professor Terence Stephenson
3.Mr Niall Dixon
4.Mr Vincent Donnelly
5.Mr Kieren Done
6.Miss Joanna Farrell
7.Miss Christine Couchman
8.Mr John Barnard
9.Miss Hannah Eldridge
10.Dr Nicholas Sievewright

Heard at: Manchester **On:** 16-19 and 23-25 April 2018

Before: Employment Judge Howard
Mrs C Linney
Mr BJ McCaughey

REPRESENTATION:

Claimant: In person
Respondent: Mr I Hare, Q.C.

JUDGMENT

The judgment of the Tribunal is that:

The claimant's claim of victimisation pursuant to Section 27, 109 and 110 of the Equality Act 2010 is not well founded and is dismissed against all the respondents.

REASONS

1. We heard Dr Krishna's claim over 7 days in the Manchester Employment Tribunal on the above dates. Dr Krishna gave evidence and on behalf of the GMC and the other named respondents we heard from the following (the job titles described are those that the witnesses held at the time of these events):

Vincent Donnelly, Investigations Manager & Assistant Registrar
Kieren Done, Investigating Officer
Hannah Eldridge, Legal Advisor
Dr Nicholas Sievewright, Consultant Psychiatrist
Joanna Farrell, Head of Investigations
Carl Thomas, Investigating Officer.

2. At the outset of the hearing Dr Krishna stated that he was happy to be referred to as Dr Krishna rather than Dr Thalagavara. Dr Krishna has an ongoing mental health condition of depression and anxiety; adjustments to the hearing to accommodate his condition were explored with him as described below.

3. During the hearing we were referred to documents contained within a hearing bundle compiled by the respondents' solicitor and a bundle of additional documents compiled by Dr Krishna. In this judgment, we refer to the first respondent as the GMC and all other respondents by name.

The Issues

4. Dr Krishna's claim has a lengthy procedural history. Since he issued proceedings on the 21st of June 2016 there have been 5 preliminary hearings, some of which Dr Krishna did not attend. Dr Krishna is a consultant psychiatrist who had worked in the UK for some time before the events at issued occurred. Since then he has been mainly living in India but is in email contact with the respondents' solicitors and the tribunal. Dr Krishna's claim originally included discrimination on grounds of race and disability, victimisation, harassment, and failure to make reasonable adjustments; subsequently he withdrew various elements and at a preliminary hearing on 26th May 2017, several allegations of detriment were dismissed as having no reasonable prospect of success; with the effect that the issues in the case have narrowed significantly and it is now a claim of victimisation only.

5. On review of the correspondence and preliminary hearings, a pattern of failing to engage with directions and cooperate with the respondents' solicitors in the process of disclosure and preparation of the hearing bundle by Dr Krishna was apparent. Rather than focus on agreeing an index for the bundle and despite directions to do that, Dr Krishna sent thousands of pages of documents by email attachments to the respondents' solicitor.

6. On the 8th of November 2017 a preliminary hearing was held by Employment Judge Franey in which Dr Krishna took part by telephone and the list of issues to be

decided by the Tribunal was identified at Annex B. The issues laid out five protected acts upon which Dr Krishna relied, resulting in 24 detriments as follows:

1. Are any, or all, of the following protected acts for the purposes of s. 27 of the EqA?

    (i) on 25 November 2013, Dr Krishna copied to one the GMC's Investigating Officers (among 18 others) a six-page email he had sent to a Professor Hawley of the Cwm Taf Local Health Board (the Health Board) in which Dr Krishna made various complaints about the victimisation he had received from the Health Board
    (ii) on 20 March 2014, Dr Krishna wrote to the Third Respondent ("Mr Dickson") complaining that he felt harassed and victimised by the "threat" of referral to an FPP if he declined to undergo a health assessment made by the Fourth ("Mr Donnelly") and Fifth ("Mr Done") Respondents
    (iii) on 3 November 2014, Dr Krishna complained to the Professional Standards Authority ("PSA") about the GMC's pursuing fitness to practise proceedings against him
    (iv) on 6 November 2014, Dr Krishna complained to the PSA about the GMC's pursuing fitness to practise proceedings against him, and
    (v) on 7 November 2014, Dr Krishna complained to the PSA about the GMC's pursuing fitness to practise proceedings against him.

2. Are the facts such that the Tribunal could conclude that the Respondents subjected Dr Krishna to the following detriments because of the any protected acts in any or all of the following respects?

As regards (i) above:

(a) Mr Done on 3 February 2014 harassed him to consent to a Health Assessment;
(b) Mr Donnelly on 18 February 2014 harassed him to consent to a Health Assessment; and
(c) Mr Done on 18 March 2014 threatened to him with referral to an FPP if he refused to consent to a Health Assessment by 25 March 2014;

As regards (i) and (ii):

(d) Mr Done continued with the investigation after 21 March 2014;
(e) Ms Farrell (on behalf of Mr Dickson) on 22 April 2014 threatened him with referral to an FPP if he refused a Health Assessment;
(f) The GMC, Mr Done and Mr Donnelly refused to obtain his Occupational Health, psychology and psychiatric reports before the Health Assessment with the Tenth Respondent ("Dr Seivewright");
(g) Dr Seivewright lied in his report dated 2 July 2014 about the duration of his depression and the association of physical health and depression;
(h) The GMC harassed him into seeing another health examiner on 4 July 2014;
(i) Mr Donnelly informed him on 15 August 2014 that the investigation may continue despite an application for voluntary erasure;

(j) The GMC refused to investigate his complaints (made in July to September 2014) against Dr Shetty, Dr Self, Dr Hailwood, Dr Griffiths, Dr Jones, Dr Winston, Dr Quirke, Dr Tidley, Professor Richards and Dr Joseph;
(k) The GMC, Mr Dickson and the Seventh Respondent ("Ms Couchman") on 26 September 2014 dismissed his grievances against Mr Donnelly;
(l) The GMC, Mr Dickson and the Ms Couchman on 26 September 2014 refused to investigate his complaint against Dr Jones;
(m) The GMC, Mr Done, Mr Donnelly and Dr Seivewright placed false information before the GMC's Case Examiners;
(n) The GMC and Mr Donnelly sought an interim order of conditions for 12 months;

As regards (i)-(v):

(o) Ms Couchman threatened him with referral to the FPP if he refused a Health Assessment on 17 December 2014;
(p) The Eighth Respondent ("Mr Barnard") declined on 17 September 2015 to review the decision not to investigate Dr Joseph by lying about the content of the letter from the Health Board dated 27 August 2013;
(q) The GMC on 22 June 2015 made two fresh allegations of misconduct against him for refusing the Health Assessment and for breaching patient confidentiality;
(r) The GMC, Mr Donnelly, Mr Done and Dr Seivewright caused the Case Examiners to discriminate against him;
(s) The Case Examiners referred him to the FPP on 23 September 2015;
(t) The GMC resisted postponement of the MPT hearing;
(u) The Second Respondent ("Professor Stephenson") failed to respond to his complaint dated 13 May 2016;
(v) The Ninth Respondent ("Ms Eldridge") failed to disclose all the documents to the MPT;
(w) The GMC on 15 June 2015 rejected his request for administrative erasure; and
(x) The GMC on 17 June 2016 threatened him with conditions for up to three years or suspension of his registration for up to 12 months if he refused to comply with the requests for a Health Assessment.

3. If so, can the Respondents nevertheless show that they did not contravene s. 27 of the EqA?

4. Are the claims in time or should time be extended?

5. What is the appropriate remedy, if any?

7. That list is subject to the following revisions;

7.1 Mr Hare conceded that the matters identified as protected acts laid out in Annex B were all protected acts for the purposes of Section 27 of the Equality Act 2010.
7.2 Mr Hare confirmed that a jurisdictional issue on time limits was raised in respect of detriments (j) and (p) only; that the GMC had refused to investigate Dr Krishna's complaints against several doctors and that Mr

Barnard, the 8th respondent, had declined to review the decision not to investigate one of the doctors; Dr Joseph.

8. Dr Krishna served his witness statement on the 6th of February 2018. It was not structured by reference to Annex B as EJ Franey had suggested, but was essentially a chronology of correspondence. Some passages appeared not to be relevant to the issues, some issues appeared not to have been addressed.

9. On the 11th of February 2018, Dr Krishna provided about 10,000 documents in a series of 84 emails. He later reduced that to around 6,000 pages. On the 9th of March 2018, he served a revised witness statement, cross referenced with his bundle.

