EMPLOYMENT TRIBUNALS

Claimant **Respondent**
Mr Obiukwu Iwuchukwu **City Hospitals Sunderland NHS Foundation Trust**

RESERVED JUDGMENT OF THE EMPLOYMENT TRIBUNAL

Held at North Shields **On 15th 30th 31st October 1st and 2nd November 2018**
Deliberations 7th and 9th November 2018

EMPLOYMENT JUDGE GARNON (sitting alone)

Appearances
For Claimant: Mr C Echendu – Non-practising Barrister
For Respondent: Mr S Sweeney of Counsel

JUDGMENT

The claim of unfair dismissal is well founded . I award compensation , being a basic award only , reduced by 50% under s 122 (2) of the Employment Rights Act 1996 (the Act) of £2850. The Recoupment Regulations do not apply.

REASONS (bold print is my emphasis and italics are quotations)

1. Introduction and Issues

1.1. After 13 days of evidence and submissions in July and two days of deliberations on 2 August and 8 September 2016, a tribunal chaired by Employment Judge Buchanan with members Ms A Tarn and Ms S Mee (" the original tribunal ") gave a reserved judgment on claims of breaches of the Equality Act 2010 (EqA) related to the protected characteristic of race against the respondent and Mr Ian Martin, and unfair dismissal by the respondent. The judgment on the unfair dismissal claim was that a relevant transfer was not the principal reason for dismissal nor was any protected disclosure. The judgment was in the claimant's favour on his claim of "ordinary" unfair dismissal. It set out its conclusions in part 11 of the reasons divided into logical sections. It rejected the claimant's allegations of "criminal conspiracy", in particularsetting him up so as to cause harm to his patient on 13 August 2013, very robustly. It found no fabricated evidence against him; there were causes of concern about his clinical practice which were dealt with in a Royal College of Surgeons (RCS) report; the capability panel placed great reliance on that report which the original tribunal said was " *a very thorough and detailed review*"; because of its thoroughness, the National Clinical Assessment Services ("NCAS") declined to do an assessment of its own.

1.2. On the EqA claims only a small part succeeded and against the respondent only. The claimant's appeal to the Employment Appeal Tribunal (EAT) was rejected on initial consideration. A principle of law, known by the Latin name "res judicata", is that once a case

has been fully heard and a decision reached, it may not be heard again, unless successfully appealed. I am not restricted from finding a planned transfer of the Breast Service to Gateshead may have **played a part** in detrimental actions of the respondent. Neither am I precluded from finding information about the claimant provided by certain people to the dismissal panel was motivated by personal dislike of the claimant, or professional jealousy. However, race discrimination cannot be revisited.

1.3. The respondent also appealed. His Honour Judge Shanks sitting alone, on 22 and 23 February 2018 , gave judgment on 26 April 2018 allowing the appeal against the findings of breaches of the EqA and dismissed those claims. He allowed the appeal against the finding of unfair dismissal and remitted that claim to be heard by a new tribunal. His Honour said:
49 .., I have concluded that the ET's decision on unfair dismissal involved errors of law and cannot stand and I allow the appeal against the finding of unfair dismissal. However, it is clearly not appropriate for me to reach my own conclusion on the matter since it ***may involve further factual inquiry*** *and, in any event,* ***will involve a fresh judgment as to the reasonableness of the panel's decision*** *and the matter will therefore have to be remitted.*
50. Inconvenient as it may be, .. I do not think it would be right to remit the case back to the same ET .. However, ***I see no reason why any findings of primary fact in section 7 of the ET's Judgment should be disturbed and I would hope that the new ET would be able to make its decision on the basis of the ET's Judgment read in the light of this Judgment and any documents in the case, without the need for further evidence.***

1.4. His Honour ordered a preliminary hearing be held by the ET to consider what further evidence (if any) should be presented. Before that hearing on 11 July 2018, I had read the EAT judgment and that of the original tribunal, which ran to 90 pages setting out with lucidity not only points on which it found in favour of the claimant but those upon which it did not. Following that hearing, I was hoping for more concise witness statements ,fewer documents and full agreement on which findings of fact of the original tribunal could be left undisturbed. Unfortunately these hopes have not been fulfilled. Unless I read or hear evidence which leads me to a different finding ,I will not ”disturb” the findings of the original tribunal. I may reach different conclusions to those of the original tribunal, even if based on the same facts. For the respondent, I heard Mr Ian Cliffe Martin, Medical Director; Ms Julia Pattison, Chair of the dismissal panel; and Ms Kathleen Griffin Head of Human Resources. I read the statements of Mr Stephen Holtham, Dr Sean Fenwick, Ms Julie Jones and Mr Peter Sutton. I heard the claimant and read the statements of Mr Robert Quick an Officer of Hospital Consultants and Specialists Association (HCSA) an independent trade union representing the interests of Hospital Consultants and Specialists, and Professor Phillip Drew . The document bundle was vast, filling six lever arch files.

1.5. On the first day of this hearing Mr Echendu showed me a document in which the Court of Appeal has granted leave to appeal against HH Judge Shanks’ decision. I expressed my reservations about continuing but both Counsel wished me to do so and for good reason. If I find the dismissal was unfair for whatever reason , it will be necessary to make findings on any “ Polkey” reduction. It is likely to save time and cost for all concerned to continue today.

1.6. There is a material in the claimant’s statement which I will take into account insofar as it shows information provided to the capability panel may have been “tainted” by the animosity born towards him by those who provided it. This will only help him win if I find a reasonable investigation by the capability panel should have uncovered the information upon which they were relying was unsafe. The claimant’s statement contains

I was never wanted by Kevin Clark in Gateshead right from 2010. It was the original plan Kevin had with Peter Surtees, Ian Martin and Steve Holtham not to allow me to move to Gateshead.
All the processes from allegations, investigations and dismissal were sham and therefore, my dismissal was completely unfair. The reason for dismissal was concocted and manipulated to achieve the agenda of the trio.

1.7. The extent if any to which a serious incident on 13 August 2013 contributed to the decision to dismiss, the allegations of documents being "false" and the " conspiracy theory" are matters for me to decide .The claimant's statement also alleges unfair procedure, especially the appeal, which clearly I must address .

1.8. Points upon which the original tribunal based its decision on the unfair dismissal claim include (i) the respondent's failure to consider alternatives especially the process known as **remediation** (ii) **delay** in dealing with concerns about the claimant's clinical competence resulting in him being prevented from doing clinical work for a long period of time, thus making remediation more difficult (iii) the prejudicial effect of references in the investigation to **"conduct" matters** which should have been kept separate.

1.9. I believe it best to define the issues broadly . They are
(a) what were the set of facts known to or beliefs held by the persons who took the decision to dismiss which constituted the principal reason for dismissal?
(c) did those facts and beliefs relate to the claimant's capability or, in the alternative, his conduct? If both, which was the principal reason?
(d) was the decision to dismiss the claimant within the band of reasonable responses? In particular
(i) were there reasonable grounds for its beliefs and did the respondent conduct a reasonable assessment of the claimant's alleged poor performance/lack of capability?
(ii) if so, did it give appropriate consideration to allowing him an opportunity to improve before dismissing? In particular, as he had been prevented from carrying on with parts of his work about which no concerns were raised, was it unfair not to afford him a greater opportunity to show he could remedy whatever concerns were legitimately held?
(iii) did it follow a fair procedure in dismissing him and/or in dealing with his appeal?
(e) If not, what are the chances it would nevertheless have dismissed if a fair procedure had been followed?
(f) if the dismissal was unfair did the claimant cause or contribute to it by his culpable and blameworthy conduct and does any conduct of his before the dismissal make it just and equitable to reduce his basic award?

2. Findings of Fact

2.1. The claimant was born on 13 January 1964. He qualified as a doctor in Nigeria in 1986 and relocated to UK in November 1990. In 1993 he became a Fellow of the Royal College of Surgeons. From December 1995, he held various posts at hospitals in the UK as a Registrar then Senior Registrar general surgeon but developed an interest in breast surgery. From October 2005 he spent a year working as a specialist registrar in breast and general surgery at Leeds. In 2006 he obtained the degree of Doctor of Medicine from the University of Hull. The early parts of his statement, which I accept, give more detail of his career, research, publications and innovations for which he received national awards and international recognition. He then writes "*I can confidently confirm that I remained a recognised figure and*

contributor in Oncoplastic breast Surgery and there was ***no genuine concern that warranted the investigation*** *and subsequent dismissal on ground of capability".* **The point is that in any profession, or other job, a person who has performed at the highest level may cease to do so for a number of reasons.**

2.2. The claimant started with the respondent on 12 February 2007 as a Consultant General Surgeon with a special interest in Breast Surgery. There was one other Consultant in Breast Surgery, Mr Alan Rich. In 2008, the claimant became the Clinical Lead in Breast Surgery following the retirement of Mr Rich which created a shortage of Consultants. Mr Peter Surtees, then Clinical Director, moved over to the breast service from colorectal surgery. In 2010, the claimant left the general surgery emergency rota to concentrate on breast surgery. He was expected to train Mr Surtees on Sentinel Node Biopsies (SNB) in which he specialised. The national minimum for a surgeon to maintain competence in SNB was 30 patients per annum and, though Sunderland treated above 180 new breast cancers, about 170 were symptomatic, so SNB is usually not performed. The claimant told Mr Surtees he would train him when the Breast Unit had sufficient breast screening patients for two Consultants, as it would be useless training him sooner. Mr Surtees was not happy with this .

2.3. "Advancing the Bigger Picture" ("ABP") was a collaboration between three Health Care Trusts in South Tyne and Wear designed to centralise some medical services within one or other of them to provide a better service and save money. Gateshead was one of the Trusts and has a high reputation for breast screening and treatment. In 2010, it was decided to centralise Breast surgery at Gateshead. The breast cancer screening service was centralised in Gateshead by the Government. From 2009 the claimant was required to attend weekly breast surgery Multi Disciplinary Team (MDT) meetings at Gateshead as well as those in Sunderland, which he usually chaired.

2.4. In **March 2010,** a disagreement arose between the claimant and Mr Klaus Overbeck, a German Consultant, over the booking and order of cases in theatre . Mr Overbeck had written in an earlier email "*we are not operating out of a hut in Congo"* . The claimant reminded him of this and said the UK is a tolerant country and not like 'Nazi Germany' . Mr Overbeck made an allegation to the Clinical Director ,Mr Surtees, that the claimant used the words "Nazi German" and called him a Nazi. I shall call this "the Overbeck incident". The claimant was suspended and says

I was the Clinical Lead in Breast Surgery ... This German consultant colleague of mine had been seeing me as an African black man and as such should not head the unit or make decisions over issues relating to management of the breast/surgical unit.
Because of this perception, he took aggressive approach towards me over the arrangement of the order of cases in the theatre. I felt intimidated and demeaned by his action which I reported to my clinical Director –Peter Surtees and Medical Director-Les Boobis
This incident highlighted the extent Peter Surtees went just because I failed to train him on Sentinel Nodes Biopsies.
The claimant was excluded from work on 23 March 2010. A disciplinary hearing was held on 12 May and 7 June 2010 as a result of which he was given a final written warning for two years. It was decided it was not necessary to refer the matter to the General Medical Council (GMC). The claimant was advised of his right of appeal. The appeal was not successful. The "Overbeck incident" was dealt with fully by the original Tribunal in the context of the race discrimination claim but may have some relevance to the unfair dismissal claim in that it shows the claimant's tendency , when he feels disrespected , to **retaliate.**

2.5. On **12 May 2010** whilst the claimant was suspended due to the Overbeck incident , Professor ("Prof") Leslie Boobis, then Medical Director, received a telephone call from the Medical Director, David Beaumont, and a Lead Clinician, Mr Keith Godfrey, at Gateshead raising concerns about the claimant's practice, his attendance and conduct at MDT meetings in Gateshead, his **management of patients after discussion at MDT meetings** and alleged intimidating behaviour towards a staff member at Gateshead. Prof Boobis wrote to various people to investigate matters and on **11 June 2010** gave the claimant details also saying it was not appropriate for him to return to work whilst investigation was ongoing. This was confirmed in a meeting on 23 June.

2.6. Mr Martin was Case Investigator in 2010 but had not had much professional or social contact with the claimant before. He was aware the claimant had been excluded from work due to the Overbeck incident when he commenced his investigation. He investigated the concerns and recommended there was no case to answer and the exclusion be lifted, as soon as the Overbeck matter had been concluded. He arranged a phased return and retraining for the claimant, as he had been excluded for a number f months. When the mother of one of his friends was diagnosed with breast cancer in 2011, Mr Martin recommended the claimant to deal with her case.

2.7. When the claimant returned to work after 9 Months of suspension, he was given the condition of training Mr Surtees in SNB. He explained to Prof Boobis having two Consultants doing SNB with insufficient number of screen-detected cases would not work as both would not meet the required number of patients. He asked Prof Boobis to secure agreement with Gateshead, where patients sent from Sunderland could chose to be treated after being screen detected, they should be sent back for treatment He argued only then would there be enough for him and Mr Surtees to do SNB. Prof Boobis did not agree.

2.8. The year 2011 was as not uneventful as it appeared to me from reading witness statements. In his oral evidence, the claimant explained more clearly than before that his patients were admitted to a ward with gynaecology, urology and sometimes colorectal cases. Breast implants must be kept sterile. He told Mr Surtees reconstructive breast surgery recovery must be in a ward where nurses do not go from a patient who may be excreting urine or faeces to a post operative breast patient. His point was never acted upon. The number of the breast cancer cases also increased. He was, as a sole consultant ,with some help from Mr Surtees, treating 180 cancers per annum when the average UK breast surgeon treats 70. He also said he was under resourced in that he had little or no secretarial support, so getting notes which he had dictated typed, proved problematic. One response to that situation is to dictate shorter notes which may result in bad habits in record-keeping. He said he lost junior doctors which resulted in him having to take phone calls directly from nurses. This could explain complaints about him taking phone calls during MDT meetings. **In circumstances where the claimant could have said " *my standards are not as high as I am capable of achieving , but that is not my fault*", the line he took with the Trust , the original Tribunal and in his statement for this hearing was " *there is nothing wrong with my standards , I am being falsely accused".***

2.9. A specialist Breast Nurse, Michelle Derbyshire, carried out in **March 2012** what she. described as a "*very small audit*" of post-operative problems between July 2011 and February 2012 with patients who had a mastectomy and immediate reconstruction. Of 13 patients 5 had minor complications, 4 had major complications and 4 had no complications. She said: "A*t the time of presenting this information to Obi he was very upset and informed*

me that under no circumstances should I share this information with anyone as it was a reflection on his practice". Having regard to the matters in the previous paragraph, it is no coincidence the audit period showed a high complication rate, because that is when the ward infection problems occurred. I find she did show that report to the claimant in March , he was upset and told her not to show it to anybody. I can think of no reason why she would go to the trouble of writing an audit in March but not show it to anybody until September. On 30 March 2012, Mr Surtees resigned as a Consultant in Breast Surgery leaving the claimant as the only Consultant surgeon in the Unit. In his resignation letter Mr Surtees said he thought Breast surgery in Sunderland would soon end .

2.10. I now deal with some matters in far less detail than the original tribunal whose reasons from paragraph 7.7 – 7.19 I adopt entirely . "Revalidation" is a statute backed process of 5 yearly checks on the fitness to practise of medical practitioners . It depends upon the successful completion of annual appraisals often done by an appraiser who does not have the same speciality as the appraisee , so will normally accept what the appraisee says about specialist matters . The claimant had successful annual appraisals.

2.11. The capability of medical staff is managed in accordance with the Department of Health's *"Maintaining High Professional Standards in the Modern NHS"* ("MHPS"). It applies across the NHS as a process for handling capability issues in respect of doctors quickly and fairly. It recognises the importance of tackling performance issues through training and other remedial, rather than disciplinary, action. It requires all Trusts to have in place procedures for handling "*serious concerns*", being when the actions of a doctor have or may adversely affect patient care. Concerns can come to light in a variety of ways including those expressed by other NHS professionals. All serious concerns must be registered with the Chief Executive who must ensure a "***Case Manager***" is appointed. However an issue is raised, it is for the Medical Director to work with the Head of HR to decide the appropriate course. The Medical Director is to act as Case Manager in cases involving consultants .

2.12. MHPS makes clear patient safety is paramount and it may be necessary to place temporary restrictions on the practice of a doctor if concerns are raised. The case manager should discuss the matter with NCAS and must decide whether an informal approach can be taken or a formal investigation is needed. **Where a formal route needs to be followed,** the Medical Director must, after discussion with the Chief Executive and Head of HR, appoint an "*appropriately experienced or trained person as* ***case investigator****".*

2.13. The practitioner must be informed in writing by the case manager as soon as it has been decided an investigation is to be undertaken, told the name of the case investigator and made aware of the specific allegations or concerns raised. The practitioner must be allowed to see any correspondence relating to the case and a list of the people the case investigator will interview. The practitioner must be allowed the opportunity to put forward his view of events to the case investigator and given the opportunity to be accompanied. The case investigator's report should give the case manager sufficient to decide whether restrictions on practice or exclusion from work should be considered, and whether serious concerns should be referred to the GMC. Alternatives to exclusion are desirable when NCAS is involved in assessment because "*it is much more difficult to assess a doctor who is excluded from practice than one who is working".*

2.14. When serious issues are raised the employer must urgently consider whether it is necessary to place temporary restrictions on the practitioner eg doing only certain forms of clinical duties, or administrative, research or other educational duties.

2.15. From the start of 2013 Mr Martin, a consultant oral and maxillofacial surgeon, was Medical Director, ultimately responsible for assuring the Trust Board as to the quality and safety of its medical staff. In addition, as the Responsible Officer (under the Medical Profession (Responsible Officers) Regulations 2013) he **must** investigate concerns about a practitioner's fitness to practise and, where appropriate, refer concerns to the GMC . All serious concerns regarding the performance of doctors are brought to his attention and he is responsible for ensuring they are dealt with appropriately.

2.16. Mr Martin was the Case Manager who dealt with the matters which led to the claimant's dismissal. As a medical practitioner he is aware of "MHPS" and had training provided jointly by the Revalidation Support Team (RST) and NCAS. As Medical Director and Case Manager, **he has to address** concerns in respect of any Consultant.

2.17. When a report has been received, the Case Manager must give the practitioner the opportunity to comment in writing on its factual content. If the matter cannot be resolved, it must be referred to NCAS "*for it to consider whether an assessment should be carried out and to provide assistance in drawing up an action plan".*

2.18. A capability panel will normally be chaired by an executive director of the Trust. No member so far as reasonably possible should have had previous involvement in the investigation. The panel must be advised by a senior member of HR and a senior clinician from the same or similar clinical speciality as the practitioner from another NHS employer. Possible outcomes are no action; an oral agreement for improvement within a specified time, a written warning, a final written warning, or termination. The decision must be confirmed in writing and include notification of the right of appeal.

