EMPLOYMENT TRIBUNALS

Claimant: Miss L Thomas

Respondent: Lancashire Teaching Hospitals NHS Foundation Trust

Heard at: Manchester **On:** 14-18 May 2018
21-25 May 2018
29 and 30 May 2018
3-7 December 2018
12-14 December 2018
26 February to 1 March 2019
(in Chambers)

Before: Employment Judge Sherratt
Mr R W Harrison
Ms V Worthington

REPRESENTATION:

Claimant: Ms H Trotter, Counsel
Respondent: Mr A Sugarman, Counsel

JUDGMENT

The judgment of the Tribunal is that:

1. The claimant made protected disclosures in respect of the items set out below, and more particularly in a schedule of alleged disclosures, at paragraphs 1(b), 5, 8, 9, 12, 13, 15, 16, 17, 19 and 20.

2. The claimant did not make protected disclosures in respect of items 2, 3, 4, 6, 7, 10, 11, 14 and 18.

3. The claimant was not subjected to any detriments by any act, or any deliberate failure to act, of the respondent done on the ground that the claimant had made a protected disclosure.

4. The claimant's allegations of direct discrimination done on the ground of sex are dismissed on withdrawal.

5. The claimant was unfairly dismissed but the Tribunal does not find that the principal reason for the dismissal was that the claimant made a protected disclosure.

REASONS

Introduction

1. The respondent is the Lancashire Teaching Hospitals NHS Foundation Trust. The claimant is a surgeon. She did her training in India and has been registered as a doctor in the UK since 2002. She became a Fellow of the Royal College of Surgeons of Ireland in 2002 and of England in 2010.

2. The claimant's first substantive consultant post was with the respondent starting on 8 July 2013 as a consultant surgeon in otorhinolaryngology which is specialism involving the medical and surgical management of patients with diseases and disorders of the ear, nose and throat. The claimant has a special interest in head and neck oncology. She was based at the Royal Preston Hospital.

3. The claimant's employment ended on 31 March 2017 when the notice she had given to the Trust expired.

The Claims

4. The claim form was received on 12 July 2017 naming two respondents. The first was Lancashire Teaching Hospitals NHS Foundation Trust and the second was Professor Mark Pugh, who was at the relevant time the respondent's Medical Director. In a Judgment sent to the parties on 7 November 2017 the complaints against Professor Pugh were dismissed upon withdrawal and he was removed as a respondent.

5. The claimant's complaint of victimisation pursuant to section 27 of the Equality Act 2010 was dismissed on withdrawal in a Judgment sent to the parties on 16 November 2017.

6. Case Management Orders sent on the same date allowed the claimant to amend the claim form so as to allege that the direct sex discrimination for which she sought a remedy encompassed dismissal as defined in section 39(7)(b) of the Equality Act 2010. The complaints pursued and the issues arising from them were set out in the List of Issues annexed to the case Management Orders which superseded an earlier list made in September 2017.

7. The List of Complaints and Issues is as follows:

Preliminary Issue – Protected Disclosures – Part IV Employment Rights Act 1996

1. Did the Claimant disclose information on any of the following occasions:

   (1) on 19 May 2015, in respect of patient safety issues at the neck lump clinic;

(2) on 10 June 2015, in respect of the Claimant's concerns over patient safety at the neck lump clinic and the poor care of a patient referred to as 'HB';

(3) on 18 July 2015, regarding patients being subjected to repeated scans and Fine Needle Aspiration specimens;

(4) on 1 and 2 September 2015, regarding: (i) the interpersonal rivalries affecting client care; (ii) a lack of robust corporate governance; (iii) the extent of tumour recurrence; (iv) the recommendation of surgery without definitive cancer diagnoses; (v) John de Carpentier's treatment of two patients; (vi) her aforementioned concerns regarding patient safety at the neck lump clinic; and (vii) her concerns that she would be victimised;

(5) on 23 September 2015, in relation to the Claimant's concerns over the treatment of two of John de Carpentier's patients;

(6) on 17 November 2015, in relation to the Claimant being subjected to harassment from her colleagues;

(7) between 13 and 18 November 2015, regarding the Claimant's concerns about her colleagues' harassing behaviour towards her;

(8) on 4 December 2015, in relation to the Claimant's colleagues raising unjustified concerns over the Claimant's work **[conceded by respondents]**;

(9) on 11 January 2016, regarding the Claimant's victimisation by her colleagues **[conceded by respondents]**;

(10) on 7 February 2016, in respect of the continued poor service in the neck lump clinic and the Trust's failure to take steps to address it;

(11) on 24 February 2016, regarding the Claimant's colleagues' unpleasant, demeaning and unprofessional treatment of her;

(12) on 18 April 2016, in respect of her concerns over the safety of two particular patients;

(13) on 20 April 2016, in respect of various patient safety and corporate governance matters previously highlighted to Professor Pugh **[conceded by respondents in respect of a letter of 31 March 2016]**;

(14) on 26 April 2016, in respect of the high number of thyroidectomies and clinicians making decisions without reference to the evidence;

(15) on 1 July 2016 and 1 September 2016, in relation to the Claimant's colleagues' behaviour towards her, the Trust's failure to address her

concerns over the neck lump clinic, and John de Carpentier's lack of probity **[conceded by respondents]**;

(16) on 29 September 2016, in respect of an inappropriate decision made about a particular patient without ensuring reasonable pathological certainty **[conceded by respondents]**;

(17) on 23 January 2017, in respect of the shortcomings of the MHPS Investigation and Report and the Claimant's victimisation by her colleagues **[conceded by respondents]**;

(18) on 17 February 2017, in respect of the shortcomings of the MHPS Investigation and Report and the Claimant's victimisation by her colleagues;

(19) on 17 February 2017, in respect of the Trust's victimisation of and discrimination towards the Claimant; and

(20) on 31 March 2017, in respect of the continued safety issues with MDTs and decisions of consultants which were not in keeping with good medical practice **[conceded by respondents]**?

2. If so, did the claimant reasonably believe that the information tended to show one or more of the matters set out in section 43B(1) of the Employment Rights Act 1996 ("ERA 1996")?

3. If so, did the claimant reasonably believe her disclosures were made in the public interest?

4. If so, were the disclosures made in accordance with any of sections 43C to 43H?

Detriment in Employment section 47B ERA 1996

5. Was the Claimant subjected to any of the following detriments by any act or deliberate failure to act by the respondent:

(1) The failure to apply the Trust's whistleblowing, grievance and bullying and harassment policy to protect the Claimant from retaliation from 21 April 2014 to date;

(2) Hostile, aggressive and poor behaviour by colleagues in MDT meetings from around late September/early October 2015 to September/October 2016;

(3) Incident report forms being raised against the Claimant by her colleagues between 27 October 2015 and 17 November 2015;

(4) A joint letter of complaint sent to Professor Pugh by four consultant colleagues on 19 November 2015 making allegations against the Claimant;

(5) Being told to reflect on her knowledge, skills and behaviour in a meeting with Professor Pugh and Mr Bhowmick on 20 November 2015;

(6) Failure to provide the Claimant with full details of the complaints made against her by despite repeated requests from 20 November 2015 to 10 June 2016;

(7) The restrictions imposed on the Claimant's practice from 25 February 2016 onwards;

(8) The removal of a patient from under the Claimant's care on 9 March 2016 when it had previously been agreed she could treat the patient;

(9) Subjecting the Claimant to a prolonged and partisan MHPS investigation with flawed findings between March 2016 and 12 December 2016;

(10) The Trust's failure to give any meaningful consideration to lifting the restrictions on the Claimant's practice from 13 June 2016 to 31 March 2017;

(11) The imposition of a period of supervised practice and NCAS assessment at another unit from 18 January 2017 onwards;

(12) Failing to investigate the Claimant's grievance dated 17 February 2017 within a reasonable period of time, or at all, and in breach of the Trust's grievance procedure and/or bullying and harassment at work policy and procedure and disciplinary procedure; and

(13) The referral of the Claimant to the GMC and HPAN notification in relation to her future employment from 31 March 2017 to date.

6. Was the Claimant subjected to any of the following detriments by any act or deliberate failure to act by Professor Pugh:

(a) Failing to provide the Claimant with full details of the complaints made against her despite repeated request that they do so from 20 November 2015 to 10 June 2016;

(b) Telling the Claimant to reflect on her knowledge, skills and behaviour in a meeting with Mr Bhowmick on 20 November 2015;

(c) Imposing restrictions on the Claimant's practice without assessing the merits of the Claimant's complaints and despite being forewarned that she was being victimised from 25 February 2016 onwards;

(d) Subjecting the Claimant to a prolonged and partisan MHPS investigation with flawed findings between March 2016 and 12 December 2016;

(e) Removing a patient from under the Claimant's care on 9 March 2016 when he had previously been agreed she could treat the patient;

(f) Failing to give any meaningful consideration to lifting the restrictions on the Claimant's practice from 13 June 2016 to 31 March 2017;

(g) Seeking to impose a period of supervised practice and NCAS assessment at another unit from 18 January 2017 onwards; and

(h) Referring the Claimant to the GMC and requested an HPAN alert in relation to her future employment from 31 March 2017 to date.

7. If the Claimant was subjected to the detriments above can the respondent show that the ground on which each act or deliberate failure to act was done was not that she had made protected disclosures?

8. In so far as any acts or deliberate failures to act for which the claimant seeks a remedy occurred more than three months prior to the presentation of her complaint, allowing for the effect of early conciliation, can the claimant show:

(a) That the act or failure was part of a series of similar acts or failures ending within that period, or

(b) That it was not reasonably practicable for the complaint to have been presented within time and it was presented within such further period as the Tribunal considers reasonable?

Equality Act 2010

Direct Sex Discrimination section 13

9. Are the facts such that the Tribunal could conclude that the respondent because of sex treated the claimant less favourably than it treated her male comparators John de Carpentier and Shakeel Aktar (or would have treated a hypothetical comparator whose material circumstances were no different) in any of the following respects:

(a) failing to apply its whistleblowing, grievance and bullying and harassment policies to the Claimant to protect her from retaliation from 21 April 2014 to date;

(b) placing restrictions on the Claimant's clinical practice from 25 February 2016 onwards;

(c) subjecting the Claimant to an MHPS investigation in relation to her practice and conduct from March 2016 and 12 December 2016;

(d) on 9 March 2016, removing a patient from the Claimant's care when it had previously been agreed that she could treat that patient;

(e) failing to give any meaningful consideration to lifting the restrictions on the Claimant's practice from 13 June 2016 to 31 March 2017;

(f) requiring her to accept a period of supervised practice and an NCAS assessment based at another unit from 18 January 2017 onwards;

(g) penalising the Claimant for her refusal to accede to supervised practice at another unit and criticising her for lacking insight from 18 January 2017 to date;

(h) failing to investigate the Claimant's grievance dated 17 February 2017 within a reasonable period of time, or at all, and in breach of the Trust's grievance procedure and/or bullying and harassment at work policy and procedure and disciplinary procedure;

(i) referring the Claimant to the GMC and requesting that an HPAN alert be issued in respect of her from 31 March 2017 to date, and/or

(j) if the claimant establishes that her resignation should be construed as a dismissal (see issue 12 below), by dismissing the claimant?

10. If so, can the respondents nevertheless show that they did not contravene section 13?

Equality Act Time Limits

11. In so far as any of the matters for which the claimant seeks a remedy occurred more than three months prior to the presentation of her complaint, allowing for the effect of early conciliation, can the claimant show –

(a) That it formed part of conduct extending over a period ending less than three months before presentation, or

(b) That it would be just and equitable for the Tribunal to allow a longer period?

Unfair Dismissal – Part X Employment Rights Act 1996

Dismissal

12. Did the Claimant's resignation on notice on 23 January 2017 (leading to the termination of her employment on 31 March 2017) amount to a dismissal within the meaning of section 95(1)(c) Employment Rights Act 1996, in that:

(a) The Trust breached the express terms of the Claimant's contract and the implied term of mutual trust and confidence by any of the actions listed at paragraphs 5,6,9 and 12 above, taken alone or in cumulation;

(b) That breach was a reason for the resignation, and

(c) The claimant had not lost the right to resign by affirming the contract by delay or otherwise?

Reason

13. What was the sole or principal reason for the treatment amounting to a fundamental breach of contract? Was it:

(a) one or more protected disclosures, rendering dismissal automatically unfair under section 103A ERA 1996?

(b) some other substantial reason falling within section 98(1)(b) ERA 1996, in which case the question of fairness arises, or

(c) neither of the above, in which case the dismissal is unfair under section 98?

Fairness

14. If the respondent shows a potentially fair reason for the dismissal of the claimant, was dismissal fair or unfair under section 98(4) ERA 1996?

Remedy

15. If any of the Claimant's claims are upheld, should the Employment Tribunal make:

(a) A declaration that she has:

i. Been unlawfully discriminated against by reason of her sex;

ii. Suffered detriments for making qualifying protected disclosures; and

iii. been unfairly dismissed?

(b) An award of compensation for:

i. injury to feelings;

ii. her pecuniary losses;

iii. aggravated damages;

iv. 25% uplift for breach of the ACAS Code of Practice on Disciplinary and Grievance Procedures;

v. Interest; and

vi. such other relief within its jurisdiction as the Employment Tribunal may direct?

8. On Friday 14 December 2018 the claimant's counsel withdrew the allegation in respect of detriment (m) accepting the contention made on behalf of the respondent that referrals to the GMC are privileged and because no HPAN notification was ever sent.

9. Also on 14 December the claimant withdrew her complaint of direct sex discrimination. This rendered much of the evidence heard by the Tribunal irrelevant for the purposes of this judgment.

10. The withdrawn allegations now appear in the List of Complaints and Issues in grey rather than in black.

11. A schedule was prepared in respect of the alleged public interest disclosures, summarising them and providing a summary of the responses. Allegation 18 was conceded by the claimant in evidence not to be a disclosure but a detriment, and so it is shown in grey.

The Evidence

12. The claimant produced a witness statement set out over 100 pages containing 398 paragraphs. The claimant was subject to extensive cross examination. The claimant also called Miss Q van Den Blink and she was cross examined. The claimant tendered a witness statement from Mrs M Ranka employed by the respondent as a consultant in restorative dentistry and Clinical Director of Dental Specialities.

13. The respondent called eight witnesses. They are listed and their roles are described below in the order in which they were called:

Andrew Fishburn	Clinical Nurse Specialist
Arnab Bhowmick	Consultant Surgeon
Arun Cardozo	Consultant Surgeon
Muthiah Sivaramalingam	Consultant Oncologist
John de Carpentier	ENT Surgeon
Geraldine Skailes	Medical Director and Consultant Oncologist
Kishore Pursnani	Consultant Surgeon
Mark Pugh	Former Medical Director and current Consultant in Critical Care Medicine and Anaesthetics

14. There were five lever arch files containing around 2,600 pages. Approximately 20% of them were referred to during the hearing.

The Judgment

15. We shall first of all deal with the alleged public interest disclosures. We shall then move on to consider the alleged detriments before concluding by looking at the question of constructive unfair dismissal.

