EMPLOYMENT TRIBUNALS (SCOTLAND)

Case No: S/4100783/17 Held at Aberdeen on 5, 6, 8, 12, 13, 19, 20, 21, 22, 23 & 27 November 2018 and 25 January 2019

Employment Judge: Mr J M Hendry
Members: Ms P Peterkin
Ms M Williams Edgar

Mr Nicholas Renny	Claimant Represented by: Mr F H Lefevre – Solicitor
Grampian Health Board	Respondent Represented by: Mr A Hardman – Advocate Instructed by: Mr C Reeve – Solicitor

JUDGMENT OF THE EMPLOYMENT TRIBUNAL

The unanimous decision of the Tribunal is that the claimant's application for a finding of Unfair (Constructive) Dismissal fails and is dismissed.

REASONS

1. The claimant in his ET1 contended that he had been unfairly 'constructively' dismissed from his employment as a Consultant Surgeon through the actions of his employers which actions extended over a period of time. He blamed the respondent's senior management for his suspension, for failing to arrange either proper external or internal reviews into various matters culminating in their reporting him to the GMC and for refusing to allow him to return to his full duties.

2. The respondent is an NHS Health Board providing health services in the North East of Scotland. They denied that they had given the claimant cause to resign and that in any event he delayed too long in doing so.

Issues

3. Parties did not agree a list of issues prior to the hearing but the legal issues presented to the Tribunal were:

1. Did the claimant resign because of the conduct of the respondent?;
2. If so, what was the conduct which caused the claimant to resign?
3. Did the claimant resign after he became aware of that conduct in sufficient circumstances to be considered not to have affirmed his contract?
4. Was that conduct calculated and/or likely to destroy or seriously damage the relationship of confidence and trust between employer and employee?
5. If so did the respondent conduct itself in such a manner without reasonable and proper cause?
6. Was the claimant entitled to resign because of the respondent's conduct and did he wait too long?

4. The Tribunal had to glean the particular incidents on which the claimant relied from his evidence and from the final submissions and this was not an easy task. We would observe that the claimant's belief was that the respondent's management, especially at a senior level, were not well disposed towards him and were, if not the initial source of his difficulties, then those with ultimate responsibility for how the situation developed. He found this explanation the one that fitted most closely with his perception of events. He found it impossible to contemplate any reasonable and proper motive for the actions of his colleagues and managers towards him. He ultimately did not accept that there was any merit whatsoever in the criticisms levelled at his practice or behaviour.

5. It became apparent during the hearing that the claimant's Schedule of Loss could not be finalised or agreed principally because of issues around the impact of events on his pension and salary entitlements. It was agreed that remedy would be dealt with at another hearing.

6. The Findings are not wholly in chronological order as events overlap and to understand particular issues we have dealt with some areas of the evidence separately for ease of understanding.

Evidence

7. The Tribunal had regard to the productions lodged by parties. It heard evidence from the following witnesses starting with the claimant who gave evidence on his own behalf. Dr Ross gave evidence for the claimant and the other witnesses for the respondent:

- Dr Donald Ross (retired Medical Director)
- Dr Nicolas Fluck Medical Director
- Dr Malcolm Metcalfe Deputy Medical Director
- Dr Fiona McKay (retired Assistant Medical Director)

- Dr Paul Bachoo Medical Director (Acute)

Facts

Background

8. The claimant is an experienced and qualified Consultant Oral and Maxillofacial ('Maxfac') Surgeon specialising in Head and Neck Cancer surgery. He is well qualified, experienced and has had a distinguished career. He holds separate qualifications in dentistry and is registered both with the General Medical Council ('GMC') as a physician and with the General Dental Council ('GDC') as a dentist. He had worked for the respondents since the 1 August 1995.

9. In 2014 the 'Maxfac' Department at Aberdeen Royal Infirmary ('ARI') was a small busy department which had, at the relevant time, four qualified surgeons including the claimant with one surgeon also specialising in cancer work namely Mr. Terry Lowe ('TL'). The other two surgeons were Marty Ryan ('MR') who was the Clinical Lead and Rory Morrison ('RM'). There was considerable unrelenting pressure of work on the surgeons working there. At one point the claimant had to work alone as the only Maxfac surgeon doing head and neck cancer surgery. The department was a stressful environment with physical and mental pressures on surgeons.

10. The surgeons working in Aberdeen also had to work with colleagues elsewhere in the region who might be carrying out Maxfac work.

11. The claimant enjoyed good personal and professional relations with Consultants in other departments and in the past with his three Maxfac colleagues. Mr Morrison was some years junior to the claimant and had trained under the claimant.

12. As the department was small it was vital for its proper functioning that all four surgeons had full trust in each other and both cooperated and communicated fully with each other. They would, at points, often be involved in the care of their colleague's patients particularly post operatively.

13. The surgery in which the claimant was involved was itself often complex, physically and mentally draining with operations lasting many hours and sometimes requiring more than one surgeon to be involved. It generally involved the removal of cancerous tissue and reconstruction of the area affected.

14. The claimant had recognised some time before 2017 that having sufficient stamina was an important aspect of his work. He had been open with colleagues that he hoped to retire at about 60 before his stamina began to wane. He also had some health problems. In the event the claimant had to put on hold any hopes of retirement for personal reasons and through changes in the likely value of his pension provision.

15. The process adopted in ARI in relation to surgery for head and neck patients was that the proposed surgery and treatment regime (which could include therapies such as chemotherapy and radiotherapy) would be briefly discussed at a multi- disciplinary team ('MDT'). This included representatives from other specialties.

16. The hospital has a system called the 'Datex' system where untoward events are recorded daily by all staff. These can be simple straightforward matters or more serious failings. The Datex forms are reviewed by more senior management and escalated to higher management if appropriate. The purpose was to try and identify any pattern or series of recurrent difficulties to allow remedial action can be taken.

17. The hospital also carried out what were known as morbidity reviews where the circumstances around a patient's death were considered. The content of these meetings was not recorded in detail.

Hewage Case

18. In 2007 an employment tribunal claim was lodged against the respondent by a Mrs Sumithra Hewage a Consultant Orthodontist alleging both unfair dismissal and discrimination. She was successful and obtained a Judgment from the Employment Tribunal against the respondents which was then subject to various levels of appeal. In the course of their Judgment the Employment Tribunal criticised the reliability of evidence given by one of the respondent's witnesses a Dr R Dijkhuizen. The claimant gave supporting evidence for Mrs Hewage. The claim, which was costly, was finally settled by the respondent some years after the initial Judgment after they had been unsuccessful in an appeal before the Supreme Court.

19. The claimant was a prominent member of a Consultant Sub-Committee ("CSC"). He had concerns over the behaviour of the respondent's Medical Director, Mr R Dijkhuizen and his involvement in events leading to Mrs Hewage raising her Employment Tribunal proceedings. He believed that Dr Dijkhuizen's actions in the case had damaged his credibility and reputation. He considered that it also highlighted wider problems with the management in the Board.

20. In 2008 The claimant applied for the post of Clinical Director of Surgery. He was unsuccessful. He attributed the appointment of a less experienced colleague to antipathy towards him arising from his support of Mrs Hewage.

21. The claimant believed that while the employment tribunal case was proceeding through the various appeal processes, which took several years, that he should not pursue his concerns about Dr Dijkhuizen's role in the matter through any formal channels. However, after the Judgment was finally issued in 2012 the claimant and other Consultant colleagues who shared

these concerns wrote to the respondents pointing out that the respondents, and specifically Dr Dijkhuizen, had been singled out for trenchant criticism in the Judgment which they felt undermined his position as the current Medical Director.

22. Dr Dijkhuizen wrote to Mr N Binnie, the Chair of CSC on 7 March 2013 (**Rp167-169**) complaining that in his view the CSC had used the Tribunal Judgment to try and undermine his position as Medical Director. He complained that the CSC had broken the principles of fair treatment and violated his personal rights in that they had set about "canvassing opinion and encouraging his Consultant colleagues to write in about their views of Dr. Dijkhuizen'. He also complained about the lack of confidentiality in the process and indicated that in his view they had not conducted themselves properly. He stated that unless the campaign against him stopped he would hold any of the CSC members involved responsible under the respondent's Dignity at Work Policy. The letter was copied to at least 20 senior staff.

Background to Complaints against the Claimant

23. Although the claimant had enjoyed good relations with his three consultant colleagues over the years he had begun to diverge from them in his approach to practice. This had led to a distancing between the claimant and those colleagues. In particular the claimant would avoid collaborating with his counterpart TL the only other Maxfac surgeon carrying out cancer work. In turn the claimant's colleagues began to have concerns about the claimant's technical abilities particularly in relation to his ability to cut out sufficient cancerous material, his use of 'frozen sections' to detect the margins of cancerous growth and in creating viable flaps of tissue for reconstruction. The latter procedure involved delicate surgery to provide the flap with a blood supply. They harboured concerns that he was not communicating effectively with them and not taking part or sufficient part in ward rounds and handovers to colleagues. Their concerns came to a head when they became worried that he had carried out a very complex and lengthy operation without seeking

their assistance but rather had relied on the services of a senior Registrar. The Registrar had expressed his unhappiness about the matter. They were concerned that the patient had a flap of skin attached to the operation site as a repair by the claimant. The flap had later failed (died) because of insufficient blood supply. TL in particular was critical of the claimant's technical ability to carry out such procedures. The claimant maintained that the flap had failed because of post- operative difficulties.

24. MR informally raised his and his colleagues' concerns about the claimant's practice with Mr Satchi Swami the Unit Clinical Director. Mr Swami ('SS') was a Consultant in Neurology. This was prompted by specific concerns they had relating to a proposed operation the claimant intended carrying out the following week.

25. Dr. Nicholas Fluck ('NF') was the Unit Clinical Director. As such he was the claimant's Line Manager. He later became Medical Director. He had little direct contact with the claimant until these events. He was contacted by SS who told him that the claimant's colleagues MR, TL and RM were concerned about an operation that was scheduled for the following Monday to be performed by the claimant. It was a complex head and neck cancer procedure involving a difficult "free flap restoration". They were concerned that he had not sought their assistance. The information passed to NF was that the claimant's colleagues believed that a patient might be harmed if the proposed procedure was carried through. They wanted the procedure stopped.

26. After discussing the situation with SS he agreed that two lines of approach would be taken. The first was that his colleagues should discuss the operation with Mr Renny and try and resolve the matter informally. In the meantime, he would try and obtain wider feedback in relation to the claimant's overall practice. NF was concerned that if the operation was cancelled there would be a considerable delay in rescheduling it and that this delay itself might be harmful. NF was conscious that the claimant's colleagues had raised serious

concerns with him and he wanted to know how the cases were being prepared (through the MDT) and whether there was any information from the claimant's practice flagged up at morbidity and mortality procedures or through the Datex system. Unfortunately, detailed record keeping was not kept of these meetings. There was no background information that NF obtained at this point that caused him to have any concerns about the claimant's practice and the outcomes for his patients. In these circumstances he declined to stop the operation. He also concluded that there was no indication that the claimant's proposed procedure was untoward in some way.

27. NF then left matters to SS to try and open up a conversation between the claimant and his colleagues.

28. The claimant was telephoned by SS on the 31 May or 1 June. SS told him that his three Consultant colleagues had met him that day and expressed concerns about his management of head and neck cancer patients. The claimant believed that his colleagues did not have the full detailed picture of his patient's conditions that he did. The claimant gave a detailed narration of his recollection of events and of the condition of the patients he had been treating at the time. He suggested that there was a difference in approach between himself and in particular TL. This he believed was reflected in the difference between the "Glasgow school of thought" on head and neck surgery and others who like himself had not been trained in Glasgow. The dispute centred around how far a surgeon should cut into possibly healthy tissue to ensure that the cancerous tissue had been removed with the claimant taking a more conservative approach There was also appeared to a dispute as to when "frozen sections" should be used by surgeons to assist them. This process could be used to try and determine incision margins. They are small 'slivers' of tissue which are cut and analysed to try and determine the spread of cancer into healthy tissue.