2.19. MHPS requires "*Every Trust must therefore establish an internal appeal process for appeals against decision of a capability panel".* An appeal panel has to comprise an independent chairman appointed from a national list not by local selection, a non executive officer of the Trust and a medically qualified member not employed by the Trust . MHPS is an old document and provides in theory for steps which cannot easily be taken. Appeals should be heard as soon as possible, so it provides a timetable *"appeal by written statement submitted to the designated appeal point (normally the Director of Human Resources) within 25 working days of the date of written confirmation of the original decision. Hearing to take place within 25 days of date of lodging appeal. Decision reported to the appellant and the Trust within 5 working days of the conclusion of the hearing. The timetable should be agreed between the Trust and the appellant and thereafter varied only by mutual agreement ".*

2.20. The Trust has a Remediation Policy designed to assure patients, the public and doctors themselves patient safety is the highest priority. Remediation is defined as the process of addressing performance concerns **which have been recognised** through (amongst other processes) an investigation so that the doctor has the opportunity to practice safely. If capability **and** conduct matters arise then a decision should be taken by the Head of HR and the Medical Director whether to combine the matters or deal with them separately.

2.21. Mr Stephen Holtham has been employed by the Trust since 2 January 2008 as a Consultant Colorectal Surgeon. In 2009 he became Clinical Governance Lead, conducting investigations and audits for General Surgery, then in July 2012 Clinical Director for General Surgery when Mr Surtees stepped down.

2.22. In September 2012 Dr Kathryn Wright a Consultant Oncologist at the Newcastle Trust raised concerns about to the claimant's attitude in MDT meetings and him not reflecting the advice from the MDT to the patients. In an e-mail she referred to specific cases. The original tribunal found Mr Holtham felt there was nothing firm to investigate. He was aware from the monthly Morbidity and Mortality (M&M) meetings, data presented put into question complication rates in the Breast Unit, although the concerns were low level. The claimant rarely attended the M&M meetings therefore did not have an opportunity to explain the data. **I struggle to see why, in view of the "stitch in time" philosophy which underpins MHPS , Mr Holtham did not take more decisive action**. Mr Sweeney argued a consultant should fairly be allowed to address concerns himself, which for a time seems right, but the concerns being raised as to the claimant's apparent dismissal of the views of others , especially those less qualified than himself, echoed those raised in 2010, and should have rung an alarm bell that he may view himself an unaccountable to the MDT.

2.23. On **24 September 2012** Mr Holtham wrote to Prof Boobis saying he had been approached by Dr Wright and "*I have also been made aware that an audit of wound infections has been carried out but the breast care nurse has been specifically asked not to discuss it by Obi. I have also been approached by one of the anaesthetists regarding Obi's behaviour in theatre. As there is a great deal of history in the breast unit, I wanted to ask for some guidance as to how I should address this*". Nothing was done at the time.

2.24. At about the same time, Nurse Derbyshire had raised her audit, and a **lack of challenge at the MDT meeting since Mr Surtees had left**, with Mr Holtham who asked the claimant to conduct an audit and present his findings at the monthly M&M meeting to establish whether there was an issue. The claimant believed the data was within the realms of normality and there were acceptable reasons for the complications. The claimant attended an M&M meeting in January 2013 but the data he presented was not complete, so Mr Holtham asked him to present it again. The claimant (or his Registrar) produced an audit which reviewed complications over the last 12 months, showing 127 patients with 47% having no complications, 34% having minor ones, 10% having moderate ones and 9% having major ones. He attended a M&M meeting in April 2013 to present this.

2.25. Mr Martin had no involvement whatsoever in the audit of breast surgery in 2012, which pre-dated his appointment as Medical Director. On **25 April 2013**, he was approached by Consultant Radiologist, Dr Jenny Connor, expressing concerns related to an apparent high post surgical complication rate; treatment plans agreed by the MDT not being adhered to; the claimant appearing disengaged during the MDT, taking numerous phone calls; him being reluctant to consider the opinions of other members; and **leaving clinics early**. Mr Martin confirmed he would make enquiries and sent an email shortly afterwards to Mr Holtham who replied the same day saying he was aware of concerns regarding post-operative complications rates from the Breast Nurses and the claimant had been asked to undertake a more substantial audit and report on his own practice. Mr Holtham provided a copy email dated 12 October 2012 from Nurse Derbyshire summarising her audit and a letter from Dr Wright with concerns from the Breast MDT. Mr Holtham proposed to obtain clinical audit data and forwarded his previous email to Prof Boobis raising Dr Wright's concerns. Mr Martin sought advice from Ms Griffin who was Head of Human Resources at all material times.

2.26. In an appraisal carried out by Mr Shanmungam Vetrivel a Consultant General and Vascular Surgeon, on a date which is difficult to read but I believe is 4 May 2013, the clinical outcomes of the claimant's work were satisfactory and his workload described as "*way above that of his peers while the morbidity is comparable".* Under the heading "*Safety*

and Quality", it was noted he was managing the breast service as a solitary consultant. It continued: "*Obi has presented his audit of morbidity and outcomes to the surgical directorate…His audit had identified a spell of increased wound infection in his breast reconstruction patients towards the end of last year..."* It was noted his colleagues regarded him very highly and all had stated that he was fit to practice. The claimant noted "*the coming "bigger picture" cannot come too early as we have had long standing shortage of staff at consultant level…."*. The fact the claimant's work was at the early stage of investigation was not made known to Mr Vetrivel.

2.27. I will deal later with statistics derived from Caspe Healthcare Knowledge System ("CHKS"). It is clear Mr Vetrivel did see a CHKS report, sometimes called a CLIP report, but I cannot tell what period it covered or whether it was specifically about the claimant rather than the Hospital or a department of it . It was satisfactory.

2.28. On **23 May 2013**, Mr Martin emailed Mr Holtham formally requesting **a preliminary investigation** in accordance with MHPS. Ms Griffin confirmed Mr Hobdey, Divisional HR Manager, could provide HR advice to Mr Holtham. Mr Martin emailed the claimant on **24 May 2013** setting out the allegations, confirming Mr Holtham would undertake the investigation and Mr Martin would contact NCAS in accordance with MHPS. He said Mr Holtham would provide an audit of the claimant's complication rates **independently validated and benchmarked** against regional or national outcomes . That never happened.

2.29. On 28 May 2013, Mr Martin contacted NCAS to tell them of the steps he was taking. The investigation was a "*preliminary fact finding exercise*" in accordance with paragraph 8 of Part I of MHPS. **Mr Holtham was not a Case Investigator** because the matter was not yet on the "formal route". The action taken by Mr Martin was approved by NCAS by letter of 29 May 2013 containing a history of concerns raised about the claimant from 2009 onwards – including the final written warning in respect of the Overbeck incident.

2.30**. On 10 June 2013** Mr Holtham received an email from Mr Hobdey setting out his views on the next steps needed as (a) speak to key members of the MDT , (Dr Wright, the claimant, the breast care nurses and Dr Connor). Mr Holtham spoke to Dr Wright and the Breast Nurses and gained an impression of the concerns before speaking with the claimant.

2.31. On **14 June 2013** Mr Holtham sent to Mr Martin the audit the claimant had presented to the M&M meeting in April 2013. As a Colorectal Surgeon, Mr Holtham lacked the expertise to interpret the results. He did not think it was appropriate to ask Mr Surtees because of the relationship difficulties between him and the claimant and, as the Trust did not have another Consultant Breast Surgeon ,on **19 June** he met with Mr Martin and suggested asking Mr Kevin Clark, Clinical Lead for Breast Surgery at Gateshead, to review the data and provide his opinion. Mr Holtham sent an e-mail to Mr Clark on 19 June 2013 requesting his assistance. Mr Clark was on annual leave and responded on 1 July 2013 suggesting he and Mr Holtham meet to discuss the audit.

2.32. On **18 June 2013** Ms Dawn Youseff (Business Manager) was contacted by the organiser of a conference in Milan which the claimant had arranged to attend, to ask where he was. He had been given study leave to attend. As his line manager, Mr Holtham contacted him as soon as he was informed to enquire as to his whereabouts. He could not reach him but the claimant returned the call on the evening of 19 June saying that on the

way to the airport he had become unwell with sickness and diarrhoea and he was unable to call. He confirmed he would be in work the next day. Ms Youssef and HR felt the claimant had not complied with the Trust's procedure for reporting sickness absence.

2.33. **On 19 June 2013** an allegation was raised the claimant had been seeing private patients at times he was required to work for the Trust. It was made to HR and Mr Holtham was not informed by whom. He emailed Mr Martin asking what he needed to investigate. Mr Martin responded the allegations of leaving clinics early and conducting private practice in NHS time were **potentially** linked and suggested questions to ask. Mr Holtham spoke to Dr Sensarma, a senior doctor, and the Breast Nurses who said sometimes the claimant did leave clinics early. That did not necessarily mean he was not engaged in Trust business. As it potentially involved fraud, Mr Hobdey contacted the local counter fraud specialist, Kathryn Wilson. Mr Holtham corresponded with her to confirm the private hospitals at which the claimant may have worked. Ms Wilson made enquiries with them to obtain records of his practice and reported directly to Mr Hobdey and Ms Youseff. Mr Holtham understands there was **no overlap** between the time spent in private clinics and the time he was supposed to be in clinics at the Trust. **If that is so, this allegation should never have re-surfaced**.

2.34. Counter fraud were also concerned there was a discrepancy between the dates he had requested to be on study leave and the dates he had informed the conference organisers he would attend ,with 3 days that could not be accounted for. Ms Wilson later submitted a report to Mr Hobdey on **19 August 2013** recommending the matter was dealt with internally rather than as a criminal investigation.

2.35. The original Tribunal found " *Already matters relating to conduct concerns were being investigated in conjunction with capability concerns*." **I do not agree this is necessarily unfair. However, it is outside the band of a fair procedure, if an allegation is made and insufficient evidence found to put it as a "charge", whether of capability or conduct , to mention it , even in passing, in documents or submissions put before a panel deciding other "charges".**

2.36. Returning to the main issues of the claimant's clinical competence, judgment and relations with colleagues on the MDT, Mr Holtham looked into treatment plans discussed in the MDT and reviewed patient notes. There did appear to be some deviation from agreed plans in some instances, but Consultants are free to convey their recommendations to the patient as well as the plan recommended by the MDT. It would be unusual, but not wrong , not to follow the MDT plan.

2.37. Mr Holtham spoke with Dr Wright and the Breast Nurses who all confirmed the claimant could be difficult and obstructive in MDT meetings, he was awkward and challenging to deal with. None of them wanted their names to be associated with the investigation and were not prepared to give a written statement. Mr Holtham discussed this with Mr Hobdey and agreed they would not take the matter further **without evidence.** I find this puzzling in that, if patient safety is at risk, people should be ordered to provide information.

2.38. Between 25 June and 1 July 2013, Mr Martin was copied into emails regarding the claimant's speeding violations and the potential impact on insurance of his Trust lease car. As Medical Director, he is one of only two at the Trust who can authorise the issue of a lease car. He understood he was being copied in because the Trust was contemplating

withdrawing the claimant's lease car. His thoughts were simply that the Trust needed to make sure the claimant was still insured. After Mr Hobdey had a discussion with Ms Griffin, he went to see Mr Martin in late July 2013 to ask whether this issue needed to be explored from a possible conduct perspective. Ms Griffin was concerned the claimant had not disclosed his penalty points, was about to go to Court and may lose his licence.

2.39. Mr Hobdey told Mr Martin of the claimant's apparent failure to attend planned study leave in Milan. Mr Martin updated NCAS in a planned review call in early July 2013 and a letter dated 8 July 2013 from NCAS, summarises their discussion. On **11 July** Mr Martin wrote to the claimant to set out the additional concerns for investigation and met with Mr Holtham that day to discuss these. **All these peripheral allegations had some basis but, coming as they did one after the other is a short space of time, co-incidentally in my view, it is easy to see why the claimant felt he was being subjected to a witchhunt**.

2.40. **On 13 August 2013** the claimant was operating on a patient who was a senior nurse known both to him and the theatre staff. During the operation he was handed an alcohol, rather than aqueous, based antiseptic solution which he applied to the patient. He then used a diathermy pen which targets electrically induced heat to stop the wound from bleeding. It ignited the alcohol preparation and the patient suffered a major burn. It was described in the subsequent investigation as though a flash of lightening had entered the theatre. All staff were given counselling. As Medical Director, Mr Martin was notified by the Clinical Governance lead Mr Graham O'Dair, almost immediately. He sent Mr O'Dair at 11:24am an e-mail which ended "*Clearly this is a very upsetting incident for Obi and the staff in theatre and therefore the list should be suspended and arrangements made for any staff including Obi to receive appropriate support and counselling …*". Mr Martin ensured the matter was recorded as a Serious Incident (SI) and a Root Cause Analysis (RCA) investigation was set up. He also immediately forwarded the details to Mr Ken Bremner, the Chief Executive.

2.41. Mr Martin says the potential for a patient being burned when diathermy is used in the presence of alcohol based solutions is a recognised hazard but capable of being avoided if proper precautions are taken so it is not a risk about which a clinician would be expected to forewarn a patient in order to obtain their informed consent to surgery.

2.42. Mr Martin later learned from Mr O'Dair, that whilst most of the operating list was cancelled, two patients who had localising needles radiologically inserted earlier that day were awaiting the second part of a two stage procedure. The claimant wanted to complete the surgery. Acknowledging the difficulty in abandoning and rearranging procedures which were partially complete, Mr O'Dair decided those two should proceed, with him assisting the claimant. Mr O'Dair told Mr Martin the claimant was the only surgeon in General Surgery using alcohol based preparations . On 15 August 2013 Mr Martin wrote to the claimant instructing him to cease their use and made arrangements for all stocks to be removed from the Trust. **Mr O'Dair later reported that when assisting the claimant on 13 August 2013, he had concerns about his technique of draping the patient, and his use of the diathermy pen which were of potential relevance to the cause of the fire in theatre. Mr Holtham also discussed concerns about this with him some days afterwards when Mr Martin advised Mr Holtham to speak with Mr O'Dair and raise the issues direct with the claimant as soon as possible so remedial action could be taken. Both Mr O'Dair and Mr Holtham later provided a written note of their concerns about the claimant's diathermy technique.** Mr O'Dair copied Mr Martin into his email of 27 August 2013 to the RCA investigator, Bev Frankland, the Trust's Risk Manager.

2.43. On **19 August 2013,** Mr Holtham met with the claimant , along with Mr Hobdey to take a statement from him. They discussed his complication rates and Mr Holtham explained he had sent the audit to Mr Clark at Gateshead **.** The meeting was minuted and recorded the claimant was "*comfortable for another surgeon to review audit*". Before the original Tribunal the claimant asserted this was not correct but they preferred the evidence of Mr Holtham and the minutes. I have no reason to depart from this.

2.44. The claimant explained he had made changes to his theatre procedures and looked more closely at the post operative environment on the ward where all his in-patients would be admitted. Mr Holtham suggested a future re-auditing of wound infection rates following the changes to see if the changes had improved the complications rate.

2.45. In relation to his attendance at MDT, the claimant stated the limited numbers at the MDT meetings reduced their effectiveness. Mr Holtham had reports the claimant either arrived late, left early or did not attend at all and, when challenged about this, would have an explanation such as *'Sunderland patients were not discussed until last'*. He had a contractual obligation to attend but it was also sensible because the proposed transfer would address his concerns about being a sole Consultant.

2.46. The claimant accepted he left clinics early on a Wednesday but denied this was to perform private practice. There was no evidence he was seeing private patients in NHS time so Mr Holtham did not take the matter further. The claimant agreed to provide further information regarding the conference in Milan, stated he had provided details of his driving convictions and would inform the Trust of the outcome of his court appearance.

2.47. Mr Martin in a planned review call to provide an update in respect of the preliminary investigation took advice from NCAS on 21 August 2013. He was advised to commence a formal investigation under MHPS by a suitably qualified and experienced individual and give consideration to a formal investigation of the allegations relating to probity around study leave and alleged driving offences. Mr Martin thought it appropriate to await the outcome of the assessment of the audit of complications, and Mr Holtham's preliminary investigation. He was also advised to refer the claimant to Occupational Health (OH) to rule out any underlying health problems which might be affecting his performance. He did so on 28 August 2013. On 20 September 2013 OH said there were no underlying health concerns.

2.48. On **23 August 2013** Mr Holtham received an email from Dr Andy Morrison Consultant Anaesthetist and Clinical Director of Theatres and Anaesthesia, asking him to investigate an incident in theatre between the claimant and Dr Bhaskar a Staff Grade doctor in Dr Morrison's team. Mr Holtham spoke to Mr Martin about this and he confirmed in an email of 4 September the terms of reference should be extended to include this issue. Shortly afterwards, Mr Martin also was contacted by Dr Morrison. The claimant sent an email on **6 September 2013**, responding to the complaint. Dr Bhaskar did not wish to make a formal complaint. The matter was therefore not pursued and **should never have re-surfaced**.

2.49. On **23 August 2013**, Mr Holtham was asked to attend theatre by the senior sister as the claimant was insisting a scrub nurse assist him with an operation but the nurse felt uncomfortable doing so. Mr Holtham attended immediately and suggested he could scrub in and assist, but the claimant felt this was unnecessary. Whilst he was discussing the situation with the claimant he was aware he was using diathermy very liberally and was activating the diathermy pen when it was not in contact with the patient. **This can result in**

"arcing" resulting in superficial burns. Mr Holtham felt this revealed a lack of care in surgical technique. He informed Mr Martin. On **27 August 2013**, Mr Martin brought forward the call he had scheduled with NCAS for 4 September 2013 to later that day, to seek advice about whether he should restrict the claimant's practice. NCAS agreed with his proposal to discuss it with relevant director colleagues. The formal investigation required by MHPS and referred to by NCAS in a letter of 27 August 2013 was not commissioned as such**.**

2.50. Mr Holtham met with Mr Clark who expressed his view there was concern about complication rates which would warrant further investigation to see whether it was a serious problem or whether the complications have been over reported. Mr Clark suggested an independent investigation by a body such as the Royal College of Surgeons (RCS) which would either confirm or refute the claimant's complication rate was too high. Mr Holtham asked him to confirm his views in writing directly to Mr Martin.

2.51. On **27 August 2013** Mr Holtham submitted his findings by email at 22:42, and sent a revised version by email on 29 August 2013 . The outcome of his initial investigation was:

a. Members of the MDT reported the atmosphere as fractious and arguments were robust but they had sympathy for the claimant as the sole Consultant Breast Surgeon. Mr Holtham anticipated this issue would be resolved by the integration of breast services with Gateshead and more core members attending the MDT.

b. There was evidence the claimant left clinics early on a Wednesday but only when a staff grade doctor was present to conclude the clinic and he left clinic late on other days. **There was no evidence his NHS clinics and private practice overlapped.**

c. The claimant failed to attend planned study leave in Milan between Monday 17 and Friday 21 June 2013 and failed to report his sickness to the Trust until the evening of Wednesday 19 June. He had provided sufficient evidence in support of the dates he requested study leave and this aligned with the dates he had informed the conference organisers he would be in attendance. He had been reminded of his obligations in respect of reporting sickness in future.**That apart there was no evidence of wrongdoing**.

d. He had received penalty points whilst driving his lease car and failed to inform the insurance providers. He claimed not to know about this requirement and stated letters regarding the penalty points were received by the Trust and forwarded to him ,so the Trust knew about them. Mr Holtham did not consider the Trust's systems to be robust enough and recommended this was looked into but found the claimant was personally responsible for a breach of the policy. **That apart there was no evidence of wrongdoing**.

e. Following Mr Clark's review of the clinical outcomes and infection rates audit, it appeared there was a complications rate which was a cause for concern. Mr Holtham recommended the claimant's practice be assessed by independent external review.