16. There has been a considerable volume of evidence and of cross examination. We shall only deal with the matters that we consider relevant to the issues in respect of which we have to make findings. As we are intending to deal with matters individually then there may be some duplication.

Public Interest Disclosures

17. The sections of the Employment Rights Act 1996 that are relevant to this question are:

> **43A Meaning of "protected disclosure"**
>
> In this Act a "protected disclosure" means a qualifying disclosure (as defined by section 43B) which is made by a worker in accordance with any of sections 43C to 43H.
>
> **43B Disclosures qualifying for protection**
>
> (1) In this Part a "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following –
>
> (a) that a criminal offence has been committed, is being committed or is likely to be committed,
>
> (b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,
>
> (c) that a miscarriage of justice has occurred, is occurring or is likely to occur,
>
> (d) that the health or safety of any individual has been, is being or is likely to be endangered,
>
> (e) that the environment has been, is being or is likely to be damaged, or
>
> (f) that information tending to show any matter falling within any one of the preceding paragraphs has been, or is likely to be deliberately concealed.
>
> (2) For the purposes of subsection (1), it is immaterial whether the relevant failure occurred, occurs or would occur in the United Kingdom or elsewhere, and whether the law applying to it is that of the United Kingdom or of any other country or territory.

(3) A disclosure of information is not a qualifying disclosure if the person making the disclosure commits an offence by making it.

(4) A disclosure of information in respect of which a claim to legal professional privilege (or, in Scotland, to confidentiality as between client and professional legal adviser) could be maintained in legal proceedings is not a qualifying disclosure if it is made by a person to whom the information had been disclosed in the course of obtaining legal advice.

(5) In this Part "the relevant failure", in relation to a qualifying disclosure, means the matter falling within paragraphs (a) to (f) of subsection (1).

43C Disclosure to employer or other responsible person

(1) A qualifying disclosure is made in accordance with this section if the worker makes the disclosure in good faith –

(a) to his employer, or

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

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

(ii) any other matter for which a person other than his employer has legal responsibility,

to that other person.

(2) A worker who, in accordance with a procedure whose use by him is authorised by his employer, makes a qualifying disclosure to a person other than his employer, is to be treated for the purposes of this Part as making the qualifying disclosure to his employer.

43G Disclosure in other cases

(1) A qualifying disclosure is made in accordance with this section if –

(a) the worker makes the disclosure in good faith;

(b) he reasonably believes that the information disclosed, and any allegation contained in it, are substantially true;

(c) he does not make the disclosure for purposes of personal gain;

(d) any of the conditions in subsection (2) is met; and

(e) in all the circumstances of the case, it is reasonable for him to make the disclosure.

(2) The conditions referred to in subsection (1)(d) are –

(a) that, at the time he makes the disclosure, the worker reasonably believes that he will be subjected to a detriment by his employer if he makes a disclosure to his employer or in accordance with section 43F;

(b) that, in a case where no person is prescribed for the purposes of section 43F in relation to the relevant failure, the worker reasonably believes that it is likely that evidence relating to the relevant failure will be concealed or destroyed if he makes a disclosure to his employer; or

(c) that the worker has previously made a disclosure of substantially the same information –

(i) to his employer; or

(ii) in accordance with section 43F.

(3) In determining for the purposes of subsection (1)(e) whether it is reasonable for the worker to make the disclosure, regard shall be had, in particular, to –

(a) the identity of the person to whom the disclosure is made;

(b) the seriousness of the relevant failure;

(c) whether the relevant failure is continuing or is likely to occur in the future;

(d) whether the disclosure is made in breach of a duty of confidentiality owed by the employer to any other person;

(e) in a case falling within subsection (2)(c)(i) or (ii), any action which the employer or the person to whom the previous disclosure in accordance with section 43F was made has taken or might reasonably be expected to have taken as a result of the previous disclosure; and

(f) in a case falling within subsection (2)(c)(i), whether in making the disclosure to the employer the worker complied with any procedure whose use by him was authorised by the employer.

(4) For the purposes of this section a subsequent disclosure may be regarded as a disclosure of substantially the same information as that disclosed by a previous disclosure as mentioned in subsection (2)(c) even though the subsequent disclosure extends to information about action taken or not taken by any person as a result of the previous disclosure.

The Protected Disclosures

18. When considering whether or not the claimant has made the individual protected disclosures alleged we have taken into account the written submissions from both counsel.

19. In respect of the alleged protected disclosures the claimant does not state that she is making a protected disclosure at the time.

20. In her evidence the claimant said that she had not read the respondent's whistle-blowing policy but that she was aware of the concept of whistle-blowing from her previous NHS service.

21. In the public interest disclosure schedule the claimant refers to actual/potential breach of section 43B(1)(b) and (d) of the Employment Rights Act 1996. (1)(b) is that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject, and (d) is that the health or safety of any individual has been, is being or is likely to be endangered.

22. As to legal obligation, the claimant includes reference to the Good Medical Practice, a GMC publication, together with the GMC's Leadership and Management for All Doctors document, and a reference to the statutory duty of candour.

23. Counsel for the claimant submits that the likely or actual breach of legal obligation goes to the duty of candour which the claimant says is explained by the GMC in their guidance which imposes mandatory duties and obligations upon doctors and breach of which could lead to professional sanctions and a referral to the GMC.

24. Counsel for the respondent submits that these documents produced by the GMC giving guidance are guidance and do not amount to a legal obligation.

25. We prefer the respondent's submission and conclude that the GMC documents are guidance and not legal obligations for the purposes of section 43B(1)(b).

26. As to the health or safety of any individual has been, is being or is likely to be endangered, counsel for the claimant contends that there is clear public interest in the health and safety of patients being endangered, whether by the actions of an individual or by pathways and processes in play at the respondent.

27. Counsel for the respondent contends that the key provision for most of the claimant's disclosures is that relating to the health and safety of an individual being endangered but for that paragraph to be engaged counsel submits that it is necessary that the health or safety of any individual "has been, is being or is likely to be endangered" which begs two questions:

(a) when is health and safety endangered? and

(b) how likely must it be that health and safety is endangered?

28. Counsel for the respondent submits that in accordance with the case of **Kraus v Penna PLC [2004] IRLR 260** it is clear that the term "likely" requires more than a

possibility or a risk that the employer might fail to comply with a relevant legal obligation, it means "probable" or "more probable than not". As such counsel submits that the information disclosed by the claimant must tend to show (in her reasonable belief) that it is more probable than not that someone's health or safety is endangered not just that there is a possibility of the same.

29. In agreeing with counsel's general proposition on this point we note that he has missed out the words "is likely to be endangered" from his submission and we must take account of the question of likelihood when reaching our conclusions.

Public Interest Disclosure 1

30. Taken from the schedule, by email on 19 May 2015 the claimant wrote to John de Carpentier about her concerns regarding the neck lump clinic in respect of patient safety including:

(a) The fact that patients were triaged by nurses who did not have the clinical training to evaluate the various differential diagnoses that could arise;

(b) Outlining some of the misdiagnoses that had occurred and that this had led to some patients receiving the wrong treatment for months;

(c) The delays in starting treatment;

(d) Negative patient feedback and experience; and

(e) The fact that she had very little time to see patients prior to surgery so had a limited understanding of how the patient was and whether they were suitable for the treatment plan.

31. The concerns were raised to John de Carpentier via his secretary, Arun Cardozo, Avinash Pahade and repeated to A Bhowmick and G Skailes on 20 May 2015 and later to M Pugh. The legal basis is said to be that the health or safety of an individual has been endangered, was being endangered or was likely to be endangered and/or that there had been, was being or was likely to be a breach of a legal obligation.

32. The basis on which the disclosure was said to be in the public interest was ensuring and maintaining timely and adequate standards of care for suspected cancer patients, of whom there were approximately 15 per week, is of paramount public interest, not least given the potentially serious consequences to the lives and wellbeing of those patients. Also John de Carpentier managing the neck lump clinic and surgical work generated from it directly contributed to long waiting times for complex rhinology patients and extra costs to the respondent NHS Trust in managing those waiting lists and delayed treatments.

33. The respondent does not admit that this is a protected disclosure as it is not a disclosure of information to the employer.

34. As to the origin of the claimant's email on 14 May 2015 John de Carpentier, through his secretary, had sent an email to the claimant and two colleagues about the rapid access neck lump and thyroid clinic stating:

> "By way of reviewing this service, I am looking for any comments, be they positive or negative, about the way you've experienced this service running. In particular I would be grateful if you could tell me if you are happy or unhappy about patients that may have been seen in the neck lump clinic and referred on to you, possibly for surgery."

35. The claimant replied on 19 May at 17:48 copying her reply to Mr Cardozo and Mr Pahade. She gave her feedback including the matters summarised above, and in conclusion she stated:

> "These are my views and intended for the improvement of the service and most importantly the care of patients who entrust their lives to us. This is not in any way meant as a personal criticism. I do have very high regard of you as a colleague and am particularly grateful since you were instrumental in my appointment."

36. It is submitted on behalf of the claimant that the disclosure is made to the employer in the light of John de Carpentier's clinical seniority and when it is later repeated to Mr Bhowmick, Dr Skailes and Professor Pugh they are members of the respondent's management team.

37. We accept that Mr Bhowmick, Dr Skailes and Professor Pugh are members of the respondent's management team.

38. As to patient safety, counsel for the claimant submits that the disclosures made clearly go to issues of patient safety. The claimant was adamant as to that during her cross examination. Dr Skailes accepted in cross examination that if the triage or diagnosis system led to delays in the multidisciplinary team discussions and therefore a delay in treatment then it would impact upon patient safety. However, the claimant genuinely believed in the concerns that she raised, setting out her concerns in a balanced way with details of the patients to whom she referred and her understanding of their cases and the misdiagnoses and delays at which she was concerned. Also the fact that she raised concerns about the cancer nurse specialists taking a pro forma rather than a nuanced clinical history, and it was they who decided whether or not there would be an ultrasound guided fine needle aspiration of the patient in question. The claimant believes that her concerns were correct but in the alternative she had a reasonable belief that the concerns she raised were correct.

39. Counsel for the respondent submits that this is a good example of something which is not a disclosure. The claimant took up the invitation made by Mr de Carpentier. She was plainly not intending to and did not disclose information tending to show something falling within section 43B(1)(b) or (d) and it is further denied that the information she disclosed tended to show it was more likely than not that patients were being or were likely to be harmed. Had she genuinely reasonably believed it likely that health and safety was being endangered as opposed to thinking that the service could be improved then she would have raised it earlier and not only when specifically asked to comment about the service.

40. Counsel refers us to the case of **Korashi v Abertawe Bro Morgannwg University Local Health Board [2012] IRLR 4**, a case in the Employment Appeal Tribunal which held that:

> "(a) 'Reasonableness' of course involves an objective standard, but it has to be looked at from the perspective of someone in the employee's position. This may look like a watering down of the 'reasonable belief' test but it can in fact have the opposite effect. Many whistle-blowers especially in the medial area will be insiders with a high level of knowledge, there may be things that might be reasonable for a lay person to have believed that it would not be reasonable for them to believe;
>
> (b) Where there are a multitude of disclosures there must be a reasonable belief in relation to each; it is not enough to show a reasonable belief in the general gist of the complaints."

41. In cross examination the claimant accepted that she did not work in the neck lump clinic but she had spoken to nurses. She said there was no way that she would have made the allegation without knowing the facts. She was not saying that every line in the email amounted to a protected disclosure.

42. Mr de Carpentier rebuts the views of the claimant as set out in her email, but we have to consider whether the claimant disclosed information, whether she had a reasonable belief in it, whether it was made in the public interest and whether it tended to show that the health or safety of any individual had been, was being or was likely to be endangered.

43. We conclude that in relation to item (b) the alleged misdiagnoses which the claimant says had led to some patients receiving the wrong treatment for months, that the claimant did disclose information which she reasonably believed and that, because it related to several patients of the department, was made in the public interest and that, in the light of the evidence of Dr Skailes, the health or safety of those individuals had been, was being or was likely to be endangered.

44. We find that the claimant made a qualifying disclosure to her employer in respect of item (b) only in the 19 May 2015 email.

<u>Public Interest Disclosure 2</u>

45. The second alleged public interest disclosure is that on 10 June 2015 the claimant, by email, raised issues regarding patient safety at the neck lump clinic and the poor care of a patient referred to as HB. The concerns were raised to Messrs Pugh, Mitchell, Cardozo, de Carpentier and Ms Skailes and again related to the health and safety of an individual. There is reference to breach of legal obligation. It was said that the disclosure was in the public interest to ensure and maintain adequate standards of care for patients not least given the potentially serious consequences to the lives and wellbeing of individuals. Patient HB was used as an example.

46. The respondent does not admit this is a protected disclosure saying that the claimant's email was in response to an email from Mr de Carpentier in which he

informed Dr Skailes that a patient was unhappy. The claimant's reply does not disclose information which tends to show a matter falling within section 43B. As such it also does not meet the public interest requirement.

47. On 28 May 2015 John de Carpentier emailed Geraldine Skailes saying that it had come to his attention that comments were passed about the care of patient HB in the head and neck MDT meeting on 26 May. The patient has had a significantly delayed diagnosis and had been discussed before. Dr Skailes suggested that the patient had come through the neck lump clinic, inferring that this had contributed to his delay. Miss Thomas, now responsible for the patient, suggested that the patient had rung up and was very angry but she had no idea of why. Unfortunately, said Mr de Carpentier, this was yet another example of clinicians being less than frank within the MDT and he believed Miss Thomas had a very clear idea of why the patient was unhappy and he gave a timeline from 18 March when the patient was referred by the GP onwards. He summarised it by saying that the patient went with the normal speed and efficiency with appropriate investigations and referral through the neck lump MDT. He suggested that Miss Thomas had not explained to the MDT that the patient was unhappy about investigations that had been requested by her without communicating this to the patient and had made him unhappy, adding weight to a somewhat unreasonable bias against the only part of his treatment that was performed at their routine level of efficiency and competence.

48. The email which the claimant contends amounted to a protected disclosure was sent by her on 10 June. She was glad that John de Carpentier brought it up as it was one of the best examples of systems/process delays that are endemic to head/neck patients. The delay was directly related to how the pathway was run currently which she had brought to the attention of Mr de Carpentier when he asked for feedback on the neck lump clinic. The patient unfortunately had metastatic disease from an unknown primary and as is common for such patients they had to be discussed in a number of MDT meetings often requiring various investigations done in a sequential manner.

49. He attended the neck lump clinic under Mr de Carpentier on 25 March 2015 and was seen by Mr Pahade:

> "USG-FNA done which only showed squamous atypia, CT and MRI requested and documented that he will be seen with results."

50. The patient was referred to the head and neck MDT on 7 April 2015 and no-one there knew anything about him. When his name came up for discussion the claimant found him on a database and read out what information was available then on the system. There was no diagnosis of cancer and the scans did not identify any obvious primary. The MDT recommendation was "further FNA/TRU-CUT from neck node to establish diagnosis and if cancer PET scan to be done to identify primary".