29. SS reported his discussions with the claimant to NF.

30. The claimant was due to operate in the morning of the 3 June. He found his three colleagues waiting for him in the ward office. MR explained their concerns. The claimant was taken by surprise. He felt 'ambushed'. It was agreed to meet again when more time was available.

31. On 18 June on his return from leave the claimant was asked to meet TL, NR and RM. A meeting was arranged to take place on the 26 June at 6pm. The meeting was partially recorded by Dictaphone. A partial transcript was later prepared (**Rp170-183**).

32. The meeting lasted for a couple of hours. The three Consultants outlined their concerns about various decisions that claimant had made concerning a number of particular patients. They were concerned that he had not asked for help nor was he accepting advice. They expressed concerns that he was not clearing cancerous tissue by surgery and having to carry out additional procedures to clear the cancer. They mentioned concerns raised by a member of nursing staff ('CR'). The claimant seemed to agree that there had been some difficulties. He accepted that it was harder as he got older but dismissed the wider concerns (**Rp178-179**) The claimant's colleagues also raised a number of concerns and criticisms they had about his competence in certain procedures like restoration and 'free flaps'. TL mentioned the different philosophy they seemed to have from the claimant. The meeting became heated and acrimonious. There was little common ground between the claimant and his colleagues but it was agreed to meet again.

33. Following the meeting the claimant sought out and spoke to CR who denied that she had concerns.

34. The meeting had a strong impact on the claimant. He felt very shaken. He had not realised the depth of feeling in the Consultant team around these concerns which came as a surprise to him.

35. The claimant's Consultant colleagues came to the view that informal discussions with the claimant were not going to resolve their concerns and decided to collectively take further action. They were concerned about the safety of patients. They hoped that the claimant would consider retirement.

36. Following the meeting MR wrote to the claimant on 12 July referring to the meetings on 3 June and 26 June. He made reference to the claimant previously having considered retiring from head and neck cancer surgery at 55. The letter was copied to RM and TL and also to Mr M Thoms, the Unit Operational Manager and SS.

37. The claimant was off with stress from the 27 June until 11 August. Thereafter he would periodically suffer from anxiety and depression.

38. Mr Thoms ('MT') wrote to the claimant on 23 July indicating that that MR had been in contact and asking if he would consider a third meeting to discuss the concerns with MT or SS (**Rp186**).

39. The claimant responded by e-mail on 24 July confirming that his stress condition was related to the two meetings he had with his Consultant colleagues and indicated that he would consider a further meeting as suggested by MT. He wrote that he realised that the department would '*never be the cohesive unit it has previously been*' He stated that the meeting with his Consultant colleagues had ended with agreement that further discussions would be required. He indicated that he believed that two of his colleagues MR and RM had not been involved in head and neck cancer surgery for some years had been misled in some aspects of the discussion. He wrote:-

> "*there are now some issues of trust between the Consultants which unfortunately may now never be resolved. Having spoken to others I do have concerns that allegations have been made which are misrepresented, untrue and/or exaggerated, and also have concerns that this policy and the way it has been handled by my colleagues has breached Dignity at work policy.*"

40. The claimant compiled a history of events as he saw them and enclosed it in the letter.

41. The claimant agreed not to carry out and head and neck cancer cases meantime.

42. A meeting took place on 6 August 2013 involving the claimant, SS and MT accompanied by Tracy MacDonald from the respondent's HR department. The purpose of the meeting was to find a way forward given the issues raised in relation to clinical practice with the claimant, in turn, raising the behaviour of his colleagues. The claimant accepted he did not undertake frequent free flap surgery. He agreed to stop such procedures meantime. However, the claimant indicated that he could not collaborate with TL anymore. He advised that he did not wish to retire early or move to the Dental School or elsewhere. The Dignity at Work Policy was discussed and Mrs MacDonald gave NR a copy. Mediation by a third party was discussed. At the meeting SS suggested that if the claimant's colleagues put their concerns in writing the preferred option was to look at the issues through an external investigation carried out by experts in that field.

43. On 7 August the three Consultants wrote to SS setting out their concerns (**JBp204-205**). They wrote:-

> "*We have become increasingly concerned about the clinical performance and behavior of our colleague Mr Nicholas Renny. We now recognise that we must raise these concerns formally with our clinical management team.*
>
> *In the past, repeated attempts from all of us, both individually and collectively, have not been successful in addressing the problems that we see. More recently over the last several weeks there has been cases which have accentuated and re-enforced our concerns and bring us to the disconcerting situation in which we now find ourselves. In addition to our concerns we have also seen complaints and adverse comments raised by our junior staff and other colleagues including nursing staff.*

Our concerns are centred around the management of Head and Neck oncology cases including;

Suspect judgment in relation to surgical planning and management of these cases.

Persistent inadequate re-section of tumours and subsequent repeated re-sections of the index tumour site and an attempt to address residual and recurrent disease.

Inability to reconstruct patients as would be expected in a contemporary Maxillofacial Head and Neck practice.

The letter continued:

……We have real concerns that the sub-optimal treatment of these patients compromises chance of survival, number of patients requiring additional radiotherapy and increased risk of developing loco-regional tumour recurrence, a necessitating repeated operations and ultimately adversely affecting quality of life with poor outcomes.
For years we have all been involved in the day-to-day management of Mr Renny's oncology patients and have in the past been concerned about a proportion of these cases. Our concerns have been openly discussed though largely dismissed by Mr Renny. More recently the adverse events have increased in frequency and once again, despite raising concerns directly with Mr Renny he has failed to engage with us and seems to becoming more and more isolated, arguing repeatedly that there are no grounds for concern. We cannot accept a simple "difference of opinion" as a reasonable explanation for the issues we have raised. There has been no satisfactory acknowledgement of our concerns to date.

Regrettably the situation has now become so disturbing that we as a consulting group feel there is nothing further we can do within our department and are duty bound according to the GMC good medical practice to request that NHSG clinical management review the matter urgently."

The letter was signed by all three.

44. On the 9 August the claimant emailed TM to advise him that he had been in contact with MR about meeting to discuss how he could work in the department. MR had told him they were formalising the complaint and there was no room for further discussion (**JBp207**).

45. SS had reported to NF that the informal discussions had not been successful and that following the two meetings in June the claimant and his colleagues were polarised and relationships had broken down. At this point NR discussed the matter further with SS, MT and also with Dr. Dijkhuizen who was the Medical Director.

46. Dr. Dijkhuizen agreed that an informal approach was best at this stage. NR left it to SS to speak to the three Consultants. SS reported back that they were speaking with one voice that they continued to express concerns about the claimant's clinical practice.

47. Matters were made more complex for the respondent's management as the claimant was off ill until the 11 August with stress. NF took the view that following the letter of 7 August in which he believed that the three Consultants had raised more detailed and serious concerns that it would be appropriate to meet and discuss the letter with the claimant on his return. The issues raised were specific to head and neck cancer surgery and he did not believe that there was any independent and sufficiently expert doctor available internally who could carry out a review. Any such person would in any event have to have sufficient 'weight' to have their views accepted by the claimant and his three colleagues. He considered the 'pros and cons' of having an external review with the attendant cost and delay but concluded that this was the preferred option.

48. A meeting took place on 9 August. Notes were taken (**JBp206**). The following approach was recorded as agreed by senior management:

- There was no immediate cause for concern regarding patient safety therefore Mr Renny would return to work on Tuesday 13 August 2013 with no restrictions on practice;
- There would be no fact finding instigated under Framework for Support with regard to Mr Renny;
- If any of the Surgeons which to highlight a specific case now, a datex can be completed for internal investigation;

- All head and neck cancer cases to be discussed in the MDT for decisions to be made for treatment. All of the Surgeons need to prescribe to this practice;
- If Mr Renny has in the interim complex cases (1/2 a year then he needs to ensure that he is supported with the involvement of the MDT and a Plastic Surgeon;
- External peer review to take place. Two individuals representing both approaches to be sought. All Surgeons to be asked for suggestions of individuals. Dr. Fluck to discuss with Dr. Colin Strachan;
- Mr Swammy and Mr Thoms to meet with Mr Ryan, Mr Low and Mr Morrison to report Mr Renny's return on Tuesday 13 August and inform above.

49. It was accordingly agreed that the respondents would look to find an external expert in head and neck cancer surgery to carry out a review.

50. The three Consultants wrote to SS on 12 August having been advised of the respondent's intention to carry out such a review. They noted that the claimant was due to return on 13 August. They re-emphasised the serious nature of the concerns.

51. The claimant wrote to SS responding to the letters (**Rp211-215**) setting out his position in some detail. He denied that he had ever had an individual meeting with TL about the situation. His position was that there was no basis for individual and collective concerns raised or that his practices had been repeatedly challenged in the past. He pointed out that Mr Ryan had not carried out a cancer case in more than 15 years. He took the position that an internal review would be better using non-MaxFac peer review possibly by Ear Nose and Throat Surgeons who he believed had similar and appropriate expertise. This review he suggested should focus on outcomes.

52. NF considered what should be done on the claimant's return to work. It appeared to him that the claimant was isolated amongst his three colleagues and that the respondents could not ignore the level of concern being expressed by them which was of a highly technical nature. He accepted that there might be a difference of professional opinion or philosophy in relation to broadly how cancer patients were treated. He was concerned as to whether or not Mr Renny's practice had fallen outside accepted norms. He initially hoped that the two views namely, Mr Renny's and those of the other three Consultants could be accommodated in some way but came to realise as matters progressed that this was not going to happen. He was conscious that the Department could only work if there was a high degree of collaboration and communication between all the Consultants. He was concerned about patient care and safety if the department was dysfunctional and there was a lack of cooperation between the Consultants.

53. Steps were taken by the respondent's management to contact the British Association of Oral and Maxillofacial Surgeons to get advice from them. SS wrote to them on the 22 August (**Rp1319**) seeking their assistance:

> "*At Aberdeen Royal Infirmary, an OMFS Unit comprised of three full-time Consultants, two of them who specialise in head and neck cancer. Three of these Consultants have raised patient safety concerns with us around the practice of the fourth Consultant with reference to Head and Neck cases. The concerns revolve around patient management choice, whether the interventions represent current UK practice and some issues of technical competence.*"

54. He indicated that the respondents were currently drafting terms of reference and wondered if the Association could suggest the names of two well-respected UK experts. In the event after discussions with them it was decided that, on their advice, that the reference should be to the Royal College of Surgeons who could then appoint appropriate experts. The Royal College had experience in carrying out such reviews and had an established process.

55. A meeting took place between the claimant and MT, SS and Tracey McDonald. The claimant was told that his case was being handled using the policies 'Framework for Support' and that the respondent's managers were at the fact finding stage. They explained that they did not have anyone internally who could prepare an independent report and were looking at an external report. The claimant asked whether an ENT surgeon could be tasked with the matter. MT said that they felt they needed a MaxFac consultant to give a view. SS said that the functioning of the department was also under consideration. The meeting was minuted (**Rp232-233**) The claimant asked for copies of the allegations to allow him to prepare for the review. There was then a discussion of practical difficulties in managing patients meantime and possible delays in treatment. The claimant raised the issue of confidentiality and rumours that he was 'not allowed to do cancer anymore'. MT undertook to investigate and speak to the consultants involved and to remind staff about confidentiality. He said that any specific allegation would be investigated. The claimant gave the meeting an update on treatment he had been receiving from Occupational Health.

56. On the 11 September the claimant along with the three other Consultants were advised that a report was to be obtained from the Royal College of Surgeon in England ('RCSE') and a copy of the draft terms of reference sent out for comment (**Rp235**). The claimant responded on the 18 September (**Rp234/235**). He noted that he had previously suggested a wider review by ENT. He made various comments about the proposed terms of review. He wrote: *''If this is really to be an impartial and unbiased review, as the framework for support suggests, then I feel these aspects need to be included''* (**Rp235**).