10. A further preliminary hearing was held by telephone on the 9th of April 2018 by EJ Franey upon the respondents' application, raising concerns about Dr Krishna's continued failure to comply with case management orders. In his Order, EJ Franey recorded that *'the respondents had sent the claimant a draft index to the final hearing bundle on the 22nd of December 2017, in accordance with directions, given for agreement by the 12th of January 2018. Over a few days from the 9th of January 2018 the claimant sent a series of emails attaching a substantial volume of additional documents. The respondent considered that a number did not appear relevant to the issues for determination and no agreement was reached on the index.'*

11. EJ Franey was concerned that Dr Krishna might be having difficulty identifying what was relevant to the issues and what was not and refused his request to rely on any documents which were not in the respondent's bundle, which was 678 pages long. However, EJ Franey noted that the possibility that something relevant had been missed couldn't be excluded and to enable Dr Krishna and the tribunal to identify whether that was so, he ordered the respondent to prepare a version of Annex B, cross referenced with the bundle so that Dr Krishna could see, at a glance which documents were already in the bundle, relevant to each of the issues. EJ Franey told Dr Krishna to consider if there was any missing document of importance to the issues and explained that it was in Dr Krishna's own interests to tell the respondent if there were any missing documents as soon as possible, as *'if the respondents agree that they can go into the evidence, the tribunal need not spend time dealing with this at the final hearing. If there's no agreement the tribunal will determine at the final hearing whether additional documents can be relied upon.'*

12. Dr Krishna ignored this advice and did not contact the respondent. Instead, on the morning of this hearing he provided 6 copies of his own bundle of documents, extending to some 500 pages, without an index; Dr Krishna explained he'd forgotten to print an index out.

13. Dr Krishna made an application to admit his documents, supported by a written application which referred to the documents by item, not page number. The application was resisted by Mr Hare on the grounds of relevance and proportionality. On pragmatic grounds, he did not object to a small number of the documents being admitted, although he questioned their relevance and these documents were put into a bundle described as 'the claimant's additional documents'.

14. We considered Dr Krishna's application and refused to admit any further documents except those few referred to above. We decided that the vast bulk of the documents were not relevant to the issues in the case. Most were only relevant to Dr Krishna's dispute with his former employer; the Health Board. The documents that were admitted, by consent, were; a report of an interview with the Assistant Director of the GMC; Anna Rowland; a report from Professor Louie Appleby on the impact of GMC investigations upon doctors, reports and interviews raising concern at the disproportionate number of referrals of doctors from BME communities to the GMC and at the experience of doctors who 'whistle-blow'; GMC's 'Guidance for decision makers on directing a health assessment' and a letter from Dr Krishna to the Health Board dated 29th October 2014.

15. Further, applying the overriding objective we considered that it would be disproportionate to allow Dr Krishna to introduce this significant amount of additional documentation, given the inevitable impact upon the listed hearing and its length and his history of not engaging properly with the process of preparing an agreed bundle of documents for the hearing, despite many opportunities to do so.

16. Dr Krishna's bundle also contained documents which he considered relevant to remedy. We decided that we would only hear evidence on matters relevant to liability; make our decision on whether Dr Krishna's claim succeeded and, if so, then decide what documents were relevant to remedy.

17. It had been recorded in an earlier preliminary hearing held by EJ Feeney that Dr Krishna might need additional time to formulate his questions and identify relevant documents during the hearing because of the effects of his mental health condition of depression and anxiety. Dr Krishna confirmed that this was still the position; he was managing his anxiety/depression with the aid of medication. With that in mind and considering that, whilst Dr Krishna is an educated and intelligent man of professional standing, he is a litigant in person, without the assistance of legal advice, pursuing a claim of some complexity with a substantial number of allegations, we accommodated all those matters with a sensible and realistic timetable which Dr Krishna agreed at the outside of the hearing as follows:

Day 1 am - preliminary matters, pm - reading
Day 2 - claimant's evidence
Day 3 - Mr Donnelly
Day 4 am - Mr Done, pm - Miss Eldridge
Day 5, am - Dr Sievewright, pm - Miss Farrell
Day 6, am - Mr Thomas/ submissions, pm - deliberations
Day 7 - deliberations, judgement, directions on remedy, as appropriate.

18. Dr Krishna' witness statement did not address causation at all. Mindful of the factors described above, we exercised a good deal of latitude in allowing Dr Krishna to give explanations and evidence relevant to causation, detriments and more generally, during his evidence and in cross examination. Likewise, Dr Krishna was permitted to question the respondents and witnesses on a range of matters that often strayed beyond the list of issues and had little, if any, relevance. Mindful of the Tribunal's obligations to ensure a fair hearing, that the parties are on an equal footing and that the proceedings are conducted in a proportionate and timely manner, I intervened regularly, encouraging Dr Krishna to focus on the relevant

issues and where necessary rephrasing questions so that the witness understood what was being put to him or her. Save for a moment of frustration early on in his cross examination of Mr Donnelly, Dr Krishna cooperated with the timetable agreed and all the parties and witnesses conducted themselves in a courteous manner.

The findings of fact relevant to the issues

19. Dr Krishna is a doctor formerly registered with the GMC. The GMC is the regulator of the profession of doctor in the United Kingdom under the Medical Act 1983. The other Respondents are current or former employees, office holders or independent contractors of the GMC who have been involved in some way with Dr Krishna's fitness to practise proceedings or have been sent correspondence by him.

20. There is little dispute between Dr Krishna and all the respondents on the essential facts of this case in that all agree that the events described in evidence took place. Almost all of the contact between Dr Krishna and the respondents was through email and letters. The dispute centres on how those events are characterised. Dr Krishna views the respondents' actions as a sequence of detrimental acts arising from his disclosures whereas the respondents portray them as a simple application of the GMC's statutory duty in investigating Dr Krishna's fitness to practise, unconnected to his disclosures.

The GMC's statutory functions

21. In closing submission, Mr Hare provided the following overview of the GMC's duties and powers relevant to this case, which we adopt:

The main or over-arching objective of the GMC is the protection of the public (s. 1(1A) [610] Medical Act):

1(1A) The over-arching objective of the General Council in exercising their functions is the protection of the public.
(1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—
(a) to protect, promote and maintain the health, safety and well-being of the public,
(b) to promote and maintain public confidence in the medical profession, and
(c) to promote and maintain proper professional standards and conduct for members of that profession.

Under the General Medical Council (Fitness to Practise) Rules 2004 ("the 2004 Rules"), allegations against registered doctors are first considered by the Registrar who is required to refer them to the Case Examiners if they fall within the statutory definition of an allegation that a doctor's fitness to practise is impaired.

Rule 4 of the 2004 Rules [571-572] provides:

An allegation shall initially be considered by the Registrar.
(2) Subject to paragraphs (3) to (5) and rule 5, where the Registrar considers that the allegation falls within section 35C(2) of the Act, he shall refer the matter to a medical and a lay Case Examiner for consideration under rule 8.

Rule 2 provides:

"allegation" means an allegation that the fitness to practise of a practitioner is impaired and includes an allegation treated as arising by virtue of section 35CC(3) of the Act and an allegation relating to a person whose registration is suspended;

Section 35C of the MA provides:

35C.— Functions of the Investigation Committee
(1) This section applies where an allegation is made to the General Council against—
(a) a fully registered person; or
(b) a person who is provisionally registered,
that his fitness to practise is impaired.
(2) A person's fitness to practise shall be regarded as "impaired" for the purposes of this Act by reason only of—
(a) misconduct;
. . .
(d) adverse physical or mental health;

The Registrar is empowered to carry out investigations, including directing a Health Assessment where appropriate. Rule 7 provides:

(2) The Registrar shall carry out any investigations, whether or not any have been carried out under rule 4(4), as in his opinion are appropriate to the consideration of the allegation under rule 8.
(3) The Registrar may direct that an assessment of the practitioner's performance or health be carried out in accordance with Schedule 1 or 2.

The Registrar also has the power to refer an allegation to an Interim Orders Tribunal (formerly an Interim Orders Panel) under Rule 6:

If, at any stage, the Registrar is of the opinion that an Interim Orders Tribunal should consider making an interim order in relation to a practitioner, he shall refer the allegation to the MPTS for them to arrange for it to be considered by such a Tribunal accordingly.

Once referred by the Registrar, allegations must be considered by the Case Examiners who have the following powers under Rule 8:

(1) An allegation referred by the Registrar under rule 4(2), 5(2), 12(6)(b) or 28(2)(b) shall be considered by the Case Examiners.
(2) Upon consideration of an allegation, the Case Examiners may unanimously decide–
(a) that the allegation should not proceed further;
(b) to issue a warning to the practitioner in accordance with rule 11(2);
(c) to refer the allegation to the Committee under rule 11(3) for determination under rule 11(6); or
(d) to refer the allegation to the MPTS for them to arrange for determination by a Medical Practitioners Tribunal [formerly known as the fitness to practice panel].