51. The next thing the claimant knew anything about him was when Mr Cardozo's secretary passed the patient's details to her secretary on 16 April following his instruction when he came back from leave. The patient was down for a biopsy on 21 April hence he was offered an appointment at her next clinic on 23 April which was HB's next clinical contact after 25 March.

52. The claimant was not in clinic as there was an emergency in theatre. He was told of the MDT plan for him and that the biopsy was not ready. He was told that further tests may be needed once the biopsy was ready and he was happy for this to be arranged. Another doctor discussed the patient with the claimant on 23 April. The PET scan request was done on 24 April and the scan was done on 1 May. The patient was discussed again in the MDT on 5 May and MDT recommended OGD (same day) and referral to CUP MDT. The patient was contacted to arrange a clinic appointment for 7 May. He said this was not suitable and he wanted a report over the phone but it was not the practice of the claimant to give a cancer diagnosis over the telephone.

53. The CUP MDT on 11 May recommended bronchoscopy which was brought to the claimant's attention on 12 May. She made a referral for this on the day and saw the patient on 12 May to inform him of diagnosis and where there were in terms of investigations and further management.

54. An OGD on 11 May was cancelled by the patient and rescheduled for 20 May and EBUS-FNA was done on 21 May.

55. The claimant saw HB on 26 May 2015 to explain OGD and EBUS findings and that both biopsy reports were not ready. He was discussed on 1 June in one MDT and on 2 June in another, then seen by an oncologist and the claimant on 2 June and his treatment started on 3 June.

56. According to the claimant, she made every effort to see the patient as soon as results were available and there was no delay on her side in requesting/organising any investigations or referrals. There were numerous phone calls and emails to various consultants personally by her to ensure the patient was seen and results reported proactively. There were two Bank Holidays and she was on annual leave.

57. The patient was seen in the claimant's clinic four times (three times personally) in the six weeks he was under her care. He had a number of procedures with pathology reports to be coordinated and discussed multiple times in three different MDTs before a treatment recommendation could be made. She was told that the patient was angry but she had not met him until 12 May and hence her comment that she did not know. The patient came under her care on 23 April not 7 April as mentioned by John de Carpentier, who she did not think had seen the patient.

58. It was the view of the claimant that the patient’s experience could have been better if:

(5) A repeat biopsy was planned on 25 May or 1 April or seen with the results in neck lump clinic.

(6) He was under one of the HN surgeons right from the start as there would be continuity of care, rather than being transferred halfway with incomplete work-up, without a referral letter about what was happening and what the patient had been told.

(7) Or he continued under Mr de Carpentier until all investigative work-up was done and transferred to appropriate consultant for treatment.

(8) The patient kept abreast of what was happening by our cancer nurse specialists who had met him on 25 March and should be aware of exactly what was happening to the patient.

(9) It was interesting to note that the patient did not contact the cancer nurse specialists as a port of call when he was distressed/angry/did not know what was happening.

59. In submissions for the claimant counsel contends that the disclosure was to the employer in the form of Messrs Pugh and Skailes, and it detailed her concerns about endemic process delays to head and neck patients suggesting it is clear that patients suffering from malignant conditions would be adversely affected by delays in their treatment and that their health may well be endangered by the same, and the patient safety concern is therefore obvious. The matters set out in the email contribute to the delay and poor patient experience, imperilling the patient's safety.

60. According to counsel for the claimant, Dr Skailes conceded that were the disclosure accurate it pertained to patient safety, a stance that Arnab Bhowmick agreed with.

61. For the respondent, counsel submits that had the claimant genuinely and reasonably thought that HB's health and safety had been endangered, as opposed to him being provided with a better service, then she would have raised that earlier and independently. Although the claimant alleges there was a delay in his treatment there is no suggestion in the email that his health and safety was likely to be endangered. The claimant did not put in a formal complaint (Datix). Rather, says the respondent, this is an email setting out and defending the claimant's position in response to Mr de Carpentier's email. It is not a disclosure of information which in the reasonable belief of the claimant she was making in the public interest. It related to the treatment of one patient and provided no further evidence of it being endemic.

62. We have looked at our notes of evidence and we cannot see that the second alleged disclosure was discussed with Dr Skailes in her cross examination. As to Mr Bhowmick, we again do not appear to have a note of anything said by him in relation to the second alleged public interest disclosure.

63. Looking at the witness statement of Professor Pugh, he was copied into the claimant's email and in accordance with his practice, made known to his team, that he would not look at emails to which he was copied rather than was the direct recipient, he said it unlikely he would have seen this email at the time but if he had seen it he would have viewed it as a professional disagreement between two colleagues. If there was harm to a patient then this should have been subject to the incident reporting system of the Trust.

64. Dr Skailes also deals with this matter in her witness statement. She refers to the email from Mr de Carpentier on 28 May who had taken an inference that there had been delays through the neck lump clinic. His view was that the patient was processed at normal speed and the delays resulted in the patient complaining had occurred later, largely through a lack of communication by the claimant. Having received the claimant's response she considered it was an example of the points she raised in her email to Mr de Carpentier. She did not consider this to be a significant issue. She felt the exchange was like children in the playground and did not think it

merited a reply, however insofar as there appeared to be any lateness this looked less likely to flow from the neck lump clinic. She was not aware that this proceeded beyond the exchange of emails.

65. We are not satisfied that this email amounts to a protected disclosure on the basis that we cannot be satisfied that HB's health and safety had been or was likely to be endangered. He was a patient of the respondent going down the pathway followed by many patients, albeit with some delay, and some of that delay was caused by HB himself not being available for appointments. Had the claimant been of the view that HB's health had been endangered then in our judgment she would have made a formal complaint using the respondent's Datix system.

Public Interest Disclosure 3

66. The third alleged disclosure is said to relate to 18 July 2015 when the claimant raised by email concerns about patients having repeated scans and fine needle aspiration specimens which were leading to higher numbers of surgeries. The complaint was made to Mark Pugh, Geraldine Skailes and Arnab Bhowmick, and again it related to the health and safety of an individual being endangered.

67. The claimant thought it was in the public interest to ensure and maintain adequate standards of care for approximately 150 patients with thyroid lumps, it being of paramount public interest not least given the potentially serious consequences to the lives and wellbeing of those individuals and others. The higher number of surgeries constituted an inefficient use of finances and resources by the respondent NHS Trust which is supported by the Treasury.

68. The respondent does not admit that this is a protected disclosure. It is part of a general discussion about improving patient pathways and is an expression of the claimant's opinion on the issue. It does not disclose information which tends to show a matter falling within section 43B and as such it also does not meet the public interest requirement.

69. On Saturday 18 July 2015 the claimant sent an email to Mr Bhowmick and Professor Pugh copied to Dr Skailes on the subject of neck lump patients:

> "This is my suggestion to sort out the pathways.
>
> Currently there are two neck lump clinics run by John: one at Preston on Wednesday and another at Chorley on Thursday. Wednesday clinic is supported by Radiology while Thursday clinic isn't supported.
>
> 1. Thyroid lump under John – nurses can see patients, take history and send for USG+/- FNA. Patients come back with results to see John.
>
> (i) All THY 4s and 5s will be better to be sent on to Arun and me. (We can split the patients. This way any patient who may need a neck dissection either lateral or central can also be planned).
>
> (ii) All THY 3s can be pulled and split between three of us. John still can do 50% of them and we can have 25% each. This way he gets a majority but both Arun and myself will have enough

numbers to main skills and peer review purposes. (Vast majority of thyroids needing thyroidectomy will be THY3).

We have to agree to some standard protocols. It is wrong to put patient through 5-6 USGs, 4-5 FNAs and a huge waste of resources. We will have to agree on acceptable protocols, which is best discussed and agreed including the Radiologist.

2. Two WWK clinics, one for Chorley and one for Preston. All non thyroid neck lumps should be split into these with first few slots for patients with lumps so that they can be sent for USG-FNA and seen back by the end of clinic. Once they are slotted as two WWK clinics all two WWK referrals can also be booked onto them. Since we have other doctors as well in clinic there will be capability and managers doesn't have to keep paying WLIs nor ring and beg who can do extra clinic every week, which is what currently happening (significant amounts are paid to do those extra clinics). This way all suspected cancer referrals are seen by cancer surgeons, assessed and appropriate information given for USG, scans ordered and planned for diagnostic/therapeutic procedures. There will be continuity of care, appropriate allied referrals started early and held bar theatre list planning.

   I don't think Arun and I will have any problems working together, we can either have a common pool or have own PTS generated from the clinics we do. We will anyway be sharing a secretary.

   By Sept a second HN Radiologist is going to join so it should be possible to plan the clinics in such a way that both Sachin and Hilary could cover one WWK clinic each and they could alternate the thyroid lump clinic. This way patients are given a much better service and it is equitable to all concerned. USG will be done by HN Radiologists which will be better. It will also ease the pressure of needing to do all USG/FNAs in one clinic where currently Sachin can only offer six slots.

   We don't necessarily have to identify separate clinics over and above what we do, we just have to check whether one of the existing clinics can be re-designated into two WWK clinics based on Radiology and Pathology availability.

   So out of three clinics we do (as part of standard DCC) one will be two WWK clinic, one will be HNMDT/combined clinic and one will be general ENT clinic which will help our general ENT practice satisfying all appraisal/revalidation/peer review requirements."

70. Looking at this email we note the claimant starts by saying it is her suggestion to sort out the pathways and concludes that what she proposes will help the general ENT practice, satisfying all appraisal/revalidation/peer review requirements.

71. Whilst the claimant does say it is wrong to put patients through 5-6 USGs and 4-5 FNAs, she does not make any reference to the health and safety of any patients being endangered, nor does she refer to higher numbers of surgeries. Indeed the

claimant seeks to have enough numbers to maintain her own skills and for peer review purposes in relation to carrying out surgery.

72. We are not satisfied that this amounts to a protected disclosure.

Public Interest Disclosure 4

73. The fourth alleged public interest disclosure is said to arise when the respondent invites the Royal College of Surgeons (RCS) to review the head and neck multidisciplinary team. The claimant claims to make disclosures to four people of the Royal College of Surgeons, and so we must first consider whether as a matter of law it is possible for a public disclosure to be made to the Royal College of Surgeons in these circumstances.

74. According to the submissions on behalf of the claimant, she contends that this disclosure constitutes the repetition of a disclosure made previously to her employers in the first and third public interest disclosures over which she was concerned she would be victimised. The claimant also contends that as the RCS review was initiated by the Trust itself with a view to getting a balanced third party expert view for the Trust to act on, she believed all the disclosures to the RCS review to be to her employer, the only difference being that disclosures were going to the employer in an anonymised fashion.

75. Earlier in her submissions the claimant's counsel has referred to section 43G of the Act which "pertains to disclosures which have already been made to the employer or disclosures which the complainant fears will lead to their victimisation and which are then made to a third party. The claimant contends that this applies to allegation 4 in the Scott Schedule".

76. Counsel for the respondent submits that:

> "The RCS is not the claimant's employer and nor a prescribed person. It is understood the claimant wishes to rely upon section 43G. It is denied the conditions in section 43G(2) are met, in relation to 43G(2)(a):
>
> (a) At the time of the RCS interview, even if the claimant had made a disclosure (which is denied) on her own case she had not yet been subjected to a detriment (aside from the misconceived allegation detriment 1). She had not utilised the whistle-blowing procedure. Dr Siva had not suggested she would be victimised. It is denied she could reasonably have believed she would be subject to a detriment if she made the disclosure to her employer, something she could do anonymously in any event under the policy;
>
> (b) The claimant could have made the disclosure in accordance with the respondent's whistle-blowing policy or to a prescribed person in accordance with section 43F. The GMC is a prescribed Body in relation to the registration and fitness to practice of the profession and in relation to any activities for which it has functions. The NHS Commissioning Board and NHS Improvement are also prescribed Bodies for the purposes of the matters which the claimant was raising and NHS Counter Fraud Authority for matters relating to fraud, corruption or other

> unlawful activity. The claimant has failed to explain why she did not do so nor what she believed she would be subjected to a detriment if she did so.
>
> It is not understood C seeks to rely on section 43G(2)(b), in any event no evidence has been adduced in support of such a case. As for section 43G(2)(c) it is denied the claimant had previously made a disclosure of substantially the same information to the respondent or under section 43F. The specific disclosures relied on in the schedule are not disclosures the claimant had raised with the respondent other than in relation to generic concerns about the neck lump clinic.
>
> Under section 43G(1)(e) it must also be reasonable in all the circumstances to make the disclosure. It is accepted that those disclosures relating to functioning of MDT were reasonable for C to raise given that was the purpose of the RCS review. C (which we think should be R) avers she went beyond that raising allegations..."

77. Section 43G is set out above, and so we shall consider the various aspects which the claimant has to satisfy us of in order to make a protected disclosure.

78. If we accept that the claimant reasonably believed that the information disclosed and any allegations made were substantially true, and we know that the claimant did not make the disclosures for personal gain, we have to be satisfied that any of the conditions in subsection (2) are met and that in all the circumstances of the case it was reasonable for her to make the disclosure to the RCS.

79. Subsection (2) has subparagraphs (a), (b) and (c). The claimant is not submitting that at the time she made the disclosure she reasonably believed she would be subjected to a detriment by the employer if she made the disclosure, whether to the employer or to a prescribed person under section 43F, so the only basis upon which the claimant is proceeding is (c), that the worker has previously made a disclosure of substantially the same information –

(i) to his employer; or

(ii) in accordance with section 43F.

80. We therefore have to consider what is said to be disclosed in public interest disclosure 4 compared with what the claimant disclosed in public interest disclosures 1 and 3, which we have set out above.

81. According to the schedule in respect of allegation 4, during the claimant's interviews with the Royal College of Surgeons she raised concerns that:

(a) There were interpersonal clashes within the team which meant some colleagues were more interested in rivalries and point scoring, especially during MDTs rather than considering and implementing best practices for the patient;

(b) There was lack of robust clinical governance and documentation to learn from mistakes;

(c) Concerns about oral and maxillofacial surgery patients having high surgical margins positive for tumour after resection, and there were relatively high numbers of patients coming back to the unit with recurrent tumours;

(d) Radical surgery had sometimes been recommended without a firm cancer diagnosis;

(e) John de Carpentier had misrepresented the facts in notes and MDTs in relation to two patients to cover up his mistakes or complications;

(f) Concerns about the neck lump clinic; and

(g) That she was afraid of being victimised for raising these concerns.

82. We remind ourselves of counsel for the claimant's submission that the contents of disclosure 4 constitute the repetition of disclosures previously made in items 1 and 3. Having examined public interest disclosures alleged at 1 and 3, we conclude that they are different from public interest disclosure 4, with nothing in 4 being raised previously in numbers 1 and 3. In these circumstances we do not find that the claimant's alleged disclosure comes within the parameters set out in section 43G and therefore we do not find the claimant made a protected disclosure to the Royal College of Surgeons.