Of these points , (a) and (e) merited further investigation and action, whereas the rest were either not valid concerns at all or of no relevance to the points which were.

2.52. Mr Martin met the claimant on **2 September 2013** to tell him the findings and recommendations of the preliminary investigation. They agreed he would approach the RCS to conduct an Invited Review (IR) and discussed proposed Terms of Reference. The claimant requested an amendment to draft Terms that the RCS were *"to investigate whether [Mr Iwuchukwu's] workload and level of support were appropriate"*, to which Mr Martin agreed. He confirmed his decision after discussion with Ms Julia Pattison (Deputy Chief Executive and Director Finance) and Ms Jan Armstrong (Deputy Director of HR) in the absence of Mr Bremner and Ms Griffin , to restrict the claimant's practice to non-clinical duties pending the RCS Invited Review Mechanism (IRM) and to "*keep this restriction under*

continuous review, as you would a formal exclusion, as a matter of good practice".

2.53. On **2 September 2013** Mr Martin wrote to the RCS requesting the IRM and setting out proposed terms of reference. A letter sent to the claimant that day confirmed his duties should not include any contact with patients. A note of the meeting was sent to the claimant including "*Steve Holtham has spoken to Kevin Clark lead breast surgeon at Gateshead and his opinion is that the level of complications is a concern and they advise to have an external assessment which was also agreed by NCAS*". **In Mr Martin's view the RCS IR was the next logical and fair step. While, under the letter of MHPS, a formal route could have started and a Case Investigator been appointed, as NCAS had suggested, I agree entirely the course being followed was sensible and fair. Any consultant in the Trust could have investigated concerns about the claimant's relations with colleagues , but none would have the knowledge to challenge his clinical decisions on which patients to treat and which treatments best suited the needs of each patient. Appointing such a person as a formal case investigator would be less fair to the claimant, as well as the Trust and patients,than an independent, expert RCS IR team .**

2.54. On **3 September 2013** Mr Clark wrote to Mr Holtham and Mr Martin confirming his previously expressed views. He pointed out hard conclusions were not possible as data on the month of May 2012 was missing so was only available for 112 of the 127 patients. Certain complications reported **were removed** for reasons the claimant rightly explained to me which reduced the complication rate to about 25%. It was confirmed only broad assumptions could be made from data available but the conclusion reads "*I believe a complication rate of 25% is too high and would certainly warrant further investigation in a detailed manner to see whether this is a serious problem or the complications have been over-reported and there is no safety issue for the patients. I do not feel I am the person to conduct this investigation as I am due to be a colleague of Mr Iwuchukwu in the near future when the breast MDTs from Gateshead and Sunderland amalgamate. However the reported complications do appear on the high side and an independent investigation is warranted. A body such as the Royal College would either confirm or refute the claims that Mr Iwuchukwu's complication rate is too high. I understand initial concerns were raised by one of the Sunderland breast MDT members and obviously from the patient safety point of view this does require clarification*". **This letter shows the audit Mr Clark examined was the one prepared by the claimant's registrar NOT the one prepared by Nurse Derbyshire. The claimant's case is Mr Clark and others were intent on ruining his career but it shows no hostility to the claimant , only a suggestion of a truly external assessment**.

2.55. On 3 September 2013 the claimant asked Mr Martin and Mr Holtham for a repeat audit of his complications on the basis the audit where his complications rates appeared high had been carried out when there was a high infection rate in the hospital and ward D47 was closed. He also wanted a further audit because he said he had changed his practices. Mr Martin did not arrange for a further audit but the claimant could have done one himself . Mr Martin anticipated the RCS IR team would want to look at a broad spectrum of information so the claimant's comments could be addressed then . He spoke with NCAS on 4 September 2013, in a planned call to review developments.

2.56. Mr Martin says any doctor who keeps proper records, as all should, will be able to explain to another expert in his field **if statistics look bad, why they are bad**. CHKS does not prove or disprove capability, and neither do audits. Mr Martin described them as a "*smoke detector*" to prompt examination of individual patient case notes. I accept this

because any professional person with a speciality is surely best assessed by people who know as much, if not more, than he does.

2.57. **On 5 September 2013,** the RCS IRM Co-ordinator confirmed the RCS would conduct an IR. The claimant raised concerns by an e-mail of 6 September 2013 mainly about the decision to refer the complaint from Dr Morrison to Mr Holtham for investigation and make the RCS aware of it.

2.58. On **6 September 2013** Mr Martin wrote to the claimant saying the proposed transfer of the breast service to Gateshead originally due to take place on 1 June 2013 but postponed to 1 September was on hold whilst the RCS IR was carried out. The claimant noted he had worked long hours and to end up in that situation was like a" *kick in the teeth*".

2.59. On **16 September 2013** Mr Martin met with Ms Pattison (as deputy to the chief executive) and Mr Hobdey. A review of the SI on 13 August 2013 was noted and it was agreed the restrictions placed on the claimant's duties should remain in place. The original Tribunal concluded they were not kept under adequate review. **I disagree in that I see them being looked at again on several occasions , but every time something meant the restrictions could not appropriately be lifted in Mr Martin's view.**

2.60. On **17 September 2013** Mr Holtham wrote to Mr Martin a brief letter in which he confirmed his view the claimant's diathermy technique and precautions were poor. **On** 18 September Mr Martin asked Mr Holtham to document this fully which he did the same day .

2.61. The Trust's Head of Nursing and Patient Safety, Judith Hunter, emailed Mr Martin on **25 September 2013** saying the patient who had been injured on 13 August had informed Mrs Hunter that, in discussion prior to her procedure, the claimant had advised her he intended to use an alcohol based solution having found it to be more effective at preventing infection. That account appeared consistent with Mr O'Dair saying the claimant was the only surgeon in General Surgery using alcohol based preparations **and** with the claimant's completed Incident Report form, **and,** when requested by Mr Martin to undertake he would no longer use alcohol preparations, he gave such assurance without denying having used it. There appeared to be inconsistencies with his statement to the RCA investigation, that he usually used an aqueous solution and had not known the solution handed to him was alcohol based. Mr Martin felt these matters might bring the claimant's probity into question so sought guidance from the GMC's Employer Liaison Advisor, Helen Dolan, and NCAS, on **27 September 2013** about excluding the claimant from work under paragraph 14 of Part 2 MHPS to allow an investigation into the issue.

2.62. It was decided further investigation was needed and junior staff would need to be interviewed. A letter from NCAS reads:- "*You are now concerned there is a risk that (the claimant)* ***might seek to influence witnesses*** *who will be interviewed in relation to the diathermy incident. You have therefore decided to immediately exclude (the claimant) from work with effect from 27 September, following the guidance set out in paragraph 14 of Part II of MHPS. You are aware immediate exclusion can be continued for no more than two weeks but you said that you are reasonably confident the necessary interviews can be completed within that time period and that the exclusion might then be able to be lifted*". It was noted the matter was to be added to the terms of reference of the "*wider Trust investigation*".

2.63. Mr Martin met the claimant that same day to confirm his immediate exclusion for 2 weeks pending investigation. Ultimately, **the investigation concluded it was unlikely the conflicting versions would be resolved so no further action was taken as there was insufficient evidence the claimant had been dishonest**. **In my view, this issue either had to be resolved or , if it could not be , excluded from the case presented against the claimant in relation to his capability.** Mr Martin sent emails to NCAS and to Ms Dolan on **8 October 2013** confirming the outcome and wrote to the claimant on **9 October 2013** lifting his exclusion .He remained restricted to non-clinical duties pending the RCS- IR.

2.64. The RCA report was signed off on **26 November 2013**. The key finding was "**system failures**" were the root cause. "*Failings have been identified across several disciplines, processes and practice.* ***Human error*** *was a contributory factor but the processes and practices in the trust should have been effective in preventing this incident from taking place*". The report confirmed the scrub nurse was acting in that capacity for the first time for the claimant . She usually worked in the recovery part of the theatre but had extensive experience as a scrub nurse in other theatre settings. The report spoke of the difficulties faced by staff being switched between areas and procedures at short notice such as "*setting up a theatre for use and then being allocated at short notice to work elsewhere*". **It did not exonerate the claimant or identify whose "human error" it was.**

2.65. At the original Tribunal hearing, the claimant expressed great concern the scrub nurse who was to assist him on 13 August 2013 was removed from theatre after the WHO checklist team brief had been carried out. This RCA report refers to the nurse "*working as a floor nurse on this occasion, the scrub nurse for the procedure had never acted as scrub nurse for breast surgery in this theatre previously …*". A key recommendation was "*The trust should review the system of staff deployment in the operating theatres to ensure it provides for the safest possible working environment*".

2.66.The RCS – IR would take place on 12- 13 December 2013. The professional reviewers would be Mr James Bristol, consultant breast and endocrine surgeon and Ms Sarah Downey, consultant breast surgeon. The lay reviewer was to be Ms Sally Williams. On 9 October 2013 the claimant confirmed he was *"alright with the reviewers".* Mr Martin delegated the planning for the IR to Mr Holtham and Dawn Youssef.

2.67. Ms Julie Jones has worked for the Trust since 1992. On 4 January 2010 she was appointed Clinical Governance Facilitator which involved reviewing the Trust's performance against other Trusts using benchmarking software, including Caspe Healthcare Knowledge System ("CHKS"). CHKS uses standard metrics to measure quality and safety. "Information Services" input data monthly which is checked by the Data Assurance Team for accuracy. Hospital Episodes Statistics (HES) is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. CHKS obtains data from HES (as well as directly from Trusts that subscribe to CHKS) so that Trusts can benchmark nationally. She used CHKS to produce approximately 21 reports per month.

2.68. On **9 October 2013** Ms Jones received an email from Mr Martin, asking her to run a thorough report on the claimant's surgical practice as he anticipated this would be something the RCS IR would wish to see. It was the first time she had been asked to run a report on a particular Consultant. The software had that capability, by filtering the data using a Consultant's GMC code. Consultants were able to run reports on themselves or their line managers could. Prof Boobis was very IT literate and probably did so, but Mr Martin said he

would not know how which is why he asked Ms Jones. Her manager Mr Schuster asked she make it a priority.

2.69. On **15 October 2013** Mr Martin sent to Mr Hobdey and Mr Holtham a list of documentation required by the RCS and suggested their case notes review should be on cases where complications had occurred. This is logical and fair provided the reveiwers know the samples are from only that group.

2.70. Ms Jones entered a date parameter 1 April 2011 to 31 March 2013, filtered the data using the claimant's GMC code and obtained screenshots of the information. She then prepared a report, typing narrative to accompany the screenshots which was her interpretation of the data. On 22 October 2013 she emailed it to Mr Martin. She says Mr Martin did not instruct her to find evidence to demonstrate the claimant was 'guilty' of anything. I accept that. The 3 page report identified some issues, when comparing the claimant's complication rate to his peer group. The World Health Organisation (WHO) has classifications of diagnoses and allocates to them codes which can be applied internationally. Those coded T85 appeared to be the most significant. The claimant responded asking the report to be extended to 31 July 2013 instead of 31 March 2013. Ms Jones did so, and sent a copy to the claimant.

2.71. An important point raised by the claimant in his oral evidence was this CHKS report, which I shall call the "second report" , was "red" which means unsatisfactory when the report which Mr Vetrival had seen when he did his appraisal on 4 May was "green" .The appraisal was due to been done in March 2013, and I have no evidence as to what date parameters the report seen by Mr Vetrival covered. Neither can I tell who produced it, or whether it excluded T85 complications. It may have been produced by the claimant himself. It may have been his line manager at the time, Mr Holtham or it may have been Prof Boobis.

2.72. Whenever two statistical reports are being compared it is absolutely essential to ensure one is comparing like with like. If there were real doubts about the accuracy of the second report they should have been raised to the IR and later the capability panel and a full **explanation given by the claimant** as to why one or other of the reports was inaccurate. As will be seen shortly, instead of making such relevant points , the claimant embarked upon a series of attacks on individuals alleging a conspiracy to fabricate evidence against him. If one has a sensible answer to an allegation, attack is rarely if ever the best method of defence. At this time the claimant, being restricted from clinical duties, had plenty of time to produce a rational answer to any doubts the reports raised. In his oral evidence he said he did not even open the second report attached to the email sent to him by Ms Jones for 3-4 weeks, but simply assumed it would correspond with that which had been seen at the appraisal, so he was shocked when he eventually did open it to find it had gone from green to red.

2.73. On **23 October 2013** Mr Martin suggested to Mr Holtham and Dawn Youssef they should liaise with Ms Jones to draw the sample for the RCS case note review from the complication groups. He said "*I intend to share this with Obi*". On that day he sent the claimant an e-mail including "*The reviewers have suggested undertaking a case note review and I have suggested that they sample from the patients who suffered complications*". The claimant asserted at the original Tribunal Mr Martin had misled the RCS into thinking the selected notes were taken at random from all patients treated by him , but they found it was known the notes selected were from cases where complications had arisen.

2.74. I have no evidence to warrant departing from that finding. Obviously, if reviewers thought 20 cases had been selected at random from all the claimant had treated and most of the 20 showed problems it would indicate a greater level of concern. That was not the case.

2.75. On **27 November 2013**, some four weeks later, the claimant emailed Mr Martin saying some of the complications identified were not his. Ms Jones met with the claimant that day. The WHO has sub codes under T85 for 'mechanical complication of breast prosthesis and implant' and " removal of breast implants". Poly Implant Prostese (PIP) implants, mainly inserted in the private sector, were often faulty and it was agreed they could be removed on the NHS. As the code relates to breast implants generally removing it from the data meant all implant cases which resulted in complications (PIP or not) would not be shown in the CHKS report. Ms Jones could not produce graphs to include only implants inserted by the claimant but exclude implants inserted by others as there was no functionality in CHKS to do this.

2.76. Having already amended the CHKS report once, Mr Martin was reluctant Ms Jones should be put to further time and effort so pointed out to the claimant he was at liberty to prepare his own evidence for the RCS. The claimant emailed again on 28 November 2013 appealing to Mr Martin not to present the CHKS report to the RCS in its current form. Mr Martin responded on 2 December 2013, only 10 days before the RCS visit and inside the 2 week period by which relevant documents had been requested to be provided to the RCS, acknowledging the concern, but in view of the short timeframe, suggesting the claimant use data which Prof Boobis had given to him to show why the second report might over-estimate his complications. The claimant replied again asking for all complications relating to PIP implants to be removed from the report. They discussed this by telephone. Mr Martin agreed to see if the report exclude PIP implant cases. It could exclude all implant removals.

2.77. Ms Jones emailed on 3 December 2013 with an updated CHKS Report excluding all complications arising from removal of breast implants, which I will call the "third report" .It showed a marked reduction in the claimant's complication rate. Mr Martin asked Ms Jones if this meant complications arising from removal of implants the claimant himself had inserted were excluded so the third report may underestimate the claimant's complication rates. Ms Jones confirmed his understanding was correct. **Any consultant breast surgeon would appreciate, and know how to allow for, the intrinsic unfairness to all NHS breast surgeons of including as a complication against their name a successful removal of an implant inserted by another breast surgeon,** usually privately for cosmetic reasons. Of the patient case notes reviewed by the RCS IR, only one related to a PIP implant.

2.78. The RCS – IR took place on 12 -13 December 2013 as planned. Mr Martin was unable to attend for interview during the visit due to prior commitments so was interviewed by telephone on 10 December 2013. By a letter received on 23 December 2013, Mr Martin was advised the reviewers believed there were sufficient concerns about the claimant's practice to state the current restrictions on practice should continue. Many concerns were around breast reconstruction work but the reviewers also identified issues about **his receptiveness to the views of colleagues** and his ability to engage productively with the MDT. They had evidence to suggest the outcome and complication rates in some areas of the claimant's work was below standard as was his **recording and analysis of complications**. The reviewers agreed his workload and support were not appropriate and noted a lack of clarity about the recording of MDT decisions but sufficient numbers of individuals expressing concern about his behaviour to indicate it did not currently meet expected standards of

professional practice. Mr Bristol wanted to return to review clinical records.That was agreed to take place, and did, on 25 January 2014. The RCS review did not specify the percentage of the claimant's work represented by reconstruction work. The original Tribunal found it was about 20% and there were no concerns **about his surgical work** in the other 80%. **I accept that with the vital qualification that ensuring patient safety involves more than the technical skill of a practitioner**. The full report was expected within 4 to 6 weeks thereafter.

2.79. Whilst the claimant's restriction to non-clinical duties continued, arrangements had been made for Gateshead and Newcastle to provide support to the Trust's Breast Service. On **12 February 2014** , Mr Lewis Atkinson, Assistant Divisional Manager Surgical Services at Gateshead, contacted Ms Youssef saying some patients referred to Gateshead by the Trust were not post-cancer, but **cosmetic procedures**. Gateshead's concern was about how, and by whom, the cost of those procedures would be met. Ms Youssef replied to Mr Atkinson copying in Mr Martin saying the concern had been raised a week previously **by Mr Clark** about whether the patients in question had been seen by the claimant privately before the complications arose which led to their being referred to Gateshead. Mr Martin **had to raise these** concerns with NCAS about the claimant's probity. NCAS advised a different individual should carry out that investigation rather than Mr Holtham . On **15 April 2014** Mr Martin told the claimant he had asked Mr Andrew Loughney, Associate Medical Director, to investigate. Mr Martin asked that Mr Clark provide details of the cases concerned. **Mr Clark did not** ,so Mr Martin decided the question of any conflict between the claimant's private and NHS practice should not be pursued. This serious allegation was not decided one way or the other, but left "hanging", creating suspicion.

2.80. On **28 February 2014** Mr Martin received the first 6 sections of the draft RCS report which was also sent to the claimant. It set out the timetable for the interviews the reviewers had conducted . The claimant had been seen for an hour on 12 and again on 13 December 2013 and at the end of that day for feedback lasting 15 minutes. The claimant challenged the accuracy of those timings but the original Tribunal concluded they were correct and he did not pursue the point before me. At section 6 the documents reviewed were listed and included appraisal documents and several CHKS reports. The final version was received on **7 April 2014**. Section 7 set out information which supported the conclusions reached in section 8. It noted the claimant attended 8 out of 17 M&M meetings until restrictions were placed on his practice and whilst some absences were due to attendance at clinics, others were not. When he attended he was perceived as "*disengaged*" . Critical comments were made about his record keeping not being methodical or thorough.