The events

22. Dr Krishna was suspended by the Health Board on the 4th of October 2013. The GMC was informed by letter of 4th of October 2013 that; *'Dr Krishna has been medically suspended since the 23rd of August 2013 pending the outcome of a preliminary investigation into a number of concerns regarding his behaviour and performance. He is also receiving support and treatment through our Occupational Health department'.* Enclosed with that letter was copies of the correspondence sent to Dr Krishna by the Health Board suspending him from duty and inviting him to an investigation to explore a number of allegations that were laid out in the letter as follows*: 'allegations from staff and patients that you display a rigidity in your approach and will not listen to other opinions, specifically;*

- *you appear not able to work effectively in a multidisciplinary team e.g. you display an inappropriate rigidity to your practise and an adherence to the dogma of the medical model which has led to team tensions e.g. staff had reported feeling disrespected by you*
- *you have displayed an inappropriately emotional response in several meetings e.g. a SPE meeting, team meeting, meetings with your CD, culminating in your leaving the meetings at an inappropriate time*
- *you displayed inappropriate behaviour towards patients during a ward round on ward 22 on the 10th of July 2013; which led to two patient advocates making a formal complaint about your consultation with these patients and the patients asking not to be treated by you again*
- *you appear unable to manage to run a clinic at a pace expected of a middle grade doctor despite the issue being discussed several times with you e.g. the excessive length of time of your consultations and unnecessarily lengthy letters*
- *you failed to exercise appropriate clinical judgement when you refused to respond to a potentially critical clinal episode involving a patient with chest pains*
- *you have failed to engage appropriately with your CD regarding your sickness absence and to comply with reasonable management requests'*

The Health Board's letter and enclosures were referred to the GMC's triage team who determined that it amounted to an allegation that could call into question Dr Krishna's fitness to practise in accordance with Section 35(c)(2) of the Medical Act and/or rule 4(2) of the Fitness to Practise rules.

23. We were referred to the GMC's 'Guidance on the Meaning of Fitness to Practise' and the Guidance for Decision Makers on Assessing Risk in Cases Involving Health Concerns'. It was clear that the information provided by the Health Board contained information that properly gave rise to a question of fitness to practise in accordance with those rules.

24. A decision having been made that further investigation was required, the issue was referred to Mr Jordan, Investigation Officer, a member of the GMC's investigation team which sits within the Fitness to Practise Directorate. Dr Krishna was informed by letter of the 28th of October 2013 and replied that he was '*unable to respond at this stage due to a number of factors'*.

25. On the 31st of October 2013 the Head of HR at the Health Board contacted Mr Jordan and told him that the Board had serious concerns about Dr Krishna's mental

health; that Dr Krishna had threatened suicide on several occasions and that they were considering whether Dr Krishna should be sectioned under the Mental Health Act.

26. Mr Jordan referred the matter to a Medical Case Examiner for advice on whether a health assessment of Dr Krishna would be appropriate. A Medical Case Examiner is a senior member of GMC staff who has authority to make decisions on a case such as whether a doctor under investigation should be invited to undergo a health assessment. The Medical Case Examiner's advice was that, before inviting Dr Krishna to undergo a health assessment, it would be appropriate to establish if he had access to continuing support at a local level; *It would be sensible to obtain up to date information about his state of health and the risk of suicide from Occupational Health. Please obtain confirmation from doctors' treating team/advisors that he is well enough to attend the health assessment as an invitation could exacerbate his health problems.'*

27. Mr Jordan sought advice from his Investigations Manager, Mr Donnelly, as to what steps should be taken. Mr Donnelly also exercised the functions of an Assistant Registrar in addition to his role as Investigation Manager. Mr Donnelly asked Mr Jordan to get an update from the Health Board. Mr Jordan contacted Dr Quirke, deputy medical director of the Health Board who told him that Dr Krishna had been admitted under the Mental Health Act and that his wife and son were under the care of social services. Dr Quirke forwarded a letter from Dr Krishna in which he had written; *'I'm talking about an escape option not just for me but for the whole of my family involving my wife and my 5-year-old son. They might not agree with the option as I'm talking about suicide pact.'* In evidence Dr Krishna was keen to point out that, in fact, he had been a voluntary in-patient, but agreed that he had been admitted to a psychiatric ward.

28. Mr Donnelly explained that he had been extremely concerned that Dr Krishna may represent a credible suicide risk and instructed Mr Jordan to bear in mind the sensitive nature of the case and the effect any correspondence may have on his mental health. He asked to see all correspondence before it was sent and instructed Mr Jordan to make further enquiries.

29. On the 18th of November 2013, Mr Jordan was informed by the Health Board that Dr Krishna would soon be discharged. Mr Donnelly reviewed the case and instructed Mr Jordan to contact Dr Krishna's treating psychiatrist, Dr Huw Davis, stating; *'we need to know if Dr Krishna is still in the Princess of Wales hospital or if he has been discharged. If Dr Krishna is still an in-patient is there any indication of when he's likely to be discharged?*
If he's been discharged we need to establish whether he's still under the care of Dr Davis. Dr Davis understandably may be reluctant to disclose information to us, you need to stress that our primary concern is not to aggravate what is already a fragile situation. Our main concern is that we do not do anything which is likely to have a detrimental impact on Dr Krishna's health. But we also need to ensure that he does not pose any risk to the public if he were to continue to practise unrestricted.
Advise Dr Davis that in situations like this we would like his opinion of when Dr Krishna is well enough to engage with us in the investigation process. If Dr Krishna has been discharged we need to raise an IOP [Interim Orders Panel – now Tribunal] *decision with the CEs* [case examiners] *immediately'.*

30. An Interim Orders Panel – now known as Tribunal – consists of members appointed through open competition by the Medical Practioners' Tribunal Service. A doctor can be referred to an IOT if the GMC receives concerns about them which may suggest that action is needed to protect the public, the wider public interest or the doctor's own interests until the matter is resolved. Referrals can only be made by the registrar or assistant registrar or by a case examiner.

31. On the 25th of November 2013, Dr Krishna copied the GMC into a six-page email he'd sent to Professor Hawley of the Health Board in which he complained about the victimisation and harassment he'd received from the Health Board (protected act (i)). Dr Krishna copied his email into a range of professionals and bodies concerned with his son's care, the Health Board, his mental health physicians and his wife and young son.

32. Mr Jordan contacted the Consultant Psychiatrist who had treated Dr Krishna in hospital, Dr Paul Emmerson, asking whether inviting Dr Krishna to a health assessment would have an adverse impact on his health. Dr Emmerson replied by email on the 29th of November 2013, stating;
'Dr Krishna is currently a patient under my care and has been an in-patient in Ward 14 of Princess of Wales hospital in Bridgend. He's currently suffering from moderate depression and anxiety. This has been caused by stress largely related to his employment including an ongoing internal investigation there.
In my opinion it would be detrimental to his health and wellbeing to invite him to an IOP while the outcome and any potential repercussions of the other investigation are unknown. I feel this would add extra stress which would be difficult for him to deal with currently and may lead to a deterioration of his mental state.
If you require any further information please do not hesitate to contact me. Dr Krishna is being discharged from the ward within the next couple of days and his care will return to his community consultant Dr Huw Davis.'

33. The GMC was copied into a further letter from Dr Krishna on the 29th of November 2013 explaining that he was leaving for India the following day to stay indefinitely with his family. Mr Donnelly sought advice from Assistant Director Peter Swain as to the next steps, who advised; *'assuming it remains the position that we have no evidence of Dr Krishna working or seeking to work elsewhere in the UK I suggest we seek a cancellation of this IOP referral on the basis of the lack of evidence of risk to patients combined with the risk to Dr Krishna's own interests were we to progress an IOP referral. We might then explore with Dr Emmerson how Dr Krishna might respond to a carefully worded invitation to health assessment. Another option would be to write to Dr Emmerson asking him with Dr Krishna's consent to provide a medical report to us as evidence of Dr Krishna's impairment following which we propose to invite Dr Krishna to accept undertakings. Of course, if Dr Krishna has indeed left the country there may be nothing we can do until he returns.'*

34. At the beginning of December 2013, Mr Done took over as Investigating Officer and on the 15th of January 2014 he contacted Dr Huw Davis who advised that *'an IOP hearing would be catastrophic to Dr Krishna's health',* however Dr Davis was supportive of a health assessment; as Mr Done recorded; *'Dr Davis was very clear that this* [an invitation to a health assessment] *would be good for the doctor. He said that he has a differential diagnosis for Dr Krishna and the extra layers provided by*

the health assessment would be beneficial for the doctor. He said Dr Krishna might actually like the process. Dr Davis reported that Dr Krishna is flying back to the UK for a forensic assessment – an assessment that he initiated and requested himself. Dr Davis was clear that Dr Krishna might enjoy the health assessment process and it certainly wouldn't be detrimental.' As Mr Donnelly explained, although he thought that Dr Krishna was in India, the GMC had no certainty as to where he was and when he might be returning to the UK.