Public Interest Disclosure 5

83. This relates to 23 September 2015 when the claimant submitted an incident form regarding her concerns about two patients JS and PK. The document was said to be submitted to Professor Pugh and concerned health and safety. According to the claimant, the basis on which this was in the public interest was ensuring and maintaining adequate standards of care for patients being of paramount public interest not least given the potentially serious consequences to the lives and wellbeing of individuals. The two patients had unnecessary and unacceptable complications; inaccurate and misleading records affect public trust and confidence in doctors. These issues also constituted an inefficient use of finances and resources by the respondent NHS Trust which is supported by the Treasury.

84. The respondent does not admit that this is a protected disclosure saying that on reviewing the medical records, in the light of the incident form being submitted, it was apparent that there were no issue regarding the treatment of the patients. The incidents were closed without any action being taken or required. As such the respondent does not admit that he claimant had a reasonable belief as required by section 43B.

85. The claimant submitted a Datix incident review form in respect of PK on 23 September 2015. She gave her name and provided details of the location of the incident and then described an incident which is said to have occurred on 28 August 2014 (more than 12 months before the report).

86. The alleged incident is described and the claimant states that she was not aware of the details until much later when the final histology was available. She had brought it to the attention of the RCS reviewers who advised her to bring it to the

Medical Director's notice as it was a patient safety issue. Following discussion with the Medical Director she was advised to put in a Datix, which she did.

87. The respondent considered the report and graded it in terms of likelihood as rare – not expected to occur for years, and in terms of consequence as negligible – no adverse impact on recovery or care. There is a note to the effect that on 1 November 2016 operation notes were reviewed and the note clearly says a tracheal hole was repaired. The information within the Datix is incorrect. It would be closed. No harm.

88. From the claimant's witness statement she met Mark Pugh, Clinical Director, on 18 September 2015 and provided details for the two patients she had discussed with the RCS. She referred to there being an unusual complication in that Mr de Carpentier had caused a hole in the patient's trachea during thyroidectomy surgery. This is a very unusual complication and is not described as a standard complication of such surgery. In the MDT discussion when pathology was discussed Mr de Carpentier claimed that the tumour had invaded the patient's trachea and this made a hole which he had to repair. She told Professor Pugh this was not reflected in the notes of the operation, the histology showed no invasive tumour and there was no tracheal tissue in the sample removed. This, she says, was another mistake in patient management which Mr de Carpentier had tried to cover up. She was asked to submit a Datix report but said she was worried about repercussions if she did. She decided to submit it herself but stating it was done on the advice of Mark Pugh. The report referred to the unusual and undescribed complication for a standard thyroidectomy and the contradiction between the surgical notes and the MDT discussion. Noting that the Datix outcome concluded there was no harm, the claimant was not sure how it could have been concluded there was no harm when the patient came for a day surgery and had a totally unexpected complication and stayed in hospital until five days later and was re-admitted following discharge. It did not address the MDT documentation and the original pathology report showing there was no tumour invasion of the trachea, therefore according to the claimant this must have been caused during surgery.

89. In cross examination the claimant said that she had to look at the notes to do the Datix.

90. Also in cross examination she confirmed the disclosure relates to PK. Although she referred to two cases when talking to the RCS she does not know who may have lodged a Datix concerning the other patient, JS.

91. Counsel for the claimant submits that the Datix system is the internal incident reporting system of the respondent employer, and so the claimant would contend that this was self-evidently a disclosure to the employer. She refers to the Datix referring to two patients. (As far as we understand, the Datix refers to one patient although the claimant does refer to another ongoing Datix where the same surgeon does something similar).

92. The claimant raises concerns in respect of both patients in respect of their care and effectively the claimant is raising concerns that mistakes were made in surgery that were covered up. The claimant contends that this goes to clear issues of patient safety both in terms of treatment and record-keeping. The claimant therefore

contends that her concerns were correct or in the alternative she had a reasonable belief in the concerns that she raised.

93. For the respondent it is submitted that the Datix was about one patient only, with passing reference to another. It is not admitted that the claimant had any reasonable belief that this patient's health and safety was on the balance of probabilities or that there was/had been a breach of any legal obligation. Further, it is not admitted that the claimant had a reasonable belief that this disclosure was in the public interest. The claimant was not involved in the surgery. The incident was over a year earlier. The claimant had not raised any concerns at the time or when she later became aware of the histology. She raised it with the RCS team.

94. The governance team of the respondent dealt with it and concluded there was no harm to the patient and that the Datix was incorrect. The patient's notes recorded that there had been a hole in the trachea which was repaired.

95. In respect of this disclosure we accept that the claimant disclosed information and that when she made the incident report she had a reasonable belief that it tended to show that the health and safety of the patient had been endangered. Given that it relates to patient safety in a hospital situation we also find that this was made in the public interest. This amounted to a protected disclosure.

Public Interest Disclosure 6

96. This relates to 17 November 2015 when the claimant raised concerns orally regarding her colleagues' harassing behaviour towards her at a head and neck operational meeting at which various people were present, including Arun Cardozo and John de Carpentier.

97. The claimant alleges that there had been, was being or was likely to be a breach of legal obligation under section 43B(1)(b) and that the basis on which this disclosure was in the public interest was ensuring and maintaining adequate standards of care for patients being of paramount public interest, not least given the potentially serious consequences to the lives and wellbeing of individuals. This was an NHS Trust which all members of the public could access and which is supported by the Treasury. Collegiality and close cooperation between colleagues responsible for a lifesaving service paid for by the public purse is in the public interest, and it is in the public interest for all doctors to act in accordance with the standards set by the respondent Trust and GMC to protect, promote and maintain the health and safety of the public.

98. The respondent does not admit this is a protected disclosure. The respondent does not admit that the claimant disclosed any information which tended to show that there was a breach of legal obligation nor that there was any disclosure in the public interest.

99. The oral concerns were noted in the minutes of the meeting of 17 November 2015. Under the heading "serious concern discussed" there was reference to the external visit by the RCS, and then the final sentence of the paragraph stated:

> "LT still has concerns, should be discussed later."

100. According to the claimant in her witness statement in connection with the head and neck operational meetings on 17 November 2015, which were held to discuss whether the behavioural issues within the MDTs had been addressed following the RCS report, the claimant stated she still had concerns and that her colleagues' behaviour towards her was poor and asked for this to be reflected in the minutes of the meeting.

101. In our judgment this does not amount to a protected disclosure. The claimant has not set out information. We are not satisfied that anyone was there at a managerial level for the respondent and we are not satisfied that any legal obligations had been breached. The claimant does not, for instance, allege that she was being harassed on the basis of either sex or race. She is concerned more with the general duties of doctors provided by the GMC which do not, in our judgment, amount to legal obligations for the purposes of public interest disclosure legislation.

Public Interest Disclosure 7

102. This is alleged to have occurred from 13-18 September when the claimant raised concerns orally regarding her colleague's harassing behaviour towards her. The person receiving the concerns was said to be Geraldine Skailes and again this is alleged to be breach of a legal obligation.

103. The respondent denies that the claimant disclosed any information which tended to show any breach of legal obligation whether as set out in this schedule or otherwise:

> "Any discussion that took place between the claimant and Dr Skailes related to her personal circumstances and, if, which is denied, there has been a relevant disclosure of information, it is denied that it was made in the public interest."

104. On the basis that we did not accept that item 6 amounted to a public interest disclosure, we do not accept that item 7 amounts to a public interest disclosure in the absence of any legal obligation being breached.

Public Interest Disclosure 8

105. The eighth disclosure relates to 4 December 2015 where the claimant raised with Professor Mark Pugh oral concerns about her colleagues' harassing behaviour towards her and the fact that they were raising unjustified concerns regarding her work as a result of her raising concerns about John de Carpentier and the neck lump clinic.

106. The claimant alleges that there had been, was being or was likely to be a breach of legal obligation – section 43B(1)(b) of the Employment Rights Act 1996, namely section 47B(1) of the Employment Rights Act 1996 and specific GMC regulations.

107. Section 47B(1) of the Employment Rights Act relates to a worker having the right not to be subjected to any detriment by any act or any deliberate failure to act by the employer done on the ground that the worker has made a protected disclosure.

108. The respondent admits that the claimant made a protected disclosure during the course of this conversation, but no other admissions are made.

Public Interest Disclosure 9

109. This relates to 11 January 2016 when the claimant raised to Professor Mark Pugh oral concerns regarding her colleagues' harassing behaviour towards her, with again the allegation that there was being or was likely to a breach of a legal obligation and specific GMC regulations.

The respondent admits that the claimant made a protected disclosure during the course of the discussion with no other admissions being made.

Public Interest Disclosure 10

110. This relates to 7 February 2016 when the claimant emailed a proposed model for the neck lump clinic which discussed issues regarding poor service such as:

(a) Those identified in the RCS report;

(b) Delays in the pathway;

(c) A consultant not doing the full remit of thyroid cancer or head and neck surgery is assessing such patients;

(d) Urgent clinics being cancelled when that consultant was on annual leave;

(e) Clinical nurse specialists being overworked;

(f) Poor diagnostic accuracy of the neck lump clinic;

(g) Issues with fine needle aspiration and difficulties with assessing reasons for these issues due to too many people conducting these and too many variations in how they are conducted;

(h) Lack of a structured clinical template; and

(i) The very high follow-up rate with patients.

111. The claimant directed this to Arnab Bhowmick, Kate Howarth (General Manager), Suzanne Hargreaves (Director of Operations) and Professor Mark Pugh. The claimant alleges that the health and safety of an individual had been endangered, was being endangered or was likely to be endangered, and/or that there had been, was being or was likely to be a breach of a legal obligation.

112. It was in the public to ensure and maintain adequate standards of care for patients which was of paramount interest not least given the potentially serious consequences to the lives and wellbeing of individuals; and at (b), (c), (d), (f), (g) and (h) effective patient pathways would decrease patient harm, save the respondent NHS Trust and the public purse money and be an efficient use of human resources.

113. The respondent does not admit that it was a protected disclosure and does not admit that the claimant disclosed any information which tended to show that there was breach of legal obligation. The email of the claimant is part of a discussion of service improvement and developing clinical pathways for the head and neck specialty.

114. On 7 February 2016 the claimant's email was sent attaching a set of slides giving a model for a neck lump clinic. She said that this was her suggestion taking into consideration all aspects, including least disruption to job plans, clinic space availability etc.

115. The claimant does at the start of her slide presentation refer to current problems as set out above, but we do not see anything in the presentation to suggest that the health and safety of an individual has been endangered, was being endangered or was likely to be endangered.

116. The legal obligations referred to are those provided by the GMC which we have not found are legal obligations for the purposes of public interest disclosures.

117. We do not find that this was a protected disclosure.

Public Interest Disclosure 11

118. On 24 February 2016 the claimant emailed core clinicians regarding her colleagues' harassing behaviour towards her by reference to an MDT held the previous day on 23 February. The email was to Pugh, Cardozo, Sivaramalingham, Nigam, Shakeel, Skailes, Bhowmick, Graham, Arafat, Anjum, Wood and Mathor. The claimant says that there had been, was being or was likely to be a breach of legal obligation, namely section 47B(1) of the Employment Relations Act 1996 relating to a worker having the right not to be subjected to any detriment on the ground that the worker has made a protected disclosure.

119. The reasons why this was in the public interest was ensuring and maintaining adequate standards of care for patients, not least given the potentially serious consequences to the lives and wellbeing of individuals. Collegiality and close cooperation between colleagues responsible for a lifesaving service paid for by the public purse is in the public interest, and it is in the public interest for doctors to act in accordance with the standards set by the respondent NHS Trust and the GMC whose purpose is to protect, promote and maintain the health and safety of the public.

120. The respondent does not admit that this is a protected disclosure nor that the claimant disclosed any information which tended to show there was a breach of legal obligation nor that there was any disclosure in the public interest.

The Claimant's Email

121. The claimant's email was sent on 24 February 2016 at 15:23 addressed to Messrs Cardozo, Sivaramalingham, Nigam and Aktar with the other recipients being copied. The subject was "MDT behaviour" and the claimant wanted to put it formally on record that in the previous day's MDT there was behaviour by clinicians which she found very unpleasant, demeaning and unprofessional. She wanted to remind

them all of their GMC obligations to maintain acceptable standards of care and behaviour. If there was evidence of poor practice it needed to be audited against accepted standards and found to be lacking before aspersions were cast on abilities or outcomes. It was very undermining and unprofessional to call upon a consultant to publicly prove his or her prior personal series. She was certain most surgeons and oncologists have evolved their practice from their training time or since they started as a consultant. It was completely inappropriate to snidely pass comments for everyone to hear which might pose a threat to someone's future as a surgeon or consultant. The Trust had employed every single consultant after satisfying itself they were suitably qualified for the job, so she did not think she had to prove her personal series of 50 to every single one of them prior to every single operation. She also pointed out that implying to patients that other clinicians' skills or experience could be doubtful in joint consultations would confuse and upset patients. Conclusion:

> "Sometimes poor behaviour needs to be made visible/publicly challenged to help stop. Each time it is allowed to pass, it reinforces/encourages such behaviours."

122. Looking at the claimant's witness statement she refers to poor behaviour towards her. In a discussion about a particular patient the claimant said she had tried to interject and put her point. She was not being listened to but eventually it was agreed that the patient should proceed for a biopsy as suggested by the claimant rather than a neck dissection. This was one of the first times in a number of months that her recommendation was listened to by the MDT, but the manner in which her colleagues initially refused to listen and talked over her to try to justify their own view was in her view entirely inappropriate and she was quite upset.

123. Analysing the claimant's alleged disclosure in the form of her email we cannot find anything to suggest to the respondent that there has been a failure to comply with any legal obligation towards her by subjecting her to any detriment done on the ground that she had made a protected disclosure. We do not therefore find this amounted to a protected disclosure.

<u>Public Interest Disclosure 12</u>

124. On 18 April 2016 the claimant submitted two incident reports about:

(1) A patient receiving radiotherapy without a diagnosis of cancer, and where the "tumour" had shrunk significantly without any treatment; and

(2) John de Carpentier operating on a suspected sinonasal tumour patient when:

(i) he was restricted against doing such operations;

(ii) he did not know whether this was the best option for the patient;

(iii) the MDT plan was only to perform a biopsy; and

(iv) the patient had complications.

125. According to the respondent, although it did not agree with the analysis of the claimant as set out in the two Datix forms the respondent accepts that the claimant was disclosing information which she reasonably believed tended to show that the health and safety of an individual had been endangered and that this was in the public interest.

Public Interest Disclosure 13

126. On 20 April 2016 the claimant emailed Professor Pugh to raise a number of concerns including:

(a) concerns raised about the neck lump clinic prior to the RCS report and that no further action had been taken to ensure safety and suitability for this pathway;

(b) setting out relevant information and documents that had not been shared with the RCS for its review;

(c) high oral and maxillofacial flap failure rates;

(d) failures within the MDT leadership;

(e) the fact the claimant had been told to refrain from raising incident forms but that the system was being abused by her colleagues;

(f) the deterioration of care over the years due to pathways and MDT dynamics;

(g) consultants were covering up their mistakes; and

(h) that John de Carpentier, who had been asked not to operate on sinonasal cancers, had undertaken these procedures.