57. After comments had been received a second draft was sent for comment as before.

RCSE Report

58. On the 6 January 2014 a letter was sent by Dr Dijkhuizen as Medical Director to the RCSE under their invited review mechanism to instigate a review. He was the appropriate person to request the review as Medical Director. The action was taken after discussions with the senior management team and with their support. It was requested that the report focus on the differences of opinion between the claimant and his colleagues regarding his clinical performance, standards and variability in patient management and the functioning of the MDT.

59. The terms of reference were adjusted throughout January and February. The RCSE wrote to Dr Dijkhuizen formally acknowledging the request for a review on the 28 February 2014 (**Rp264-266**).

60. A review team was appointed under the Invited Review Mechanism utilised by the RCSE (**R1p245**). The letter gave details of the review team which consisted of two experienced practitioners Mr David Cunliffe FRCS as Lead Reviewer and Mr Cyrus Kerewala FRCS and a lay Reviewer Ms Jane Corfield. The letter set out the process that was to be adopted.

61. Information was sought by the review team prior to the team visiting the hospital (**Rp246/248**) They visited ARI on the 16 and 17 April. The review team looked at the MDT and at cases dealt with by the claimant including outcomes. They considered the letters of concern written by the Consultants along with other evidence including a statement from the claimant and other information presented by him. It considered the professional difference in approach between the claimant and TL. They reviewed the history of six of the claimant's patients.

62. The report (**Rp323-377**) that was prepared was sent to the respondents in about late July. The report considered the interpersonal relationships within the service and concluded (**Rp.340/341**):

"*The review team heard that relationships within the Maxillofacial Department, and particularly between the Consultants delivering the head and neck and quality service, had deteriorated.*

Awareness among those interviewed of the interpersonal difficulties in the Department varied. Managers and consultants who worked closely with the relevant consultants were in no doubt that relations were strained, whereas junior members of the team and nursing were less familiar with the situation.

It was reported that consultants in the head and neck quality service had previously worked very closely and had a good relationship. The review team heard differing accounts of the point at which relations began to deteriorate and the reasons for this.

One consultant expressed the view that relationships within the team had declined very suddenly when concerns were raised over Mr Renny's practice by his consultant colleagues in August 2013.

Others reported that team relationships had been poor for some time. The review team heard that around 4 years ago a meeting took place at which there appeared to have been some disagreement over the division of resection and reconstruction work between Mr Lowe and Mr Renny which resulted in the relationship becoming increasingly strained and led to an arrangement whereby very few cases were undertaken by the consultants jointly. The Review team was not provided by the Health Board with any data or numbers of cases jointly undertaken by Mr Renny and Mr Lowe. This was reported by one interviewee, however, that the number of joint cases had decreased from an average of 10-20 per year to 2-3 in 2012/2013. They undertook no joint cases at all in 2013.

The review team heard that the lack of team working in the oral and maxillofacial Department led to patients and staff receiving confusing and conflicting information at times."

63. The report also gave examples of the impact the poor interpersonal relationships in the Maxfac department had on joint working. The review team concluded that the MDT had not been functioning satisfactorily. The review team came to the following specific conclusions:

"*The review team were of the view that the variability and management approaches within the head and neck on quality of service was out with the acceptable limits.*

The review team considered that varied approaches to patient management within a service of any size does not, in itself, problematic and can be beneficial for patients. Representation of a range of views in a department or team can foster effective discussion and challenge of clinical decision making and can provide patients with a greater choice in the way in which the treatment is managed.

However, the review team concluded that such positive features with varying approaches were absent in this instance. Instead, the divergent

views of a service provided by only two Consultants as to what constitutes best practice have caused them to be highly critical of one another's work, to withdraw from joint working arrangements that had previously functioned well and to providing inconsistent and confusing messages to colleagues and patients.

The review team was concerned to hear from interviewees and the suggestion that both Consultants, partly in response to one another had become intransigent and at times immoderate in their approaches over time, to the detriment of the standard of care delivered by the service. It considered that poor team relationships were an important factor in this increasing polarisation of individual positions…….The review team was particularly concerned by the evidence provided of staff and patients receiving conflicting information from Consultants as a result of polarised use and poor team communication in the head and neck and quality of service and considered that the example provided whereby a patient receiving conflicting information as to whether her prognosis was terminal, constituted an entirely unacceptable standard of patient care."

64. The review team recommended that the claimant's head and neck cancer patients should receive appropriate safe and timely follow up care irrespective of current staffing issues. They also made specific comments on a sample group of patients. They concluded that the claimant's engagement with the MDT process was a cause for concern. They considered that the cases reviewed provided examples of an inconsistent and ill-timed presentation of patients as well as a failure to adhere to MDT's decisions (**Rp.364**). They considered the claimant's use of "debulking" in the treatment of a patient over a number of years constituted a failure to adhere to appropriate standards.

65. In relation to the claimant's overall practice they concluded (**p.365**):

"*Based on information received, the review team concluded that there was a cause for concern with regards to Mr Renny's management approach and clinical decision making in head and neck cancer cases, the adequacy of his surgical interventions, and his maintenance of expertise and complex procedures.*
At the conclusion of the review visit the review team therefore advised the Health Board that the restrictions imposed on Mr Renny's practice should remain in place until such time as the Health Board had an opportunity to consider the review team's detailed conclusions and recommendations in this report."

66. The Report continued:

> ‘‘Management Approach & Clinical Decision Making
>
> *The review team considered that a conservative approach to the treatment of head and neck cancer which seeks to preserve function is not in itself inappropriate. However, during the review visit, the review team saw evidence of poor clinical decision making from Mr Renny when applying this approach”.*

67. They further concluded (**p366**):

> “*Adequacy of Surgical Interventions*
>
> *Based on the information received, although from an unvalidated audit, the review team concluded that Mr Renny’s head and neck cancer excisions resulted in an unacceptably high rate of close or positive margins, thereby increasing the need for resection and the use of adjuvant radiotherapy. This could have implications for local recurrence of the cancer, survival rates and patient related morbidity”.*

68. The reviewers had concerns about the claimant’s post-operative assessment, engagement with the MDT process and failure to adhere to decisions taken there. Finally, they concluded that in the light of the concerns outlined in the report in relation to the claimant’s management approach to head and neck oncology, clinical decision making, surgical outcomes and engagement with the MDT that he should remain restricted from practice in this area at the present time. They wrote: (**p368**)

> ‘‘…*Given the causes for concern identified by this report, the review team is clear in its view that if, as part of these discussions, Mr Renny expressed a desire to return to undertaking surgery in the field of Head and Neck oncology, he should not be permitted to practice independently in this area until such time as the safety of his practice can be assured. It is therefore, recommended that before returning to Head and Neck oncology work, Mr Renny would need to complete a period of practice under the direct supervision of another Consultant Oral and Maxillofacial Surgeon with appropriate expertise in Head and Neck Oncology. In the event that all parties were assured that Mr Renny’s practice was safe, the outcomes of the surgery would need to be subject to regular and robust continuous audit. Given his stated intention to retire from practice in the next few years re-training might be considered inappropriate.*
>
> *The review team was also clear that the primary basis of any decisions reached about the areas of practice that Mr Renny should undertake*

should be in the best interests of patients and arrangements put in place should be sufficiently robust to ensure that they receive safe care."

69. The Report was considered by the respondent's managers. They discussed its terms with the three Consultants and considered its ramifications.

70. The claimant attended a meeting with senior management on the 23 July 2014 to discuss the report. He was asked for his initial thoughts on it and was advised that no decisions would be taken at the meeting. The claimant indicated that he had cause for concern in relations to parts of the report which he did not accept. He was asked to put these in writing. The claimant was pessimistic about the time it would take to rebuild working relationships in the department. The claimant said that if his practice was restricted he would accept this but wanted to follow up existing patients. This meeting was followed up by letter dated 5 August (**Rp380-381**).

71. A complaint was received by the respondents from one of the claimant's patients (**Rp382**) She had been seen by the claimant in April 2014 She was complaining that she was required to see another surgeon in August who was apparently not aware of the claimant's earlier diagnosis.

72. The claimant had previously expressed concerns to the respondents that his patients were not being followed up properly.

73. Regular meetings take place between the respondent's senior management and the regional representative of the General Medical Council to discuss matters of common interest such as complaints made against doctors.

74. On the 20 August a meeting took place with the GMC local representative Mr Paxton at which the RCSE report was discussed. This was normal practice. This included a discussion about the claimant and in general references to the GMC about a doctor's fitness to practice ('FtP').

75. On the 22 August a meeting took place of senior management including NF and Dr Dijkhuizen to discuss the claimant's position. It was noted that a dispute had arisen with the claimant alleging that some of his patient's notes had been tampered with. The relationships in the Maxfac department were felt to be deteriorating even further. The question of whether the claimant could work in the Highland Heath Board area was discussed as was a possible referral to the GMC and suspension. The respondent's management were concerned that although they could restrict the work the claimant could carry out to non-cancer cases they could not prevent him carrying out such elsewhere such as in private practice. The meeting agreed that the allegations that had been made had to be investigated. They decided that the claimant should be suspended.

76. The claimant had a full Theatre list on the 25 August. On completion of his list he was invited to a meeting with Dr Metcalfe ('MM') and was suspended on the grounds that there had been a breakdown of trust within the team. He was advised that there would be a fact-finding exercise. He was told that the GMC might be made aware of the situation.

77. MM also commissioned an internal report into the apparent breakdown in relationships between the Consultants in the Maxfac Department. The fact-finding exercise was carried out by Dr C. Bain, Clinical Director, Cameron Matthew Unit Operational Director and Mrs Lesley Woodham from the respondent's HR department. Witnesses were interviewed over a period. A style letter sent to potential witnesses was produced (**Rp249**).

78. Dr Dijkhuizen wrote to the GMC (**Rp412**) on the 25 August referring the claimant to them. He made reference to the earlier discussion with the GMC regional representative Mr Paxton. He wrote:

> "*I'm concerned, however, that Mr Renny has worked elsewhere in the NHS and in the private sector, and I as his responsible officer and employer have no control over his practice in these areas.*

Following the meeting with the management team last week, a decision has been taken that Mr Renny is to be suspended from work. This was deemed necessary in order to protect colleagues from counter allegations and prevent further deterioration in the team working where there has been a breakdown of trust.
A further step taken is to begin looking at a possible recall of patients treated by Mr Renny, in the light of the attached report. This initially involves identifying all pathology results from Mr Renny's patients over a five year period to look at those where a malignancy is found. I am aware of the recent Kennedy Report's 'Lessons to be Learned and Recommendations'. I would thus be keen to receive any guidance from you in relation to a recall, in particular contact details for Trusts who have previous experience of this are and are considered to be examples of good practice."

79. The respondents advised Occupational Health that the claimant had been suspended to allow them to provide support to him.

80. MM wrote to the claimant on the 26 August setting out what had been discussed at the suspension meeting (**Rp418-419**):

"*I write with reference to the meeting held in the 3rd Floor East Meeting Room Ashgrove House at 5.30pm on Monday 25 August 2014…. In accordance with NHS Grampian's Framework for Support, a copy of which will be posted to you, I write to confirm that you have been suspended from duty, on full pay, with effect from the time of meeting on Monday 25th August, for an initial period of two weeks.*
The reason for suspension, which is for your own protection, is:
Breakdown of trust and working relationships within the team and the potential impact this may have on patient care.
It was felt that due on (to?) current circumstances there was no alternative to suspension, however, your suspension will be reviewed periodically and lifted, if appropriate, as soon as possible. The suspension also pertains to any other form of employment you have with NHS Grampian. The suspension is a neutral act and not a disciplinary measure, the purpose being to protect all concerned and to allow a thorough investigation."