35. On the 2nd of February 2014, Dr Krishna emailed the GMC stating; *'I'd again plead GMC to expedite the investigation and help me return to pain employment, enjoy family life, and moreover recover from anxiety and depression.'* As was the case in all correspondence sent by Dr Krishna over this period, his email was copied to various family members, various health professionals involved with him and his family, various individuals at the Health Board, housing officers and other individuals.

36. By email of the 3rd of February 2014, Mr Done asked Dr Krishna if he was still in the UK or had returned to India stating; *"I ask because we'd like to invite you to a health assessment which will involve you meeting with two psychiatrists. I appreciate that you want the GMC's investigation to be expediated; it was placed on hold whilst you were in India.'* In evidence, Mr Done explained that this email was a preparatory step to ascertain whether Dr Krishna was available for a health assessment if a decision to refer him for one was made. This email is detriment (a).

37. Mr Done sought further advice from the case examiner on whether Dr Krishna should be invited to a health assessment and in the light of Dr Davis's view, the medical health examiner replied on the 10th of February 2014 that; *'I previously provided advice in this case advising caution in asking the doctor to attend the health assessment, however I note the recent telephone note from a call with Dr Davis . . . please invite Dr Krishna to attend the health assessment with the likely diagnosis of F32 depressive episode'.* Mr Donnelly then sent a health assessment invitation letter to Dr Krishna on the 18th of February 2014. (detriment (b)). As Mr Donnelly explained in evidence, the form of the letter was a template produced on the GMC's electronic case management system 'Seibel'. The GMC operates a paperless case management system so all correspondence and communication is captured and retained on Seibel.

38. The letter stated; *"as you are aware the GMC has received information about you from Cwn Taf Local Health Board. I enclose a copy for your reference as listed in Annex A to this letter.*
The information suggests that your fitness to practise may be impaired on health grounds by reason of F32 depressive episode. We invite you to agree to be examined by two medical examiners and to the examiners providing us with reports on your fitness to practise . . . the examiners will be asked to report on your physical and mental health and whether they consider you to be fit to practise either generally or on a limited basis. . . if the reports recommend medical supervision or any limitations on your practise you may be invited to give undertakings on the basis of the reports . . ."

39. Dr Krishna was asked for his consent and to provide details of treating physicians, as; '*the medical examiners may contact Dr Davis, your general practitioner and any other doctors who treated you recently'.* The letter went on to

state that *'the rules require me to tell you that if you decline to be examined or if having agreed you subsequently fail to attend the medical examinations or if you do not reply to me within 14 days of the date of this letter the question of your fitness to practise may be referred for formal hearing by a fitness to practise panel. The panel have powers to restrict or supervisor your registration'.*

40. A range of documentation including 'guidance and help for doctors', a fact sheet, a doctor support service leaflet, a copy of the General Medical Council fitness to practise rules 2004, consent forms and so on were attached to the letter.

41. By letter of 26th of February 2014, Dr Krishna replied that he agreed to be medically examined according to GMC policies and procedures but he qualified his consent to contacting doctors stating; *'I agree for medical examiners to contact the following doctors who've been involved in either only assessments or both assessments and treatment subject to my consent for release to medical examiners after me checking for accuracies of facts in the reports. Please let me know if GMC is agreeable with my above requests so that I can send the names and addresses for the doctors at the earliest.'*

42. By email of the 28th of February 2014, Mr Done replied *'I acknowledge that you are willing to undergo a health assessment and agree that the GMC can contact your treating doctors. Please could you complete the consent form I sent you.'*

43. In a sequence of correspondence thereafter, copied in by Dr Krishna to a range of different organisations and individuals, Mr Done sought to obtain a completed consent form from Dr Krishna and Dr Krishna repeatedly raised his allegations of harassment, victimisation and discrimination against the Health Board and other organisations, emphasised the extent of his anxiety and depression, and asked the respondent to provide documentation.

44. Mr Done provided Dr Krishna with further copies of all the information received by the GMC and reassured him that *'anything the GMC receive during an investigation is disclosable to you'.*

45. On the 5th of March 2014, Mr Done wrote to Dr Krishna stating; *'I think it would be better for all concerned if the health assessment process begins as soon as possible. The first step is to return the signed consent form. The GMC can then start contacting assessors and arranging appointments. In the meantime, you can send any other information you feel is relevant. However, please note that as the GMC is being copied into much correspondence between yourself and other organisations there is no need to duplicate the information you have already provided.'*

46. On the 12th of March 2014, Mr Done again explained to Dr Krishna; *'I think it would benefit all parties if we begin the health assessment as soon as possible and so I would be grateful if you could complete and return the consent form. You can be sure that the assessors will have knowledge of the case and you can be sure that I will send you copies of the assessors' reports as soon as receive them.'*

47. The extent of Dr Krishna's mental distress at that time was illustrated by several emails sent by him about the health board to a range of organisations and

people, including the GMC, in which he stated; *'the bastards are playing a cruel joke with my life and career leaving me living dead by shamelessly torturing a mentally ill doctor. I don't know how long my ordeal will last please give me strength to see through this torture for the sake of my family friends and patients I hope I can rest in peace'; 'psychopaths must have just finished partying or in deep sleep right now nevertheless I am made to suffer for their sins please give me strength to bear the pain'* and *'to GMC and company to see that pain in me sooner yours victim of Rhonda mafia'; 'oh Lord mental pain is unbearable give me strength to bear the unbearable'.*

48. On the 18th of March 2018, Mr Done wrote to Dr Krishna stating; *'Please could you confirm in writing whether you agree to be examined and return the consent form by the 25th of March 2014 if you don't reply by this date your case may be referred to a fitness to practise panel. If you have any queries or concerns please do not hesitate to contact me.'* (detriment (c)).

49. In response, Dr Krishna emailed a request for clarification of various issues and by letter of the 20th of March 2014 addressed to Niall Dixon, Chief Executive and Registrar of the respondent, complained that; *'I regret to mention that I feel coerced by Mr Vincent Donnelly Assistant Registrar and Mr Kieron Done Investigating Officer to provide below declaration with fear and anxiety of serious repercussions from GMC . . . . the eventuality of possible harassment and victimisation by GMC by threatening referral to fitness to practise panel repeatedly if I were not to comply with Mr Donnelly and Mr Done's request.'* In his letter Dr Krishna again consented to be examined. That letter is protected act (ii).

50. By email of the 21st of March 2014, Mr Done replied to points raised by Dr Krishna; clarifying that the investigation was ongoing, providing a copy of the health assessment bundle, and explaining the purpose of the health assessment as *'the health assessment helps the GMC to consider whether a doctor's fitness to practise is impaired on health grounds . . .'* and *'the purpose of the GMC's investigation is not to resolve any employment disputes, the GMC's sole remit it terms of an investigation is to consider whether a doctor is currently fit to practise and patients are protected'*.

51. Dr Krishna's complaint was considered by Joanna Farrell, Head of Investigation. As Miss Farrell explained in her evidence, at any one time the GMC's Investigations Directorate deals with some 2,000 investigations, carried out by Investigation Officers and overseen by a team of 7 or 8 Investigation Managers who report to her. This was her first involvement in Dr Krishna's case.

52. As Mr Done, Mr Donnelly and Miss Farrell all confirmed, it was common for doctors under investigation to raise concerns or complaints about the process. Given the large volume of investigations, they emphasised that the GMC is rigorous in ensuring that investigative procedures are adhered to, irrespective of whether a doctor raises any concerns or complaints. We found Mr Donnelly, Mr Done and Miss Farrell to be convincing and consistent and their evidence was supported by the wealth of documentary evidence, including the GMC's guidance and procedures, that this was the approach that they all took. In fact, the documentary evidence illustrated the considerable lengths to which Mr Done, the other Investigating Officers and Mr Donnelly went to accommodate Dr Krishna's fragile mental health in all their

dealings with him. What was apparent during Dr Krishna's evidence was that he did not appreciate that he had a responsibility to co-operate in investigations; quite the opposite, as his continuous prevarication demonstrated.

53. By letter of the 22nd of April 2014, Miss Farrell replied; *'I'm sorry you have felt coerced into complying to our request to undergo a health assessment. I know that Mr Donnelly and Mr Done haven't intended to make you feel this way. It's however important that you understand what may happen if you don't agree to a health assessment. As a doctor registered with the GMC you have certain responsibilities to help us with our investigations. Any doctor who does not cooperate with out investigations may be referred to a fitness to practise panel because that is the only route open to us if we cannot investigation concerns appropriately'.*
Dr Krishna relies upon this letter as detriment (e).

54. Appointments were made for Dr Krishna to be examined by two medical examiners; Dr Sievewright on the 30th of June 2014 and Dr Jamil on the 4th of July 2014. In the meanwhile, Dr Krishna continued to copy the GMC and various staff members into emails about other matters such as his housing situation and family circumstances.