127. Although the respondent did not admit this matter at the outset during the course of the hearing, it was admitted that this email did contain some protected disclosures but denied that they had any causative effect in anything that happened thereafter. Counsel in his submissions points out that there were no detriments which were said to flow in the immediate aftermath of it.

Public Interest Disclosure 14

128. On 26 April during a meeting the claimant provided a table she had produced showing the high numbers of thyroidectomies performed at the Trust compared to other hospitals within the region, and that clinicians were making decisions without reference to the evidence available.

129. The disclosure was said to be made to Professor Pugh and Rajendra Chowdhary (sic). It alleged that the health and safety of an individual had been endangered and that approximately 150 patients could have been adversely affected by these unnecessary procedures. The excessive number of patients undergoing this invasive procedure is a waste of NHS financial resource. Rather the focus should have been on seeing rhinology patients. The respondent NHS Trust was breaching waiting times for rhinology procedures, potentially leading to a fine whilst

paying John de Carpentier to undertake extra lists and contracted out independent cover. Ensuring and maintaining adequate standards of care for patients if of paramount public interest not least given the potentially serious consequences to the lives and wellbeing of individuals. This was an NHS Trust which all members of the public could access and which is supported by the Treasury.

130. The respondent does not admit this is a protected disclosure and does not admit that the claimant disclosed any information which tended to show that there was a breach of legal obligation, or that the claimant produced at that meeting the table referred to.

131. According to the claimant's witness statement, she met with Mark Pugh on 26 April and she was accompanied by her Medico legal adviser, Rajendra Chaudhary. Given that Rajendra Chaudhary was the claimant's medico legal adviser we find that there cannot have been a disclosure to Rajendra Chaudhary.

132. According to the claimant, she had collated a number of documents in preparation for this meeting and showed to Mark Pugh to support the concerns that she had raised and they are in the bundle at pages 980-1055. She offered to hand them over but he did not take them and told her instead to hand them in as part of the investigation, and the documents included a document the claimant had created called "Certain facts around HNMDT and service" which summarised the key data she had collated for the meeting, and that is the document at page 980. The disclosure relates to thyroidectomies and the information is concerning the number of thyroid surgeries per hospital, which according to the claimant shows:

Trust	Population Served	Number of procedures
Preston	440,000	161 (94 plus 67)
Blackpool	440,000	66.5
Morecambe	350,000	84

133. Looking at the information provided by the claimant we accept that it shows that in the Preston Trust there was a higher number of thyroid surgeries per hospital than at Blackpool and Morecambe, but there is no information to show that the health and safety of any individual had been endangered or was likely to be endangered. We therefore do not accept that this amounted to a protected disclosure.

Public Interest Disclosure 15

134. On 1 July and 1 September 2016, the claimant during her MHPS interviews orally raised concerns about her colleagues' harassing behaviour towards her, the Trust's failure to address her concerns regarding the neck lump clinic and John de Carpentier's lack of probity. We need say nothing more about this allegation other than that the respondent admits that the claimant made a protected disclosure during the interview. No other admission is made.

Public Interest Disclosure 16

135. This relates to 29 September 2016 when the claimant emailed Arun Cardozo and Dr Sivaramalingham in respect of treatment decisions made about a patient without ensuring reasonable pathological certainty. Again this needs no further comment as the respondent admits that the claimant's email of this date is a protected disclosure. No other admissions are made.

Public Interest Disclosure 17

136. This relates to 23 January 2017 when in the claimant's resignation she informed Professor Pugh about her concerns with the MHPS investigation and that she had been victimised by her colleagues. Again the respondent admits that the claimant's letter of this date is a protected disclosure but no other admissions are made.

Public Interest Disclosure 18

137. This related to 17 February 2017 and was that the claimant raised a grievance outlining her concerns with the MHPS investigation and the findings in the report and that she had been victimised for raising protected disclosures.

138. In the course of her evidence the claimant conceded that this allegation was not of a disclosure but of a detriment, so it falls to be removed from the allegations of protected disclosures.

Public Interest Disclosure 19

139. On 31 March 2017 the claimant wrote to Professor Pugh in respect of the Trust's victimisation and discrimination of the claimant. This allegation is that there had been, was being or was likely to be a breach of a legal obligation described as "section 27 of the Equality Act 2010, and breach of the Trust's [and Professor Pugh's]".

140. Section 27 of the Equality Act 2010 deals with allegations of victimisation based on a protected characteristic from the Equality Act. The claimant claims that it is in the public interest that NHS Trusts operate a fair and non-discriminatory practice which does not victimise individuals for raising issues regarding equality and discrimination or for whistle-blowing (as above) and to encourage others to speak out. It is, she says, in the public interest for all doctors to act in accordance with standards set by the NHS Trust and the GMC whose purpose is to protect promote and maintain the health and safety of the public.

141. The respondent does not admit that this letter is a protected disclosure on the basis that it is not a disclosure that is made in the public interest.

142. On 31 March the claimant sent an email to Professor Pugh. She attached a letter to appeal against the investigation report and recommendations, and she attached some of the concerns she had about the service.

143. Looking at the letter, the claimant can only conclude that the way she has been treated was due to her having raised clinical concerns regarding another colleague's practice or because she is female.

144. Under the heading "Victimisation and Discrimination" the claimant feels that the process followed against her has been a witch-hunt. She referred to the concerns that she had raised against a colleague and suggests that this directly led to the incident forms and complaints against her being submitted by her colleagues, which ultimately led to the MHPS investigation being commenced against her and restrictions being placed on her practice. According to the claimant, this was evident from the timing of the complaints being raised in November 2015 shortly after the RCS interim report became public. The complaints were clearly part of a coordinated campaign against her having been raised by multiple colleagues, and she believed they were done at the behest of the individual against whom she had raised issues regarding his practice. This coordinated effort against her had resulted in restrictions being placed on her practice, a negative MHPS report and Dr Pugh's recommendations, all of which she considered a direct result of raising clinical concerns regarding a colleague's practice. She concluded that she had been discriminated against by the Trust. She said the reason for the difference in treatment being herself a female and junior most surgical consultant in the team as opposed to her more senior male colleagues. She had restrictions placed upon her where her concerns of poor practice in relation to a more senior male colleague were not acted upon. There had been no MHPS investigation or restriction on their practice and the neck lump clinic was not taken from Mr de Carpentier, notwithstanding the RCS recommendation. This was, she said, detrimental to patients and financially detrimental to the Trust and showed a significant difference in treatment between her more senior male colleagues and herself. She referred to inaccuracies in the NCAS letters, and again concluded the reason for the difference in treatment was because she was female or had raised clinical concerns.

145. In her submissions counsel for the claimant contends that a disclosure to Professor Pugh constitutes disclosure to the employer by virtue of his senior managerial position. The claimant in her letter sets out a number of ongoing concerns: that she had been victimised and discriminated against because she was a whistle-blower or because she was female. Despite the fact that the claimant has now withdrawn the latter of those two heads of claim, it is clear that this letter goes directly to her allegations of whistle-blowing detriment and constitutes a disclosure that she was being subjected to detriment because of her whistle-blowing. This is an allegation that the Trust was not complying with its legal obligations not to discriminate against whistle-blowers or to subject them to detriment. The claimant contends that there is clear public interest in a culture as the respondent's, whereby those who raise concerns about inadequacies in patient treatment are bullied by senior colleagues, ignored by management and forced into an untenable professional position because of management's slavish and blinkered adherence to a report which was woefully and clearly inadequate.

146. The respondent does not admit that this amounts to a protected disclosure because it is denied that there was any disclosure of information which in the claimant's reasonable belief was made in the public interest. These are complaints about the claimant's own treatment.

147. We find that the claimant was disclosing information about the way in which she believed the Trust treated whistle-blowers and/or acted in a discriminatory way against her on the basis of sex by treating her differently from male colleagues.

148. As to public interest, the Tribunal takes the view that it must be in the public interest for an NHS whistle-blower to be protected from detriment done on the ground that the person concerned has made a protected disclosure. It is important that whistle-blowers within the NHS are encouraged to come forward in appropriate circumstances.

149. In our judgment the claimant made a protected disclosure in respect of the treatment of whistleblowers.

Public Interest Disclosure 20

150. On 31 March 2017 by email the claimant raised concerns about:

(a) The unsafe nature of the MDT – it was unsafe despite the Royal College of Surgeons' review;

(b) She had already submitted two incident reports on similar cases;

(c) Left out of list

(d) Two of her patients had come to harm due to consultants trying to score points against her;

(e) Audits produced following the RCS review had been carefully selected and analysed to hide high complication rates;

(f) John de Carpentier undertook extensive endoscopic sinus surgery with significant post-operative complications and re-admission for a patient who had viral conjunctivitis;

(g) The neck lump clinic still had nurses seeing patients and organising further investigations without a full clinical assessment.

151. The claimant also raised concerns that treatment decisions and actions of consultants were not in keeping with good medical practice by reference to two specific cases:

(a) A patient who underwent radical surgery despite the final histology being benign; and

(b) A patient was operated on despite there being no lesion, benign or malignant.

152. Suffice to say that the respondent agrees that the claimant's letter of 31 March 2017 headed "Subject: Ongoing patient concerns" is a protected disclosure.

The Alleged Detriments

153. In her submissions on behalf of the claimant counsel makes various comments as to events involving the claimant and others, but she does not work through the detriments set out in the List of Issues from (a)-(m).

Detriment 1

154. Counsel for the claimant does not refer to any matters of law in relation to the claim alleging detriment under section 47B of the Employment Rights Act 1996.

155. Counsel for the respondent refers to the time limit provided by section 48(3) where such detriment claims have to be brought within three months beginning with the date of the act or failure to act to which the complaint relates or, where the act or failure is part of a series of similar acts or failures, within three months of the last of them. Counsel reminds us that there is a "not reasonably practicable" extension in certain circumstances provided the claim is submitted within such further period thereafter as the Tribunal as the Tribunal considers reasonable.

156. The relevant test is of acts "done on the ground that the worker has made a protected disclosure" and in counsel's submission it requires an analysis of the mental processes (conscious or unconscious) which caused the decision maker to act, as in a discrimination claim, what has sometimes been described as their "motivation". The test is not satisfied by the simple application of a "but for" test. It is necessary to look at the mental processes of the particular decision maker who is said to have subjected the claimant to a detriment.

157. In **Malik v Cenkos Securities PLC UKEAT/0100/17** the employee sought to argue that detriment came about because of the action of several managers, not just the manager ultimately imposing the detriment. That approach was rejected. If all the managers were acting jointly in taking the relevant decisions that would be different, but that was not the case. It was necessary to look at the motivation of the particular decision maker. Indeed it is more because of the possibility of individual liability for detriment.

158. In his submission "on the ground that" means "materially influenced" the decision in the sense of being more than a trivial influence, which comes under the authority of **Fecitt v NHS Manchester [2012[ICR 372**. The need to identify with specificity the decision maker's reason is seen clearly in **Bolton School v Evans [2006] EWCA Civ 1653**, where the reason for the detrimental treatment has to be the disclosure itself not ancillary separable features of it.

159. Once a claimant has established a protected disclosure, and that she has been subjected to detriment, section 48(2) provides that it is for the employer to show the ground on which any act or deliberate failure to act was done. The statutory provision means that the Tribunal may uphold the claim if the employer is unable to show the ground on which the act was done but does not have to. It does not follow that a claim will succeed by default.

160. The first detriment alleged is the failure to apply the Trust's whistle-blowing, grievance and bullying and harassment policy to protect the claimant from retaliation from 21 April 2014 to date.

161. Counsel for the respondent submits that this contention is misconceived because:

(a) the claimant's first alleged protected disclosure is not until 19 May 2015 so even if there was such a failure from April 2014 it cannot have been because of any protected disclosure;

(b) the claimant at no stage sought to invoke the whistle-blowing procedure or the grievance/harassment policy. It is difficult to see how the claimant can argue that the respondent's failure to apply the grievance procedure when no grievance procedure had been lodged is a detriment, let alone one because of alleged whistle-blowing;

(c) the respondent denies there was any "retaliation" and so denies it failed to protect the claimant from it;

(d) when the claimant lodged a complaint of bullying it was thoroughly investigated by an independent third party on behalf of the Trust;

(e) if the respondent did so fail it is denied because the claimant had made protected disclosures; and

(f) the allegation is bad for want of particularity in any event.

162. The Tribunal respectfully agrees with the submissions of counsel for the respondent, and without any particularity in respect of the allegations we are unable to conclude that the respondent either acted to failed to act in this regard on the ground that the claimant had made one or more protected disclosures.

Detriment 2

163. This alleges hostile, aggressive and poor behaviour by colleagues in MDT meetings from around late September/early October 2015 to September/October 2016.

164. In her submissions on behalf of the claimant Ms Trotter does not set out the evidence in support of the alleged detriment. There is therefore no specificity to the allegation.

165. For the respondent, counsel submits that acts prior to 12 March 2017 are out of time and the second alleged detriment is at the least 5-6 months out of time. He goes on to suggest why things might or might not have happened to the claimant in the head and neck multidisciplinary team meetings.

166. Again we are unable to make any specific findings as to which hostile, aggressive and poor behaviour by colleagues the claimant wishes us to consider, and thus there is no behaviour that we can examine to see whether or not it was done on the ground that the claimant had made one or more protected disclosures.

167. We are unable to make a finding that the claimant was subjected to this detriment on the ground that she had made one or more protected disclosures.

168. In her particulars of claim the claimant particularises the allegation concerning the way in which she was treated in the multidisciplinary team meetings, but in her witness statement under the hearing "Behaviour towards me in MDT meetings in 2015" the claimant associates the alleged detriment with the sixth and seventh public interest disclosures.

169. We did not find in favour of the claimant in respect of the sixth and seventh public interest disclosures and so we are unable to find that the claimant was

subjected to any detriment done on the ground that she had made protected disclosures 6 and 7.

Detriment 3

170. This involves incident report forms being raised against the claimant by her colleagues between 27 October and 17 November 2015.

171. In the claimant's particulars she refers to five Datix incident reports being raised against her by her colleagues between 27 October and 17 November 2015.

172. In her witness statement under the heading "Allegations raised against me following the RCS review outcome" the claimant states that:

> "Within just over five weeks of the RCS outcome being made known, seven Datix reports had been submitted against me (I have referred to five Datix reports in my ET1 at paragraph 64, but I have seen following disclosure in these proceedings that seven were raised during this period)."

173. Although in submission counsel for the claimant does not seek to link any particular alleged protected disclosure with this detriment we conclude, on the basis of the claimant's witness statement, that the alleged detriment was allegedly done on the ground that the claimant had made disclosures to the Royal College of Surgeons. As we have found that these were not protected disclosures we are unable to find that the incident report forms raised against the claimant by her colleagues between 27 October and 17 November 2015 were done on the ground that the claimant had made a protected disclosure.

Detriment 4

174. The fourth alleged detriment relates to a joint letter of complaint sent to Professor Pugh by four consultant colleagues on 19 November 2015 making allegations against the claimant.

175. On 19 November 2015 Dr Sivaramalingham, Mr Nigam and Mr Cardozo signed a letter addressed to Professor Mark Pugh. Mr de Carpentier's name appears on the letter in typed script but he did not sign it. The letter was to bring to the attention of Professor Pugh their concerns regarding the claimant.