81. The claimant was advised that his e-mail account would be suspended and that he would not be allowed access to the premises. The letter continued:

"*We advised that an anonymised report on the situation will be tabled at the NHS Grampian Performance Reference Group on 4th September and that a letter has gone to the GMC, a copy of which was handed to you at our meeting yesterday.*"

82. On the 11 September MT wrote to the claimant reminding him that he had not received his written feedback on the RCSE report and in relation to two complaints the respondents had received (**Rp423**). On the same date the three consultants were advised about the fact-finding investigation.

83. The claimant was unhappy at his suspension and after consulting the BMA he believed that the correct process had not been followed. He contacted the respondents HR department with his concerns. He believed that there should have been an intermediate meeting, alternatives to suspension should have been discussed and it should have been the last resort. He asked why he had suspended several days after the decision had been made. These were recorded by the department in an email dated 12 September 2014 (**Rp426**).

84. The respondents arranged to interview staff including the claimant and his three consultant colleagues and this was carried out through September, October, November and December.

85. On the 17 September MT sent the claimant copies of the supporting material sent to the RCSE (**Rp448**). He also confirmed that he had received the claimant's request for access to certain information which would be considered.

86. On the 18 September MT wrote to the claimant advising that the notes taken at RCSE meetings were not releasable as witnesses had been assured they would not be quoted or their views attributed. Access was arranged to allow the claimant access to his emails.

87. The claimant's suspension was reviewed on the 25 September at which the claimant and his BMA representative were present. Various matters were discussed including the claimants wish to get access to his office, notes and email account.

88. MM wrote to the claimant following the meeting setting out what had been discussed (**Rp451-452**). He noted that finding the claimant alternative work would take time and that it was hoped that the fact-finding investigation would be completed within a reasonable timescale. Carrying out non- clinical work was discussed. The claimant was later allowed 'read only' access to his email account.

Referral to GMC

89. Following referral to the GMC that organisation applied to the Medical Practitioners Tribunal Service for interim orders suspending the claimant from practice. The claimant was legally represented at a hearing before the Medical Practitioners Tribunal Service which took place on the 7 October Interim orders were granted for a period of 15 months which included the claimant having to inform the GMC of any new post or work he applied to do and a prohibition on carrying out head and neck surgery. This was confirmed by letter dated 8 October 2014 sent to Dr Dijkhuzen (**Rp456-457**).

90. Dr Dijkhuizen retired early in October.

91. The suspension was reviewed once more on the 6 October and continued. The claimant was concerned about his regular revalidation as a surgeon and was reassured that the suspension stopped the period running. Discussions took place about difficulties the claimant had accessing his computer which MM confirmed he should raise with MT and the IT department. MM wrote confirming what had been discussed by letter dated 14 October (**Rp464 - 465**).

92. By mid October the respondents were making arrangements for the claimant's patients to be reviewed.

93. TL conducted an audit of some of the claimant's patients.

94. The claimant was interviewed as part of the fact-finding investigation on the 9 October.

95. The claimant's suspension was once more reviewed on the 27 October and the claimant advised about the progress of the investigation by Dr Bain and reasons for delay such as the school holidays. The claimant asked for clarity about the alleged breakdown in relationships and was told that the then Medical Director had said that relationships had broken down to the extent that his consultant colleagues felt they could no longer work with him. The suspension was continued. A letter dated 5 November (**Rp477-478**) was sent by MM confirming the terms of the discussions that had taken place.

96. On the 6 November the claimant sent the respondents some documents for consideration in the investigation (**Rp483**) including a response to the audit prepared by TL. The claimant had still not formally responded to the RCSE report citing difficulties in gaining access to patient notes.

97. The claimant had his suspension reviewed once more on the 17 November. He was told that the investigation was almost complete. The suspension was continued meantime (**Rp499**).

98. The claimant held a registration with the General Dental Council. The claimant self- referred himself to them because of the GMC investigation. They contacted the respondents in late November about the claimant and were passed a copy of the RCSE report by MM. MM advised them about the current position and suggested that the outstanding issues would not impact on his registration as a dentist. The Council took no formal action against the claimant.

99. The claimant's suspension was continued on the 9 December and 7 January.

100. The fact- finding report was issued on the 13 January 2015 (**Rp526-535**) The findings were:

- *Investigation team found evidence to suggest that there has been an irreconcilable breakdown in relationships and the trust between Mr*

Renny and his three consulting colleagues in the Maxillofacial Department;

- *The investigation team found evidence that this was related to a fundamental difference in clinical colostomies;*
- *All clinical interviewees described the breakdown of relationships has been related to resection margins within clinical activity;*
- *There has been a slow decline over a number of years in working relationships between Mr Renny and his three departmental colleagues based on their clinical approach which has affected the wider team. The evidence appears to support being offered to Mr Renny in the declining situation which he refused;*
- *The investigation team heard concerns from staff at all levels within the Maxillofacial Department that over a number of years that Mr Renny's communication style and team working had led to confusion for colleagues;*
- *Investigators heard evidence that when Mr Renny did undertake ward rounds they were infrequent, unplanned and relied on limited verbal and written communication. They felt this resulted in confusion amongst nursing staff and junior doctors around agreed plans of care;*
- *Mr Renny appears to believe in cultural hierarchy based on length of service rather than trust and mutual respect;*
- *Working relations between Mr Lowe, Mr Morrison and Mr Ryan are good and have been evidenced by staff working effectively for patient care;*
- *The investigation found evidence that Mr Renny has difficulty in undertaking team activities on the ward. This was evidenced by several interviews corroborating that Mr Renny did not attend team ward rounds nor communicate effectively with staff at all levels in relation to facial care;*
- *The investigators found evidence that the gradual breakdown in relationship has had a significant impact on the psychological wellbeing of the senior medical team. A number of medical staff during interview were clearly emotional and under stress;*
- *At interview Mr Renny focused on the findings and make up of the RCS Report. He does not accept the recommendations and believes the report was biased in favour of Mr Low's practice;*
- *Although clinical practice was not the remit of the investigation it should be noted that members of the Maxillofacial team volunteered that they would not wish their loved ones to be treated by Mr Renny surgically for Cancer;*
- *Interviewees believe Mr Renny thinks that Mr Low has a personal vendetta against him; the interview team found no evidence of this;*
- *Interviewees provided evidence which suggested Mr Renny has been alleging potential malpractice on his colleagues since the outcome of the RCS Report;*
  - *This has caused the stress for the entire senior medical team;*
  - *This has led to distrust of Mr Renny's future team working and the remaining senior medical team are fearful of re-establishing the working relationship with him;*

- *Mr Renny is frequently described as a "gentleman" and was described as friendly and approachable;*
- *Mr Renny was portrayed as the organiser of social activities;*
- *Some staff were upset that there was a lack of clarity regarding Mr Renny's present absence from work;*
- *The investigators found that despite the ongoing issues, the department is functioning relatively normally to take account of the onerous workload;*
- *The investigators have found evidence that most staff in the department had been broadly protected from the deterioration in the consultant relationships;*
- *The RCS Report appears to have been shared differently;*
- *The four Maxillofacial consultants have received full RCS Report;*
- *Some interviewees received different extracts of the RCS Report depending on their discipline this allowed some staff to create inferred conclusions.*

101. The report recommended that to support any future return to the work place the respondents had to ensure the following recommendations were met:

a. *Mr Renny must accept the findings and their recommendations in the RCS Report within timescales made by NHS Grampian.*
b. *Continuous formal external support for Mr Renny's re-introduction into the department must be in place.*
c. *Mr Renny must integrate fully with current ways of team working (e.g. ward rounds, appropriate handover) and this should be reflected in his job plan.*
d. *Mr Renny must positively contribute to the repair of the working relationships.*
e. *Mr Renny and NHS Grampian must agree a suitable mentor to support acceptable standards of behaviour.*
f. *Mr Renny must accept that his own behaviours have also detrimental effected the working relationships with his fellow consultant and colleagues.*
i. *He must co-operate fully with any processes that have resulted in both in this fact finding and RCS report.*
ii. *Mr Renny must write a letter of apology to his consultant colleagues.*

The report concluded that if the recommendations could not be met then the claimant could not return to his previous position due to the irreconcilable breakdown in trust and working relationships.

102. A meeting took place on the 28 January 2015 with MM and the claimant to review the claimant's suspension and to discuss the fact-finding report. MM

advised the claimant that they aimed to get him back to work. There was a discussion about the claimant working elsewhere other than at ARI and the practicalities of this. The claimant was asked how he envisaged a return to ARI and he said that he would behave professionally but would 'retreat to his room'. This caused MM concern as to whether any return to the department could be achieved.

103. The recall/review of a number of the claimant's patients began on the 2 February (**Rp544**).

104. On the 12 February the claimant was in contact with Malcolm Wright the Chief Executive about concerns he had about his patients.

105. A further meeting took place on the 19 February 2015 to review the claimant's continued suspension and discuss the fact-finding report. At the meeting the claimant provided a detailed written response to the report. He accepted that relationships had broken down. The suspension was lifted. It was agreed that the claimant would work on non-clinical duties from Summerfield House in Aberdeen from the 23 February. He was offered a meeting with NF to assist his return and OHS asked for a rehabilitation programme. A letter dated 24 February was sent to the claimant confirming the position (**Rp566**). MM wrote setting out what had occurred:

> ''*You handed a copy of your detailed response to the report and we advised you we would take this away and read it. You also advised us that you did not agree with the report, however, do accept that there has been an irreconcilable breakdown of relationships within the department and you told us that you no longer trust the people in the Maxillofacial department.*
>
> *I asked you if that meant you had made the decision that you do not wish to return to work in the department and you replied you would rather work elsewhere. You said you would have hoped you could go back to the department but feel there is too much malice from Mr Lowe and that you don't see how you could ever work with him again. You did add that you felt it may be possible to work with Mr Morrice and Mr Ryan if they were prepared to concede that some of their actions were wrong, and that they've been influenced by Mr Lowe. You said at the moment they seem set in the view what they did was correct – even though you had pointed out things they did which were wrong.*

I said that the report is like putting a mirror in front of you and it may not be pleasant. We really do want to aim to move things forward – colleagues may respond differently and you may dispute what they have said, but we are where we are. Mediation is there if all parties are willing but if not, and we haven't asked the others, the starting point is to ask if you are willing. However, the situation is not easy and clearly you feel people have been very critical."

There was a discussion in relation to the claimant possibly working in Elgin and whether he felt he could work through the MDT.

106. The claimant was then in contact with Malcolm Wright the Chief Executive (**Rp586**) enclosing various papers he had prepared. He mentioned the constructive tone of the last meeting he had with management. He also raised concerns about possible misconduct since 2013 in relation to the review and follow up of his patients involving TL. He raised six specific cases. He also requested a copy of the RCSE report which he suggested contained multiple factual inaccuracies. He wrote:

"*It should be borne in mind that Mr Lowe had access to all of Mr Renny's patients from July 2013 from which to choose case criticisms. Mr Renny in contrast has never had access to Mr Lowe's patients and has had no access to his previous H & N patients since 2013, which has been compounded by NHSG's refusal to allow Mr Renny access to case records where concerns had been raised, to date. Regretfully it is possible that further patient concerns in the OMFS H & N surgery will emerge in due course."*

107. On 20 March 2015 a meeting took place between MM and the three consultants to discuss the situation and the practicalities of whether the claimant could work in Elgin or Orkney. This would mean cooperating with the Maxfac department and consultants. They expressed the view that they had concerns about the claimant returning in any capacity. They could not see how working outside Aberdeen could work and commented on their knowledge that the claimant did not accept any criticism and was saying that he should not have been suspended. The meeting was minuted (**Rp580-581**).

108. The comments of TL were recorded as:

"*TL said that he has had threats from NR, his behavior is vicious, NR has no insight into his behavior – and the patient's safety concerns are huge. Having NR back to work is not workable or practical. NR does not realise or accept that it was never about NR as a person, it was always about patients and concerns for them.*"

109. Following an earlier telephone discussion between the claimant and Malcolm Wright about the claimant's concerns about his patients he emailed Mr Wright to check he had received his email (**Rp614**).