2.81. At the original Tribunal hearing and again before me , the claimant asserted the third report was not before the RCS panel. His statement said "*The **CHKS report** relied upon by the Royal College of Surgeon was false , fabricated by Ian Martin in conspiracy with Kevin Clark. Even Mr Martin is aware of the falsehood of the document which RCS England visitors believed and included in their report"* It also said ". *The **reconstruction Audit** relied upon by RCS in providing their opinion report to Ian Martin Respondent was the false audit produced by my Breast Care Nurse Michelle Derbyshire who was incited by Peter Surtees and Steve Holtham in conspiracy with Ian Martin to produce false audit report".*

2.82.1. On the first point, the original Tribunal assessed the evidence of Ms Sarah Downey of the RCS IR panel as entirely reliable that **both the second and third reports** were seen and considered. The claimant remained adamant the IR saw only the second report in which his complication rates were higher. Mr Echendu argues the percentage complication rates

mentioned in the RCS report show they were looking at the second not the third. My reading of it does not sustain his argument. Even if the RCS panel looked only at the second report, it does not mean they did not consider other evidence as to the true meaning of CHKS reports generally, which, as experts in the field, they would understand were broad indications of a trend rather than conclusive proof of anything. For the latter, they would need to look at individual patient case notes and speak to people . They did both. **I find they saw both but relied on neither. They used their expertise , while noting the CHKS data, to arrive at conclusions based on a broad range of evidence they gathered**. The claimant had the third report, so if he felt it was the only reliable one, he should have drawn it to the reviewers' attention.

2.82.2. On the second point, the original Tribunal were satisfied the audit prepared by the claimant (or his registrar) which was reviewed by Mr Clark was before the IR panel it being described as "*annual audit of complications following breast cancer surgery – Mr Iwuchukwu*". The audit prepared by the breast care nurses was also before them being described as "*Breast reconstruction complications audit July 2011-February 2012 presented March 2012*". It is referred to saying it dealt with 13 patients ,which it did. The period covered by the registrar's audit was longer and later than the nurse audit. Mr Echendu asserted the material furnished to the RCS was "false". but I find no evidence of that.

2.83. The RCS report noted the claimant did not feel part of the general surgery department and "*the department had not supported him as it should have done*". It noted he was the nominated chair of the Sunderland MDT meeting and his attendance was 79.6% which was almost as good as any other member. There was reference to the CHKS report of 1 April 2011-31 July 2013 at page 1071 where his performance was better than or in line with peer levels with the exception of complication rate for " attributed" and "treated" where it was high. In bold print on page 1072 it says "*Thus the unacceptably high level of complications associated with implant based reconstructions cannot solely be attributable to deficient technical skills, and the overall evidence we have seen suggests that it is largely events outwith the operating environment, such as clinical judgment in patient selection, that is responsible*". Mr Martin's oral evidence was that in his view the claimant performed procedures in an attempt to "save" situations which were unsavable, thus causing a CHKS entry of a complication for each procedure, which is a matter of patient and treatment selection. The RCS panel noted the views of the claimant's colleagues were polarised, some very complimentary whilst others described him as *"brusque bordering on aggressive".*

2.84. Section 8 set out the conclusions. There were sufficient concerns about the claimant's practice for the current restrictions to continue. There was evidence to suggest his complication rate in some areas of work was below expected standards, as was his attention to patient selection, recording and analysis of complications. The reviewers had examined case records of a random sample of **those** operations and found a level of complication and implant loss exceeding that to be expected.

2.85. It accepted the claimant's workload was at the upper limit of manageable for a single surgeon. He had carried out all SNB's himself citing insufficient number of cases where it would be used with which to maintain competency for two surgeons . The IR concluded there were enough cases for two. It noted there had been a lack of clarity and recording of MDT decisions but "*It was unclear from some of the notes that the treatment offered to patients faithfully represented the views of the MDT meeting and in some cases clearly it did not*". In respect of the technical competence within the operating environment it was concluded

"*There are poor outcomes of sufficient magnitude to indicate a serious problem, although it is impossible to pinpoint a single precise fault: the poor outcomes are likely to be due to a combination of factors many of which by themselves might have little impact*".

2.86. In respect of behaviour and inter professional relationships, it was concluded **sufficient numbers of individuals** expressed concerns to indicate the claimant's conduct did not meet expected standards of professional practice. In some cases he was unable to engage in non confrontational debate and he **found it hard to accept different opinions**. There had been a breakdown of trust between him and many members of the MDT.

2.87. Section 9 set out recommendations
(i) the claimant should remain restricted from clinical practice until other recommendations had been addressed
(II) the respondent take urgent steps to finalise their plans for the future of breast surgery and allowing a sole surgeon in breast surgery to continue at one site should not be part of any reconfigured breast service
(III) the respondent consider what surgical practice it would be appropriate for the claimant to undertake to ensure a return to practice preserved patient safety and the provision of high quality care. "*It is the view of the reviewers that he should not be allowed to undertake any breast reconstructive work. He should not be allowed to be the clinician relaying breast MDT decisions to the patient* ***nor be the sole arbiter of the outcomes of discussions with patients where legitimate treatment choices exist****. …*".
(iv) the claimant should have an experienced mentor and, given the time he had been out of practice, should not be able to return to independent surgical practice without a period of "*direct clinical oversight to ensure patient safety is maintained. If he were to resume surgical practice there should be at least one further consultant breast surgeon with a significant presence on the same site as him, ie attending outpatient and operating sessions and most important providing a regular presence at the breast MDT meetings*".

2.88. Appendix 2 contained a summary of the notes of the 20 patients reviewed by Mr Bristol. There was frequent reference to very poor record keeping. Case 8 related to the patient injured on 13 August 2013. The reviewers' commented the management of the case had shown poor decision making at all stages (prior to August 2013) and a failure to take advice from colleagues which was "*incomprehensible*". At page 1094 there is a crucial entry about the 13 August incident in which the reviewer comments the claimant has "*a tendency to persist with attempts to salvage non-salvageable situations with "more than the same" almost* ***a state of denial*** *that the wrong choices have been made* ". This echoes Mr Martin's view of the claimant's treatment choices and, as will be seen in my conclusions , my view of why he has presented his case as he has. Some case reviews received positive comment, but not many. This report contained serious criticisms but was not one sided. Some of its recommendations were always going to be difficult for the Trust to deliver. **However, by early April 2014, the situation was that if the claimant had accepted there was some problems revealed by the RCS report and said he would work with others to restore himself to the standards of the surgeon he clearly had been in the past, his future could have taken an entirely different route. He did the exact opposite.**

2.89. Having read the report, Mr Martin sought advice from the GMC Employer Liaison Adviser and from NCAS. He discussed the matter with Mr Bremner and Ms Griffin. The GMC adviser recommended the claimant be referred to the GMC Fitness to Practice Directorate. On **15 April 2014** , a week after receiving the RCS Report Mr Martin wrote to the claimant

saying he intended to make a formal referral to the GMC in his capacity as Responsible Officer. He did so that day. Mr Martin was also advised the claimant should be formally referred to NCAS to see if NCAS felt a capability assessment of him would be appropriate.

2.90. Mr Martin met with Mr Keith Godfrey of Gateshead to discuss the transfer of the Unit given the recommendations in the RCS report. On 25 April 2014 Mr Godfrey wrote saying Gateshead were keen to take the service, but not prepared to take on the claimant.

2.91. Mr Martin prepared a draft referral to NCAS and sent it to the claimant for comment The claimant complained he had not had the opportunity to discuss the RCS report with Mr Martin expressing his grave concerns about its content. He was allowed an extension of time to comment on the NCAS referral and those comments, some 20 pages , were added in section 7. In particular he said reconstructive work only formed 20% of his operative work and there were no concerns in relation to the rest . **Even if that were so as regards his technical abilities in theatre, an integral part of being a safe surgeon is patient selection, treatment choices with patients, record keeping and listening to the views of others in an MDT**. He alleged attempts made over the previous four years **to set up** a list of accusations to build a case against him and he considered there was an undercurrent of hate "*probably to do with my race or belief*". He said several false and completely unfounded allegations had been made against him particularly that he was not prepared to listen to or consider advice from members of the MDT or his peers.

2.92. The RCS report said at page 1073 he " ***showed limited insight into how he was perceived by others***".This puts diplomatically what appeared to all the respondents' witnesses I heard, the original Tribunal and to me, a greater and more intractable problem than technical skill. Taken together with references at page 1075 to the claimant's stress and behaviour in the early to mid 2013, the picture which emerges is of a man resentful of the Trust's management of the breast service, feeling he was under attack and taking out his frustrations on colleagues, particularly those "junior" to himself. Such a situation is likely to lead to decline in performance and risk to patients. Everyone but the claimant could see it.

2.93. On **30 April 2014** Mr Martin sent the referral to NCAS. On 8 May 2014 NCAS declined to carry out a performance assessment on the basis one would not provide any additional information to that in the RCS report and it would not be possible to observe the claimant's practice given he was restricted. Mr Martin was on annual leave from 12 -28 May 2014, followed by a week of external duties. He was not back at the Trust full time until 9 June. On **14 May 2014** the respondent was advised the claimant was being represented by Mr Robert Quick of the Hospital Consultants and Specialists Association ("HCSA").

2.94. On **20 May 2014** Dawn Youssef sent to Mr Martin an incident report she had received completed by a member of the administrative staff saying the claimant had potentially tampered with the notes of a patient required for a case involving litigation. It transpired he had copied the notes and in so doing caused them to become disorganised. Mr Martin later accepted this was a true explanation and the matter did not progress further.

2.95. On **30 May 2014** the claimant wrote to Mr Martin expressing various concerns about the RCS report. The GMC Fitness to Practice Directorate by letter of 13 June 2014 (received **30 June 2014)** told the Trust the Interim Orders Panel (IOP) of the Medical Practitioners Tribunal had imposed conditions on the claimant's medical registration which restricted him to performing breast surgery on NHS patients at the Trust supervised at the level of a

Foundation Level 1 trainee doctor. This restriction remained in place to and beyond his dismissal.The GMC commented *"The panel has determined that, based on the information before it today, there may be impairment of your fitness to practice which poses a real risk to members of the public and which may adversely affect the public interest. After balancing your interests and the interests of the public, the panel has decided that an interim order is necessary to guard against such a risk".* **This decision was reached after a hearing at which the claimant was professionally represented. It was not, and in my view could not have been, influenced, directly or indirectly, by anyone from the Trust.**

2.96. Ms Griffin had been absent due to sickness from 12 August to 2 September 2013 so not involved in the 13 August 2013 incident or concerns about the information the claimant had given to the RCA investigation which resulted in his exclusion. She received the email from Mr Quick. A Divisional HR Manager, Mr Bill Holliday by this stage was supporting Mr Martin's management of the case.

2.97. On **3 June 2014**, Ms Griffin received a copy of a grievance submitted to Mr Bremner. In summary, the claimant was aggrieved he was subject to performance management in circumstances where he felt unsupported as the Trust's single Consultant Breast Surgeon. He said Mr Martin was 'indifferent' to the difficulties he was experiencing, was **deliberately setting out to harm him** and this was *'bullying and harassment and discrimination.'* Ms Griffin arranged for Mr Loughney, who had been asked to deal with the "cosmetic procedures" allegation , to investigate the claimant's concerns at the first informal stage of the Trust's Grievance Procedure . She appointed Mr Holliday to provide HR support.

2.98. When Mr Martin read the grievance he noted a complaint about him raising the Overbeck incident with the RCS and NCAS. Those bodies had **required** disclosure of any previous disciplinary matters. It was already known to NCAS who had advised Prof Boobis at the time . He noted the repeated allegation the CHKS report sent to RCS had been falsified and despite his informing Mr Martin, he went ahead to submit the wrong data.

2.99. On **11 June 2014** and after taking account of the claimant's comments, NCAS wrote to Mr Martin to confirm their final decision they would not conduct an assessment as it would add nothing to the RCS review.

2.100. Having received this, Mr Martin told Ms Griffin his view was to proceed to a capability hearing. She advised he should explore whether a remediation programme for the claimant could be found at another NHS organisation. Mr Martin did not think it would be possible but followed that advice. He initially contacted the Specialist Advisory Committee of the RCS to ask what help they could provide. They referred him to the Association of Breast Surgery. He wrote to them on 18 June 2014 and was given possible contacts in Glasgow and Manchester who had previous experience of remediation.

2.101. On **18 June 2014** Mr Martin forwarded the claimant's comments in his email of 30 May 2014, regarding the RCS IR process and Report to Mr MacCallum at the RCS. He asked the IR Panel to provide any comments they may have . He chased for a response on 30 June, 18 July and 23 July before receiving an email on 24 July 2014 saying the IR Panel thought the comments represented a difference of opinion, rather than detailing any factual inaccuracy in the Report . He asked the claimant whether he wanted a point by point response which he did. This was requested on 5 August 2014. RCS responded on 8

September 2014 which Mr Martin forwarded to the claimant on **9 September 2014.**

2.102. Still in search of external remediation opportunities , Mr Martin contacted the Regional Director of Professional Affairs at the RCS on 18 July 2014 to ask whether appropriate mentoring could be provided but was advised they could not assist.

2.103. On **7 August 2014**, with a view to discussing remediation, Mr Martin met the claimant and Mr Quick. The meeting started confrontationally. The claimant expressed his discontent with the RCS IR process and Report, as well as Mr Martin's handling of his case. Mr Quick said *"he wants to get back into practice so he can prove you and the report wrong."* **Mr Martin explained a pre-requisite of remediation was the claimant should recognise his peers in the IR had justifiable concerns, and his apparent lack of insight into this gave concern about the likely effectiveness of remediation.** The claimant persisted in his objections to the RCS IR report and historical issues relating to the Sunderland breast service. Mr Quick stated *"Obi has reflected on the criticism and is determined to prove people wrong and to restore his career path. He wants to achieve this.* ***He accepts he is not perfect, no one is…We are where we are, but he is happy to work together here or elsewhere*** *to get his career back on track."* At this point, the meeting became more constructive. They discussed the two options offered by the Association of Breast Surgery and agreed Mr Martin should also contact Newcastle and Gateshead as well as Northumbria Healthcare NHS Trust, where the claimant identified a colleague who may be willing to help. Mr Martin said it would need agreement from the Medical Director of any other Trust and the five being asked to consider remediation would need to be aware of the RCS report and the GMC restrictions. Mr Martin offered to wait until the IR panel responded to the claimant's concerns but the claimant agreed the requests for help should not be delayed.

2.104. I find the approach based on the claimant's recognition of his own shortcomings came from Mr Quick, not the claimant himself. **The essential pre-requisite of successful remediation is recognition there are matters to be remedied. The capability panel found no sign of this from the claimant, and neither did I**. To illustrate why I pick a few points, italics being quotations from his statement for this hearing, which show he believes all criticisms of him are ill founded and the result of a conspiracy to portray his performance as deficient when, in his view, it was not. I reject that conspiracy theory as did the original tribunal. In respect of his receptiveness to the views of others in the MDT and colleagues generally, as the RCS report says the concerns came over a long period of time , some repeatedly from "*sufficient numbers of individuals".* There would have to be 10-12 , not 3-4 conspirators to make the theory plausible . I will make some observations on points in bold especially at 2.104 2-4 and 10 in my conclusions.

2.104.1. The claimant refers to his " purported" complications, saying, the CHKS software consistently demonstrated his outcomes to be very much within those of colleagues nationally" *apart from the* ***criminal forgery*** *overseen by Mr Martin where patients who had their PIP implants removed where made to look like complications. A professor of Oncoplastic Breast Surgery, Professor Drew also explained this* ***crime*** *in a clear unambiguous way to the employment tribunal hearing in the summer of 2016*"

2.104.2. Mr Martin ***incited*** *breast care nurses to carry out a disjointed false audit without my knowledge or consent*, and ***Ms Wright and Ms Derbyshire co-operated*** *with the destructive agenda of Mr Surtees, Mr Holtham, who took over as Clinical Director* ***despite being a***

***junior colleague of the claimant and a former trainee as a registrar**, started to champion Mr Surtees agenda.*

2.104.3. "*Kevin Clark .. became uncomfortable because of threat to his position as he knew the claimant was **more qualified than him**, and it was expected he would take up the leadership of the central breast Hub when merged together*" and *In April 2013, three months before the merger, the trio, Surtees, Martin and Holtham, in conspiracy with Clark started to execute their plan concocted against me in order to stop me moving over to Gateshead. **The trio had incited three people -Jenny Connor, Katherine Wright and Derbyshire to raise concerns regarding me**."*

2.104.4. *Mr Martin Instructed Mr Holtham to investigate , **directed Holtham to provide the false audit produced by Ms Derbyshire. The breast care nurses are not surgeons** and have no previous experience or training in oncoplastic surgery to conduct an audit of infections without my knowledge as reconstructive surgery was introduced by me for the first time in Sunderland.*

2.104.5. *Mr Martin directed Mr Holtham to send the nurse audit to Mr Clark who held preliminary meetings on how they would fabricate and raise fallacious report in the name of audit report to achieve their hidden agenda. They had been **in conspiracy to commit criminal offence even before** the purported report was given to Ian Martin in **Sept 2013**.*

2.104.6. *Kevin Clark raised false report on the audit and failed to benchmark his report with any known national or local benchmark **nor his own complication rates**. He sent the false malicious report to Ian Martin on the 3 September 2013. **No comparison or any reliable authority relied upon for his wicked report***

2.104.7. *Mr Martin drew terms of reference and **sponsored selected RCS members** to produce report on the basis of Mr Clark's report and false audit report produced by Derbyshire **on incitement by Peter Surtees**, Steve Holtham and Ian Martin.*

2.104.8. *He **packaged solely complication cases** documents carefully selected to meet his needs .He selected those he had previously influenced to raise false allegations to be interviewed by RCS (IRM) Team.*

2.104.9. He directed *Julie Jones **to commit criminal act by falsifying a CHKS report** which was **updated in June 2013** for the purpose of the RCS (IRM) team in order to ruin my career*

2.104.10. Of the incident on 13 August 2013, he says
*… **The theatre nurses and Anaesthetics knew what kind of solutions I use for operation specifically they know I do not use alcohol chlorhexidine at all.***

*On this fateful day my scrub nurse was taken away on the point of my commencing the case in the theatre to carry out the surgical procedure and after the WHO checklist had been already completed and a new nurse was brought to give me an alcohol solution which was **decanted into the same pink colour of the solution** I use for operation and this resulted in fire outbreak. This nurse was an anaesthetic nurse and not an operating theatre nurse, when I asked why the change so late, the response was "instructions from above". Although 11 people panel was set up to investigate this incident, but despite finding that the incident was*

caused by system failure no one has said anything who ordered my theatre nurse to be taken away at the last minute and who had sent the strange nurse that gave me the inflammatory alcohol solution. ***Despite the findings that this was not caused by me****, Ian Martin still went ahead and ask* ***his invited Royal College panel*** *to use it against me including using this incident to stop me from clinical practice and continued to present false information to relevant bodies on this such as GMC.*

Having hindsight of how my Scrub nurse was taken away and how the new nurse who had never worked with me before ***was sponsored to deceive me into using*** *what had caused the fire incident it became obvious* ***that I was set up****. Due to this fire, I was excluded first and my role subsequently restricted to purely non-clinical work requiring no contact with patients even though a* ***root cause analysis found I was not to blame*** *but system failure. I alone was "suspended" while the fire incident was being investigated, and this includes the nurses.*

Mr Martin later accused me of being an incapable surgeon and told me he would get the NCAS to assess my manual dexterity, to which I told him to take me anywhere in the world for my skills to be assessed, after that he never mentioned it again.