176. Looking at the claimant's witness statement we have set out above what happened within just over five weeks of the RCS outcome being made known. The claimant then goes on to state:

> "Further, on 19 November 2015 Sivaramalingham, Nigam, de Carpentier and Cardozo sent a joint letter to Mark Pugh…"

177. In our judgment the claimant is alleging that the fourth detriment arises out of the RCS review outcome. We have found that the claimant did not make protected disclosures to the Royal College of Surgeons and therefore we are unable to find that the letter of complaint was sent on the ground that the claimant had made a protected disclosure.

Detriment 5

178. The fifth alleged detriment relates to the claimant being told to reflect on her knowledge, skills and behaviour in a meeting with Professor Pugh and Mr Bhowmick on 20 November 2015.

179. In the claimant's witness statement, still under the hearing "Allegations raised against me following the RCS review outcome", the claimant states that:

> "On 20 November 2015 I was invited to a meeting with Mark Pugh and Arnab Bhowmick and I was informed that allegations had been raised against me. I was not told about the content of, or the number of, Datix reports which had been raised or the joint letters that had been sent by my colleagues. Mark said we all knew it would take some time for the RCS review outcome to settle down but given the concerns raised I had to ask myself whether my colleagues were all wrong or whether I was wrong. He asked me to reflect on my skills, behaviour and performance and to meet them again in two weeks' time. At the time neither the Datix reports nor the joint letters had been investigated. Despite this I was told by Mark to reflect upon my skills, behaviour and performance. Clearly Mark and Arnab had predetermined the outcome of these allegations and decided that I was at fault."

180. Professor Pugh and Mr Bhowmick confirm that they did meet with the claimant on 20 November 2015 to discuss the letters received.

181. On the basis that the letters and/or Datix reports arose from matters which we have not found to be protected disclosures, we again are unable to find that whatever may have been said to the claimant by Professor Pugh and/or Mr Bhowmick on 20 November 2015 was done on the ground that the claimant had made a protected disclosure.

Detriment 6

182. The sixth alleged detriment is in respect of a failure to provide the claimant with full details of the complaints made against her despite repeated requests from 20 November 2015 to 10 June 2016.

183. Counsel for the claimant does not deal with this alleged detriment in her submissions.

184. Counsel for the respondent submits that Professor Pugh fully accepted in evidence that he had failed to provide the evidence to the claimant in this period despite repeated requests. He also accepted that he did not progress the MHPS investigation as he would have liked. It is plain, however, that this was not because she had made protected disclosures, nor was it suggested to him in evidence that it was, nor is there any reason why it would be. Indeed, there is no evidence whatsoever that Professor Pugh's mental processes were ever, in relation to any decision, tainted by the claimant's alleged protected disclosures.

185. Looking at her witness statement the claimant does not seem to link this alleged detriment with any particular protected disclosure.

186. In his witness statement Professor Pugh tells us that:

> "Around March 2017 the Trust was facing a crisis with its Accident and Emergency Department at Chorley Hospital. This had been an issue for some time but was becoming critical. The Trust had been unable to ensure that the A & E Department was properly staffed and I had to make the decision to downgrade it. This was done after extensive efforts to retain the A & E Department as it was. I was required to meet with the local Health Commissioners, Members of Parliament, the press, patient groups and staff groups and dealing with many other enquiries. This issue became all-consuming in the period from January 2016 to April 2016. It meant that I was not able to give a proper level of attention to my other duties as Medical Director during this time. This will also have had an adverse impact on the issues facing the claimant. I would also add that at any one time I would have a caseload of an average of ten doctors being investigated and seeking support from NCAS – this was not an isolated case."

187. In cross examination Professor Pugh accepted that he had not provided information and/or documentation to the claimant in a timely manner, and at the end of his cross examination he denied that he had acted in this way because the claimant was a whistle-blower and/or that she was female. He conceded, with hindsight, that there were failings on his part during the process, in particular around keeping to timelines.

188. Looking at the mental processes of Professor Pugh, we accept that he did not fail to provide the claimant with full details of the complaints against her because she had made protected disclosures. In our judgment Professor Pugh had so many things to do in his role as Medical Director that he was unable properly to apply himself to all of them, and the claimant was not always his first priority. We do not therefore conclude that the failure to provide the claimant with full details of the complaints was done on the ground that she had made one or more protected disclosures.

Detriment 7

189. The seventh alleged detriment is that restrictions were imposed on the claimant's practice from 25 February 2016 onwards.

190. In her witness statement the claimant tells us that on 25 February 2016 she met with Mark Pugh and he told her that an MHPS investigation would commence. "He had spoken with NCAS and they felt I should not undertake any cancer cases whilst these issues were being investigated". Mark Pugh explained to her that this was a temporary restriction and would remain in place for the duration of the investigation, but that he would review it every four weeks. He stated benign work would be diverted to the claimant instead and that he had told the Head and Neck Manager to ensure that this happened.

191. According to Professor Pugh, he met with the claimant on 25 February to inform her that he intended to commence an MHPS investigation into the concerns that had been raised against her, and also into the complaints that she had made. He explained that he would be the case manager for both investigations and would be responsible for appointing the case investigators. He explained what concerns he had that were to be covered within the investigation and then he informed the claimant that he did not want her to conduct any cancer cases while the

investigations were being carried out. This was, he said, to protect her and the patients, and he explained that she was to focus on benign work rather than oncology.

192. In a letter dated 7 March 2016 Professor Pugh wrote to the claimant to confirm the key points discussed at their meeting on 25 February 2016, and he stated:

> "I advised you that when I spoke with NCAS they felt it was appropriate to not undertaken any cancer cases whilst the issues were being investigated. I explained that the reason for this was twofold, firstly it was to protect you and secondly, to protect the patient, as concerns had been raised about your practice, and as the Medical Director I have to ensure that all clinical practice is at the necessary standard. I advised you that this was a temporary restriction that was to remain in place for the duration of the investigation. The restrictions would be reviewed every four weeks. We explored this a little further and I clarified that you were to focus on benign work rather than oncology. I said I would speak with the team to ensure the work was diverted to you."

193. NCAS is the National Clinical Assessment Service which is an operating division of the NHS Litigation Authority. Medical Directors, and others, are able to contact NCAS for advice in respect of doctors working within their Trusts. In this case the respondent, through Dr Pugh, appears to have dealt with the same adviser throughout. Correspondence from NCAS refers to the doctor by number rather than by name, and at the end of letters it states that the NCAS adviser is happy for a copy of the correspondence to be shared with the doctor in question.

194. In a letter from NCAS dated 17 February 2016 under the heading "Case discussion and advice" the following appears:

> "We discussed that the investigation under Part I of MHPS into the performance and behaviour/attitude issues is still proceeding. You are the case manager in that investigation. You said that it had been difficult to obtain specific details about some of those allegations but you have now received a number of written allegations about those matters. We discussed the terms of reference for the investigation. I advised that the terms of reference had to be clear and identify specific allegations.
>
> We then went on to discuss the allegations relating to [the claimant's] decision making in relation to cancer patients. We discussed how these additional concerns should be investigated as part of the current investigation under Part I of MHPS. I explained that you could amend the terms of reference to include these additional allegations.
>
> We discussed that the Trust is undertaking a separate investigation into the allegations of bullying and harassment made by [the claimant] about her colleagues. You have arranged for external investigators to undertake that investigation, which you anticipate will be concluded before the investigation under Part I of MHPS.

> We discussed the provisions under Part II of MHPS. You told me that you had concerns about patient safety in relation to [the claimant's] decision making around the care of cancer patients. Accordingly, we discussed that you are intending to place restrictions on her practice. Her practice will be partially restricted to the extent that she will be restricted from undertaking any diagnosis or referral in any cases of suspected cancer, but will be allowed to continue with the rest of her clinical practice. We discussed this is an appropriate alternative to exclusion as referred to under paragraphs 7 and 18 of Part II of MHPS, which state that alternatives to exclusion should be considered, including restrictions on practice. I advised that you should review that restriction on a regular basis….
>
> I advised you to meet with [the claimant] to inform her of the further allegations and the steps which you are taking to deal with these additional allegations, including discussing with her the restrictions on her practice…
>
> I explained that you will also need to write to her in accordance with the provisions under paragraph 13 of Part I of MHPS and to confirm the restrictions on her practice."

195. We consider that the mental processes leading Mark Pugh to restrict the claimant's current practice from 25 February 2016 onwards were properly reflected in his letter dated 7 March 2016 which was sent following his meeting with the claimant which itself was preceded by his discussion with NCAS. This discussion included the possibility of restricting the claimant's practice.

196. We are satisfied that the reasons for restricting the claimant's practice were as set out in the 7 March letter and were not done on the ground that the claimant had made one or more protected disclosures.

Detriment 8

197. The eighth alleged detriment concerns the removal of a patient from under the claimant's care on 9 March 2016 when it had previously been agreed she could treat the patient.

198. In Professor Pugh's 7 March letter he states:

> "You advised that you had a cancer patient booked for 7 March 2016 who had been waiting some time for an appointment and you did not want them to have further delays. I therefore agreed that you could still see the patient and the restrictions would take place following this point. However, since we met there have been further discussions in relation to this patient and a decision has been made that they will no longer be treated at Lancashire Teaching Hospitals, therefore, the restrictions are to be put in place immediately."

199. According to the claimant, who does not seem to link this alleged detriment with any particular protected disclosure, she was initially told that she could continue to treat one cancer patient who was a Jehovah's Witness where there were additional issues for surgery as the patient was opposed to blood transfusions because of his religious beliefs. The Trust had initially allowed her to continue treating this patient, however Mark Pugh changed his mind and on 1 March 2016 on

Arnab Bhowmick's advice insisted she perform the surgery with another experienced surgeon because of this potential complication "even when I had told them both that this was planned as a joint case with Mr Ajum and Mr Srinivasan (Plastics and Reconstructive Surgeon), who were experienced surgeons themselves and members of the head and neck MDT. I have since found out that Arun Cardozo had written to recommend that I should not be allowed to treat this patient".

200. Om 26 February 2016 Arnab Bhowmick sent an email to Mark Pugh forwarding an email from Arun Cardozo. Mr Bhowmick's view was that in the light of circumstances and also lack of support for this surgery being carried out locally, that a surgeon with sufficient experience of this type of case should be present, and he would be interested to see if this had been set up with a vascular surgeon available.

201. Arun Cardozo summarised the patient in great medical detail and noted, amongst other things, that the claimant had referred the patient to Newcastle for a second opinion:

> "It was discussed at the MDT on 23 February 2016 but following the MDT Mr Nigam (Consultant ENT/Head and Neck Surgeon – Blackpool), Dr A Mirza (Consultant Oncologist) and Dr Muthu Siva (Consultant Oncologist) approached me about their concerns about this patient having the procedure done at Preston as it is not an operation done here frequently – certainly not by the ENT team. I agreed that the ENT team had not done an open resection of a tonsil tumour at Preston in the past six years that I have been here. We agreed that there were the following concerns about the surgery being done by a team that does not do this surgery on a regular basis:
>
> (1) Recurrent post chemoradiotherapy disease – making resection more challenging due to fibrosis making dissection and identification of gross tumour margins more difficult.
>
> (2) Possibility of bleeding complications due to a tumour resection close to the carotid vessels – in a Jehovah's Witness who has declined transfusion.
>
> (3) Poor tumour biology (HPV related disease that has recurred despite a course of radical chemoradiotherapy) – will require adequate surgical margins to achieve microscopic tumour clearance.
>
> (4) No option for further adjuvant post op radiotherapy.
>
> In my role as the Clinical Lead for head and neck cancer services I confidentially discussed my concerns with Ms Thomas and advised her that, since the patient had already been seen by the head and neck team at Newcastle – she always had the option of referring the patient back to them for surgery (as they are more experienced at performing this sort of surgery on a regular basis) and this was a particularly challenging case for the reasons outlined above. Ms Thomas unfortunately took this advice as a personal attack on her surgical abilities and accused me of trying to undermine her."

202. The claimant sent an email to Mark Pugh and Arnab Bhowmick on March 2016 following their discussion where they had wanted another appropriately experienced ENT surgeon to be present, and they gave a timeframe of two days for a name to be provided. She said that she did not have many options nor did she want everyone in the ENT world to know the difficulties she was facing, but she spoke to Professor Paleri (of Newcastle) to see whether he could come for the case because he knows the background of the MDT and has seen the patient already. Professor Paleri had agreed but had a clinic on that day and without six weeks' notice it was not possible for him to cancel and he requested an official request to his Medical Director copied to his Clinical Director as well so that he can be released from clinic. Could this be done and could it be ensured that there would be an ICU bed for 14 March as so many arrangements had gone into the case.

203. Mark Pugh responded to the claimant on 3 March stating that this case posed a difficult conundrum for all concerned, and he set out those concerns including:

> "…limited experience of the procedure within the Trust in the last two years, with the claimant having performed a single similar case jointly with Mr Cardozo when she first arrived, the inability of the Trust to guarantee a critical care bed and the necessity to facilitate an external surgeon. In the light of everything and in discussion with Mr Bhowmick it was their considered opinion that it would be in the best interests of the patient for them to be treated at the expert surgeon's own unit. The surgeon would be able to offer surgery at the beginning of April. He hoped she could appreciate that the decision was taken with due consideration for all of the factors described above and in the overall best interests of the patient and in recognition of the unique and complex nature of their illness."

204. Looking at the mental processes of Professor Pugh, supported by Mr Bhowmick, we are satisfied that the decision to move the patient from the claimant's care was made for good and valid surgical reasons and not on the ground that the claimant had made one or more protected disclosures.

Detriment 9

205. The ninth alleged detriment involves subjecting the claimant to a prolonged and partisan MHPS investigation with flawed findings between March 2016 and 12 December 2016.

206. We have set out above the discussions between Professor Pugh and the NCAS adviser which led to the MHPS investigation. Based on our findings above we are satisfied that when Professor Pugh decided to initiate the MHPS investigation he was doing it for the reasons set out, which related to the claimant's medical practice and his concerns about it and not on the ground that the claimant had made one or more protected disclosures.

207. As to that investigation, it was carried out by Mr Kishore Pursnani who was employed by the respondent as a consultant surgeon, and had been employed by the Trust since April 2005. In his role as a consultant surgeon he was familiar with the operation and importance of multidisciplinary team meetings, although he was not involved in the head and neck MDT.

208. Mark Pugh requested that he conduct an investigation into concerns made against the claimant in accordance with Maintaining High Professional Standards in the modern NHS framework.

209. During the course of his cross-examination Mr Pursnani accepted that the terms of reference to which he worked, the level of his investigation and the consequent report, left something to be desired. We shall return to this topic later when we look at the question of constructive dismissal.

210. Having said that we are satisfied, from the evidence given by Mr Pursnani, that the way in which he went about the investigation was not done on the ground that the claimant had made protected disclosures but because he genuinely did what he thought was the right thing at the time in following up the invitation from Professor Pugh to carry out the investigation.