55. Dr Krishna alleged as detriment (f), that Mr Done and Mr Donnelly refused to obtain his Occupational Health psychology and psychiatric reports before the health assessment with Dr Sievewright. As Mr Done explained in evidence, the GMC's procedure on health assessment was that the health assessor would be provided with documents which the investigating officer considered relevant and the medical assessor would obtain any further medical or other reports that he or she felt appropriate. This is reflected in the letter of instruction to Dr Sievewright dated 23rd of June 2014 which states; *'further information: Dr Krishna has provided consent for you to approach other doctors involved in his care and a copy of the consent is enclosed with the papers. Having spoken to the doctors concerned it's left to your discretion whether to seek copies of medical records subject to the appropriate consents being available or whether to consult other professional and personal acquaintances of the doctor.'* This was also explained to Dr Krishna in Mr Donnelly's letter of 18th of February 2018.

56. Dr Krishna met with Dr Sievewright on the 30th of June 2014 and Dr Sievewright's report was dated 2nd of July 2014. Dr Sievewright had seen copies of Dr Krishna's letter of the 25th of November 2013 and other emails regarding the investigation. As he reported; *'The ones I have seen are significant in themselves expressing much anger at the Health Board who have dismissed him, the GMC and the social services who took action against him being with his wife and child after he alluded to a possible suicide pact'* and '*it was clear that he was very tense and he became quickly very angry when the subject turned to the Health Board, the GMC, social services, or others who he sees as having ruined his life . . . he swore angrily about the perceived injustices'.*

57. Under *'background history'*, Dr Sievewright recorded personal information that Dr Krishna had told him. At the Tribunal hearing, Dr Krishna accused Dr Sievewright of telling lies and insisted that some of these details were untrue. Dr Sievewright explained, as we accepted, that he was simply recording what Dr Krishna had told him. Likewise, under *'general medical history'*, Dr Sievewright recorded that,

following a diagnosis of Hodgkin's Lymphoma, Dr Krishna had a period of depression. Dr Sievewright's opinion was that; *'Dr Krishna has had some physical health problems as indicated above while psychiatric problems appear to have been more recent. I do not consider that he has a personality disorder and there had been no evidence of substance abuse. On the basis of the limited interviews to which he agreed at the time I very strongly suspect that he has a severe depressive illness and I will use the ICD-10 category F33.2 as he may have had more than one episode. The category is major depressive disorder recurrent severe without psychotic features meaning that I have not classed him as psychotic at the present time. However his concerns about his situation definitely extend to ideas of a paranoid nature and I view his very frequent angry and sometimes abusive emails to various people in the context of his illness. . . Dr Krishna believes that he is too unwell to practise at present and furthermore feels that there should not be active investigations underway whilst he's ill on certified sickness. My own opinion is that he is not fit to practise currently . . . he is definitely in need of continued psychiatric treatment'.*

58. Dr Krishna believes that Dr Sievewrights' report suggested that his mental health had arisen from his physical health conditions. However, as Dr Sievewright explained and was clear from the report, he was not attributing Dr Krishna's current mental health to that cause. Dr Krishna was unable to identify any 'lie' told by Dr Sievewright in that Occupational Health report and it was clear that Dr Sievewright had not lied.

59. Several days later Dr Krishna attended the appointment with the second medical assessor Dr Jamil. Dr Jamil reported that Dr Krishna had told her that he did not consent to a psychiatric assessment and so she had asked him to leave but that subsequently she had been bombarded with emails he was sending to various individuals and with whom he had conflicts, commenting; *'I consider this an inappropriate behaviour I can forward the emails if you wish but it does highlight his hostility and unusual state of mind.'* Dr Krishna relied upon this second appointment as detriment (h); that the GMC harassed him into seeing another health examiner on the 4th of July 2014. However, there was no evidence in the bundle or shown to us by Dr Krishna to support this. His attendance was clearly voluntary and there was no contact with the GMC between the two appointments.

60. As Dr Krishna accepted in evidence and was clear from his conduct and his own correspondence at the time; for example, on the 22nd of September 2014 he stated, *'unfortunately I do not think I'm fit to practise straight away without treatment',* and from the report of Dr Sievewright, Dr Krishna was undoubtedly suffering from a severe mental health condition which gave rise to legitimate concerns about his fitness to practise.

61. During August and September 2014, Dr Krishna complained to the GMC about several former colleagues at the health board whose conduct and integrity he wanted the GMC to investigate. The GMC refused to investigate his complaints as not calling into question those doctors' fitness to practise; explaining that it was not within the GMC's jurisdiction to become involved in disputes between colleagues; '*these types of concerns can be considered under the NHS grievance process or an employment tribunal.'* In respect of Dr Krishna's specific complaint about Professor Richards' professional conduct, he was advised, *'should the outcome of any local*

investigation processes find that Professor Richards had acted inappropriately we may be able to reconsider whether we should open an investigation'. (detriment (j)). During the hearing Dr Krishna reduced the scope of this detriment to his complaints about Dr Jones, Dr Winston, Dr Quirke, Professor Richards and Dr Joseph.

62. Dr Krishna sought a review of the decision not to investigate Dr Joseph which was dealt with by an Assistant Registrar, Mr Barnard and communicated to Dr Krishna on the 17th of September 2015 (detriment (p)). Mr Barnard reviewed the decision and upheld it, finding that there were no grounds for a review, as the original decision *'had not been materially flawed nor was necessary for the protection of the public'*. Dr Krishna's allegation that Mr Barnard had lied about the content of the letter from the Health Board dated 27th of August 2013 was not substantiated in his evidence.

63. Dr Krishna complained again about Mr Donnelly to which Miss Couchman, Head of the Corporate Review team replied by letter of 26th of September 2014, stating; *'in relation to your complaint regarding Vincent Donnelly I can see that Joanna Farrell, Head of Investigation, recently addressed this in her letter to you dated 5th of September 2014. I've looked at our correspondence to you and I agree with Joanna that Vincent has sent you many letters and updates on the progress of your case. I can see no evidence of victimisation or harassment by him or any other members of our staff. If you're able to provide specific evidence to support your concerns I'll be happy to look at it for you, however based on the information I've seen no further action will be taken regarding this.*'(detriment (k)).

64. In July 2014, the Health Board raised a further matter for investigation, that Dr Krishna had inappropriately disclosed the unredacted medical records of a patient to the Health Inspectorate of Wales, The Public Services Ombudsman for Wales and the Police.

65. Mr Donnelly made a further referral for a case examiner's opinion, explaining that *'In his most recent communications with the GMC he has indicated that he will return to the UK on 7th October 2014 to undergo psychiatric treatment….It is 9 months since the case examiner last considered whether Dr Krishna should be referred to IOP. Since then we have had very little information as to whether or not Dr Krishna has been receiving treatment for his condition whilst in India and have no indication as to whether or not he intends to seek work now he has returned to the UK..'* The case examiner decided on the 14th of October 2014 that; *'Dr Krishna should be referred to an IOP* [Interim Orders Panel] *for determination. The case examiner was concerned that the GMC had no confirmation as to Dr Krishna's whereabouts and that the conduct and performance issues that brought Dr Krishna to the attention of the GMC and his more recent issue of breach of patient confidentiality all appeared to arise because of the doctor's severe mental health problems . . . there is credible evidence that the doctor's fitness to practise might be impaired and that an IOP referral was warranted in the interests of the doctor and the protection of members of the public. … The tone of much of his recent correspondence suggests that his language and communication remains inappropriate for a doctor. Although he does not appear to be working – he's not under the governance of a stable employer – his variable insight and financial pressures have the potential to lead him to seek locum work if he deemed himself to be better. The situation presents a real risk for patient safety'*, and *'it remains the*

case that while the doctor's registration continues to be unrestricted patient safety and public confidence in the medical profession cannot be assured'.

66. On the 3rd of November 2014, Dr Krishna complained to the Professional Standards Authority about the GMC's handling of his case. He sent a copy of his complaint by email to the GMC (protected act (iii). On the 4th of November 2014, Mr Donnelly wrote to Dr Krishna advising him that an IOP hearing would be held because; *'information suggests your fitness to practise may be impaired by recent misconduct and adverse mental health and in view of a) behavioural and performance concerns as referred to the GMC by Cwn Taf University Health Board, b) the opinion of the GMC health advisor who diagnosed ICD-10 classification F33.20'.*

67. The hearing was held on the 12th of November 2014, Dr Krishna did not attend and the panel imposed restrictions on Dr Krishna's ability to practise medicine for a 12-month period to allow the GMC to complete its investigation, including arranging a further health assessment.

68. During this Tribunal hearing, Dr Krishna withdrew his allegation that the respondent and Mr Donnelly had sought an interim order for restrictions for 12 months (detriment (n)).