2.104.11. *Even after having received his* ***manipulated RCS sponsored*** *report, and applied for NCAS performance assessment,* ***he blocked NCAS by refusing*** *to allow NCAS to carry out performance assessment on me on the ground that it would not be feasible to place me on clinical practice.*

2.104.12. *.. we have two irrefutable proofs of the quality of my work while employed with City Hospital Sunderland which compare my work directly with my colleagues, firstly the corrected CHKS report and more importantly the Royal College of Surgeons ..conducted the* ***only audit of its kind*** *across board looking specifically at breast reconstruction; the outcome is enclosed among the documents and demonstrate my results to be among the best in the UK when compared with my colleagues. My operative logbook demonstrates my implant loss rate to be 11% while the national average was 12%. I rest my case."*
The audit to which the claimant refers was produced by him at this hearing .It is entitled "National Mastectomy and Breast Reconstruction Audit 2011." I do not have the full document or know when in 2011 it was prepared .Part 7 starts by saying that, at **18 months after** their mastectomy or reconstruction operation, women were asked about the aesthetic outcomes and the chapter provides the "mean adjusted scores". The Trust scores highly in comparison to other hospitals. The operations must have taken place in a period covering 2009/10. The claimant was not a sole surgeon until Mr Surtees left in March 2012. Also, he spent most of 2010 on suspension. It proves nothing about events from the time Nurse Derbyshire raised concerns onwards. **The audit simply does not prove, what he says it proves**. That said, I accept he was for most of his career a good surgeon.

2.105. Returning to the 7 August meeting, Mr Quick asked if the claimant's employment would transfer under TUPE on transfer of the breast service to Gateshead. At this time, Mr Martin still thought the breast service would ultimately transfer to Gateshead with the claimant in it, provided he could be successfully remediated. This was the logic in approaching Gateshead for a remediation placement. Mr Martin contacted the medical directors of ,Trusts in Glasgow, Manchester, Gateshead, Newcastle and Northumbria to see if they would be prepared to assist. All responded saying they were not. Mr Martin notified the claimant of this in an e-mail of 9 September 2014. The claimant said there were other

colleagues who could assist beside the five written to, but did not provide detail then or subsequently. No other enquiries were made.

2.106. The original Tribunal concluded the steps taken to consider remediation at this stage were" *late, perfunctory and little more than a tick box exercise".* I agree it was late but do not accept the rest. The claimant had worked previously with Prof Drew in Hull in 2002 who supervised his doctorate. The claimant published many highly regarded papers from 2002-2014 often in conjunction with Prof Drew. The original tribunal found the claimant approached Prof Drew ,then consultant oncoplastic breast surgeon at the Royal Cornwall Hospital Trust, **after his dismissal** and went to work with him unpaid , under supervision. After two months a locum position in general surgery became available and the claimant filled that role from 2015 still subject to GMC conditions. I can think of no reason why the claimant did not suggest something similar to Mr Martin , and no reason Mr Martin should know of the possibility, without being told, of Prof Drew's ability and willingness to help at a Trust in the far South West of England.

2.107. Mr Martin concluded the only way to proceed was to convene a capability panel. He contacted Ms Griffin, Mr Bremner, and the designated board member Mr Davison to discuss this. They agreed, so on **10 September 2014**, Mr Martin wrote to the claimant confirming that was his intention. Later a hearing was set for **23 December 2014**.

2.108. On **7 October** the claimant emailed Mr Bremner raising again his objection to the process by which he was currently under scrutiny and making criticisms of the way Mr Martin had dealt with him .Also repeated were his allegations of discrimination. Ms Griffin took legal advice and considered the best approach was to suspend the capability panel scheduled for 23 December 2014 and conduct a formal review of the process to date in respect of "*your competence **and behavioural concerns** to date, including the concerns raised regarding the data underpinning such matters"* .

2.109. On **4 November 2014** Ms Griffin wrote to the claimant setting out the proposal. She said the capability panel would be postponed but not cancelled. Following MHPS a Case Investigator would be formally appointed. Mr Martin was not entirely comfortable to continue as case manager. Ms Griffin took the view he should, but if the Case Investigator found evidence of vindictive or discriminatory treatment of the claimant by Mr Martin that was to be reported directly to Ms Griffin rather than to Mr Martin. **NCAS advised any grievance procedures should be handled separately, in parallel to the capability process which *"should not be allowed to stall or be derailed"* .**

2.110. Mr Martin felt the concerns regarding the claimant's performance had been extant for almost 18 months, during which Mr Clark, the RCS IR, the GMC , the Interim Orders Panel of the Medical Practitioners Tribunal, and NCAS had found genuine problems. Whilst he recognised the need to deal with the grievance, it appeared to him to be an attempt to detract attention from concerns about the claimant's safety to practice which, as Medical Director and MHPS Case Manager, Mr Martin had a professional duty to address. I understand Mr Martin view it was high time those concerns were addressed, but I also see Ms Griffin's point that if the panel were to proceed when allegations of the RCS and GMC being provided with misleading or incomplete information. as well as allegations of race discrimination, remained unresolved, the Trust would be subjected to criticism, if the panel were to decide on dismissal without those matters having been investigated.

2.111. Dr Sean Fenwick a Consultant Nephrologist / Physician was the Trust's Deputy Medical Director in addition to his full time clinical role. He was the Case Investigator appointed. He only knew the claimant to say "Hello" to in passing. On **4 November 2014**, he was given a copy of a letter Ms Griffin had sent to the claimant setting out the background to his appointment as Case Investigator and summarising his remit. The letter enclosed Terms of Reference for the investigation. He was given a copy of Mr Martin's existing papers which included the preliminary investigation by Mr Holtham, the RCS report and correspondence with NCAS. He was also given the claimant's email of 7 October to Mr Bremner.

2.112. He had a meeting with the claimant and his representative on 26 November 2014 which lasted over three hours. It was minuted . Much of it dealt with the claimant's workload, the accuracy of the data submitted to RCS and **the other matters referred to by RCS** about his conduct at MDT meetings and note keeping. The claimant said he had not been told by Mr Martin the RCA report into the incident on 13 August 2013 had concluded he was not to blame which had caused him "*unbearable pressure*". That report had **not** concluded he was blameless but left the question of the extent, if any, to which he was, unresolved.

2.113. Dr Fenwick met with Dr Wright **on 17 December 2014**. They discussed the behaviour of the claimant at MDT meetings. Dr Wright spoke of the number of telephone calls taken by the claimant and the necessity for the meeting to wait until he had finished. She described the claimant as dominating ,**even arrogant**, at such meetings. Ms Purvis from HR was with Dr Fenwick at both meetings. They both took notes subsequently typed into a single record sent to Dr Wright to confirm it was accurate. The deadline for submitting the investigation report was approaching and so he began a draft shortly after meeting Dr Wright. He completed the Case Investigation Report and sent a copy to Mr Martin on 31 December 2014 saying it was subject to confirmation from Dr Wright as to the accuracy of the notes.

2.114. Dr Wright called him on 7 January 2015 to say she did not think the notes were accurate and she was going to provide her own statement . While her statement contained more detail ,it did not differ in substance from the notes . An email to Mr Martin on 13 January 2015 attached a revised Investigation Report.

2.115. As far as relevant to the unfair dismissal claim , Dr Fenwick concluded
(a) the data on which the RCS report was based was not incorrect or inaccurate
(b) as for deviation from procedure,. "*In summary the only evidence I have seen of any procedural deviation in dealing with the issues of concern relates to delay in providing a preliminary fact finding report in the period April to August 2013 at a time when the full report could not have been provided earlier due to the fact that the Trust was awaiting the opinion of an external expert on the issues pertaining to OI's complication rates. I have seen no evidence of any alternative explanation for the delay*". He said **consideration should given** as to whether that delay was reasonable.
(c) having set out the various audits, the claimant's satisfactory appraisals, his initial response of 17 July 2013, the outbreak of vomiting and diarrhoea on Ward D47, the claimant's workload , that he operated as a single consultant breast surgeon and the largely positive patient feedback he wrote "*In my view therefore there is sufficient conflicting evidence as to the nature, seriousness **and reasons** for OI's complication rates to **warrant consideration**. The available options in this respect are set out at paragraph 8 below*".
(d) there was sufficient evidence the claimant did not adhere to agreed treatment plans and was disengaged during MDT meetings **to warrant further consideration**.

(e) there was **no evidence** clinical staff or patient safety had been compromised as a consequence of the claimant leaving his Wednesday clinic early on occasions and **no issues of concern** in relation to the Milan study trip.
(f) the claimant had failed to advise the respondent of his driving record and the respondent should consider whether its internal procedures needed tightening on such matters.

2.116. Section 8 identified the competency concerns. I need not set them out in full but they include "***lack of insight***" and difficult relationships with colleagues. Dr Fenwick raised these questions (a) whether there were genuine and substantial competence concerns that could not be explained by workload or other external factors and so may require remediation(b) if so how remediation might be achieved in view of the current restrictions and (c) the availability of external placements and (d) whether the breast service provided at Sunderland could and should continue. He set out four options
(a) the recruitment of an additional consultant to support and remediate the claimant,
(b) whether remediation for the claimant should be sought at an alternative location,
(c) whether to support the claimant in finding alternative employment
(d) whether to put the claimant's case before a capability panel.
The report identified those options but went no further. The original Tribunal dealt with it in more detail because they were seized of the discrimination claims. I find this was a balanced fair report, though it has been of little if any assistance to me and I doubt it was of much assistance to the capability panel. In effect, it expressed Dr Fenwick's view on matters on which the capability panel had to make the decision. I have highlighted matters he said needed " further consideration". **By whom?** He might mean the case manager, but that would make Mr Martin responsible for deciding matters on which the claimant was alleging Mr Martin was to blame . **On balance I think he must mean a capability panel**.

2.117. In response, the claimant sent a variety of papers. His comments were detailed in contrast to his preparation for the RCS visit in December 2013. He said the Overbeck incident should not have been mentioned in the referral to the RCS. He challenged how the CHKS data could have gone from green at the 2013 appraisal to red shortly after and attributed that to PIP implant complications being recorded against him. **He asserted the trigger for his suspension from clinical duties and referral to the GMC and RCS was the incident on 13 August 2013**.

2.118. Mr Martin took a further step. The Trust has a Designated Deputy Responsible Officer (a Medical Director in another Trust) who steps in as Responsible Officer for Mr Martin in the event of a conflict of interest between him and a doctor he is revalidating. It was Dr Alan Rodgers, Medical Director at South Tyneside Trust, who agreed to review the papers and provide his views to Mr Martin. In summary, Dr Rodgers concluded a capability panel would seem a sensible route and the claimant appeared to have ***"no recognition of any failings and a lack of insight"***. Mr Martin discussed Dr Rodgers' comments with Ms Griffin and they agreed it was reasonable to now proceed to a capability panel hearing. Mr Martin delegated the task to HR to convene an appropriate panel and find a date.

2.119. A capability panel hearing was scheduled to take place on Tuesday 24 March 2015. There was some difficulty in convening a panel strictly in accordance with MHPS as there were not two remaining members of the Trust Board who had not had **some** involvement. Ms Pattison (Director of Finance) was to Chair the hearing leaving Mr Bremner available in the event of any appeal. After legal advice, Professor Namita Kumar was approached to join the

panel . A Consultant herself, she had been involved in medical education for over 18 years with activities for the Royal College of Physicians Trainees' Committee; Education Training and Standards Board and as an examiner for Membership of the Royal College of Physicians . In 2003, she was appointed as a board member of the Postgraduate Medical and Education Training Board by the Secretary of State for Health. In 2013, she appointed as Postgraduate Dean for Health Education England in the North East, and also made an Honorary Clinical Professor by Durham University in May 2014. Given her background, she would understand the clinical, medical and educational issues under consideration.

2.120. MHPS requires an independent clinician not employed by the Trust, and preferably from the same discipline as the employee. Arrangements had been made for a specialist to sit on the panel but he became unwell so, in early March 2015, Ms Griffin contacted Mr Martin who contacted the Association of Breast Surgeons and the RCS . Mr Michael McKirdy, Consultant Breast Surgeon of the Royal Alexandra Hospital, Paisley became the independent medical member not employed by the Trust. HR support was provided by the Trust's Deputy Director of HR, Mrs Armstrong.

2.121. Ms Julia Pattison has worked for the Trust since 2005 and by 2014 was Executive Director of Finance. She had no formal training in HR procedures but had sat on appeal panels in disciplinary matters This was her first time chairing a capability panel involving a doctor. She had limited knowledge of the claimant . She was copied into emails regarding his driving penalty points in 2013, which can impact on the Trust's lease car and driver insurance arrangements, so are notified to a Finance Director. She sat on the panel for his appeal against a Final Written Warning about the Overbeck incident. She was consulted about excluding him in September 2013 because, under MHPS, decisions on exclusion need agreement of the Chief Executive, the Director of HR and the Medical Director. At the time both the Chief Executive, Mr Bremner and the Director of HR, Ms Griffin, were on annual leave, so Ms Pattison was involved **purely as Deputy** Chief Executive.

2.122. The HR department provided each panel member with **documents running to nearly 1000 pages**. Ms Pattison spent about 3 days reading in advance. She deliberately did not meet with the other members prior to the hearing. From the papers, she understood the concerns were that the claimant:
(i) **appeared to have** a high post-surgical complication rate;
(ii) **did not adhere to treatment plans agreed by the MDT**;
(iii) appeared disengaged during MDT meetings, taking numerous phone calls and was **reluctant to consider the views of other members**;
(iv) left clinics early
(v) failed to attend planned study leave;
(vi) failed to inform the Trust of driving licence penalty points.
Probably due to the sheer volume of evidence, she did not identify the last three points had been effectively disposed of by Mr Holtham's and/or Dr Fenwick's reports.

2.123. Ms Pattison noted :
(i) a preliminary investigation into the performance concerns and advice taken in connection with complication rates from Mr Clark
(ii) advice taken from NCAS
(iii) the RCS IR (later explained to her by Mr McKirdy as a specialist review of a person or service intended to address problems before they become unmanageable) had concluded

there were concerns about the claimant's competence **and behaviours.**
(iv) his case had been referred to the GMC and interim orders imposed requiring he be supervised in Breast Surgery at all times, by another Consultant, effectively at the level of a Foundation Year 1 doctor. The Trust did not employ a suitable consultant.
(v) efforts had been made to find a placement at another organisation but all had declined.

2.124. The claimant's statement of case focussed on his belief the data pertaining to his complications rates submitted to the RCS IR was incorrect. He disputed the findings and asserted RCS IR had not given him time to talk the issues through and explain himself. He alluded to a lack of workplace support and capacity. Mr Martin's statement says the claimant "*asserted that he did not have high complication rates and that I had concocted such evidence against him. In relation to comments in the RCS Report which indicated that he did not get on with colleagues – in MDT for example - Mr Iwuchukwu asserted that his colleagues (the same colleagues who had been interviewed by the IRM panel) liked him.* ***It also raised issues about the investigation of concerns regarding his probity in relation to the SI on 13 August 2013*** *and the factual content and interpretation of his complications data and the individual case note reviews. He took particular issue with the finding that he failed to faithfully adhere to decisions of the MDT and to involve the breast cancer nurses in assisting patients to make choices. He also raised concerns about his workload".*

2.125. Ms Pattison read Dr Fenwick's report as having considered the accuracy of the data given to the RCS IR and found the information provided was correct.

2.126. Ms Pattison believed the capability panel needed to consider **whether** there were **any** concerns about the claimant's practice which required remediation and, if so, to **assess the practical prospects for remediation**, before making any decisions about his employment. As Chair, her role was to ensure the proper conduct of the hearing, that both sides had a full opportunity to put their case, to ask questions and to clarify any issues arising so the panel could reach a fair and reasoned decision.

2.127. The capability panel hearing took place on 24 March 2015.The claimant attended , represented by Mr James Rowley of Ryan Solicitors. Mr Quick accompanied him too. Ms Gemma White, PA, was note taker. Mr Martin presented the Management Statement of Case assisted by Dr Fenwick, which summarised the concerns and steps taken to investigate and address them.

2.128. Ms Pattison says: "*Mr Rowley took the opportunity to clarify the key concerns regarding Mr Iwuchukwu's performance which were to be considered by the capability hearing. These were* ***ultimately*** *not controversial. Mr Martin confirmed that the Management Case was* ***focussed on*** *the* ***clinical performance concerns and behaviours*** *and that* ***issues of concern relating to Mr Iwuchukwu's conduct specifically, for example, regarding a failure to notify the Trust of driving licence penalty points which he had received, had not been put forward for consideration by the capability panel****.* She then refers to "*some confusion on Mr Rowley's part*" about a letter from NCAS contained in Dr Fenwick's report, which Mr Rowley thought was a case of mistaken identity. His instructions were the claimant had not been the subject of previous retraining. Mr Martin explained the claimant had been subject to disciplinary proceedings over the Overbeck incident and, after a period of exclusion, he had returned to work on a phased return with retraining. There was a brief adjournment whilst Mr Rowley took instructions and ultimately, Mr Martin confirmed

the reference to the earlier disciplinary proceedings had come from NCAS's own files rather than information he had volunteered to NCAS during his calls, the disciplinary sanction was now spent and the capability panel was not considering that issue in any event.

2.129. Next the Panel had an opportunity to ask questions of the Management Statement of Case which they did. Next Mr Rowley presented the claimant's case, management and the Panel asked the claimant questions before Mr Martin and Mr Rowley were asked to present a summary of their cases. After about 6 hours the hearing closed at 3.25pm.

2.130.The claimant (a) asserted Mr Martin had concocted evidence against him (b) denied failure to implement decisions of the Sunderland breast MDT (c) asserted the area of concerns in the RCS report related to his implant reconstructive work only which accounted only for 20% of his workload, of which some related to autologous LD (latissimus dorsi) reconstructive work with which there were no issues raised ,a point he stated he had made clear to the RCS reviewers (d) explained the high complication rate by noting it had coincided with four factors (i) periods of increased infection in the hospital , (ii) relaxation by him of strict criteria on reconstructive cases (now reversed), (iii) the use of Permacol ADM (acellular dermal matrices) which had since stopped when problems relating to that substance were appreciated and (iv) most of the patients treated by him were symptomatic breast cancer patients (as opposed to screen detected) of whom 80% needed axillary clearance which was known to be associated with greater complication risk. He also made the point the CHKS report included in the papers for the RCS included as complications many patients who had uneventful removal of PIP implants which had not been inserted by him and showing those as a complication meant his figures were skewed. He commented on each of the 20 sets of case notes referred to in the RCS report. The question put more than once by Mr Echendu to Ms Pattison was whether the panel " *relied 100%* "on the RCS report, which she confirmed they did. However, that only means they thought the report was reliable, it does not mean they did not question its content before coming to that conclusion, or that they relied on nothing but the RCS report.