110. A meeting took place on the 6 May 2015 between the claimant, his BMA representative and MM to discuss the RCSE report and the out-come of the fact- finding report, the claimant's Dignity at Work complaint and options for suitable alternative employment. The claimant said that he did not accept the findings of the RCSE report and that it should have been an individual review. He suggested that this was a breach of NHS Grampian policy and that the reviewers had missing information and data. He alleged that the final report had possibly been changed. MM accepted that the review was of a small number of cases. He asked the claimant if he would accept the findings of a wider review.MM agree to consider this.

111. Following the meeting MM emailed the claimant on the 10 May after considering the current situation (**Rp612**). He noted:

"*As I stated at our last meeting, having now caught up with most of the correspondence, I am concerned that the clinical actions taken so far have been based upon how selective small number of cases from your own practice. Having said that the GMC has, by an IOP, nevertheless restricted your practice and is in the process of further examining matters. From your own information we assume that the review of this will be in the near future. The ruling here will be essential to determine (ing?) how to proceed. For example if you feel there is sufficient evidence to continue to restrict your practice then we would have to continue as we are currently doing. If they feel there is insufficient evidence to make a ruling then we will need to consider a full external investigation of not only your own practice but that of your colleagues too. I doubt this will just be acceptable to only look at oncology patients. It does have a risk to yourself but you affirm that if such an investigation established that your*

own practice was not up to acceptable standard that you would fully accept this ruling.
Susan and myself have major reservations about you putting in a D@W action against your colleagues as we feel (and as we explained back) that this might well make things worse for yourself. This is why we asked you to reconsider matters but agreed to respect your decision and you have now decided to proceed with this so will initiate the requisite action."

112. The claimant e-mailed Susan Coull in HR with his detailed comments on the meetings of the 6 May 2015 and 14 May confirming that he wanted to proceed. In October (**Rp627**) 2015 he wrote:

"*During the meeting of 6/5/2015 I did state that I did not accept the RCS Eng IRM review outcome and provided Malcolm Metcalfe with my initial comments upon the MDT section of the IRM report on 7/5/15, which you enclosed. I had previously provided NHSG with more detailed comments on the background and patient sections of the RCS Eng IRM report after I had been given access to the 6 patient notes by NHSG in November 2014 – January 2015- more than 9 months after I should have had access to these patient notes according to IRM regulations. I was previously told that NHSG did not want to "re-visit" the RCS Eng and IRM report, despite my reported concerns that even though that report is the basis on which I was referred by Dr. Dijkhuizen to the GMC in August 2014.*"

In September 2015 he wrote:

"*During the meeting of 6/5/2015 I did state that I did not accept the RCS Eng IRM review outcome and provided Malcolm Metcalfe with my initial comments upon the MDT section of the IRM report on 7/5/15, which you enclosed. I had previously provided NHSG with more detailed comments on the background of patient sections of the RCS Eng IRM report after I had been given access to the six patient notes by NHSG in November 2014 – January 2015 more than nine months after I should have had access to these patient notes according to IRM Regulations. I was previously told that NHSG did not want to "revisit" the RCS Eng and IRM report, despite my reported concerns that even though that report is the basis on which I was referred by Dr. Dijkhuizen to the GMC in August 2014.''*

113. The claimant made various complaints in relation to the process that had been followed and its fairness.

114. The claimant raised concerns that evidence particularly notes used in the RCSE report had been altered. He also raised concerns about the use of the

audit carried out by TL (**Rp618/619**). He was advised that his concerns would be looked at and investigated.

115. In September 2015 the claimant raised various concerns about his colleagues and the running of the department. Some of the complaints went back to 2012. He referred to 'defamatory, fabricated and incorrect, statements not substantiated..' (**Rp635**) He pressed for a wider review of the department.

116. In the period after the lifting of the claimant's suspension MM continued to look for job opportunities for the claimant. At this time the claimant continued to raise concerns in relation to his former patients and how they were being reviewed. He was assured that these would be looked into. The concerns were passed to NF and then to the clinical management teams for action. The claimant continued to seek access to patient notes.

GMC Report.

117. The Report was issued in April 2016 by the GMC (**Rp779-805**). It concluded the proceedings taken against the claimant by the GMC and took no further action against him. It stated:

> "*We agree that in the light of the criticisms aimed at the whole department and the communications, the selective nature of the analysis of Mr Renny's cases, and allegations of poor departmental relations, the allegations in respect of Mr Renny's performance, based on the RCS report, do not meet the realistic prospect test.*
>
> *We also recognise that Mr Renny has been placed under IOT conditions since 2014, and no concerns have been raised whilst he has been under supervision. When determining the realistic prospect test is not met, we considered whether a warning would be proportionate in this case. Warnings are appropriate for a doctor's conduct represents a significant departure from Good Medical Practice, following just below the threshold for a finding of impaired fitness to practice, a warning is a follow on response to draw the doctor's attention to specific concerns and highlight that any repetition is likely to result in a finding of impaired fitness to practice, and to enhance public confidence in the profession. In view of Mr Renny's insight demonstrated in his Rule 7 response, and the mitigation offered in relation to the specific cases, we agree that a Warning would not be appropriate in this case. We note Mr Renny's remarks in his acceptance of his sub-optimal performance in case E. We would therefore close this case with the advice to Mr Renny to continue to reflect on his approach to operative planning and pre-operative investigations.*

In reaching our decision we have regard to the GMCs overarching objectives to protect, promote and maintain the health and safety of the public; promote and maintain public confidence in professions; and promote and maintain proper standards and conduct for members of the profession."

118. The claimant made no secret of the fact that he believed that he had been exonerated by the report.

Dignity at Work

119. The claimant had felt that he had been badly treated by his three colleagues particularly in the way in which they had raised their concerns at the two meetings they had in June 2013. He had other concerns about their later behaviour in relation to the RCSE report. He believed that they had deliberately forced him out of the department and had taken his private work at the Albyn Hospital. He had delayed formally raising a Dignity at Work complaint at the time but in April 2015 he lodged a formal complaint (**R p582-585**). He asserted that the earlier fact- finding investigation into a breakdown in trust was inadequate (**Rp618**).

120. The respondents tasked a Wendy Greenstreet and Fiona Findlay to carry out the investigation which they did. This involved having various witnesses interviewed including the three Maxfac consultants.

121. The report was sent to the claimant on the 24 June 2016 by MM (**Cp555**) It was circulated to the three consultants including TL. (**Rp871-876**) It concluded that there was no evidence of bullying or harassment. The following conclusions were recorded in the report concerning TL or 'R1': *14. There is evidence that the manner in which Ci and R1 communicated with each other was not always effective and that C found this upsetting. There is also evidence that C was not happy that R1 was challenging C's clinical practice and that C found this upsetting. However, there is no evidence to conclude that R's behaviour or actions towards C amounts to bullying mobbing or harassment.*

122. During this time the claimant was in regular contact with the respondent's HR department about various aspects of the different reports and processes that had occurred including allegations of bias on the part of a member of HR.

123. On the 21 June the claimant was advised that the investigation into possible tampering with medical notes was to be closed (**Rp839**) and no action taken.

124. The claimant had pressed for a wider review of patients in the Maxfac department. Following the GMC report which had raised possible procedural failings and organisational problems the respondents agreed to have an external review of patient notes. The claimant was insistent that TL's notes should be included and this was accepted. The claimant was advised at the meeting he had with Mr Bachoo and others on the 20 October (**Rp891**) that the respondents were waiting to hear from the Medical Director in NHS Lothian who would be identified to carry it out. After the claimant's departure in December 2016 a review was carried out.

Secondment to Tayside.

125. The respondent's managers had been in contact with NHS Tayside in the summer of 2015. They ageed to accept the claimant as a surgeon in their Maxfac department in Dundee. The claimant accepted the secondment.

126. On 7 October 2015 the claimant received confirmation that he was seconded to NHS Tayside (**Rp648-649**).

127. The claimant began working as a Maxfac surgeon in Tayside. He got on well with his new colleagues. No issues arose in relation to his practice there as a Maxfac surgeon. He continued to live near Aberdeen and travelled to work.

128. The claimant had a meeting with MM to review the up to date situation in January 2016 at which he confirmed that he was enjoying working in Tayside (**Rp712**).

129. A meeting took place between the claimant and MM on the 18 April 2016 (**Rp806**) He was aware that the secondment could continue but was concerned that he was not doing head and neck cancer surgery. He wanted to return to his full duties. He was disappointed that there was no plan to return him to work. The claimant had personal problems and wanted to work locally. MM suggested that continuing with the secondment would allow a breathing space to complete the Dignity and Work investigation and other outstanding matters such as the review of patient notes. He advised the claimant that he could not be 'parachuted' back to the department but they would do what they could to provide him with work. When asked by MM if he would prefer not to continue the secondment he indicated that because of his particular family circumstances and through not knowing exactly what was expected of him by way of work commitments there he was considering the matter. Shortly after this he chose to terminate his secondment with NHS Tayside. The claimant was also advised that there would be an external review of case notes. MM told him that although only a small number of his cases had been reviewed the results were concerning. The claimant continued to express concerns about the RCSE review.

130. The claimant told the meeting about his correspondence with the RCSE and his suspicion that evidence had been tampered with or was missing. The email sent by the claimant to colleagues stating that the GMC had exonerated him was raised. The claimant was told that it had caused disquiet because of its terms and that TL's work was missed out of it. The claimant's possible return to the department was discussed. He was told that the Dignity at Work complaint and the recent email had made relations worse. He was asked why he kept '*stoking the fire*'. The claimant said that he would return to the department and stay in his room and keep his head down. He said that he had not '*started it*' (p819). He continued to blame his colleagues and dispute any difficulties with his own practice. MM was dismayed that the claimant's apparent attitude and unconvinced that a return could work. He did not believe that the claimant wanted to repair relationships. The claimant stressed that only his cases had been reviewed and criticisms levelled at him

could be applied to '*anyone else*' The claimant confirmed he would accept mediation. The meeting ended with MM confirming that both sides had a lot to think about and that the respondents would have to complete the various investigations before matters could move forward. MM confirmed that he was pushing for the Dignity at Work report to be completed.

Job Applications

131. The claimant considered resignation in about September 2014 when he applied for a post in Middlesborough carrying out head and neck cancer surgery. He had worked there as a Registrar earlier in his career. He did not pursue his interest because his practice had been restricted by the GMC in October.

132. He was conscious that he had to support his family and preferred to stay near Aberdeen where he had his home. Positions as a Maxfac surgeon are not common with about 12 being advertised annually in the UK.

133. The claimant applied for a post in Jersey in 2015. In November he was re-interviewed for the post in Middlesborough and this time accepted it prior to handing in his resignation and accepted it.

Resignation

134. The claimant was unwell from the 22 August until the 15 September.

135. At the meeting the claimant had with Paul Bachoo on the 20 October (**Rp885-900**) his position was fully reviewed. The meeting was minuted. The claimant was advised that following his self-referral to the GDC the respondents had been contacted by them. They had responded to the query that the claimant was not at work at present. The termination of the secondment to Tayside. The claimant raised the possibility of returning to work in Elgin and Orkney but not carrying out head and neck cancer work. Various possible options were discussed. It was agreed that these would be looked at. The Dignity to Work report was discussed and the claimant's right to appeal confirmed.

136. Dr Bachoo subsequently met the claimant's former colleagues on the 20 November to update them and canvass their views on the claimant's return to full duties or In Moray or the Islands. The views expressed were negative.

137. The claimant continued to receive his salary, take sick pay when needed and go on holiday until his resignation. He utilised the respondent's internal policies and procedures including the Dignity at Work process.