69. Dr Krishna alleged that the respondent, Mr Done, Mr Donnelly and Dr Sievewright had placed factually incorrect and prejudiced information before the respondent's case examiners, (detriment (m)), which he believed led to the decision to refer to the IOP. We looked at those documents and they did not include factually incorrect and prejudiced information as Dr Krishna alleged. It became apparent during his evidence that Dr Krishna's concern was about the contents of Dr Sievewright's report, our findings about which have been explained above.

70. Dr Krishna continued to email various members of the GMC's staff raising concerns, queries and complaints and the GMC continued to encourage him to participate in a further health assessment. On the 17th of December 2014, Miss Couchman emailed Dr Krishna in her role as Head of the Corporate Review team in response to the very large number of emails sent by him in the previous months stating; *'I believe that the majority of the points you raised have already been responded to by me or my colleagues within our fitness to practise directorate. However, I feel it would be helpful to again set out our position here".* Under *'health assessment'* she stated *'in order to properly assess your fitness to practise we would like to complete the health assessment you previously agreed to undergo. In your previous correspondence you asked that we postpone this assessment until such time as you are able to start treatment. I understand that this is a very distressing time and that you may not agree that a health assessment is necessary. However, I would be grateful if you could let us know whether you are now prepared to complete the health assessment'*. Around that time Dr Krishna had also been making enquiries about the effect of non-payment of his registration fees and Miss Couchman explained, *'can I also take this opportunity to remind you of the advice my colleague Joanna Farrell gave you in her correspondence dated 5th of September that all registered doctors are required to pay an annual fee for the retention of their name on the register ('the ARF'). Failure to pay the ARF would put you at risk of erasure from the register. As of today's date I can see your ARF remains outstanding. It may*

be helpful to explain that it's open to you to apply to relinquish your licence if you are not practicing medicine in any capacity in the UK. Relinquishing your licence (but maintaining your registration) would mean that you would pay a significantly lower fee. Currently the annual fee for registration without a licence to practise is £140. if you'd like to relinquish your licence please write to us to confirm that is the case and we would be happy to arrange that for you'.

71. At detriment (o), Dr Krishna alleged Miss Couchman had threatened him with referral to the FPP if he refused a health assessment, however during his evidence to us, he accepted that there was no reference to such a referral in her email.

72. The difficulties faced by the GMC in dealing with the volume and content of Dr Krishna's correspondence was explained by Miss Couchman in her email when she stated; *'we understand that being the subject of a GMC fitness to practise investigation can be a difficult and stressful experience. However, over the preceding months you've sent us very many emails which have been copied to a wide range of people at the GMC. Further many of the emails are not connected to our investigation. This approach makes it very difficult for us to provide you with appropriate, consistent and timely responses'.*

73. On 6th and the 7th of November 2014, Dr Krishna sent further complaints to the Professional Standards Authority about the GMC's handling of his investigation stating, *'please be informed that I remain frightened of reprisal from GMC for having expressed concerns about mishandling of my case.'* These emails are protected acts (iv) and (v).

74. During early 2015, the GMC continued to correspond with Dr Krishna and to seek his consent to a further health assessment and Dr Krishna continued to raise a range of concerns, copied to many individuals within the GMC and the Professional Standards Authority.

75. By May 2015, no progress had been made and Dr Krishna's position was; *'I do not agree for health assessment as I'm still undergoing psychological treatment and waiting for an independent psychiatrist'*. As Mr Donnelly told us, the investigation could not progress any further because Dr Krishna was refusing to cooperate and so, in accordance with the GMC's 'rule 7' process, a letter was sent to Dr Krishna on the 22nd of June 2015 informing him that the GMC was considering a referral to a fitness to practice panel (now known as the Medical Practitioners Tribunal). The letter enclosed copies of all information gathered and set out the allegation which the case examiners would consider when deciding whether to refer his case to a fitness to practise panel, as; *'by reason of the matters set out about your fitness to practise is impaired because of your; a) misconduct, b) adverse physical or mental health, being major depressive disorder recurrent severe without psychotic features'.* This letter is detriment (q).

76. By email of the 19th of July 2015, Dr Krishna replied; *'charge 1 inappropriately disclosing the unredacted medical records of patient RD, comment; I plead guilty to the above charge, though at the time I believed it was my duty to disclose patient RD's details to public and statutory organisations'* and *'charge 2, failing to be examined by a GMC health assessor comment; I plead the fifth to the above charge*

for the following reasons' and Dr Krishna laid out the various concerns and complaints that he had about the GMC's processes thus far.

77. On the 28th of July 2015, Abbie Sedwell, Investigating Officer, referred the matter to the case examiners stating; *'Dr Krishna's been asked many times whether he'll agree to the assessment and advised of the implications if he doesn't cooperate. In the circumstances I think the only way to proceed with the case is to refer Dr Krishna to a fitness to practise panel'.* The case examiners decided that Dr Krishna should be referred to a fitness to practise panel.

78. Detriment (r) was that the GMC, Mr Donnelly, Mr Done and Dr Sievewright had caused the case examiners to discriminate against him. In evidence, Dr Krishna could give no specific information or provide any substance to that allegation and it remained entirely unclear as to what he meant by it; this despite Dr Krishna having been asked by the respondents' solicitor during case preparation, on many occasions, to provide further details. In any event, it was clear from the evidence of Mr Donnelly, Mr Done and Dr Sievewright, and from the documentation provided to the case examiners which was contained within the bundle, that none of those individuals or anyone else at the GMC had taken steps or caused the case examiners to discriminate against him in reaching the decision to refer him to a FPP. In fact, the case examiners' decision was based, in large part, on Dr Krishna's own correspondence; *'we've noted the extensive bundle of comments written by Dr Krishna to various bodies and individuals, some of which employ inappropriate and abusive language . . . and which suggest a lack of insight about his state of health and its impact upon his working and person circumstances . . .'.*

79. The case examiners also took account of Dr Sievewright's opinion and stated; *'the case examiners agree that the conduct and performance issues that have brought Dr Krishna to the attention of the GMC and the more recent issue of his breach of patient confidentiality through his circulation of unredacted patient records to third parties are all likely to be related to the doctor's mental health problems. We therefore agree that allegation 7* [which was the breach of patient confidentiality] *should not be considered separately as a probity issue but as a further symptom of the doctor's mental illness. We agree on an evidential basis that the allegations meet the realistic prospect test. We agree the doctor's lack of insight in relation to his health problem and his failure to fully engage with GMC health procedures preclude the offer of health undertakings. Accordingly, we refer Dr Krishna to a fitness to practise hearing for a determination.'*

80. The decision to refer Dr Krishna to the FPP was communicated to Dr Krishna by letter of the 23rd of September 2015 and the allegations were set out in an annex to the letter; being his *'conduct in refusing to engage with the GMC's health procedures such that his fitness to practise was impaired because of his adverse mental health',* (detriment (s)).

81. The FPP hearing was arranged for the 16th to the 20th of May 2016. In email correspondence on 12th and 13th May 2016, copied to 23 recipients in various organisations, Dr Krishna stated that he was unable to engage due to illness, that he felt unable to request a postponement because of his continuing ill health but that if the hearing proceeded in his absence he would be prejudiced. Mr Thomas, Investigating Officer, was unable to clarify Dr Krishna's position with him and so

informed the panel's listing team, stating; '*please can you make the MPTS case manager aware of the correspondence and let them decide whether to treat it as a postponement request. Should this be classified as a formal postponement request the GMC remains neutral on the application but I would like to draw the case manager's attention to the fact that the doctor has provided no medical evidence except for his correspondence that he is too ill to attend or engage with proceedings and it is a pure health case where the doctor has not cooperated with the health assessment process. There's no evidence that, should the tribunal be postponed, the doctor will be able to attend in the future, nor that he is actively seeking treatment.'*

82. The application was refused by the MPTS (medical practitioners tribunal service) case manager, Ms McCain. She noted that the GMC's position was neutral. Miss McCain's reasons related to the lateness of the application and the absence of any medical evidence or indication as to when Dr Krishna might be fit to attend any future hearing. Miss McCain went on to state; *'I find it surprising that Dr Krishna says he's unfit to engage in proceedings to any extent even to formally make a postponement request. Despite this position he's been able to craft 3 separate communications to the GMC over the 12/13 May period seeking a de facto postponement. Despite being able to prepare these letters, one of which he appears to have circulated to the addressee and 23 further recipients, Dr Krishna maintains he is unable to take any further steps to participate including, presumably, instructing a representative . . . and it's my further assessment that on the basis of his parallel litigation arising from the same circumstances and from his recent communications with the GMC he has the capacity to both formally seek a postponement and to give instructions to a representative to appear at the hearing . . . the allegation is significant and in the absence of any evidence to support the doctor's position I conclude that the public interest requires the case to proceed'.*

83. At detriment (t), Dr Krishna alleges that the GMC resisted postponement of the MPT hearing, however it was apparent from this correspondence that the GMC adopted a neutral position, albeit highlighting the absence of medical evidence.