2.131. On the issue of his blame for the 13 August 2013 incident **I asked Ms Pattison which of the following was true: the dismissal panel decided the claimant**
(a) knew he was using an alcohol solution and failed to take precautions
(b) thought he was using aqueous but failed to spot signs it was alcohol
(c) thought he was using aqueous and no check could have told him otherwise
(d) none of the above –the RCA and RCS IR had not decided it , so neither would they.

She replied it was (d) but accepted she had to make a conscious effort to exclude the incident from her considerations. **I accept she herself succeeded**.

2.132. Ms Pattison then says

The capability hearing panel initially reconvened immediately after the capability hearing to consider and to determine the issues. However, the panel had already listened to a lot of information and Mr McKirdy, ***who had been informed that the capability panel hearing would take place in the morning only****, had already missed his train back to Glasgow and had had to make arrangements to catch a later one. The Panel therefore discussed its initial view from the information we had heard. The Panel's unanimous view was that there appeared to be some substance to the performance concerns. We decided that given the time of day and the significance of the possible outcomes for Mr Iwuchukwu's future employment, there was insufficient time available to reach a conclusion on the day. The*

Panel adjourned for the day and arrangements were made to reconvene at a later date. We did however agree a number of actions to be taken prior to reconvening. These included Mr McKirdy reviewing and providing his independent clinical view of the performance issues which had been presented, Dr Kumar would provide her views on what remediation might involve, given her particular knowledge in that area from role as Post Graduate Dean. I wanted to go away and review the papers and MHPS again in light of what I had heard. Mr McKirdy and Dr Kumar's subsequent comments and observations were emailed to me ... Mrs Armstrong provided me with some information about the remediation process and its costs

Due to competing diary commitments, the earliest date on which the Panel was able to reconvene to determine the outcome of Mr Iwuchukwu's capability concerns was 24 April 2015. Even then Mr McKirdy's diary commitments were such that he participated in the reconvened Panel meeting remotely, by telephone.

Shortly before the Panel was due to reconvene, the HR Advisor to the Panel, Ms Armstrong, advised the Panel of an email received on 22 April 2015 from Mr Iwuchukwu's HCSA representative, Mr Quick (page 3018). In his email, Mr Quick advised of a possibility of a remediation placement for Mr Iwuchukwu at another NHS organisation. He also advised that an Interim Orders Panel ("IOP") of the GMC was to meet on 27 April 2015 to review the conditions on Mr Iwuchukwu's practice. Recognising that these matters might impact on the Panel's decision regarding the outcome of the capability panel hearing, the Panel decided to defer its decision until the outcome of the IOP's review was available.

However, in view of the difficulty in getting all of the Panel members together at one time, the Panel took advantage of the planned time available to consider the issues arising from the capability panel hearing. ***After approximately three hours of deliberations****, the Panel arrived at a provisional decision which we agreed would be subject to final review after the outcome of the IOP's review was made known.*

2.133. The decision of the IOP, made known to the Panel on 1 May 2015**,** was to lift the restriction on the claimant only working within the Trust but it went on: "*He must confine his medical practice to National Health Service posts in Breast Surgery where his work will be directly supervised by a named consultant…".* This did not change the provisional decision.

2.134. The unanimous decision of the Panel was:

(a) There were genuine and substantial concerns regarding the claimant's competence that could not be explained by work load, case mix or other factors and so some areas of his practice required remediation;

(b) The Trust was not able to facilitate remediation in its Breast Service as the claimant was the sole Consultant Breast Surgeon, subject to GMC IOP conditions he be supervised by an appropriate Consultant Surgeon and the Trust did not have one. Consideration was given to appointing a further Consultant but the Panel concluded there was unlikely to be sufficient work to justify that and, in any event, given the RCS comments about the problems of a single consultant, the Panel did not think it was in the interests of safe patient care;

(c) The Trust's attempts to source an external placement had so far been unsuccessful. External remediation would be of no benefit to the Trust as the breast service was to be

closed to new patients ,the future being to centralise such services in Gateshead .

(d) As for redeployment to a general surgical role , there was a Consultant vacancy but the claimant had not worked on the general surgical rota since 2010. **It would not resolve the RCS's concerns regarding the claimant's insight into his own deficiencies and/or his communication with colleagues in the MDT and patients.** The RCS Report expressed concerns about note-taking, patient selection and insight which needed drastic improvement if the claimant was safely to operate as any consultant, and said he *"should not be allowed to be the clinician relaying…decisions to patients and should not be the sole arbiter of the outcomes of discussions with patients where legitimate treatment choices exist"*. The Panel's concern was this issue, and the consequent impact for patient safety, could only be addressed by having him supervised at all times during patient consultations, which would not be reasonable.

2.135. In the circumstances, the decision was the claimant's employment be terminated on notice for reasons relating to his capability. Ms Pattison's letter dated 7 May 2015, confirms the decision and sets out the detailed reasoning. The letter in error gave the claimant 8 weeks notice but that was corrected to 12 weeks. He was notified of his right to appeal and not required to work his notice so his end date would be 6 August 2015.

2.136. I cannot speak too highly of Ms Pattison's chairing of the panel or the explanations she gave in her letter, on both of which points it is likely she received able assistance from Ms Armstrong . At risk of repetition the letter said the panel concluded it could rely on the RCS report to find (i) the claimant a high post surgical complication rate,(ii) did not always adhere to treatment plans agreed by the MDT (iii) appeared disengaged during MDT meetings. It dealt with his challenges to the report .It rejected (i) it was rushed or the claimant had not had an opportunity to explain (ii) it was **based on** incorrect or skewed CHKS data because it was not solely CHKS data which informed its conclusions (iii) RCS had restricted its review to the claimant's practice over a six month period (iv) the report was based on a "*dogma"* that implants could not be used following radiotherapy. It said the RCS had considered the impact of the claimant's workload on his complication rate and noted the claimant's changed approach to the use of Permacol and his choice of patients for reconstructive surgery. It accepted there was no evidence the claimant's non implant work was technically deficient but stopped short of finding the only clinical performance concerns were actual surgery given the findings of poor patient and treatment selection, recording of complications, receptiveness and ability to engage productively with the MDT and wider circle of colleagues.

2.137.The letter set out it had considered various options instead of dismissal and why they were not feasible. It continued *"Given the issues raised in the IRM report regarding the problems of sole practitioner service and the recommendations that you not be solely responsible for taking and conveying decisions to patients about treatment options, the panel also had concerns that an additional consultant would encounter greater difficulties in operating the Trust breast service single handedly whilst effectively supervising your remediation, either in accordance with the recommendations of the RCS IRM or any conditions imposed by the GMC/IOP. In all of the circumstances the panel regrettably concludes that the Trust does not have the capacity or the resources and it would therefore not be in the interest of providing safe patient care to support your remediation in-house*". It explained remediation in another NHS organisation would not be of benefit to the Trust as its breast service was closed to new patients and there would be no breast service for the

claimant to return to. It considered redeployment and concluded that was not workable given the concerns over the claimant's, note taking, audit and **insight** as well as it requiring further relaxation of the IOP restrictions. The only option left was to dismiss.

2.138. I was helped to understand the references to the breast service in Sunderland by the statement of Mr Peter Sutton Executive Director of Strategy and Business Development. He has knowledge of the development of Breast Care services across the NHS in the South of Tyne and Wear since 2012 as part of ABP. He had no substantive dealings with the claimant prior to or since dismissal and does not recall he ever met him. I can summarise his evidence very briefly. By 2014 the Trust could no longer guarantee a high quality, safe service to breast patients so it made the decision to close the breast service to new patients. The choice for them was between the nearest providers which were Gateshead, County Durham and Darlington, Newcastle, and North Tees and Hartlepool NHS Trusts. Prof Boobis agreed to oversee the care of existing patients whose care plan was underway. The Specialist Breast Care Nurses remained. With no new patients and the number of existing ones decreasing, staff became aggrieved and disengaged. The staff grade doctor left to take up a role elsewhere, the two Breast Nurses were appointed to vacancies in Gateshead. The Trust now only provides a partial Breast Service and has an agreement with Gateshead to release Breast Nurses when needed to review the Trust's remaining patients.

2.139.On 11 May 2015, Mr Martin informed NCAS of the outcome and had a further discussion with it on 15 June 2015 saying the claimant had lodged an appeal and there were about 30 outstanding patients' complaints relating to adverse outcomes from surgical procedures he had carried out which were unlikely to be resolved by 6 August 2015.

2.140. On 14 May 2015, Mr Quick notified the claimant's intention to appeal but that he was no longer representing him. Ms Griffin acknowledged this and by letter of 4 June 2015 asked for details of the grounds of his appeal which were provided by email on 8 June 2015. The claimant's letter to Mr Bremner on 29 May 2015 had requested his appeal be addressed within 14 days. Paragraph 33 of Part 4 of MHPS sets out the appropriate membership of a capability appeal panel and the advisors to it. Ms Griffin was conscious of the difficulty there would be in sourcing independent panel members and then co-ordinating their availability to attend a hearing, along with the managers from the original capability panel, and so she raised the point by letter of 4 June 2015, and explained she would be in contact in due course with regard to arrangements for the appeal hearing.

2.141. Ms Griffin had already decided she knew too much about the case to be providing HR advice to the appeal panel so she arranged for a HR Director colleague at a neighbouring Trust to do so . She was able to secure Ms Leena Changla (Consultant Surgeon and Lead Clinician Breast Surgery) from another NHS trust to be the independent medically qualified member. The difficulty was in finding *"An independent member (trained in legal aspects of appeals) from an approved pool"* to be *"designated Chairman"* . MHPS, written many years earlier, said the names in the "pool" were held by the Strategic Health Authority, a body long since abolished. The list was eventually tracked down to "NHS Employers" who were contacted for details of people in the approved pool, but this information was refused. Ms Griffin's PA was told by them to arrange an appeal hearing then call back, at which point NHS Employers would provide someone in the approved pool who was available . When her PA did that, the individual NHS Employers was proposing to use was not available so it had to be rearranged. It was August 2015 before Ms Griffin was able to confirm a full appeal

panel and a date for the hearing. Her letter of 14 August 2015 invited the claimant to an appeal hearing on 13 October 2015.

2.142. The response from Mr Echendu, on 27 August 2015, took issue with the Trust's processes and in particular the delay in arranging an appeal . It said the Trust was being manipulative and deceptive. Ms Griffin replied on 14 September 2015. Mr Echendu's email of 18 September 2015 said *"I therefore ask you to stop this issue of appeal as Mr Iwuchukwu sees it as further acts of intimidation, bullying and harassment"*. The arrangements were cancelled and no appeal hearing took place.

3. The Relevant Law

3.1. Section 98 of the Employment Rights Act 1996 (the Act) provides

"(1) In determining for the purposes of this Part whether the dismissal of an employee is fair or unfair it is for the employer to show –

(a) the reason (or if more than one the principal reason) for dismissal

(b) that it is either a reason falling within subsection (2) or some other substantial reason of a kind such as to justify the dismissal of an employee holding the position which the employee held.

(2) A reason falls within this subsection if it

(a) relates to the capability ..of the employee for performing work of the kind he was employed by the employer to do

(b) relates to the conduct of the employee

(3) In subsection (2) (a) –

*(a)" capability" , in relation to an employee , means his capability assessed by reference to skill**, aptitude** ,health or **any other** physical or **mental quality**.*

3.2. The reason for dismissal was said by Cairns LJ in Abernethy-v-Mott, Hay and Anderson to be a set of facts known to the employer or maybe beliefs held by him which caused him to dismiss. In Abernethy Lord Denning made clear an inflexibile and unbending attitude was related to capability, as it was a mental quality. Misconduct and incapability are often hard to differentiate. Sutton and Gates (Luton) Ltd -v- Boxall held a reason related to capability if the employee is trying his best and failing, but relates to his conduct if he is failing to exercise to the full such talents as he possesses.

3.3. At this stage an employer does not have to prove, even on a balance of probabilities, the claimant was incapable, merely that it honestly and genuinely believed he was , Taylor-v-Alidair. The reasonableness of belief is addressed under s98(4) with a neutral burden of proof and subject to the qualification I set out after the sub-section

"*Where an employer has fulfilled the requirements of subsection (1), the determination of the question whether the dismissal is fair or unfair (having regard to the reason shown by the employer) –*

(a) depends on whether in all the circumstances (including the size and administrative resources of the employer's undertaking) the employer acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the employee

(b) shall be determined in accordance with equity and the substantial merits of the case."

3.4. In all aspects substantive and procedural Iceland Frozen Foods v Jones (approved in HSBC v Madden and Sainsburys v Hitt) held the ET must not substitute its view for that of

the employer unless the view of the employer falls outside the band of reasonable responses. In UCATT v Brain, Sir John Donaldson made the point thus:
"Indeed this approach of Tribunals, putting themselves in the position of the employer, informing themselves of what the employer knew at the moment, imagining themselves in that position and then asking the question, "Would a reasonable employer in those circumstances dismiss", seems to me a very sensible approach – subject to one qualification alone, that they must not fall into the error of asking themselves the question "Would we dismiss", because you sometimes have a situation in which one reasonable employer would and one would not.

3.5. Section 98 (4) applies to all the potentially fair reasons. Comments about fairness made in cases of dismissal relating to conduct may be good guidance in a capability case. It is sometimes argued that only in conduct cases is there a requirement for a full and fair investigation British Home Stores -v- Burchell. I believe that to be wrong. Stephenson LJ in Weddel v Tepper said *" Employers suspecting an employee of misconduct justifying dismissal cannot justify their dismissal simply by stating an honest belief in his guilt. There must be reasonable grounds, and they must act reasonably in all the circumstances, having regard to equity and the substantial merits of the case. They do not have regard to equity in particular if they do not give him a fair opportunity of explaining before dismissing him.* How can any belief be reasonable if there is no adequate investigation into the facts supporting the belief?

3.6. The original tribunal found the respondent had reasonable grounds for its genuine belief. I asked Mr Echendu at the preliminary hearing on 11th July whether he would be seeking to persuade me to change that finding. In other words is the claimant now saying " *There was* ***nothing*** *wrong with my practice*" or *"There were some things wrong with a part (20%) of it which could have been put right* ". He said he would start with the former and use the latter as an alternative.

3.7. The EAT said in a " conduct case" A v B [2003] IRLR 405:
"In determining whether an employer carried out such investigation as was reasonable in all the circumstances, the relevant circumstances include the gravity of the charges and their potential effect upon the employee. Employees found to have committed a serious offence of a criminal nature may lose their reputation, their job and even the prospect of securing future employment in their chosen field. In such circumstances, anything less than an even-handed approach to the process of investigation would not be reasonable in all the circumstances.
Whether an employer has carried out such investigation as is reasonable in all the circumstances also necessarily involves a consideration of any delays. In certain circumstances, a delay in the conduct of the investigation might of itself render an otherwise fair dismissal unfair. Where the consequence of the delay is that the employee is or might be prejudiced, for example because it has led to a failure to take statements which might otherwise have been taken, or because of the effect of the delay on fading memories, this will provide additional and independent concerns about the investigative process which will support a challenge to the fairness of that process.
Whether the reason for dismissal relates to capability or conduct in my view delay and the seriousness of the impact upon the career of the employee in question will always be relevant to the test of reasonableness.

3.8. McAdie -v- Royal Bank Of Scotland was key to the EAT's decision to allow the appeal. Mr Echendu urged me to ignore this case as it is distinguishable on its facts which related to

ill health incapability. That is true , as Mr Sweeney accepts, but the principle enunciated by the Court of Appeal still applies . Lord Justice Wall said

It seems to us that there must be cases where the fact that the employer is in one sense or another responsible for an employee's incapacity is, ***as a matter of common sense and common fairness, relevant to whether, and if so when, it is reasonable to dismiss him*** *for that incapacity. It may, for example, be necessary in such a case to "go the extra mile" in finding alternative employment for such an employee, .*
However, … it must be right that the fact that an employer has caused the incapacity in question, however culpably, cannot preclude him for ever from effecting a fair dismissal.
In McAdie the Employment Tribunal found as a fact the Bank was responsible, and culpably so, for the appellant's ill-health. The EAT said
*it is important to focus not, as such, on the question of that responsibility but on the statutory question of whether it was reasonable for the Bank "in the circumstances" (****which of course include the Bank's responsibility for her illness****), to dismiss her for that reason. On ordinary principles, that question falls to be answered by reference to the situation as it was at the date that the decision was taken. Thus the question which the Tribunal should have asked itself was "was it reasonable for the Bank to dismiss Mrs. McAdie on 22 December 2004, in the circumstances as they then were,* ***including the fact that their mishandling of the situation had led to her illness?"***

That was not the approach which the Tribunal avowedly took. The elegantly-expressed reasoning at para. 87 of the Judgment - "no reasonable employer would have dismissed in these circumstances because no reasonable employer would have found themselves in these circumstances" – focuses explicitly not on what it was reasonable for the Bank to do in the circumstances in which it found itself (however culpably) but on whether it should have got into those circumstances in the first place. If that is really the approach taken by the Tribunal it was plainly a misdirection.

3.9. In Orr-v-Milton Keynes Council the issue was whether an employer, when considering dismissal of an employee for misconduct, is to be taken to know exculpatory facts which are known to the employee's manager but are withheld from the decision-maker. Moore-Bick L.J. with whom Aikens LJ agreed said

60. Sedley L.J. suggests that the person deputed to carry out the investigation on behalf of the employer must be taken to know any relevant facts which the employer actually knows, which include not only matters known to the chief executive but also any relevant facts known to any person within the organisation who in some way represents the employer in its relations with the employee. However, in my view it would be contrary to the language of the statute to hold that the employer had acted unreasonably and unfairly if in fact he had done all that could reasonably be expected of him and had made a decision that was reasonable in all the circumstances. That is why it is important to identify whose state of mind is intended to count as that of the employer for this purpose. ... The obligation to carry out a reasonable investigation as the basis of providing satisfactory grounds for thinking there has been conduct justifying dismissal necessarily directs attention to the quality of the investigation and the resulting state of mind of the person who represents the employer for that purpose. If the investigation was as thorough as could reasonably have been expected, it will support a reasonable belief in the findings, whether or not some information has fallen through the net.