Detriment 10

211. The tenth alleged detriment alleges the Trust's failure to give any meaningful consideration to lifting the restrictions on the claimant's practice from 13 June 2016 to 31 March 2017.

212. In the submission of Mr Sugarman for the respondent, according to Professor Pugh the restrictions were reviewed by him regularly although the respondent accepts there is no documentary evidence to this effect. There was no significant change in the circumstances and therefore no need to modify the restrictions. There was reasonable and proper cause to continue the restrictions. Professor Pugh kept liaising with NCAS who provided expert advice and input. In any event he submits Professor Pugh's decision making had nothing to do with any alleged protected disclosures.

213. Ms Trotter in her submissions for the claimant reminds us that her practice was fundamentally restricted, estimated by the claimant in her oral evidence as 80%, some three months after the investigation began, for reasons neither explained to her, nor evidenced by the documents alleged to have supported the same – even to this day:

> "That restriction lasted for the remainder of her employment with the respondent even when the MHPS investigation exonerated her on two of the four terms of reference."

214. There is within the bundle evidence that Professor Pugh was continuing to liaise with NCAS which include advice to him to review the restriction upon the claimant on a regular basis.

215. Having been satisfied that the reason Professor Pugh instigated the investigation and the suspension was not done on the ground that the claimant had made one or more protected disclosures we are satisfied, notwithstanding the lack of any documentary evidence to this effect, that he did give consideration to whether or not the restrictions on the claimant's practice should be lifted, and these considerations continued up until the claimant's employment ended by her resignation. By this time he and the claimant had not agreed how best to progress the claimant's position.

Detriment 11

216. The eleventh alleged detriment is the imposition of a period of supervised practice and NCAS assessment at another unit from 18 January 2017 onwards.

217. The NCAS adviser wrote to Professor Pugh on 9 December 2016 to confirm telephone conversations on 25 November and 1 December:

> "We discussed that you have now received the report from the investigation. We discussed the options under paragraph 17 of Part I of MHPS. As the case manager, you have concluded that a number of the allegations are not proven, namely those relating to the treatment of cancer patients and the allegations relating to some Trust policies. Accordingly no further action will be taken in relation to those matters. We then went on to discuss the other allegations. As the case manager you have concluded that the other two terms of reference, namely in relation to decision making/use of MDT process and interaction with other team members, have been proven and you are recommending referral to a disciplinary panel.
>
> We discussed whether these concerns were issues of conduct or capability. I referred you to paragraphs 4-9 of Part III of MHPS, which sets out some examples of misconduct in a professional context. We discussed that the concerns could potentially be issues of professional misconduct and capability. We discussed that where issues of conduct and capability are involved paragraph 8 of Part VI of MHPS provides that such cases can be complex and difficult and should usually be combined under a capability hearing.
>
> We discussed the procedures for dealing with conduct and issues of capability. I explained that professional misconduct can be dealt with under local disciplinary procedures as provided for under Part III of MHPS. Issues of capability are more complex and Part VI of MHPS must be followed. Paragraph 4 provides that if concerns about capability cannot be resolved by management the matter must be referred to NCAS, before the matter can be considered by a capability panel. Paragraph 14 of Part IV of MHPS provides that if the issues cannot be resolved through a local action plan, the matter must be referred to NCAS for it to consider whether an assessment should be carried out. Paragraph 15 provides that there may be occasions when a case has been considered by NCAS but the advice of its assessment panel is that no plan would have a realistic chance of success….
>
> You informed me that you had decided to consider referral to a capability panel but you will first ask NCAS for an assessment of the doctor's practice. I explained that in order for a practitioner to be assessed they should usually be undertaking the role for which they are contracted at the Trust. As the doctor's practice is restricted and has been for some time I advised that you should consider whether she could return to practice through a programme of remediation.
>
> I advised that NCAS could draw up a "back on track/remediation plan" which would need to be for at least six months. This remediation plan would identify the objectives which had to be addressed and set realistic timescales to meet

> those objectives. It would then set out the consequences of failing to achieve those objectives. I explained that a supervisor would have to be appointed under the plan. You informed me that it would not be possible for the doctor to undertake a remediation plan at the Trust so you will consider an external placement and then review the position regarding an NCAS assessment. I advised that any remediation plan would have been agreed with the host Trust and the doctor.
>
> I advised you to arrange to meet with the doctor to discuss the recommendations from the investigation report and the steps you are proposing to take. In that regard, you should inform her about a potential remediation plan and the proposal for it to take place at an external placement."

218. Professor Pugh met with the claimant and her BMA representative on 18 January 2017 and followed this up with a letter on 23 January 2017. According to the letter, he told the claimant that he had discussed the report at length with NCAS and that they had concerns relating to her working as part of an MDT and with cancer patients in a team manner. He recognised she was in a difficult position as her practice was restricted but and he acknowledged there was a second investigation ongoing into difficulties she had raised with colleagues so it was not an optimal situation. He explained that NCAS said they would like to offer a formal assessment.

219. He was not suggesting that there were issues regarding her conduct and capability he would take to a panel at that point, but there were aspects giving him cause for concern and it was for this reason he would like an independent assessment by NCAS. He stated he did not feel it would be possible for this to be undertaken in the current setting and NCAS agreed that the most reasonable way forward would be for her to move to another unit to enable her to return to cancer work and once in normal mode of operation there would be an NCAS assessment. No unit had yet been identified. He and NCAS felt this was a reasonable and proportionate way forward and he acknowledged she would need some time to consider this proposal. A new environment may help her to regain confidence after a difficult period.

220. After meeting privately with her BMA representative, the claimant said she would consider the option put forward and he suggested she should reflect on the discussion and decide on the best option. If she did not agree to the assessment option he explained that if there were concerns about a medic they should go through NCAS but if that option was not taken the concerns would remain unanswered. If there was no engagement with the NCAS process he would need to consider what would happen next and he outlined that he had presented the claimant with an option that was a route back to full practice which would be fully supported. If not taken this would leave him in a difficult position as the concerns remained unanswered, and he invited her to get back to him with a decision by 2 February.

221. It would appear that a period of supervised practice and an NCAS assessment was offered to rather than imposed upon the claimant, but we conclude on the basis of the thinking of Professor Pugh as outlined in his correspondence and as supported by correspondence from NCAS, that he was following through the

NCAS process and advice based upon the contents of the report, and that he was not acting as he was on the ground that the claimant had made one or more protected disclosures.

Detriment 12

222. The twelfth alleged detriment is of failing to investigate the claimant's grievance dated 17 February 2017 within a reasonable period of time, or at all, and in breach of the Trust's grievance procedure and/or bullying and harassment at work policy and procedure and disciplinary procedure.

223. In his submission Mr Sugarman states that it is right that the respondent did not appreciate that the claimant's letter of 17 February 2017 contained a grievance that she wanted investigating. The claimant did not instigate the grievance procedure in the normal way, the reference to a grievance was included at the end of the letter, as somewhat of an afterthought which unfortunately Professor Pugh simply missed. The respondent accepts that it is unfortunate that it was missed however it had nothing to do with whistle-blowing.

224. The claimant's letter in question was set out on just over two sides of A4 and at the end of the second page in the middle of a paragraph she uses the words "I wish to raise a grievance in relation to this point and the fact that I appear to be being treated differently in comparison to my colleagues who have not lodged clinical concerns".

225. In his witness statement Professor Pugh refers to the claimant's claim form in which she says that she raised a grievance and it was not investigated by the Trust. It was not until sometime after the claimant had submitted her claim and the Trust had submitted its response that the sentence in the letter referring to a grievance was identified. The Trust has a comprehensive grievance policy and the expectation is that this policy is used where there is a grievance. The claimant did not use this policy. He accepted the Trust did not investigate her letter of 17 February 2017 as a grievance because, due to an oversight, that was not spotted in her letter. Had it been spotted he would have referred her to the grievance policy.

226. We accept the explanation given by Professor Pugh as to why the claimant's grievance was not acted upon when it was made. We do not find that this failure was done on the ground that the claimant had made one or more protected disclosures. We are aware that a detailed investigation of her grievance was undertaken.

Detriment 13

227. What would have been the thirteenth alleged detriment was withdrawn by the claimant.

Unfair Dismissal

228. The first issue for us to consider is: did the claimant's resignation on notice on 23 January 2017 (leading to the termination of her employment on 31 March 2017) amount to a dismissal within the meaning of section 95(1)(c) of the Employment Rights Act 1996, in that:

(a) The Trust breached the express terms of the claimant's contract and the implied term of mutual trust and confidence by any of the actions listed above at paragraphs 5, 6, 9 and 12 above, taken alone or in cumulation?

229. We have not found for the claimant in relation to any of the alleged detriments, so we shall not consider the matters set out at 5 above. The claimant has withdrawn the matters set out at 6 above which related to Professor Pugh and at 9 above relating to direct sex discrimination, thus leaving only the question at 12, whether the resignation amounted to a dismissal on the basis of the breach of the express terms of the claimant's contract and the implied term of mutual trust and confidence.

230. The claimant attached a resignation letter to an email she sent to Professor Pugh on 20 January 2017. The letter states:

> "Many thanks for sharing the investigation report with me and meeting with me last week. I note that you did not identify any capability or conduct concerns in the report which would prompt you to call a formal hearing under any of the Trust's policies.
>
> I will reflect on the opinions expressed in the report and your comments and consider an appropriate personal development plan in the light of them. Please note that I have already undertaken the following actions in order to address any potential areas of weakness in my approach; …
>
> I have considered your decision that, in the light of the report's findings, I should work in another HN unit and undertake an NCAS assessment with a view to returning to the unit once this has been successfully completed.
>
> My written response to the investigation report details my serious concerns with it. The main concern I have is that the report supports, without apparent question, comments and opinions offered by individuals who have victimised me as a result of my raising concerns regarding practices within the unit. As your suggestion flows directly from the findings in the report that I have such serious concerns with, I do not feel able to agree to your decision. I also fear that a period of supervised practice in another unit and an external assessment will not change the opinions of the three consultants whose comments form the basis of the report. This will lead me to being in the same position I am in now in 18-24 months' time. As we discussed when we met this has been the hardest period of my career and I never want to be in this situation again.
>
> I am sorry to say that I do not have trust in Lancashire Teaching Hospitals to treat me fairly or give me justice.
>
> I would like to resign from my current post and consider my start of notice of notice period as of today. I would be taking all my eligible annual leave to the date."

231. Professor Pugh acknowledged the claimant's resignation letter and invited her to consider the letter he had sent following their meeting on 18 January and to discuss it with her representative before he would accept the resignation.

232. On 17 February the claimant sent a resignation confirmation letter in which she stated that until 19 November 2015 she had never received a complaint from colleagues regarding her behaviour. The NCAS report did not highlight any issues in this regard. Her concerns with the report were outlined in the detailed response document that she sent in advance of the meeting.

233. The investigator had drawn some potentially damaging conclusions in relation to her practice, that she had acted in a way that could be considered to be unacceptable practice and that she lacked clinical maturity and insight and she would have expected an extremely thorough and robust investigation before conclusions of this nature were drawn.

234. Cases referred to in the report were prior to the date of 1 January 2015 and were not discussed with the claimant. During her interview with the RCS she had raised a concern that she would be victimised when she raised the concern she had regarding the service and this appeared to have come true following the incident forms lodged after the report. Given the quality of the investigation and his decision to take on board any comments from anyone without evidence to support them she feared he would continue to have unanswered questions or doubts about her practice no matter how may hoops and assessments she underwent. She therefore remained of the view that she could not agree to an NCAS assessment since it flowed directly from an investigation process and report that she had serious concerns with. The claimant feared she would continue to be victimised for raising clinical concerns and that she would not be supported, treated fairly or given justice by the Trust if she remained in post and therefore she wished to stand by her decision to resign.

235. As to the report prepared by Mr Pursnani under the auspices of MHPS, counsel for the claimant reminds us that in cross examination Mr Pursnani conceded that it was in breach of a number of requirements imposed by the respondent's own policies. The terms of reference did not include any specific allegations or concerns. No critical analysis of the complaint letter or Datix reports used to justify the investigation was carried out. The claimant was not provided with the letter of complaint from her immediate colleagues until June 2016. Despite the fact that he drew conclusions as to the claimant's clinical judgment in a number of cases, the majority of those cases were not put to the claimant (only two out of eight) and Mr Pursnani did not look at any patient records. He did not, as is mandatory, appoint a senior member of medical staff, due to the fact an issue of the claimant's clinical judgment was raised during the investigation. He decided not to even interview one of the three signatories of the complaint letter or Geraldine Skailes despite her intimate knowledge of the head and neck MDT and its personalities. He did not allow the claimant the opportunity to put her version of events to all of the allegations made, failing to ask her about the majority of patients relied upon and interviewing three people, upon whom he relied, after he saw the claimant for the last time. The submission goes on to say that Mr Pursnani contended that he had looked at MDT records whilst compiling his report but there was no reference to them, no mention in his witness statement of that process and one of the only cases with specifics of an MDT discussion outlined was in fact incorrect. When the numerous breaches and failings were put to Mr Pursnani he conceded that his report was "possibly" inadequate. Difficult though that admission may have been for Mr Pursnani, it did

not go far enough – the reality is that his report was "so flawed as to be useless, unpardonably late and was absolutely not fit to be relied upon".

236. On 9 January the claimant wrote a comprehensive rebuttal of the report and sent it to Mark Pugh set out over 28 pages giving her detailed reasons why she did not agree with the findings in the report.

237. The report was one of the topics covered with Professor Pugh in his cross examination.

238. When he met the claimant to tell her of the allegations he was aware that NCAS were happy for him to share the correspondence with the claimant. This was not done. He accepted that the claimant would have felt better if there had been an independent review of her conduct.

239. When he met with the claimant on 25 February and restricted her practice he confirmed it was his decision not that of NCAS. The terms of reference did not include details of patient incidents nor the letters of complaint or the Datix forms. It was his intention to collate and supply the information but he could find no evidence that he ever did. He agreed that NCAS guidelines provide that there should be clear and specific allegations, but no specifics were given to the claimant and he accepted that this was in breach of Trust policy and NCAS guidelines.

240. Professor Pugh was taken to the respondent's capability policy and at paragraph 1.15 it provides that:

> "The practitioner concerned must be informed in writing by the case manager, as soon as it has been decided, that an investigation is to be undertaken, the name of the case investigator and make aware of the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people that the case investigator will interview. The practitioner must also be afforded the opportunity to put their view of events to the case investigator and given the opportunity to be accompanied by a staff representative or friend who is not acting in a legal capacity."

241. Professor Pugh confirmed that the NCAS correspondence had not been provided to the claimant and that the Trust was in breach of its own internal policy.

242. He accepted that the letter to Mr Pursnani with terms of reference had no specific incidents or patients referred to. There were no detailed allegations and no period for the investigation to cover.

243. He accepted that the claimant had raised concerns as to the terms of reference and with the benefit of hindsight he accepted that those concerns were justified. He had piles of paper needing attention including some relating to the MHPS investigation. He was woefully behind in his correspondence and he had apologised repeatedly to the claimant about that. He knew that there was information in the piles but he did not appear to have done it. With hindsight if he had had the capacity he would have done it. It would have been fairer or more desirable to have given the claimant the information sooner. With hindsight he could have

communicated things to her more clearly. He agreed that if he had not communicated the contents of the Datix from January 2015 then it was not fair.