84. At detriment (u), Dr Krishna complains that Professor Stephenson failed to respond to his letter of the 13th of May 2016, in which he complained that any decision in his absence would be prejudiced. Professor Stephenson was the Chair of the GMC and had not been involved in Dr Krishna's investigation and fitness to practice proceedings. Dr Krishna's letter was considered and addressed by Miss McCain and he received a reply from the Tribunal service and a copy of her full reasons for refusing to postpone the hearing.

85. Miss Eldridge was the legal advisor who prepared the case to be heard by the FPP [referred to in correspondence from then on as the MPT]. She compiled the documentation into a bundle and explained by email to Dr Krishna that she would forward a copy for his input or agreement. She organised two telephone conference to clarify the issues and necessary documentation. However, Dr Krishna did not participate. It was clear from the documentation and Miss Eldridge's evidence that she went to great lengths to engage Dr Krishna in the process, to keep him informed, and to obtain any documentation or submissions from him.

86. By letter of 21st of March 2016, Miss Eldridge provided Dr Krishna with details of the hearing, an index to and copy of the proposed hearing bundle and a copy of the 2004 (Fitness to Practice) rules. She explained that information relating to allegations investigated by the Health Board or any conclusions relating to the same had been removed to avoid any prejudice to Dr Krishna; *'i.e. it would be prejudicial if the medical practitioners' tribunal were to view material which raises concerns about you which does not form part of the charges'*.

87. The charges to be considered by the MPT was that; *'on 30th of June 2014 you were medically examined by Dr A who diagnosed you as suffering from a medical condition the nature of which is set out in schedule 1 and that by reason of the matter set out above your fitness to practise is impaired because of adverse physical or mental health'.*

88. At detriment (v), Dr Krishna alleged that Miss Eldridge had failed to disclose all the documents to the MPT. However, he was unable to clarify what documents he meant. In any event, Dr Krishna was given many opportunities to include any documents he wanted the MPT to consider in the bundle but he did not do so.

89. Dr Krishna emailed Mr Thomas on the 14th of June 2016 stating; *I suggest that you go ahead with this administrative erasure for not paying ARF.* Mr Thomas replied by email the next day, *'as you have informed the GMC that you are unable to engage with GMC procedures due to ill health I don't think that a decision to provide administrative erasure would be granted to a doctor suffering from ill health. I suggest that you read the relevant pages on our website that deal with voluntary erasure, details of which can be found here'* and a link was provided. As Mr Thomas explained in his witness statement he was not refusing administrative erasure, which was not a decision that he was entitled to make. Mr Thomas's witness statement was not challenged by Dr Krishna and we accepted Mr Thomas's account as accurate. He felt that an application for voluntary erasure would be more appropriate in the circumstances given that Dr Krishna had already indicated that he intended to apply for voluntary erasure just a week previously. Detriment (w), that a request for administrative erasure was refused on the 15th of June 2016, was not factually correct.

90. The MPT proceeded in Dr Krishna's absence. It decided to adjourn and directed that a health assessment be carried out. Dr Krishna was informed of this by letter of the 17th of June 2016, from Ms Cunliffe, Assistant Registrar, Medical Practitioners Tribunal Service (detriment (x)). He was told the consequences of failing to cooperate; *'if you refuse or otherwise fail to comply with the tribunal's direction to undertake an assessment it will consider this when it reconvenes. The tribunal will consider whether or not you've failed to comply with the direction. It will also consider whether or not there was a good reason for your refusal or failure to comply. If the tribunal makes a finding of non-compliance it may exercise its power under paragraph 5(a)(3)(d) of schedule 4 of the Act and can direct that your registration be made subject to conditions for up to 3 years or suspension for up to 12 months'.* This letter was simply informing Dr Krishna of the tribunal's powers in the event of a finding of non-compliance, in any event, it was not sent by the GMC or any of the named respondents.

91. On the 8th of June 2016, Dr Krishna applied for voluntary erasure from the GMC register stating that he could not see himself '*going through GMC fitness to practise hearings and IOP hearings any more'*. Consequently, a case examiner was asked to advise the Registrar on *'whether there was a public interest in not removing Dr Krishna from the register but instead continuing with fitness to practise proceedings'*. The Assistant Registrar advised that the ongoing fitness to practise proceedings involving Dr Krishna should not be a bar to his erasure from the medical register and administrative erasure was granted on the 29th of July 2016, upon which the fitness to practise proceedings were discontinued.

The Law

92. These proceedings are brought against the GMC as a Qualifications body under S53 Equality Act 2010 and against the named respondents for ancillary prohibited conduct at Ss 109-112 of the Act.

93. Section 53(5) of EqA provides:

(5) A qualifications body (A) must not victimise a person (B) upon whom A has conferred a relevant qualification—
(a) by withdrawing the qualification from B;
(b) by varying the terms on which B holds the qualification;
(c) by subjecting B to any other detriment.

94. Section 27 of EqA provides:

(1) A person (A) victimises another person (B) if A subjects B to a detriment because—
(a) B does a protected act, or
(b) A believes that B has done, or may do, a protected act.
(2) Each of the following is a protected act—
(a) bringing proceedings under this Act;
(b) giving evidence or information in connection with proceedings under this Act;
(c) doing any other thing for the purposes of or in connection with this Act;
(d) making an allegation (whether or not express) that A or another person has contravened this Act.

95. There is no requirement to identify a comparator for a claim of victimisation to succeed.

96. Detriment is defined broadly and subjectively: Shamoon v Chief Constable of the RUC [2003] UKHL 1; [2003] ICR 337, at [35], per Lord Hope; '*But once this requirement is satisfied, the only other limitation that can be read into the word is that indicated by Lord Brightman. As he put it in Ministry of Defence v Jeremiah [1980] QB 87, [1979] 3 All ER 833, at p 104B of the former report, one must take all the circumstances into account. This is a test of materiality. Is the treatment of such a kind that a reasonable worker would or might take the view that in all the circumstances it was to his detriment? An unjustified sense of grievance cannot amount to "detriment": Barclays Bank plc v Kapur and others (No 2)[1995] IRLR 87. But, contrary to the view that was expressed in Lord Chancellor v Coker and*

Osamor [2001] ICR 507, [2001] IRLR 116 on which the Court of Appeal relied, it is not necessary to demonstrate some physical or economic consequence.'

96. As Elias LJ held in Deer v University of Oxford [2015] IRLR 481; *'the concept of detriment is determined from the point of view of the claimant: a detriment exists if a reasonable person would or might take the view that the employer's conduct had in all the circumstances been to her detriment; but an unjustified sense of grievance cannot amount to a detriment…'*

97. Taking detriment to mean 'anything which the individual concerned might reasonably consider changed their position for the worse or put them at a disadvantage', the requirement of reasonableness requires an element of objectivity. This is emphasised in the recent case of Fanutti v The University of East Anglia UKEAT/0182/17/DM, in which HHJ Barklem found that the Tribunal did not err in law in holding that a reasonable person faced with the institution of disciplinary proceedings would recognise the requirement for allegations of misconduct to be investigated; *'it seems to me the task of the Employment Tribunal, following Shamoon, requires an objective approach to the determination of reasonableness'*.

98. As to the reason for the treatment, it is not a simple "but for" test. Rather the Tribunal should address and determine the "reason why" issue (Greater Manchester Police v Bailey [2017] EWCA Civ 425, at [12]). As the House of Lords explained (in relation to the similar provisions of the Race Relations Act 1976) in Chief Constable of West Yorkshire v Khan [2001] UKHL 48 at [29] and [77]; Lord Nicholls stated;
'*Contrary to views sometimes stated, the third ingredient ('by reason that') does not raise a question of causation as that expression is usually understood. Causation is a slippery word, but normally it is used to describe a legal exercise. From the many events leading up to the crucial happening, the court selects one or more of them which the law regards as causative of the happening. Sometimes the court may look for the 'operative' cause, or the 'effective' cause. Sometimes it may apply a 'but for' approach. For the reasons I sought to explain in* Nagarajan v London Regional Transport *[2001] 1 AC 502, 510–512, a causation exercise of this type is not required either by section 1(1)(a) or section 2. The phrases 'on racial grounds' and 'by reason that' denote a different exercise: why did the alleged discriminator act as he did? What, consciously or unconsciously, was his reason? Unlike causation, this is a subjective test. Causation is a legal conclusion. The reason why a person acted as he did is a question of fact.'*
'*Was the reference withheld "by reason that" Sergeant Khan had brought the race discrimination proceedings? In a strict causative sense it was. If the proceedings had not been brought, the reference would have been given. The proceedings were causa sine qua non. The language used in Section 2(i) is not the language of strict causation; the words "by reason" suggest to my mind that is the real reason, the core reason, the causa causans, the motive for the treatment complained of that must be identified.'*

99. The burden of proof provisions of s.136 of the EqA apply to victimisation claims. S136 Equality Act provides as follows:

'Burden of proof
(1) *This section applies to any proceedings relating to a contravention of this Act.*

(2) If there are facts from which the court could decide, in the absence of any other explanation, that a person (A) contravened the provision concerned, the court must hold that the contravention occurred.
(3) But subsection (2) does not apply if A shows that A did not contravene the provision.