3.10. Ladbroke Racing v Arnott held the statutory test of fairness is superimposed upon the employer's disciplinary rules which carry the penalty of dismissal. The case shows an employer who sticks rigidly to its procedures does not necessarily act fairly. In my view, the

"other side of the coin" is there may be circumstances where an employer does not stick rigidly to its procedures, but should still be held to have acted fairly, especially if there were good reasons for departing from written procedures.

3.11. There are two decisions of the Court of Appeal about appeal procedures which is my view could apply to any stage of the procedure . In Stoker-v-Lancashire County Council 1992 IRLR 75, the Court said a reasonable employer can be expected to comply with the full requirements of procedures set out in its own disciplinary code and any failure to do so is a matter that **may be taken into consideration** when judging the reasonableness of the employer's action. In Westminster City Council-v-Cabaj 1996 ICR 960 the Court said the relevance of an employer's failure to follow a disciplinary procedure is whether that failure denied the employer opportunity of demonstrating the reason is dismissal was not sufficient. This is a question for the tribunal to decide on the facts . A departure from the appeal procedure was held in that case not to render the dismissal unfair. I have little difficulty with these authorities because I do not think they conflict as often suggested. The question is always fairness not compliance with a written procedure. In this case HH Judge Shanks said *Mr Echendu was at pains to stress the detailed requirements of the various policies which the Trust had not followed, in particular MHPS. However, he did not really engage with the fundamental points raised or seem to appreciate that the mere fact that an employer has breached the express terms of a relevant policy or procedure does not of itself render a dismissal unfair for the purposes of section 98(4) of the Employment Rights Act 1996.*

3.12. The EAT in Afzal-v- East London Pizza Ltd held withholding the right to appeal may of itself render a dismissal unfair. In this instance however the right was not "withheld" ,only not afforded as promptly as the MHPS timetable set out. Mr Echendu said he would argue that **contributed to** overall unfairness. Another case about appeals Taylor-v-OCS Group 2006 IRLR 613 held the question is whether the procedure **as a whole** was fair. If an early stage was unfair, Smith L.J. said the Tribunal must examine the later stages " *with particular care… to determine whether, due to the fairness or unfairness of the procedures adopted, the thoroughness or lack of it of the process and the open mindedness (or not) of the decision maker , the overall process was fair notwithstanding deficiencies at the early stage* "

3.13. On the issue of whether the sanction of dismissal rather than an alternative is within the band of reasonable responses Retarded Childrens Aid Society v Day held if an employee does not appear to recognise he was wrong and is "*determined to go his own way*", it would be reasonable for the employer to conclude a warning, or further training, would be futile and it may fairly dismiss. Conversely, if the employee admits fault and offers to retrain it may be expected not to dismiss. The question I put at paragraph 3.6. above is doubly relevant.

3.14. The Court of Appeal in a conduct case, Whitbread Plc v Hall [2001] IRLR 275 said:
"… the requirement of reasonableness in s.98(4) .. relates not only to the outcome in terms of the penalty imposed by the employer but ***also to the process by which the employer arrived at that decision****. Accordingly, the employment tribunal should not simply ask whether dismissal fell within the "band of reasonable responses" but should also apply that test to the procedure used in reaching the decision to dismiss.*

3.15. In Polkey v AE Dayton Lord Bridge of Harwich said :
If an employer has failed to take the appropriate procedural steps in any particular case, the one question the Industrial Tribunal is not permitted to ask in applying the test of reasonableness proposed by section 98(4) is the hypothetical question whether it would

have made any difference to the outcome if the appropriate procedural steps had been taken. On the true construction of section 98(4) this question is simply irrelevant.
… but if the likely effect of the appropriate procedural steps is only considered, as it should be, at the stage of assessing compensation, the position is quite different. In that situation as Browne-Wilkinson J puts it in Sillifant's case
"There is no need for an "all or nothing" decision. If the.. Tribunal thinks there is doubt whether or not the employee would have been dismissed, this element can be reflected by reducing the normal amount of compensation by a percentage representing the chance that the employee would still have lost his employment".

It is clearly established the percentage may be a 100% if I am **wholly satisfied a fair dismissal would have occurred when it did** had a fair procedure been followed. . In Scope v Thornett, the Court of Appeal said even if it may be difficult to speculate on what might have happened had a fair process been followed that is no reason for a Tribunal to shirk the task of trying. In this case I have no difficulty, as I will explain in my conclusions.

3.16. Natural justice requires an employee should know the nature of the case against him and be told the important parts of the evidence upon which reliance is placed. Thereafter the employee must be given an opportunity to state his case and the decision maker must act in good faith see Spink v Express Frozen Foods. The rules of natural justice are explained in Khanum v Mid Glamorgan Area Health Authority. Slater v Leicestershire Health Authority [1989] IRLR 16 held the rules of natural justice do not form an independent ground upon which a decision to dismiss may be attacked, although a breach will clearly be an important matter when considering fairness under s.98(4).

3.17. Some breaches of natural justice are obvious. In Moyes -v- Hylton Castle Working Men's Club the right steps were gone through in convening a disciplinary panel to decide on a misconduct charge against a club steward. The panel included two officials of the club who were **witnesses** to the event, a breach of the rule of natural justice that no person should be a judge in his own cause. I appeared for the respondent at the ET when the law was that defects in procedure could be ignored if the result would have been no different. This was known as the British Labour Pump -v-Byrne principle. I called other witnesses and proved to the satisfaction of the ET the steward was guilty of the allegations against him so the outcome would have been the same. It held the dismissal was fair. The claimant appealed and when I appeared at the EAT arguing it was bound by the Court of Appeal decision in W.J.Wass -v-Binns which had approved the Byrne principle. Popplewell P. held , even before the judgment in Polkey was handed down, such was the obvious departure from natural justice, the ET decision could not stand, but on remedy it would be open to the ET to make no compensatory award. The case settled for a basic award only.

3.18. Strouthos v London Underground held the employee should only be found guilty of disciplinary offences with which he has been charged. An employee found guilty of , or sentenced for, something that had not been charged will not have received fair treatment. I see no difference in a capability case where several allegations figure. Pill LJ said

It is a basic proposition, whether in criminal or disciplinary proceedings, that the charge against the defendant or the employee facing dismissal should be precisely framed, and that evidence should be confined to the particulars given in the charge.

.. it does appear to me to be basic to legal procedures, whether criminal or disciplinary, that a defendant or employee should be found guilty, if he is found guilty at all, only of a charge which is put to him. What has been considered in the cases is the general approach required

in proceedings such as these. It is to be emphasised that it is wished to keep proceedings as informal as possible, but that does not, in my judgment, destroy the basic proposition that a defendant should only be found guilty of the offence with which he has been charged.

3.19. I differ from the view taken by the original tribunal that it is wrong to mention matters which could relate conduct when considering matters which relate to capability(as on the Sutton test it may not be clear which it is, and conduct may be **relevant** to the point made in Day) However, I believe it is intrinsically unfair that material should be put before a panel deciding whether to dismiss which is either of no probative value to the issues they have to decide or, worse still, prejudicial. This is especially so if the matter has been investigated and either no evidence found to take it any further, or a decision made the employee has done no wrong. Of the points the original tribunal found contributed to unfairness, this one troubled me most .It was mentioned by Mr Echendu but not as his strongest argument . I raised it of my own initiative and I will deal in my conclusions with the rival submissions.

3.20. Section 122 (2) of the Act says

"Where the tribunal considers that any conduct of the complainant before the dismissal (or, where the dismissal was with notice, before the notice was given) was such that it would be just and equitable to reduce or further reduce the amount of the basic award to any extent, the tribunal shall reduce or further reduce that amount accordingly".

4. Conclusions

4.1. I have no doubt the claimant has worked hard to reach a high level of competence in breast surgery. A fallacy in his approach to the concerns raised about him from 2009 onwards is his view that because he had performed well in the past, it proves he would always do so with no decline in performance. Any person's performance may decline. Although the issue for the capability panel, and for me , does not require a finding as to **why** that may have happened, logical explanations strengthen the reasonableness of any finding or belief that it had, so I will set out my views.

4.2. When the claimant started in Sunderland in 2007 Mr Rich was there. Mr Rich resigned in 2008 and the claimant became lead clinician in breast surgery. When Mr Surtees moved from colorectal surgery, tension developed between them over the issue of training in SNB. The claimant started to become unhappy in his work environment. In March 2010 the Overbeck incident occurred. It is not irrelevant to my considerations in that it shows the claimant, when he feels disrespected, as he rightly did, responded by retaliating. It was a matter the capability panel rightly disregarded.

4.3. In May 2010 the complaint which came from Gateshead to Prof Boobis included the claimant's attendance at and **conduct in** MDT meetings, **management of patients after MDT decisions** and intimidating behaviour. Mr Martin was the case investigator and although he recommended "no case to answer" due to lack of evidence, I believe he, perhaps rightly, felt there was "something to" the emboldened allegations.

4.4. The claimant, having spent most of 2010 on suspension, returned to work at the beginning of 2011 disenchanted with his employer. There are several reasons why a person who has performed to the highest level may cease to do so. Ill-health was ruled out by an OH referral. Another reason is disenchantment with one's management at work. Another is workload. The more procedures have to be performed in a given time, the less time there is for each, and, even if clinical outcomes remain broadly satisfactory, record keeping,

especially with a lack of secretarial support, may suffer. Also , finding time for meetings and listening to the views of colleagues is harder, which may result in others perceiving the claimant as having no inclination, rather than not enough time, to listen.

4.5. in 2011 and early 2012 there were high infection rates. This was spotted by Nurse Derbyshire. The 2011 RCS audit showed good results at Sunderland but the "small audit" covering mid 2011 to March 2012 showed a problem. It could have helped show any increase in "complications" was due poor post operative care on the ward. However, the claimant saw it as a criticism **of him** and directed Nurse Derbyshire in March 2012 not to share her concerns with anyone else.

4.6. In March 2012 Mr Surtees left. The claimant worked even more and, in my view, became **autocratic (**a word of Greek derivation meaning " ruling one's self") . He believed decisions about what was best for the patient were **his** to make. He says in his statement " *It will be unusual for me not to adhere by* ***my own surgical decision*** *because I worked as lone surgeon*". That betrays a fundamental misunderstanding of the role of the MDT. The words I emboldened in 2.104.2-4 show he sets little store by the opinions of those he regards as less qualified, including the breast nurses, Mr Holtham and Mr Clark. In September, when Nurse Derbyshire raised her audit, she added to her concerns " lack of challenge" at MDT meetings since Mr Surtees had left.

4.7. In July 2012 Mr Holtham became clinical director. In September Dr Wright made a disclosure to him of the **same type of behaviour** as had been alleged in May 2010. Also at that time Nurse Derbyshire disclosed her audit to Mr Holtham. He asked the claimant to do an audit of his own. The one produced in January 2013 was not good enough. It took until April 2013 before one was presented, compiled by his registrar. As Ms Griffin agreed, Mr Holtham could have taken swifter more decisive action. Mr Sweeney submitted it cannot be unfair to allow a senior consultant time to examine his own practice rather than intervene more proactively. I agree doing so was within the band of what a reasonable employer would do. **With hindsight,** earlier positive action would have been better.

4.8. At this point in time, had the claimant accepted his standards may be falling but explained why, remediation would have been eminently possible. One of the difficulties the claimant has is that he views criticisms of outcomes of surgery in which he is the lead as personal criticisms of him, and denies there is a problem. That certainly was how he came across to the people tasked with investigating his professional competence at a later stage.

4.9. At the beginning of 2013 Mr Martin took over as Medical Director. I found him to be a meticulous man who takes the roles he holds very seriously and does everything "by the book". That is not a criticism. However, in contrast to the way matters had been managed earlier, it appeared to the claimant Mr Martin was against him.

4.10. On 25 April 2013 Dr Jenny Connor, the radiologist on the Sunderland MDT, contacted Mr Martin. The allegations were **similar to those raised before**. Only when Mr Martin spoke to Mr Holtham did he learn about the concerns raised earlier by Dr Wright and Nurse Derbyshire and the audit prepared by the claimant's registrar.

4.11. On 23 May 2013 Mr Martin told Mr Holtham to do a preliminary fact find but he was not formally appointed as a case investigator under MHPS. HR were informed, as were NCAS. Even if this course was not what MHPS prescribed, it was within the band of what a reasonable employer would do.

4.12. When the registrar's audit was produced, it took until June 2013 for Mr Holtham to realise he did not have the expertise to interpret it. That is why Mr Clark became involved. There had been some tension between the claimant and Gateshead about the repatriation of Sunderland patients for treatment. I do not accept Mr Clark was biased against the claimant, still less that he expressed " false" views in order to get rid of the claimant for fear that when the units amalgamated the claimant may obtain the lead position. Even more unlikely is any conspiracy between Mr Surtees, Mr Martin, Mr Holtham and Mr Clark. Using Mr Clark was within the band of what a reasonable employer would do.

4.13. On 18 June the Milan trip incident came to light. The claimant had a perfectly innocent explanation. On the next day an allegation was made that he been seeing private patients in NHS time. Counter fraud became involved. On both allegations there was simply **no evidence of any lack of probity** on the claimant's part. Neither matter should have been referred to again after that was decided. The issue of speeding penalty points arose in late June/ early July. It had nothing to do with the claimant's competence. It could paint a prejudicial picture of the claimant as having a lax approach to keeping to rules about notifying matters to the Trust, but had no probative value. At a time he was having a satisfactory appraisal from Mr Vetrivel, the claimant's perception was he was the target of a witchhunt. I do not accept he was. These issues arose and could not be ignored but , coming one after the other in a short space of time , I understand the claimant's perception.

4.14. The 13 August was indeed, as the claimant says, a fateful day. There were three possibilities as to how the patient's breast was set on fire **(i) the claimant knew he was using an alcohol-based** solution and did not take proper precautions, (ii) **he thought he was** using an aqueous solution **but failed to check** and, had he done so, he would have realised it was alcohol, (iii) he thought he was using the aqueous solution and **no reasonable check would have revealed otherwise**. The line the claimant ran before the original tribunal and in his witness statement for this hearing that a conspiracy of what he calls "the trio" resulted in an alcohol-based solution being **decanted** into the type of bottle in which he kept an aqueous solution so as to entrap him into causing life changing burns to a patient is, as Mr Martin says, preposterous.

4.15. On that day although the whole operating list was cancelled the claimant did two more procedures. He must have been shocked after what had happened but he was the only person there to do it. Mr O'Dair spotted poor diathermy technique. It took some time before he put his concerns in writing. Less than two weeks later Mr Holtham observed the claimant activating the diathermy pen before it was in contact with the patient. It took until 18 September for Mr Holtham to put his concerns in writing fully. It came across loud and clear to me from Mr Martin's oral evidence he believes, perhaps correctly, the cause of the incident was (i) or (ii) above, not (iii) when alcohol solution and diathermy technique which led to "arcing" co-incided . If it came across so clearly to me, it probably did to everyone else with whom Mr Martin shared his views, including RCS, GMC and the capability panel.

4.16. Only a few days later on 19 August the claimant was told of Mr Clark's review. I wholly reject the claimant's argument the audit sent to Mr Clark was Nurse Derbyshire's audit because the numbers to which Mr Clark refers do not tally with it. On several occasions during this hearing, the claimant, or Mr Echendu on his behalf , appeared to be saying there was something intrinsically wrong in the claimant's complication rate not being compared with that of Mr Clark which would be as bad. Even if it was, the aim is good patient care, not equally bad patient care. The claimant says there was a failure to benchmark nationally or locally. I cannot see how this could have been of help to anyone. An easy way of avoiding complications is not to tackle difficult procedures. The claimant had almost all symptomatic

cases so his statistics would probably be worse. Only an expert in breast surgery can look at statistics, go to the patient's notes and see whether really there is an overestimation of the complications. That is exactly what Mr Clark suggested should happen **and it did**. I conclude it was reasonable to commission the RCS IR **even if it was in lieu of what MHPS prescribed**. No-one at the Trust had the specialist knowledge to investigate concerns and to recommend solutions, and anyone in the region may have their independence challenged by the claimant . Any procedural departure was within the band of reasonableness.

4.17. On 23 August the incident involving Dr Bhaskar arose but was withdrawn . However, the suspicion remained. In late August the claimant was suspended because of the suspicion regarding the account he had given to the RCA. This was never resolved either. The RCA into the 13 August incident did not report until November. It is of their report I have the strongest criticism. Whose "human error" and what " system failure" caused it to happen ? The RCA ducked the question, but certainly did not exonerate the claimant.

4.18. On 27 August Mr Holtham's report dealt with several matters, see paragraph 2.51. which should then never have surfaced again . It legitimately said the claimant's behaviour at MDT meetings was not professional though noted his colleagues sympathised as he was a sole surgeon. The last point covered was his **complication rates**. Throughout the internal process, the original Tribunal and before me, the claimant argued that if , on a true analysis, they were no worse than those of other surgeons , that should be the end of the matter . That is simply incorrect. The concerns about his autocratic approach to patient and treatment choice and receptiveness to the views of others had the **potential** to be harmful to patients.

4.19. Pending the RCS IR the claimant was restricted from all clinical practice. The original tribunal concluded that as only 20% of his surgical work was questionable, any reasonable employer at that time would, following the letter and spirit of MHPS, have restricted his practice in a lesser way. such as having him work under supervision by colleagues in general surgery to retain his basic skills. I respectfully disagree. The other concerns would still apply. Also at that time, the cause of the 13 August incident was not decided. I also disagree with the original tribunal's conclusion the respondent did not keep that restriction under regular and genuine review. I agree it went on for 20 months which made dismissal, which MHPS is designed to prevent, more likely. The question is why that happened. One reason is that from contacting RCS on 6 September 2013, it took until December for the visit and April 2014 for a final report to arrive. That delay was not in the control of the Trust.

4.20. The main thrust of the claimant's case put to the capability panel, the original tribunal and to me was the CHKS reports being "false" resulted in the RCS report being unreliable. I have rejected this for reasons already given in my findings of fact. The claimant wrongly believes they did not have, or look at, the third report , only the second. Even if they had, it does not undermine their conclusions. Classifying PIP implant removals as complications is unfair to all breast surgeons. In fact only one of the cases sampled by RCS IR involved such an removal. As Mr Martin pointed out any surgeon doing his job of record-keeping properly should be able to explain to the RCS panel, if statistics gave a misleading impression, why that was so. Prof Boobis provided the claimant with all the material with which to do so. At the claimant's insistence, the third report was run. If it had been omitted from the papers sent to RCS, he could have introduced it. I believe the claimant thought at the time he spoke to the RCS IR , he had no problems and no-one had the knowledge , or right, to require him to explain anything.

4.21. I reject the claimant's case that (i) the audit report presented to RCS was fabricated by Mr Martin and Mr Clark (ii) the CHKS report relied upon by RCS was fabricated by Mr Martin

in conspiracy with Mr Clark, (iii) RCS visitors simply believed it and (iv) the audit produced by Nurse Derbyshire was "*false*" and " *incited by Peter Surtees and Steve Holtham in conspiracy with Ian Martin*". I agree entirely with the original tribunal the RCS report was thorough. It highlighted genuine concerns. Although it contains many criticisms of the claimant, it also makes certain points in his favour for example that his workload was at the upper limit of what was manageable for a single surgeon and there was a lack of clarity and recording of MDT decisions.

