**Case No: 1401505/2015**

# EMPLOYMENT TRIBUNALS

**Claimant:** M Shoukrey

**Respondent:** BMI Healthcare Ltd

**Heard at:** **Southampton** **On:** **23 & 24 May 2019**

**Before:** **EJ Housego**
**P Bompas**
**CL Date**

**Representation**

Claimant: Ms D Grennan, of Counsel, instructed by Porter Dodson
Respondent: Mr T Adkin, of Counsel, instructed by Eversheds Sutherland

# JUDGMENT

The Respondent is ordered to pay to the Claimant the sum of £920,302.

# REASONS

## Introduction

1. The Claimant is a consultant surgeon who brought claims against the Respondent and against Dorset County Hospital NHS Foundation Trust for detriment arising from making a public interest disclosure. The Claimant worked at both hospitals as did one of his colleagues, who was his line manager at the NHS Trust and Clinical Director at the Respondent. The claim arose from reports made by the Claimant to the Respondent on 18 February 2015 and 26 June 2015, and on 24 July 2015 to the CQC about that colleague. The reports concerned the colleague's operation performed on a private patient of the Claimant at the Respondent's hospital without notifying the Claimant. The Claimant considered that the procedure employed by his colleague was unsafe, and that his actions in operating without telling the Claimant were unprofessional. This report became a substantial dispute between the Claimant and his colleague. The colleague was long established at the Respondent, and complained about the Claimant. By reason of the dispute the Respondent withdrew the Claimant's right to operate at its hospital. The NHS trust also became

involved, because the two worked in the same team at the NHS Trust, and there was a full investigation into both the Claimant and his colleague. It is this chain of events that led to the claim being made.

2. After a hearing in October and November 2016 the Claimant succeeded in some of his claims (the others being dismissed). They were that the Respondent had subjected the Claimant to detriment arising from his public interest disclosure in the following ways:

    (a) by suspending him;

    (b) by continuing that suspension despite the favourable conclusion of Professor Ellis Downes' investigation report;

    (c) failing to adhere to its own "whistleblowing policy";

    (d) failing to provide the Claimant with valid reasons for his suspension and its continuation;

    (e) ignoring the Claimant's legitimate concerns over his treatment and treated him with disdain since the making of his protected disclosures;
    …

    (i) withdrawing his practising privileges thereby preventing him for undertaking surgery privately at any of the Respondent's 70 hospitals nationwide;
    …

    (k) failing to investigate the Claimant's concerns, adequately or at all, in respect of the matters raised by him on 26 June 2015 and, whether as part of his appeal against the withdrawal of practising privileges or otherwise thereafter.

3. The Claimant was restored to his practising privileges at the Respondent, but resigned them on 07 September 2016. It is accepted by the Respondent that the Claimant was nevertheless entitled to compensation, given the findings of fact and conclusions of the Tribunal. It argues for a short period only, based on an asserted lack of causation for long term loss.

4. A claim made against the Dorset County Hospital NHS Foundation Trust was due to be heard over 10 days from 23 July 2018, but was compromised part way through the hearing, before the Claimant had finished his evidence. The judge who chaired the first hearing in this claim has retired, so that a replacement judge (me) was needed. By chance I was the judge in the claim against the Dorset County Hospital NHS Trust. I saw no reason to recuse myself by reason of this, and after full disclosure of the circumstances there was no request that I do so.

**Remedy sought and the parties' contentions**

5. The Claimant seeks compensation for the lost private earnings he says he would have earned for the rest of his career as a surgeon, from age 41 to

70. He says that he now has no prospect of any private earnings, for the reasons that follow. He puts his annual loss at around £100,000. He claims pension loss in addition as the demands on his income (currently about £114,000 and about £100,000 at the time) are such that he cannot afford the 13% employee's pension contribution and so is not in the highly beneficial NHS scheme. He seeks aggravated damages as a separate head of claim. His schedule of loss, net of tax, exceeds £3,200,000.

6. The Respondent agrees that there is a loss to be compensated, but says that, rightly or wrongly, he had a damaged reputation by reason of matters at the Dorset County Hospital which would have reduced his earning capacity as the work comes by recommendation. It points out that the area of Dorset is relatively small in population (less than 300,000) and contends that there is not the possibility of earning such sums. It says that it is not possible to earn so much privately while also being a full time consultant. It points to some asserted inconsistencies in the contentions of the Claimant. It asserts that there are opportunities for the Claimant to undertake private work either by moving house, or working remotely and staying over after operating. It says there is downward pressure on fees paid which would result in a reduction of the likely future private practice, and a reduction in gynecological work at Winterbourne. It says career long loss is not justifiable, and that had the Winterbourne closed he would not just accept that he had lost his private income but would seek out other income, and the same should apply here.