138. The claimant wrote to the Chief Executive Malcolm Wright on the 5 December resigning (**Rp912**) He wrote:

> "*I write to inform you that after over 21 years employment I will be resigning as Consultant Surgeon in the Department of Oral and Maxillofacial Surgery of NHS Grampian. I Understand that I am obliged to give you at least 3 months of notice to leave. I have been offered several Consultant posts but have recently accepted a permanent post as Consultant Oral and Maxillofacial Surgeon in H & N Cancer and Reconstructive Surgery in England.*
>
> *Despite severe shortages, NHS Grampian used to be a place that I was proud to work in and for, but the events of the past few years have decimated that feeling. I am sorry that your presence as Chief Executive, and that of the new Chairman and Medical Director have not helped to change the culture or, it seems, even recognise where wrong has been done in NHSG.*
>
> *I am looking forward to leaving OMFS/NHSG to work in England. Many in UK now seem to regard those able to leave NHSG and work elsewhere as fortunate: some cannot. Like many other colleagues who now work outwith NHSG we will however continue to live around Grampian until we no longer know or trust those treating us.*
>
> *We have yet to meet but I would be happy to meet you or participate in an exit interview.*"

139. The claimant attended an Exit Interview. Prior to that he completed a Questionnaire in relation to his reason for leaving (**Rp920-922**) He suggested that there had been no issues in his employment up until 2007 when the employment tribunal proceedings for his colleague had begun and he had not

been appointed Director of Surgery. He blamed his colleagues for not allowing him back into the department accusing them of criticisms and whispering behind his back. He commented on the Dignity at Work report and the failure to uphold his complaints. He alleged bias on the part of the HR department. He blamed a culture of 'targeting' physicians who raised concerns. At the interview in January the claimant commented that he saw no point in appealing the outcome of the Dignity at Work complaint as he had a new job (**p918**).

Witnesses

The Claimant

140. The claimant is an articulate, intelligent and engaging witness who had a very detailed knowledge of the voluminous documents before us, dates of meetings and so forth. As a historian he could not be faulted although at points we did not accept his characterisation of events. He was generally a reliable witness. However, we came to the view that he had been very badly, personally and professionally affected and wounded by the allegations of poor practice made against him by colleagues. He struck us as having limited insight into how he was perceived by those colleagues and he preferred to explain away any criticism as being ill-founded or mendacious. He could not be objective and he attributed the poorest of motives to his colleagues for their actions including having him suspended to take his private work from him. As events had unfolded he took various courses of action which rendered any likely rapprochement with those colleagues impossible. We were struck by evidence that when asked how he might be able to work with his Consultant colleagues he responded that he would act professionally but would otherwise retreat to his room. It confirmed to us that the respondent's witnesses were correct in their assessment that not only did the claimant still hold to the belief that he was in some way the wronged party and that there was no proper basis for criticism of his work, despite the terms of the reports that had been prepared, and that in these circumstances it would be impossible to repair relationships effectively for these reasons alone.

141. Dr. Donald Ross gave evidence for the claimant. Dr Ross retired from practice some years ago following a distinguished career in which he had been the respondents Medical Director. He was a credible and reliable witness but one through his continuing contact with the respondents who had become a little jaundiced with some of the respondent's actions. He was generally critical at the number of external reviews the respondents commissioned their cost and so forth. Whilst we respect his opinion he did not have the detailed information the respondent's managers had access to in relation to the claimant's particular case. We fully understand his view that such reviews have considerable disadvantages as they appear to be expensive, lengthy and time consuming. He implied that they could also be used inappropriately to 'park' problems without seeking to address them directly and they damage a doctor's career. There was no evidence before us to suggest that in the present case where serious allegations were made and to an extent found to be justified by the two reports that the referral was being used to damage the claimant's career or to 'park' the issue. From a practical point of view we are sure that the Dr Fluck would have been delighted if the issues between the claimant and the other Consultants could have been resolved quickly and amicably and the claimant returned to work in the somewhat stretched department or elsewhere in the service.

Dr. Fluck

142. The first witness for the respondents was Dr. Nicholas Fluck who was the claimant's Line Manager at the point when these events first arose but who is now Medical Director. Dr. Fluck struck us as a careful, reflective, professional and wholly honest witness who gave his evidence in a clear and convincing manner. He displayed no antipathy whatsoever towards the claimant and indeed in not preventing the claimant proceeding with the index operation. He was not prepared to immediately accept the claimant's colleague's criticism of his proposed operative procedure.

Dr. Fiona Mackay

143. Dr. Mackay had been an Associate Medical Director and had now retired. She was a clear and straightforward witness who gave her evidence in a confident manner. We had no doubt that Dr. Mackay was an honest and straightforward witness who we found overall to be entirely credible and reliable.

Mr Malcolm Metcalfe

144. Mr Metcalfe was the Depute Director. Mr Metcalfe was a careful and thoughtful witness who gave his evidence in a clear and straightforward manner. He displayed no antipathy towards the claimant and indeed the evidence showed he demonstrated considerable understanding of the claimant's predicament. He was a wholly credible and reliable witness in whom the Tribunal felt able to put considerable trust.

Dr. Paul Bachoo

145. Dr. Bachoo at the time of these events was the Depute Associate Medical Director. He stepped into the role following Dr. Metcalfe having to stand down through illness. Dr. Bachoo was a careful, candid and clear witness who we found wholly credible and reliable. His involvement in these matters was ultimately limited given the duration of his involvement. We record once more that we detected no antipathy towards the claimant only an understanding that the difficulties that the claimant and indeed the respondents were facing in getting the claimant back to work in Grampian.

Submissions

Claimant

146. Mr Lefevre prepared and lodged written submissions and spoke to those. He first of all set out the findings that he hoped the Tribunal would accept

reflected the evidence. He took the Tribunal through the events beginning in June 2013 with the first meetings between the claimant and his colleagues. The claimant had raised dignity at work issues and was told that there would be a fact finding exercise as provided for in the policies but none took place. They failed to follow their own policies under the Framework for Support policies. The respondent asked for a RCSE report as a 'service review' but none of TL's cases were reviewed. It was only the claimant's cases that were reviewed. The type of review used did not contain the same safeguards that an Individual Review under the RCSE would have contained which allows the individual to see and comment on the report before it is issued. The claimant had no such right under the Service review method.

147. The claimant's solicitor highlighted the claimant's exclusion from cancer work and the difficulties this caused. He suggested that there had been a failure to review and follow up the claimant's list of patients and that this had caused various difficulties.

148. The respondent's Counsel, Mr Hardman, helpfully prepared written submissions which he then highlighted in responding to Mr Lefevre. He began by pointing to the claimant's reasoning for lodging a Dignity at Work complaint in about in relation to matters that occurred in 2013 being his wish to expose the truth of what he believed happened and that this was also the reason for his current claim. It was noteworthy that the RCSE report did not refer the claimant to the GMC and the respondent's reasoning for doing this was flimsy. When the claimant investigated the information the RCSE had access to he found that Mr Lowe had retained access to the patient notes and he suspected they had been altered. The report made reference to retraining but no training options were ever advanced. The claimant believed that the ill will that Dr Dijkhuizen bore towards him influenced the actions taken against hi particularly the referral to the GMC.

149. It was, he emphasised, significant that the GMC closed their enquiry with no action being taken including no warning being issued. On the 30 April a meeting took place with MM and the claimant 'told off' for telling colleagues that the case had been closed. The continuation of the Tayside assignment was discussed at the meeting. The claimant's depression reoccurred at this time. The claimant was asked for a sick note in relation to his non- attendance at a scheduled meeting on the 30 June and this did not increase his confidence in the respondent's managers. The claimant suspected that the respondents had expected the GMC case to continue and had no plans for his return to work in any capacity. The claimant was concerned about revalidating in 2017 and he believed that it would not be made easy for him by NF. Mr Lefevre then examined the referral to the GMC as being the 'kiss of death' to a doctor's career and the evidence. He then examined the failure to provide the claimant with appropriate alternative work and the long periods of suspension.

150. In relation to the issue of affirmation Mr Lefevre submitted that the last straw was the meeting at which it was demonstrated that there was no prospect of returning to work in Grampian. There was no affirmation. The respondent's managers had acted in such a way as to cause a deterioration in his health and the recurrence of his depression due to their actions. Mr Lefevre then turned to the legal context referring to the last straw and the cases of **Malik v BCCI SA (1979) IRLR 462 , Agoreyo v London Borough of Lambeth (2017) EWHC , Western Excavating Ltd v Sharp (1978)1 QB 761 CA and Buckland v Bournemouth University Higher Education Corporation (2010) EWCA Civ 121**. The latter case was authority for the proposition that the passage of time is not in itself enough to count as affirmation. When the claimant made the decision to resign he was not at his usual 'normal' place of work and there was nothing inconsistent with him seeking alternative work and resigning when he did.

Respondent

151. Mr Hardman summarised the legal issues for the Tribunal and the factual matters on which the claimant appeared to rely. He asked that the Tribunal accept the respondent's witnesses as being credible and reliable. His submission was that the claimant demonstrated from the outset in 2013 that he could not contemplate any reasonable or proper motive for the actions of either his colleagues or his managers. He turned to consider the evidence in relation to the proximate cause of the claimant's resignation in December 2016. He noted in particular the comments recorded in the exit interview that the outcomes of the two investigations were incorrect, he had not appealed and did not see the point as he had a new job. The claimant had indicated that he was considering resignation as early as September 2014 when he was first interviewed for the job in Middlesborough. He could not take the job as he was restricted in his practice by the GMC. He had suggested Mr Hardman clearly made up his mind to leave at this point but did not do so. It could therefore be seen that he did not resign in 2016 because of any conduct of the respondents. Simply put the claimant preferred to go to Middlesborough where he had worked before than to stay with the respondent where he had lost the trust and confidence of his consultant colleagues.

152. Counsel then spent some time looking at the respondent's actions in their context arguing that there was no conspiracy as the claimant alleged and that good management reason shad been advanced for the various actions that had been taken. In relation to loss this had not been addressed in evidence and if the Tribunal found the dismissal unfair a remedy hearing should be arranged as suggested by Mr Lefevre.

153. Mr Hardman, also referred the Tribunal to two cases that he felt were of assistance to us:

W E Cox Toner (International) Ltd v Crook (1981) IRLR 443

Perkin v St George's Healthcare NHS Trust (2005) IRLR 934

The first case was well known to the Tribunal and related to the proper test that should be applied in cases of constructive dismissal and when a repudiatory breach is affirmed by an innocent party delaying bringing the contract to an end. The **Perkin** case has some similarity on its facts to the present in that the claimant was employed by an NHS trust and managed a group of employees with whom he appeared to have poor relationships and that a dismissal in these circumstances and on the grounds of the reason being 'some other substantial reason' was a fair dismissal.

Judgment

The Law

154. The Tribunal first of all had regard to the terms of Section 95(1)(c) of The Employment Rights Act 1996 (hereinafter the 'Act') which is in the following terms:-

"**Circumstances in which an employee is dismissed.**

(1) For the purposes of this Part an employee is dismissed by his employer if (and, subject to subsection (2). . . , only if) –

(a) …...
(b) …...

(c) the employee terminates the contract under which he is employed (with or without notice) in circumstances in which he is entitled to terminate it without notice by reason of the employer's conduct".

155. The section provides that when the employee terminates their contract (with or without notice) in circumstances in which they are entitled to do so because of the employer's conduct that will amount to a dismissal for the purposes of the Act. In the present case the claimant resigned without notice. The focus is on the employer's actions not the employee's reaction to those actions and whether the employer, looked at objectively, has been guilty of a repudiatory breach of contract. This is often not easy to apply in practice as decisions are

made by employers in a context which as in this case includes the responses made to events by the employee. The Tribunal therefore has to examine particular events closely but also to look objectively at the whole picture.