4.22. The suggestion the RCS panel were hand-picked by Mr Martin and " sponsored" to produce a biased report is more than far-fetched. Even had Mr Martin been inclined to do so, it would, in my judgment, not have been possible. The report in its final form in April recommended a continued restriction from clinical practice but also made recommendations which the Trust were in no position to deliver. It could not force Gateshead to accept transfer of the breast service. It could not provide for the claimant an experienced mentor. I reject the claimant's argument Mr Martin prevented an NCAS assessment.

4.23. Upon reading the RCS report Mr Martin decided to contact the GMC. I find he had no choice but to do so. The decision to make an interim order after a full hearing when the claimant was represented by Counsel was not , and could not have been engineered by anyone at the Trust. The Trust was informed in June 2014 of the IOP restrictions .

4.24. Mr Martin believed the claimant's grievance in June was a distraction, remediation within the Trust was impossible and outside the Trust unlikely. I can see why he thought the Trust should proceed in June 2014 to a capability panel. Ms Griffin held him back and I can see why she did. The grievance had to be dealt with and remediation fully explored. Had the Trust gone ahead with a capability panel when the basis of the RCS report was being challenged , it would have been rightly criticised. When an employer is faced with a choice of one of two courses of action, neither of which is clearly right or wrong, the choice it makes will be within the band of what a reasonable employer would do.

4.25. 0n 7 August, Mr Martin had a meeting with the claimant and Mr Quick about the possibility of remediation elsewhere. Mr Quick was clearly trying to persuade the claimant to accept a share of the blame, advance mitigation for it but embrace the idea of remediation. That was not something the claimant wanted to do. In the hearing before me, he expressed dissatisfaction with the way he had been represented by Mr Quick, Mr Rowley at the capability panel and Counsel at the Interim Orders Panel.

4.26. This is the Retarded Children's Aid Society-v-Day point. The phrase used time and again by all the respondent's witnesses was "***lack of insight***". I conclude that was **the main problem**. What I had read and heard up to the end of the respondent's case, led me to expect the claimant to be, as he appeared to the people who dealt with him, **arrogant**. Even allowing for the nervousness of witnesses in Tribunal and that some may be " on their best behaviour" ,I did not find him to be so. I found a man who , to quote the RCS, was in *"a state of denial that the wrong choices have been made* ". He was not prepared to contemplate his high standards may have dropped, let alone that he bore any of the blame for that .That is my conclusion as to why he has presented his case as he has. When Mr Sweeney asked a question which focussed on what concerns the claimant did or did not accept may need to be addressed , the claimant avoided giving a direct answer.

4.27. I agree by the time remediation was considered in August 2014, the chances of it being successful were remote but only partly due to delay . The claimant's non -acceptance was

the larger obstacle. The steps by Mr Martin in August- September 2014 were, said the original tribunal, " *taken **half-heartedly and begrudgingly** and because he had been told to do so rather than from any **genuine desire** to seek to achieve a successful remediation*". I disagree with the emboldened words. I conclude Mr Martin seriously doubted that, even if a person could be found to supervise the claimant, remediation had any prospect of success because the claimant was not accepting any fault. Mr Martin embarked on finding a placement with little enthusiasm, but he tried and found no help was offered.

4.28. By September 2014 I believe Mr Martin was right to say a capability panel had to be convened, but I also see why Ms Griffin advised a review. Again the Trust was faced with a two courses of action, neither clearly right or wrong, and its choice was within the band of what a reasonable employer would do. Dr Fenwick's report should have killed off any need for the capability panel to consider the claimant leaving Wednesday clinics early , the Milan trip ,his driving record, the matter raised by Dr Bhaskar and referrals of "cosmetic" patients to Gateshead. There is no doubt the review delayed convening a capability panel. A "procedure" starts when the investigation starts and ends when the employee's fate is finally decided. I agree the procedure lasted 20 months during which he could not practice as a surgeon but not that the delay **led** the capability panel into dismissing him. Some of the delay was caused by the claimant. Despite the length of the delay, there were reasons for it and I do not agree the actions of the respondent were outside the band of reasonableness.

4.29. A capability panel hearing was scheduled 24 March. I have no criticism whatsoever of the steps taken to pick an appropriate panel. I have differed from the original Tribunal's conclusions on whether acts and omissions of the respondent in the period before the capability panel were outside the band of reasonableness, and will return to why later. **If I had agreed with every word of its findings and conclusions, my decision on substantive fairness would have been the same.**

4.30. In the final analysis, the capability panel was faced with a surgeon of whom all of the evidence suggested he needed remediation, who was entirely unprepared to recognise that himself. The concerns set out in the dismissal letter went far beyond technical competence and complication rates. There was no consultant in the Trust who could undertake remediation and no one outside it prepared to do so. When I asked the claimant what else the panel could have done in the circumstances it faced at the time, he had no answer.

4.31. I also disagree with the original tribunal that any reasonable capability panel, faced with an experienced surgeon , and a practice described only as being "*below par"* not "*fundamentally flawed"* (the level MHPS identifies as demonstrating a standard of practice where remediation is not likely to succeed) should have given more detailed consideration to alternatives than was given . It considered all the possible alternatives including remediation elsewhere and redeployment within the Trust. That none of it was by this point practicable does not detract from the logic with which it was considered. The EAT held *the ET entirely failed .. to engage with the panel's detailed reasons for rejecting the alternatives to dismissal ("Remediation in Trust", "Third Party Remediation" and "Redeployment" to general surgery) which are set out in the dismissal letter of 24 April 2015. In my view that failure makes it clear that the ET did not properly focus on the reasonableness of the decision: that is an error of law by the ET which means that the conclusion on unfair dismissal cannot stand…."* The original tribunal also said the claimant was, since dismissal, being remediated by Prof Drew. The claimant never suggested him as a person to help at the time. If the claimant is prepared to take correction from Prof Drew it is because he looks up to him in a way he would not to anybody else the Trust could find to help, or even ask for help.

4.32. On the issues relating to substantive fairness I conclude:

(a) the capability panel genuinely believed the claimant's capability was such that he could not continue to do the job he had done and there was no other role as a Consultant General Surgeon within the Trust which he could do given the restrictions of the GMC

(b) there were reasonable grounds for the panel to reach that view. The RCS report was thorough and related to several aspects of the claimant's practice, not only complication rates, but behaviour at MDT meetings, note taking, patient and treatment selection . The panel fairly placed reliance on the RCS report, but relied on far more information including the GMC interim orders panel, and their own informed judgment .

(c) even if information provided to the RCS, GMC or the capability panel had been tainted by personal dislike, professional jealousy or even race, it was not the cause of the panel's decision. The claimant demonstrated to the panel, as he has done to me, he refuses to contemplate even the possibility that poor outcomes for his patients could be due to any failings by him. So even if there were things which the Trust could have done better in the past ,the decision of the panel, when analysed in accordance with McAdie , Day and Orr is unimpeachable.

4.33. Turning to the appeal the EAT held the original tribunal's decision that in failing to comply with the timetable for an appeal laid down by MHPS, the Trust acted as no reasonable employer would have acted and denied the claimant the opportunity to have the matter reviewed on appeal was perverse. It failed to take account of the very short timetable envisaged by the MHPS , the ,complications involved in assembling an appeal panel and , the perfectly plausible explanation for the delay put forward by Ms Griffin. I was completely convinced by Ms Griffin's evidence, largely because she and Mr Martin explained orally about MHPS referring to Strategic Health Authorities which no longer exist, that the merry-go-round upon which Ms Griffin and her PA were sent in order to find people to fulfil the functions of an appeal panel did take weeks, but unavoidably so .

4.34. I now turn to procedural fairness .I have nothing but praise for the way in which Mr Pattison **tried** to ensure a fair hearing took place. As I explained in 3.19 above I do not agree it was necessarily unfair to mention matters just because they could relate to conduct

4.35. I have a major problem with what happened immediately before and at the capability panel hearing. No matter how compelling the evidence of the claimant's decline in capability and "lack of insight" was, this was to be his last chance to save his job and career. Explaining why claims should not be struck out without a full and fair hearing, Mr Justice Megarry once said: *"the path of the law is strewn with examples of open and shut cases that somehow were not, and unanswerable charges that were in the event fully answered."*

4.36. Matters which should never have seen the light of day again were included in an enormous volume of documents running to nearly 1000 pages with which the panel members were provided. Ms Pattison spent about three days reading this in advance but did not meet with the other members and I do not know how much time they took to wade through the documentation. My concerns are twofold, prejudicial effect and distraction.

4.37. Starting with prejudicial effect, in this instance the departure from principles of justice is less stark than in Moyes but similar to Strouthos where an **implication** of greater wrongdoing than that which had been charged was introduced to the dismissing officer . Mr Sweeney said provided the steps of a fair procedure are gone through in the sense of the claimant being told the nature of the allegations against him given an opportunity to explain that is sufficient. He also submitted it cannot have been unfair not to put something as a charge which, had it been put and found proved, would have fortified the decision to dismiss

but if found not proved would not have altered the decision to dismiss. I respectfully disagree. The **potential** is that something not put as a "charge", but mentioned, is seen by the decision makers as a " distinct possibility" and informs their decision without the claimant having the opportunity to answer it.

4.38. My greatest concern is in respect of the incident 13 August 2013, and what, somewhat euphemistically, was called the claimant's "probity". The five page management statement of case produced by Mr Martin and presented by him to the panel dedicates the first half of the second page to these points saying "*the RCA investigators were unable to reconcile the differing accounts of events, so chose to concentrate their efforts in identifying the remedial processes in the systems of care within the operating theatres*" . It does not **say** it was the claimant's fault but the implication is (a) it was and (b) he had lied about it.

4.39. Added to that are passing references to other instances casting doubt on his " probity" –the Milan trip, not declaring his speeding penalty points , leaving clinics early to conduct private practice in NHS time, referrals of cosmetic cases to Gateshead. Also in a case where his relationships with colleagues was a major factor, three matters (the 2010 allegation , Dr Bhaskar and Mr Overbeck) all are mentioned. The overall effect is that matters which were either unproven or actually disproved but included in the material sent to the panel created the real risk they would form a preconception the claimant was a liar and/or an arrogant man who dominated his sub-ordinates.

4.40. Mr Sweeney was not expecting me to raise the point about extraneous matters. He answered the point at the time and , very properly, emailed the tribunal afterwards with a few additional points on which he said Mr Echendu should be allowed to respond. His email included that (a) many matters were in the papers before the panel because Dr Fenwick had been asked to consider them **by the claimant** including the Milan trip and driving licence (b) they were not mentioned in the management statement of case (c) Mr Martin confirmed they not relevant to the panel (d) the only reference to cosmetic surgery comes in the RCS report. Mr Echendu's reply Included the Trust and Mr Martin failed to put the capability panel on notice that certain conduct issues raised against the claimant had been decided and discarded **in order to cause prejudice**. I had not suggested that. He listed matters which should not have been included eg (a) intimidating behaviour regarding Dr Sensama which was investigated in 2010 and dismissed and in 2014 with Dr Bhasker which was never investigated (b) probity about his account of what happened on 13 August. Mr Echendu then says "*There is no way these would not influence the capability panel members that their decision would not significantly be vitiated by these aforementioned conduct issues above."* He then makes the assertion Mr Martin and Dr Fenwick *" **intended to deceive the capability panel** with several conduct issues rightly and wrongly raised against the claimant which were decided and should have been discarded* "

4.41. For reasons I give in paragraph 4.43., I reject the argument this was done deliberately to poison the minds and the panel. I accept Mr Pattison's evidence, in response to questions I put, that she and the other members ruled out of their considerations all these extraneous matters. I believe Mr Rowley represented the claimant well and is to be praised for making sure that the panel did focus on the real issues. However, the fact an unfair procedural step does not produce an unfair outcome does not mean I can ignore it. To do so would restore the British Labour Pump-v-Byrne doctrine disapproved by Polkey. I have agonised over whether I am thinking too much like a lawyer rather than the hypothetical "reasonable employer" but I do not think I am. Section 98 (4) draws attention to the size and administrative resources of the respondent. In Moyes -v-Hylton Castle Club they were very

small but the EAT held even they should have realised what they were doing what was wrong. This employer with all its HR support should too.

4.42. Even if material has no prejudicial effect , it diverts attention. On the issue of so called "background evidence" in race discrimination cases, Mummery LJ in Quereshi -v-Manchester Victoria University said : *Circumstantial evidence presents a serious practical problem for the Tribunal of fact. How can it be kept within reasonable limits? … The temptation for the complainant and his advisers. is to introduce into the case as many items as possible as material from which the ..Tribunal might make an inference that "racial grounds" are established. The respondent has to respond to the introduction of those items. .. The result of this exercise is that the parties and their advisers may* ***confuse each other (and the Tribunal) as to what the Tribunal really has to decide****; as to what is directly relevant to the decision which it has to make and as to what is only marginally relevant or background.*

4.43. The respondent probably included everything in the papers for "completeness" or because it wished to avoid the work of "editing" what they contained. However the effect on the claimant ,his representative, and the panel was they had to deal with matters with should not have been clouding preparation for and progress at the hearing Ms Pattison identified three issues which were not live. Mr Rowley was led to waste time on the Overbeck incident and the training period which followed it. Mr McKirdy was led to believe the capability panel would last half a day. Bearing in mind the seriousness of the charges and the possible consequences for the claimant it was always going to be far more than that. The predictable consequence was the panel did not conclude their deliberations and it was a month before they could. In the meantime they each did more research, especially Mr McKirdy. The original tribunal concluded " *The document produced by Mr McKirdy is brief and identifies the claimant's practice as "below par especially with regard to breast reconstruction". The document produced by Professor Kumar was a short email. These documents formed the basis of the discussions of the Panel which took place* ***without involving the claimant*** *on 24 April 2015, with Mr McKirdy joining by telephone, on the central and crucial questions of remediation of a "below par" practice. Given the importance of remediation, those matters were reasonably deserving of greater and more detailed consideration*." I broadly agree but add the excellent job done by Ms Pattison, who spent far more time on the case before and after the hearing than would be known to the claimant, would not give him reassurance he had a full and fair hearing.

4.44. I hold Employment Judge Buchanan and both non judicial members of the original tribunal in the highest regard. Yet I see the same errors which His Honour Judge Shanks identified. Having coped with several claims with differing burdens and standards of proof and all manner of improbable allegations, the ordinary unfair dismissal claim was where they went wrong. This illustrates how "*too much information*" can make decisions harder not easier. I have differed in some respects from those the original tribunal reached because having only one claim to consider, I have not been distracted . The danger at the capability hearing was that the claimant would be , and not have time to put his case properly . Also the panel **could** have "flown off on tangents" considering points which were of no relevance.

4.45. However, if there had been no prejudicial or irrelevant material and the claimant had all the time in the world to put his case to the panel, I am certain he would have maintained the case which he has done to this day. If I had agreed with every word of the findings and conclusions of the original tribunal, my decision on remedy would have been exactly the same, as I believe would their own decision. I draw this from paragraph 12.3 of the reasons which reads : " *Our decision on unfair dismissal means that at the remedy hearing we will*

give consideration to what would have happened had the respondent followed a reasonable procedure under MHPS. That will require us to consider embarking on a so-called Polkey exercise. In doing so we will take account of all the findings of fact we made in the judgment including-but not in any way limited to- the recommendations made by the RCS in their final report and the fact that the IOP made orders in respect of the claimant as this matter progressed. The Polkey exercise will involve consideration of whether a reasonable procedure would have led to different outcomes from the RCS and the IOP." I am certain it would not, which is why I make a 100% reduction to the compensatory award

4.46. The reason I make a 50% reduction to the basic award is that, although it is the responsibility of the employer to follow a fair procedure, the claimant is equally responsible for the panel being inundated with information they did not need and which touched on matters which were potentially prejudicial .

_____

TM GARNON EMPLOYMENT JUDGE

JUDGMENT SIGNED BY EMPLOYMENT JUDGE ON 22nd NOVEMBER 2018

NOTICE

THE EMPLOYMENT TRIBUNALS (INTEREST) ORDER 1990

Tribunal case number(s): **2500964/2015**

Name of case(s):	**Mr O Iwuchukwu**	v	**City Hospitals Sunderland Nhs Foundation Trust & Others**

The Employment Tribunals (Interest) Order 1990 provides that sums of money payable as a result of a judgment of an Employment Tribunal (excluding sums representing costs or expenses), shall carry interest where the full amount is not paid within 14 days after the day that the document containing the tribunal's written judgment is recorded as having been sent to parties. That day is known as "*the relevant decision day*". The date from which interest starts to accrue is called "*the calculation day*" and is the day immediately following the relevant decision day.

The rate of interest payable is that specified in section 17 of the Judgments Act 1838 on the relevant decision day. This is known as "the stipulated rate of interest" and the rate applicable in your case is set out below.

The following information in respect of this case is provided by the Secretary of the Tribunals in accordance with the requirements of Article 12 of the Order:-

"the relevant decision day" is: **26 November 2018**

"the calculation day" is: **27 November 2018**

"the stipulated rate of interest" is: **8%**

MISS K FEATHERSTONE
For the Employment Tribunal Office

INTEREST ON TRIBUNAL AWARDS

GUIDANCE NOTE

1. This guidance note should be read in conjunction with the booklet, 'The Judgment' which can be found on our website at www.gov.uk/government/collections/employment-tribunal-forms

If you do not have access to the internet, paper copies can be obtained by telephoning the tribunal office dealing with the claim.

2. The Employment Tribunals (Interest) Order 1990 provides for interest to be paid on employment tribunal awards (excluding sums representing costs or expenses) if they remain wholly or partly unpaid more than 14 days after the date on which the Tribunal's judgment is recorded as having been sent to the parties, which is known as "the relevant decision day".

3. The date from which interest starts to accrue is the day immediately following the relevant decision day and is called "the calculation day". The dates of both the relevant decision day and the calculation day that apply in your case are recorded on the Notice attached to the judgment. If you have received a judgment and subsequently request reasons (see 'The Judgment' booklet) the date of the relevant judgment day will remain unchanged.

4. "Interest" means simple interest accruing from day to day on such part of the sum of money awarded by the tribunal for the time being remaining unpaid. Interest does not accrue on deductions such as Tax and/or National Insurance Contributions that are to be paid to the appropriate authorities. Neither does interest accrue on any sums which the Secretary of State has claimed in a recoupment notice (see 'The Judgment' booklet).

5. Where the sum awarded is varied upon a review of the judgment by the Employment Tribunal or upon appeal to the Employment Appeal Tribunal or a higher appellate court, then interest will accrue in the same way (from "the calculation day"), but on the award as varied by the higher court and not on the sum originally awarded by the Tribunal.

6. 'The Judgment' booklet explains how employment tribunal awards are enforced. The interest element of an award is enforced in the same way.