244. On 18 May 2016 Professor Pugh wrote to the claimant following their recent meeting and her request for more information regarding the allegations made against her, and he was in a position to expand further on the initial terms of reference. He set out four headings and he confirmed the investigation would only be examining incidents or allegations reported from January 2015.

245. He accepted that there were still no specific allegations or patient details, no letters and no Datix documents, and so in May 2016 he was still in breach of the internal policy. He had been advised that he was compliant with MHPS having taken advice from more experienced colleagues. It was his understanding that the terms of reference did fulfil the MHPS requirements but with hindsight he accepted that they were not specific in terms of policy. Mr Pursnani was not in possession of the information either.

246. He acknowledged that he claimant's adviser had responded on 25 May and so he was on notice that the claimant was still not content with the terms of reference and there was a lack of information. Although he had intended to instruct someone to send the information to the claimant he did not do so.

247. When the report was received Professor Pugh agreed, on reflection, that the terms of reference were in breach of policy. He was reliant on HR advice. He accepted that the claimant had not been able to comment on witnesses seen by Mr Pursnani after he had seen the claimant. He accepted that some of the matters in the report, comments from the claimant's colleagues, were anecdotal and/or without corroboration. There was reference to an MDT recommendation which appeared to be incorrect yet this formed the basis of a conclusion. He was aware of a lack of specifics. Mr Fishburn had been seen after the claimant and there was no right of reply. There was nothing specific about the claimant acting outwith the recommendations of the MDT. He accepted the report contained general comments and no specifics.

248. According to Professor Pugh, he reviewed the report carefully but with hindsight things were apparent now. At the time he reviewed it with the HR Director herself and she raised no concerns that the report was inadequate. With hindsight several elements to it were far from ideal. The lack of specifics did not stick out like a sore thumb to him. It was his place to review the report in conjunction with the HR Director but he agreed that the buck stopped with him.

249. He accepted the claimant was entitled to believe that he would critically analyse the report before taking any decision on it, and with hindsight he agreed that he did not appear to have carried out a critical analysis to an adequate level. If done again he would look for dates, times and examples. His critical analysis was flawed. He accepted that the report contained issues that echoed previous concerns but with hindsight it was not reasonable to rely on it. The report was flawed.

250. He accepted that with hindsight it was not reasonable for him to rely on the report. He accepted the claimant's post-resignation letter in which she was explicit about the fact that she could not accept conclusions which flowed from the report. He accepted that for her she made the point that the last straw was the report and

his reliance upon it. The claimant had made it clear it was not an acceptable report for her.

251. Towards the end of his evidence it was put to him that he had acted as he did either because the claimant was a whistle-blower and/or female or because he was incompetent. He disagreed that it was because the claimant was a whistle-blower and/or female and conceded there were some issues around his performance. With hindsight he acknowledged failings on his part during this process, particularly around keeping to timelines. With hindsight they were elements fundamental to the report.

252. Ms Trotter refers to relevant case law in connection with constructive dismissal. The case of **Western Excavating v Sharp [1978] IRLR 27** confirms that unreasonable behaviour by the employer is not sufficient; it must be behaviour that breaches the contract of employment. It is also confirmed that an employee must resign soon after the breach complained of, to avoid affirming the breach by remaining in employment without protest.

253. Counsel for the claimant refers to **Malik v Bank of Credit and Commerce International [1997] IRLR 462** which held that an employer shall not without reasonable and proper cause conduct itself in a manner calculated and likely to destroy or seriously damage the relationship of confidence and trust between employer and employee.

254. In his submissions in relation to **Malik** Mr Sugarman sets out that in fact it is generally accepted and understood that rather than "calculated *and* likely to destroy or seriously damage the relationship of confidence and trust" it should be a reference to calculated *or* likely to do so. We accept that this is the case.

255. **Leeds Dental Team Limited v Rose [2014] IRLR 8** confirmed that there was no need for an intention on the employer's part, merely behaviour objectively judged to be likely to have the **Malik** effect.

256. An employee can leave in response to conduct occurring over a period of time, culminating in a "last straw", but the "last straw" must add something to the breach, albeit it may be insignificant as per **Omilaju v Waltham Forest Borough Council** cited with approval in **Kaur v Leeds Teaching Hospital NHS Trust [2018] EWCA Civ 978**.

257. Applying the law to the facts, even if what the claimant contended did not amount to a protected disclosure, in the submission of Ms Trotter there is a clear course of events during which the claimant was disparaged, bullied and disadvantaged, which culminated in her resignation. That resignation was brought about by the respondent's breach of the implied term of trust and confidence; these breaches included, but are not limited to, failing to check the appalling behaviour of John de Carpentier and Andrew Fishburn, failing to heed the claimant's complaints about the same, failing to prevent the claimant's exclusion by colleagues, placing undue reliance upon those colleagues' complaints, despite the warnings of the RCS and the claimant herself as to their agendas, failing to carry out an adequate MHPS investigation, failing to take any heed of the claimant's comprehensive rebuttal of the same and attempting to impose a period of relocation and re-skilling on the claimant despite the fact the investigation and report were not fit for purpose. The evidence of

Mr Pursnani and Professor Pugh was striking for the vast numbers of concessions made in respect of the investigation and its inadequacy, the report and its flaws and the unreasonableness of Professor Pugh in relying on the same. Professor Pugh further agreed that from the claimant's perspective the investigation report and his actions were the last straw for her.

258. The claimant contends that this fits squarely within the **Omilaju** criteria – her final straw was the culmination of the MHPS and Mark Pugh's dogged determination to ignore her explicit and detailed concerns about the same and plough on regardless. Professor Pugh repeatedly attempted to shift the blame for his inadequate analysis of the Pursnani report, despite the claimant's best efforts, onto the HR advice he was given. No evidence of that advice has ever been provided, nor was any evidence called; but even if he is right in that he was given such flawed advice, as Professor Pugh himself conceded the buck stopped with him as case manager. Not the HR adviser but Professor Pugh – he was the person ultimately responsible for ensuring the integrity of the process and he failed miserably, as he now appears to concede.

259. The submission continues that from the claimant's perspective Professor Pugh's slavish determination to impose sanctions and disadvantages upon her came as the culmination of a two year period during which she had been bullied, ostracised and oppressively scrutinised by senior colleagues, during which she had been excluded from surgical activities leading to possible de-skilling, during which generalised complaints, lacking any detail or corroboration, were apparently accepted at face value and during which the MHPS investigation to which she was subject was conducted without even giving her the courtesy of an opportunity to rebut many of the anecdotal allegations being made against her. This was, quite simply, the last straw for her – as is apparent from her resignation letter. On the basis of the evidence seen and heard and the many concessions made in particular by Professor Pugh and Mr Pursnani, but also in respect of the behaviour being meted out to the claimant, by Geraldine Skailes, Arnie Bhowmick and even (albeit begrudgingly) John de Carpentier and Andrew Fishburn, the Tribunal are respectfully asked to find that the claimant was constructively dismissed.

260. Mr Sugarman made submissions on the question of constructive dismissal. Professor Pugh said that the findings in the Pursnani report echoed his own concerns having read the claimant's file. Indeed, one can readily understand why Professor Pugh as Medical Director and MHPS case manager reading the Pursnani report thought it necessary to take further action. In evidence he said the report was reviewed with the HR Director and no concerns were raised with Professor Pugh that it was inadequate. The failings Professor Pugh accepted with hindsight did not stick out like a sore thumb as suggested to him by the claimant's counsel. He was primarily focussed on the claimant's attitude and behaviours and thus was not expecting a detailed investigation into specific clinical decisions in specific cases. The claimant did have the chance to comment on the report and did so at length. Whilst she made some fair points in her lengthy reply, the document is marked by a wholesale inability to accept any criticism. She takes issue with every single finding, sentence by sentence. She complained that the report's findings were based on the accounts of five people, three of whom were the original complainants, as if that somehow were insufficient. She continues to dismiss consensus views e.g. about where medullary thyroid cancer cases requiring a sternal split ought to be carried out

as simply “JDC’s opinion”. In the lead-up to the meeting on 18 January Professor Pugh contacted NCAS three times. He articulated his concerns which had nothing to do with protected disclosures. To find otherwise on the claimant's case will require a finding that Professor Pugh was nefariously motivated and/or part of a conspiracy willing to lie to NCAS and the Tribunal. There is simply no evidence for that serious allegation against the experienced Medical Director doing his best in very difficult circumstances. Professor Pugh says he reached conclusions on the basis of the evidence in and findings set out in the report not on the ground that the claimant had made protected disclosures. His evidence should be accepted.

261. Professor Pugh accepted in evidence a number of failings in his approach including not sufficiently critically analysing the report to identify the flaws in it when those were pointed out to him. That he did not pick up contemporaneously some of the oversights in the report revealed during the course of sustained and forensic cross-examination is not evidence that he somehow was improperly motivated.

262. There is little doubt the reason he required the claimant to undergo an NCAS assessment after a period of work carrying out full duties in another Trust was because he genuinely believed that to be appropriate in the light of the concerns that had been raised and the findings of the MHPS investigator, Mr Pursnani, as set out in his letter of 23 January 2017. There is no evidence that his mental processes were in any way affected by protected disclosures. As such on 18 January the claimant was offered the opportunity to return to the full ambit of work at another Trust following which there would be an NCAS assessment. Professor Pugh explained the discussion that was had specifically explaining that he was not suggesting there were issues of conduct or capability that he wished to take to a panel, rather that he wanted an independent assessment by NCAS. The claimant would therefore return to cancer work and only when in normal mode of operation would she be assessed. As such this was not a disciplinary or capability waring or sanction or the convening of a hearing to determine whether such a warning should be issued. It was a preliminary step to allow an assessment to be carried out. This must be borne in mind when considering whether or not the respondent’s response to the Pursnani report was without reasonable and proper cause, calculated or likely to undermine trust and confidence.

263. The respondent submits that despite the acknowledged flaws in some areas there was more than sufficient material in the report to give Professor Pugh reasonable and proper cause to adopt the approach he did. He would have been obviously open to criticism had he, in the light of such a report, allowed the claimant to carry on before as she wished. Given that he was offering the claimant a way forward without sanction and the chance to prove herself during an independent assessment by NCAS the respondent submits that it cannot be said that Professor Pugh’s decision objectively assessed per **Tullet Prebon**, was conduct so serious that it went to the root of the trust and confidence between the employer and employee and evinced an intention to abandon and altogether refuse to perform the contract. Quite the opposite: Professor Pugh was seeking to find a way to restore trust in the working relationships. As such the respondent does not accept that Professor Pugh’s decision constituted a breach of the implied term of mutual trust and confidence or indeed any other contractual term.

264. The reference in submissions to **Tullet Prebon** is to the case of **Tullet Prebon PLC & Others v BGC Broker [2011] EWCA Civ 131** where the Court of Appeal held that an employer's intention, albeit objectively assessed, is of paramount importance when considering whether the employer's conduct entitles the employee to claim constructive dismissal. The Court of Appeal held:

(a) The central question should be did the "contract breaker" clearly show "an intention to abandon and altogether refuse to perform the contract?" and

(b) Whether a repudiatory breach has occurred is a question for the Tribunal of fact with the objectively assessed intention of the employer towards the employees of paramount importance.

265. In our judgment there is no doubt that the claimant's employment ended by her resignation. We note that the claimant had considered Professor Pugh's decision, in the light of the report's findings, that she should go to work in another unit and undertake an NCAS assessment with a view to returning to the respondent once this had been successfully completed. She set out that her written response to the investigation report detailed her serious concerns with the main concern being that the report supports, without apparent question, comments and opinions offered by individuals who victimised her as a result of raising concerns regarding practices within the unit. As Professor Pugh's suggestion flowed directly from the findings of the report she had serious concerns with, she did not feel able to agree to his decision and felt that a period of supervised practice would not change the opinion of the three consultants whose comments formed the basis of the report and in 18-24 months' time she would be in the same position. She no longer had trust in Lancashire Teaching Hospitals to treat her fairly or give her justice.

266. We have set out above the evidence of Mr Pursnani and Professor Pugh in respect of the report and their acceptance in cross examination that it was effectively a fundamentally flawed report, starting without proper terms of reference and continuing with reliance upon documents not supplied to the claimant, upon evidence that the claimant was not given the opportunity to comment on, amongst other things. When the report was received and when the claimant prepared her critique of it Professor Pugh did not take on board her comments and criticisms and still accepted at the time he was making his decisions concerning the claimant's future that the report was to be relied upon.

267. Whilst accepting that the respondent may have had reasonable and proper cause to carry out an investigation under the auspices of MHPS, particularly in the light of the advice of the NCAS advice, we conclude that the flawed manner in which the respondent went about commissioning the report taken together with the flawed process used when preparing the report and thereafter relying upon it as the basis for the suggestion that the claimant might move to a different trust and be reassessed, notwithstanding the claimant's written critique of it, was likely to destroy or seriously damage the relationship of confidence and trust between employer and employee.

268. We accept that there is no need for an intention on the employer's part, merely behaviour objectively judged to be likely to have the **Malik** effect.

269. In the circumstances described we find that the behaviour of the employer objectively judged was likely to have the **Malik** effect, which indeed is what the claimant set out in her resignation letter.

270. We therefore conclude that the claimant was constructively dismissed from her employment with the respondent.

271. We find that the claimant had not lost the right to resign by affirming the contract by delay or otherwise.

272. What was the sole or principal reason for the treatment amounting to a fundamental breach of contract?

273. Was it under section 103A of the Employment Rights Act 1996, which provides that an employee who is dismissed shall be regarded for the purposes of this part as unfairly dismissed if the reason (or, if more than one, the principal reason) for the dismissal is that the employee made a protected disclosure?

274. We find that the principal reason for the dismissal was the respondent's breach of the implied term of mutual trust and confidence. We find that the claimant did not accept, for the reasons stated above, the report prepared by Mr Pursnani and accepted without criticism by Professor Pugh, and she did not accept Professor Pugh's proposed consequences for her future employment and medical practice arising from that report.

275. Having set out above our findings that Professor Pugh was not motivated by any protected disclosure that the claimant may have made we do not find that the principal reason for the dismissal was that the claimant made a protected disclosure.

276. Going back to our list of complaints and issues, having found that the sole or principal reason for the dismissal was not related to the protected disclosures then in our judgment it was for some other substantial reason of a kind such as to justify the dismissal of an employee holding the position which the employee held.

277. We find that the respondent did not act reasonably towards the claimant in connection with the matters set out above and that the dismissal was unfair.

Remedy

278. The parties are invited to resolve the question of remedy between themselves in the first instance. If this is not possible then the claimant shall apply for a remedy hearing.

Employment Judge Sherratt

11 March 2019

RESERVED JUDGMENT AND REASONS
SENT TO THE PARTIES ON

16 March 2019

FOR THE TRIBUNAL OFFICE

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