156. The Tribunal considered the guidance contained in well known case of **Western Excavating (ECC) Ltd v Sharp [1978] IRLR 27 Court of Appeal** which has laid down time honoured and helpful guidance on this matter. The nub of the matter is to be found in the judgment of the Master of the Rolls, Lord Denning, where he says at page 29, paragraph 15:-

> *"If the employer is guilty of conduct which is a significant breach going to the root of the contract of employment; or which shows that the employer no longer intends to be bound by one or more of the essential terms of the contract; then the employee is entitled to treat himself as discharged from any further performance. If he does so, then he terminates the contract by reason of the employer's conduct. He is constructively dismissed."*

157. Of particular relevance in this case was the contention that the claimant's employers had by their actions, looked at cumulatively and over a period, had destroyed the implied term of trust and confidence that requires to exist between employer and employee. In this regard we reminded ourselves of the case of **Malik v BCCI SA [1997] 3 All ER** and the dicta contained there: that a contract of employment contains an implied term to the effect that an employer: -

> "*would not, without reasonable and proper cause, conduct itself in a manner likely to destroy or seriously damage the relationship of confidence and trust between employer and employee"*.

158. The Tribunal also considered the observations of the Employment Appeal Tribunal in the case of **BG Plc v. Mr P O'Brien [2001] IRLR 496** in that in every case:-

> "*the question is whether, objectively speaking, the employer has conducted itself in a manner likely to destroy or seriously damage the*

relationship of confidence and trust between the employer and employee. *If the employer is found to be guilty of such conduct, that is something which goes to the root of the contract and amounts to a repudiatory breach, entitling the employee to resign and claim constructive dismissal. Whether there is such conduct in any cases will always be a matter for the Employment Tribunal to determine, and having heard the evidence and considered all the circumstances"*.

159. In other words the implied obligation enforces the principle that the employee is entitled to be able to have trust and confidence in his or her employer. In this case the Tribunal had to consider the actions of the employer acting through their managers as they interacted with the claimant and to the background to those actions.

160. As has been noted the breach of the implied obligation of trust and confidence may consist of a series of actions on the part of the employer which cumulatively amount to a breach of the term, although each individual incident may not do so. In particular in such a case the last act of the employer which leads to the employee leaving need not itself be a breach of contract; the question is, does the cumulative series of acts taken together amount to a breach of the implied term (see **Woods v. W M Car Services (Peterborough) Ltd** ***1981 ICR 666***. This being reference to the classic "last straw" situation.

161. These matters were canvassed more recently in the case of ***Buckland v Bournemouth University*** **[2010] EWCA Civ 121**. It was suggested in that case that:-

"*(1) In determining whether or not the employer is in fundamental breach of the implied term of trust and confidence the unvarnished* ***Mahmud*** *(****Malik****)test should be applied.*

(2) If, applying the ***Sharp*** *principles, acceptance of that breach entitled the employee to leave, he has been constructively dismissed.*

(3) It is open to the employer to show that such dismissal was for a potentially fair reason.

> *(4) If he does so, it will then be for the Employment Tribunal to decide whether dismissal for that reason, both substantively and procedurally (see **Sainsbury v Hitt** [2003] IRLR 23), fell within the range of reasonable responses and was fair."*

Affirmation

162. The Court of Appeal in England provided further guidance as to what conduct might amount to a 'last straw' in the case of **London Borough of Waltham Forrest v Omilaju [2005] IRLR 35**. Lord Justice Prophet stated:-

> *"I see no need to characterise the final straw as `unreasonable` or `blameworthy` conduct. It may be true that an act which is the last in a series of acts which, taken together, amounts to a breach of the implied term of trust and confidence will usually be unreasonable and, perhaps, even blameworthy. But, viewed in isolation, the final straw may not always be unreasonable, still less blameworthy. Nor do I see any reason why it should be. The only question is whether the final straw is the last in a series of acts or incidents which cumulatively amount to a repudiation of the contract by the employer. The last straw must contribute, however slightly, to the breach of the implied term of trust and confidence."*

Preliminary Remarks

163. It must be said that neither that the letter of resignation or the initial ET1 were particularly clear as to the reason or reasons why the claimant resigned or why he did so when he did. Even at the stage of submissions although there was lengthy reference to evidence the exact events the claimant was relying on was not always clear. It was difficult to record the evidence because there were a number of matters that were occurring in tandem. We have not gone into detail in relation to the many complaints the claimant had such as of possible tampering with evidence, or difficulties with reviewing patients because these matters were not canvassed in detail before us, they do not seem to be relied on by the claimant and in any event his concerns were all considered and appropriate investigations made by the respondent' management in the long trek towards the final parting of the ways between the parties.

164. As lay people it is difficult to understand fully the dynamics of a working hospital but it was clear to us that staff work under considerable pressure. It was also apparent that particularly in the small Maxfac department in Aberdeen it was essential for colleagues to be able to work together co-operatively and in a spirit of goodwill.

165. Dr Ross, in discussing the difficulty in managing departments colourfully described them as being the domain of various competing tribes jostling for prominence and funding. If there are such tribes then the consultants appear to be the chiefs.

166. This was a case where the passage of time did not heal the relationships between the claimant and his colleagues which became more bitter and entrenched. In his reaction to his colleagues, in his refusal to accept ant criticism and in his many allegations made against his colleagues the Tribunal came to the conclusion that he did himself no favours in trying to heal the breach that had occurred. Despite the claimant now suggesting that he was in favour of mediation his actions throughout suggested that this would have been a fruitless exercise given his own very fixed views. Counsel for the respondents in his submissions highlighted Mr Renny's own evidence in relation to why the Dignity at Work complaint was made by him about his colleagues a couple of years after the initial events giving rise to the complaint which were the initial meetings in June 2013. His response highlighted that he did not accept the criticisms of his practice made either by his colleagues or later by the RCSE and that in his own words he "did not throw the first stone".

Evidence

167. The intervention of the claimant's Consultant colleagues began the respondent's managers involvement in the differences that had arisen over the management of patients in the Maxfac department. It is apparent to us, although not explored fully in evidence, that the genesis of these difficulties

stretched back some time and that the problems in the department had remained unnoticed by senior managers. It was the decision of the three Consultants to express concerns to management that led to them collectively broaching their concerns to the claimant. There has been much criticism of these two meetings although the partial transcript of one meeting which gives considerable detail was not focussed upon in evidence. The claimant takes a particular view of the meetings. Put simply they did not go well and his self - esteem seems to have been badly undermined by them. They led to a rapid deterioration in relationships. We found it interesting to note that as early as July 2014 the claimant was expressing a lack of trust in his consultant colleagues and pondering if things would ever be the same again.

168. However, the meetings might have been successful if the claimant had more fully acknowledged the concerns of his peers. Interestingly although he now says the concerns were baseless at the time he appears to have made some acknowledgement of them in that he seems to have agreed he should be considering stepping back from some aspects of surgery (particularly 'free flap' reconstruction) and possibly slowing down in some way before retirement. In this we believe that there was some recognition or understanding by the clamant that all was not well. We noted that following the meetings he was absent with a stress condition. It certainly could not have been a happy environment for him given the workload and given that relations with his colleague Mr Lowe were apparently already strained.

169. The employer's hope that there might be some meeting of minds was ultimately misplaced but that is to judge the matter with hindsight. There is nothing wrong in principle for professional colleagues to meet to try and discuss their concerns or to be asked to try and do so. It was suggested that some form of mediation should have been tried at a much earlier stage. We can only speculate that some form of mediation might have been more successful because of what actually happened namely that there was a polarisation of positions. What might have assisted, especially for the

purposes of focussing on specific concerns and agreeing evidence, as this became a dispute later, would have been for some sort of internal panel to have been arranged to work through particular concerns with reference to specific patients at which they could note down the respective positions taken by the claimant and the others.

170. From the outset the respondent's managers did not have a clear way of deciding which side, if any, was in the right on any particular matter. We noted the evidence of Dr Fluck that he accepted that there could be a possible *bona fide* professional difference of opinion between the practice of the claimant and the majority in the department and that he was not able to determine if the criticisms of the claimant's technical ability had substance. We noted that he decided not to cancel the free flap operation planned by the claimant despite the concerns of the three consultants. This demonstrated to us both the thought that he put into his decision making and his independence. His actions certainly did not suggest some conspiracy against the claimant from senior management to take advantage of the situation that had unexpectedly arisen. It was against this background that instead of an internal fact-finding report being undertaken an external one was considered.

171. We fully accept Dr Fluck's reasoning that it is easy, especially with hindsight, to suggest that an internal report would have been quicker and more cost effective but it begs the question of who internally had the appropriate expertise to undertake such a task and who would carry weight with and be acceptable to the parties. We would observe that the claimant did not accept the report that was ultimately commissioned from RCSE and we would suggest that there would have been little likelihood of him accepting a report that was critical of him whatever the source.

172. It became clear to us from the evidence of the disputes that arose later in the process that it was unfortunate that the three Consultants were not asked to give detail of their specific concerns which would have allowed the evidence, patient notes etc, witnesses, to be identified earlier and also allowed the claimant an opportunity to respond when he still had access to those patient

notes, emails. But it should also be noted that it was up to the RCSE and GMC review panel to request the witnesses and evidence they wanted to see. In principle referring the matter to an independent body appears a perfectly reasonable response to the situation that had developed.

173. It was argued by the claimant that the Service Review enquiry carried out by RCSE was not appropriate as he was the only surgeon reviewed and apart from the MDT the wider service was not reviewed. Throughout the claimant was very keen for Mr Lowe's patients to be reviewed. When this finally happened nothing untoward was found. The claimant further argued that the Service Review did not contain sufficient safeguards for him specifically he could not comment on the draft conclusions and correct errors. There appears to be a basis for his position. We are not sure whether the claimant or indeed the respondent's managers were fully aware at the time of the possible disadvantages of this particular process over an individual review in which the claimant would see the draft report and could comment on it. Our impression from the evidence is that the respondent's managers thought that some slightly wider view of the service and how it was operating had merit rather than just solely focusing on the claimant. One of the reasons for this is that Dr Fluck considered that the dispute might be caused by a difference in approach/philosophy and that the MDT was possibly not functioning correctly as these differences could be discussed and highlighted there amongst a wider group of professionals.

174. This approach appears perfectly reasonable. It seems that there was a dispute around the role of the MDT with differences of opinion about how it was operating in practice. It should have acted as a check or additional scrutiny of both the claimant's work and that of his colleagues. If the MDT was working well then it would reassure the respondent's managers that the claimant's treatment regimes were being scrutinised and accepted by his peers and if not then improvements to its functioning would be a safeguard for the future. We also bore in mind that the claimant was allowed input into

the terms of reference. He seems to have reluctantly accepted that the process was appropriate and certainly lodged no grievance about its use at the time.

175. The claimant alleged that the views of other professional colleagues were excluded by the respondent's managers from consideration of the allegations made against him. It is somewhat naïve to suggest that if the managers had gone to other professionals and they had expressed no concerns about the claimant's work that the issue would have been resolved given the technical nature of some of the criticisms being made by the other Maxfac surgeons. If others had been brought in to comment we can see that there was a danger of the divisions and polarisation spreading further and the views of these other specialists not being seen to carry weight with either side of the dispute. In essence, therefore, although the professional colleagues that the claimant refers to in Ear Nose and Throat might have been able to give a view from their own professional standpoints and make general comments about the management of the claimant's patients and outcomes this would have limited bearing on the claimant's technical surgical abilities to carry out 'free flap' and other procedures. Although we would concede that they could have assisted was, perhaps, in providing evidence of outcomes and potential corroboration of some diagnostic judgments made by the claimant.

176. At the end of the day the choice made by the respondent's management was to seek specialist advice through an independent service review and we cannot criticise them for this this action as not being a wholly understandable and appropriate response. In the round we do not believe that asking for this particular type of report in itself was something the claimant could rely on as amounting to a breach, even a minor breach of contract.

177. Later we will consider the process that was adopted but would flag up that we were concerned that there appears to have been no clear method to allow the claimant to 'appeal' or challenge the findings of the Report either directly with the RCSE or in some way internally before its conclusions were

accepted. It is also unfortunate that the respondents HR Department did not have a clearer focus in identifying, preserving and protecting the evidence seen by the RCSE which would become the subject of tampering allegations at a later point.