100. On the application of the burden of proof, the Tribunal was guided by what is commonly known as the revised Barton guidance; *Barton v Investec Henderson Crossthwaite Securities Ltd* 2003 ICR 1205, as set out in revised form in *Wong v Igen Ltd* 2005 ICR 931. The Tribunal reminded itself, following *Madarassy v Nomura International plc* 2007 IRLR 246, that there has to be more than simply a difference in treatment and status before a tribunal can conclude that an act of discrimination has occurred. In *Laing v Manchester City Council and others* 2006 IRLR 748, in relation to the two-stage process of analysing the evidence, the EAT provided clarification that a tribunal should have regard to all the facts at the first stage of the process to see what proper inferences can be drawn.

101. As it was established that Dr Krishna had done protected acts, the question for us was whether the GMC or other named respondents had subjected him to a detriment because of any of those protected acts in the sense that any of the protected acts had any material influence on subsequent detriment treatment. That required consideration of the mental processes of the decision maker in each instance.

102. That exercise had to be approached in accordance with the burden of proof. If Dr Krishna proved facts from which we could reasonably conclude that any of his protected acts had a material influence on subsequent detrimental treatment, his case would succeed unless the respondents could establish a non-discriminatory reason for that treatment. We approached that exercise having considered all the evidence before us. It followed that if we concluded that a protected act played no part in the treatment of Dr Krishna, the victimisation complaint would fail.

The Tribunal's Conclusions

103. For the reasons explained below we decided that none of the detriments alleged by Dr Krishna were detriments in the sense envisaged by *Shamoon*, in that they arose from Dr Krishna's refusal to co-operate in the process and his unjustified sense of grievance.

104. Dr Krishna does not dispute that during these events he was suffering from severe mental illness and there was ample evidence from Dr Sievewrights' report, Dr Krishna's copious, lengthy and widely disseminated correspondence, documentation from a range of other sources, and Dr Krishna's own admissions; that his overwhelming sense of injustice at his treatment by the Health Board had extended into a paranoid view of all authority and the GMC, in particular. This caused Dr Krishna to view every action of the GMC as further acts of vindictive, oppressive and unfair behaviour. In reality, as was overwhelmingly apparent from the evidence of all the respondents and from the contemporaneous documentation, the GMC and the other respondents were simply complying with the GMC's statutory duties and obligations by carrying out a fitness to practice investigation and proceedings in a

reasonable and fair manner. In their dealings with Dr Krishna, all the respondents went to considerable lengths to accommodate his distressed mental state.

105. Some of the detriments identified by Dr Krishna had no factual basis. In respect of all the detriments that did have a factual basis, we decided that a reasonable Doctor, about whom a complaint has been made, which met the threshold criteria, would accept that the GMC had a duty to carry out an investigation in accordance with its procedure and would take steps to co-operate in that process. Dr Krishna did not do so, he persistently frustrated the process, borne from his powerful but unreasonable sense of grievance against the GMC. The steps which the GMC took to progress the investigation in the face of Dr Krishna's resistance were reasonable and proportionate and were not detrimental to him.

106. Dealing with the detriments individually our conclusions were:

(a) This was simply an inquiry, not an instruction or a request and certainly not harassment. We accepted Mr Done's explanation and found that this was not a detriment as described above.

(b) This was a request in response to Dr Krishna indicating his consent in his letter of the previous day. It was not harassment and did not amount to a detriment as described above.

(c) This was simply a statement of the rules informing Dr Krishna of the possible consequences of not cooperating with a health assessment. It did not amount to a threat and was not a detriment.

(d) Mr Done was simply continuing with an ongoing investigation in the context of Dr Krishna himself acknowledging he was not fit and seeking support. It would not be within his power to cease such an investigation, in any event. This was not a detriment.

(e) Miss Farrell did not issue a threat, she was simply replying to Dr Krishna's complaint and clarifying the position to him. This was not a detriment.

(f) These individuals did not refuse to obtain reports. Dr Krishna was aware of the process and had the opportunity to provide any reports which he wished the health assessor to see. This was not a detriment.

(g) Dr Sievewright did not lie in his report and there was no detriment.

(h) There is no factual basis for this allegation and it does not amount to a detriment.

(i) This allegation was withdrawn by Dr Krishna during the proceedings.

(j) It was not a detriment for the GMC to consider Dr Krishna's complaint and decide that it was not able to investigate as the matters raised were not fitness to practise issues.

(k) The complaint against Mr Donnelly was unfair and unfounded and arose from Dr Krishna's unjustified sense of grievance. In these circumstances the dismissal of his complaint, communicated to him with a clear explanation of why, was not a detriment.

(l) This allegation was withdrawn.

(m) The GMC, Mr Done, Mr Donnelly and Dr Sievewright did not place factually incorrect and prejudiced information before the GMC's case examiners and hence it did not amount to a detriment.

(n) This allegation was withdrawn.

(o) Miss Couchman did not threaten Dr Krishna with referral to the FPP and hence there is no detriment.

(p) The same apply as (j); it was not unreasonable to uphold the decision upon review and does not amount to a detriment.

(q) Dr Krishna had pleaded guilty to the first allegation and the second was merely the consequence his failure to participate in the health assessment process. This does not amount to a detriment.

(r) There was no evidence to support this allegation. The GMC, Mr Done, Mr Donnelly and Dr Sievewright did not cause the case examiners to discrimination against Dr Krishna and there was no detriment.

(s) The referral to a fitness to practise tribunal was an inevitable consequence of Dr Krishna's failure to participate, which arose from his own unjustified sense of grievance. As the respondents explained, there was no other option open to them. The claimant had caused the situation through his own unreasonable behaviour and the referral did not amount to a detriment.

(t) The GMC did not resist a postponement of the hearing and this does not amount to a detriment. The claimant was provided with clear reasons for the refusal to postpone the hearing, in any event, that decision was not made by the GMC or any of the other respondents. Given that Dr Krishna was given clear reasons for the refusal to postpone, the absence of a personal reply from Professor Stephenson does not amount to a detriment.

(v) There is no evidential basis to this allegation. Miss Eldridge provided all relevant documentation to the panel and Dr Krishna was given the opportunity to add anything further that he felt appropriate. This does not amount to a detriment.

(w) There was no rejection of a request for an administrative erasure on the 15th of June and this does not amount to a detriment.

(x) This was a statement of fact rather than a threat and does not amount to a detriment.

107. Even if we are wrong about our findings on detriment; Dr Krishna could not point to any evidence of a connection between the protected acts and the GMC's actions, throughout this process. There was no evidence before us of a causal link, in the sense of material influence, between any of the protected acts and the detriments. Causation was not even referred to in Dr Krishna's witness statement and he provided no evidence in cross examination for the basis of his belief of a causal link.

108. All the respondents and their witnesses gave clear and compelling accounts of why they took the steps that they did and denied any causal link with the protected acts and we accepted their evidence. Except for Dr Sievewright, none of the individual respondents had ever met Dr Krishna and the entirety of their communications with and about him were recorded within the documentation, within which there was nothing to suggest that his protected acts had any material influence on their decision making. Our conclusion is further supported by the fact that the complaint had been identified as requiring investigation, and that process had commenced before the first protected act was even made.

109. Even if there was evidence before us from which we could reasonably decide that the respondents' actions were influenced, to Dr Krishna's detriment, by his protected acts, we accepted the evidence of all those involved in the investigation and decision making process as to why they took the steps that they did; carrying out their duties and responsibilities to respond appropriately to a complaint and to investigate Dr Krishna's fitness to practice in accordance with GMC statutory obligations, policies and procedures.

110. Given our conclusions, it is not necessary to address the jurisdictional point in respect of detriments (j) and (p) in detail, save that taking into account his serious mental health issues at the time and his challenging personal and family circumstances; notwithstanding that he was capable of entering into extensive correspondence with many organisations on a range of matters and was alleging victimisation and harassment; we decided it would be just and equitable to extent time to allow those claims to proceed and so we made our findings about them alongside the others.

111. For the reasons laid out above, Dr Krisha's claim of victimisation fails and is dismissed.

Employment Judge Howard
4th June 2018

JUDGMENT AND REASONS SENT TO THE PARTIES ON
22 June 2018
FOR THE TRIBUNAL OFFICE