178. The claimant also criticised the expertise of the two authors of the Report that was finally prepared. It has to be born in mind that the RCSE engaged the two experts as being appropriately qualified and not the respondent's managers. The CV's of these experts certainly appear to show that they had considerable specialist expertise. The Report was prepared through the auspices of an independent body namely the RCSE.

179. We can well understand how upset and devastated the claimant was with the critical nature of the report. The Report became available in July 2015. This allowed the respondent's managers to address the issues raised in the Report including the recommended restrictions of the claimant's practice and the interpersonal relationship difficulties in the department.

Fact Finding Report 2015

180. In January 2015 the respondent's managers received the fact-finding report requested by MM into the apparent breakdown in trust in the Maxfac department. The report attempted to chart the history of the breakdown. It said that to return to the department the claimant would have to accept the findings and recommendations of the RCSE report. It was suggested in evidence by the claimant that this went too far as there were flaws in the report. His position was that the respondents were forcing him to accept the flawed report. We would have been concerned if this was the position when coupled with the lack of an obvious appeal mechanism against those findings. We noted that at the meeting on the 19 February with MM that the claimant's representative suggested that this could mean the 'spirit' of the report (**Rp547**). In any event the report was to an extent overshadowed by the lifting of the suspension and attempts at getting the claimant back to work. The

respondents did not, ultimately, require the claimant to accept the RSCE report in full as a precondition to returning to work.

Suspension and GMC referral and Dr Dijkhuizen's role

181. We will make some comments in relation to the role of Dr Dijkhuizen in these events. The claimant alleged that he was acting behind the scenes coordinating in some way the management response. His role was according to the claimant was both crucial and malevolent. The position taken by the claimant was that he had poor personal relations with the respondent's Medical Director Dr. Dijkhuizen because of his support of a colleague, Mrs Hewage, in Employment Tribunal proceedings against the respondent and that his suspension and later reference to the GMC was motivated by personal animosity and was unjustified.

182. Dr Dijkhuizen retired and was replaced as Medical Director in October 2015 and had no apparent influence on events thereafter. During his tenure two particularly significant events occurred that the claimant believes were orchestrated by him namely his suspension and the reference by him, just before he retired, to the GMC. We will now examine these two matters.

183. The Tribunal did not hear evidence from Dr Dijkhuizen but from other senior management figures including NF, MM and MT. We are confident that we have a picture of Dr Dijkhuizen's role in events which is much more straightforward that perhaps the claimant imagined at the time. The decision to suspend the claimant was a management decision taken because of a breakdown in relationships which was seen to be worsening. There was ample evidence before the respondent's managers of this breakdown. It was discussed by the senior management team and with input from the HR department. It has to be borne in mind that the respondent's managers were aware that to function properly the Maxfac department needed all the Consultants to respect and cooperate with each other. They had received the report from RCSE which seemed to disclose very serious concerns about the

claimant's practice and which seemed to corroborate the concerns expressed by the claimant's colleagues. There was no clear path to redeploying the claimant elsewhere within the service without him having to interact in some way with the other Consultants. The respondents were not able to allow him to work alone given the concerns about his practice. In these circumstances the claimant's suspension was justified in our view on that latter ground alone.

184. The referral to the GMC initially did give the Tribunal some concern and the role of Dr Dijkhuizen is perhaps in some minor ways slightly more opaque. The possibility of such a referral seems to have been raised in discussions between him and the regional GMC representative Mr Paxton. What he said and what advice he gave in relation to the GMC's regulatory role is not clear. The reason given by the respondent's managers for such a referral at this stage was that they had the RSCE report and although they could restrict the claimant from practicing head and neck cancer surgery they could not prevent him carrying out such work elsewhere or privately (he had a long association with the Albyn Hospital in Aberdeen).

185. This course of action was also a decision that emerged from discussions at a senior management level and with the GMC representative. Looking at the matter broadly the evidence discloses that it was done with the backing of the Management Committee. Dr. Dijkhuizen wrote the letter to the GMC in his role as the Responsible Medical Officer. In short if it was to be done then the task fell to him as Responsible Medical Officer to do it. From the claimant's perspective it was Dr Dijkhuizen's decision and was seen by him as being vindictive.

186. Dr Ross gave evidence that in his day he would have considered less severe measures given the impact of a referral on a doctor's career and the length of time it took to resolve cases through the GMC. He would have contacted the other Medical Directors in Scotland and forewarned them that the claimant was restricted in his practice. While we understand and indeed have

some sympathy with such an informal approach it has considerable difficulties today and we are doubtful that such an informal approach would have public confidence. Having the claimant promise not to carry out such work would we suggest, be almost impossible in practice to monitor and enforce if the claimant decided to break such an undertaking. There are also proper concerns about patient safety raised in the RCSE report to which the respondent's managers had to have regard.

187. Although the claimant argued that the referral was unjustified, carried out on a 'flimsy' basis and simply a punitive action taken against him it is interesting to reflect how the matter then progressed. The GMC must have considered that the issues raised were strong enough to justify them applying to the Medical Practitioners Tribunal Service for interim orders which they immediately did. That is an independent statutory body which is tasked with ensuing fitness to practice and which made interim orders suspending the claimant's right to deal with cancer cases along with other restrictions. We understand that the claimant was represented at the hearing which concluded that these orders should be made pending the conclusion of the investigation.

188. In summary, we find that there is no evidence that Dr Dijkhuizen improperly interfered with or influenced these processes or made decisions motivated by personal animosity towards the claimant nor do we find any basis to suggest that the referral was improper in some way or could objectively amount to a breach of trust and confidence. On a wide perspective we have no evidence before us to suggest some wider antipathy towards the claimant from the various senior managers involved in decision making or any connection whatsoever between decisions and the claimant's advocacy of Mrs Hewage.

Suspension

189. We looked again at the suspension of the claimant in the light of it being continued for some time. As a general rule continued suspension has to be justified and should be as short as possible. It is a serious matter. Suspension especially over a lengthy period of time can have detrimental effects on the person's capabilities and skills. In the case of a Surgeon regular practice is

needed to maintain their manual dexterity and experience of procedures. The claimant also had an understandable concern about revalidating as a physician and suspected that he would encounter difficulties with this. In the event he did not. We did not hear detailed evidence about these two concerns and noted that he had been reassured that the 'clock' was stopped for revalidation during the period of suspension. The suspension was in any event effectively superseded by the interim order granted in October by the Medical Practitioners Tribunal. The suspension was regularly reviewed and lifted fully in February 2015 when a phased return arranged. We find no matters that amount to any material breach of the implied term here. There were valid reasons for the various actions taken by the employers.

Secondment

190. The respondents were unable to find a suitable post for the claimant in Grampian but were in contact with NHS Tayside. As a result, the claimant started work there doing non-cancer work on the 12 October 2015. The claimant accepted the secondment or 'Clinical Attachment' and in his evidence he indicated that he enjoyed his time there. It must have come as a relief from the conflict in the Maxfac department at ARI. The secondment was continued until May when the claimant terminated the arrangement. During this period there were discussions about the circumstances that would allow the clamant to return to his substantive post or to some other suitable position.

191. The Tribunal came to the view that it was likely that the claimant terminated the arrangement to bring matters to a head with his employers although we accept that there may be some truth in his suggestion that there was insufficient work for him in Tayside. Again, we heard no detailed evidence about this. The secondment could have continued at least for a few months until the 'dust had cleared' and the various outstanding matters addressed. There is no doubt that the claimant saw the GMC report as clearing the way for him either to return to his substantive post or to apply to work outwith Grampian.

192. The Dignity at Work report concluded that there was no evidence that the claimant was bullied or harassed by his colleagues. The significance of this matter lies more in the fact that the claimant, despite being asked to reconsider making the complaint, did so at this point. It seems to follow a pattern of the claimant trying by various means to get back in some way his three former consultants particularly TL. It must have occurred to the claimant that such a complaint was likely to reduce the chances of any possible rapprochement with his colleagues to zero. It followed on complaints made by the claimant of TL tampering with evidence and misleading the RCSE and what seem to be highly improbable allegations of the respondents tampering with the RCSE report. This behaviour in our minds called into question at the very least the claimant's objectivity.

193. We can sympathise with the claimant in how he became frustrated at the situation in which he found himself. We did not agree with his assessment that the GMC report which became available a little before this in some way exonerated his past performance issues. That is not how we read it nor the way in which the respondents did. They still had concerns about the claimant's practice and the practical difficulties in retraining him and returning him to the department given the breakdown in relations with the remaining Consultants. It was in short, a thorny problem and not one that could be easily or quickly resolved. It was made an almost impossible task by the Dignity at Work complaint. It is also noteworthy that the claimant acknowledged the breakdown in relationships in the department almost as far back as 2013 when the initial events arose. The meeting he had in April 2016 with Dr Metcalfe during which he was asked how he would see a return working in practice amounted to a proestation that he had not started the dispute, would simply stay in his room and the meeting ended with him asking for a review of their patients. Looking these matters overall, we do not accept that the respondents were committing a repudiatory breach of contract in not immediately returning the claimant to his old post or at any later point.

Affirmation/Waiver

194. Even if we are wrong in our decision that there was no material breach demonstrated by the claimant's suspension, the commissioning the RCSE report with no clear appeal process or the refusal to return him to the Maxfac department until relationships with his colleagues could be addressed and rebuilt could amount to material breaches, and we do not accept they are, then the claimant affirmed his contract in our view. As soon as the suspension was lifted in February 2015 he agreed at that time he could not return to the department but wanted to work elsewhere. Indeed, he returned to non-clinical work and began discussing other potions to work with the respondent. His consistent position was that he should return to work. While we accept that delay in resigning is only one factor and not in itself sufficient, and there have been long delays in addressing the various difficult and complex issues here this is a case where the claimant accepted the processes adopted by the employer, because we believe he understood the reasons for those processes, and did not resign. Indeed, as late as October 2016 he was asking the respondents to return him to his full duties and fulfil their part of his contract. We accept that in the circumstances here and particularly though the claimant calling on the respondents to perform their side of the contract that he affirmed any breach.

Reason for Resignation

195. The claimant said very little in his letter of resignation to point to the reasons he was resigning. He was more forthright in his handwritten Exit Interview questionnaire where he made reference to not getting promotion in 2008, the Tribunal case involving Mrs Hewage and the alleged culture of targeting physicians like himself who raised concerns. We had no evidence that the latter two concerns were justified and the former allegation was not founded upon.

196. Mr Hardman suggested that the proximate reason for the resignation was that the job the claimant had applied for some months earlier in Middlesborough had become available again. It appears from the letter of resignation that he

had been offered several posts. It appeared to the Tribunal that the claimant was considering resignation for some time possibly as far back as 2014. As we have commented earlier at a fairly early stage he accepted that relationships had broken down and that the department would never be the same again. There were obvious obstacles in the way namely the RCSE report and then the restrictions imposed by the Medical Practitioners Tribunal and the practical difficulties as such jobs were not common and uprooting his family. Nevertheless, what is significant is that the claimant was essentially in the same position he had been for some time when he resigned. The claimant's return to the department, although discussed in April 2006 and later had been put on hold pending the Dignity at Work outcome which would be crucial in discussing any return. It also made redeployment as a Maxfac surgeon in the region doubly difficult as that also depended on a relationship with his colleagues.

197. In summary, we accept that the claimant probably intended leaving the respondent's employment for some time realising that he could not return to the department. He first applied for the job in Middlesborough in 2014. His resignation was not prompted by any new matter or any final straw but by the same job becoming available to him. In these circumstances the claimant resigned for these reasons and not in response to any perceived breach of contract on the part of the employer.

Employment Judge: **James Hendry**
Date of Judgment: **21 February 2019**
Entered in the Register: **22 February 2019**
And Copied to Parties