7. The Claimant's case in more detail is this:

    a. He has real desire to make a career in private practice. His personal circumstances are such that his substantial income as an NHS consultant is not enough for him to meet his financial obligations partly as he has a former wife in Egypt by whom he has children whom he maintains, and visits.

    b. He lives within walking distance of the Dorset hospital. He has young children, and they live in a catchment area for much oversubscribed schools. His wife's mother has dementia and is coming to live with them. It is important to him to live where he does for these 3 reasons. Also he and his wife have lived in a village before and did not enjoy doing so.

    c. His children are now 4 and 2 and he will be 61 by the time they leave school, which will be too late to start private practice.

    d. He has to live within 30 minutes of where his patients are. That is a recognised rule for surgeons. The only private hospital within 30 minutes is Winterbourne clinic. The geography is such that there is only Bournemouth Taunton and Yeovil that can be contended as possibilities. All are beyond 30 minutes, if only just in the case of Yeovil.

    e. He has moved around the country gradually getting more senior posts and is now a consultant. Consultants tend to stay in post long term, and he should not be obliged (and would find it difficult) to

move to another area of the country.

f. BMI was the largest provider in the UK of private health care so there is limited opportunity for him anywhere.

g. There are great practical difficulties in having private practice far from NHS practice.

h. There is the *"Greenwood scheme"* for private work in the NHS but he had no work from that scheme at all.

8. The Respondent says:

a. There is an obligation to mitigate loss, and it is unrealistic to say that there is no prospect of no private earnings for the rest of his career, in the 20 years from now until he reaches 65.

b. Any loss should be confined to events in 2015, and in particular the period February 2015 to June 2015. There was no causative link between any of the losses claimed after that date: they are in reality based on the heads of claim that did not succeed.

c. That the Claimant may have personal circumstances that mean he cannot afford to join the pension scheme is not the fault of the Respondent and there should be no pension loss.

d. If there is pension loss, it is double recovery to claim both the 13% contribution he says he was prevented from earning and the product of that, the pension itself. At the very least, if there is a pension loss the cost to the Claimant of paying in to get that pension has to be deducted.

e. While one consultant at the Winterbourne earns a lot, most earn for more modest figures, and it is the latter who are the true comparators, not one statistical outlier.

f. On the merits, the matters that lead to any loss post date the matters found by the Tribunal to be public interest disclosure detriments.

g. If he relies on things that happened before he resigned his practising privileges he has, by analogy with constructive dismissal, waited too long before doing so, from June 2015 to September 2016.

h. The is a relatively small pool of people in the area with means to seek private health care.

i. The events of his employment and private practice meant reputational damage that (rightly or wrongly) would be damaging to the prospects for private earnings. At best he would have risen gradually to the level of most others, £15,000 - £25,000 a year.

j. If Winterbourne had closed down, the Claimant would have done something to try to get a private income – the situation is no different where he cannot work there.

k. The 30 minute distance level is for patients under the care of the consultant. Outpatient and day case surgery would not require overnight care. If such care was needed other consultants who worked away stayed in Airbnb or hotels. All he had to do, if he did not want to do that, was to limit his surgery to day surgery cases.

l. He had not discussed working at the Poundbury Clinic, on his doorstep.

m. If there was presently no opportunity some would open up with retirements. Or new clinics might open. Career long loss is not provable on the balance of probabilities. It is speculation to reimburse for longer than 5 years.

n. There is downward pressure on fees payable by insurance companies, and increasing competition within the market, and so pressure on the margins the Respondent can make which means the prospects for private earnings are not positive.

9. In reply, the Claimant says:

a. While he could work both in Yeovil and Dorchester if he moved between them there would be no point, as the reason the consultant does this is that there is not enough private work in Yeovil, which is a private wing to an NHS hospital.

b. Nuffield Hospital in Bournemouth is 25 miles away, and is 50 minutes drive. There is one consultant who works in both, but she has homes in both Bournemouth and Dorchester. It is not realistic to do both. The private hospital in Poole is a BMI hospital so not available to him

c. The Poundbury clinic is for IVF, and does not do operations.

d. He has used a level fee income for the future, only inviting increase by reference to a low level of inflation.

e. His family life is in Dorchester, with children aged 4 and 2 (and soon a mother in law with dementia living with them) and the reason he cannot work there is the public interest disclosure detriment, and he should not be criticised for not wanting to work away.

f. There is no lack of causation, as the matters found to be detriment clearly extend to the present.

> *"(e) ignoring the Claimant's legitimate concerns over his treatment and treated him with disdain* ***since*** *the making of his protected disclosures" and*

> *(k) failing to investigate the Claimant's concerns, adequately or at all, in respect of the matters raised by him on 26 June 2015 and, whether as part of his appeal against the withdrawal of practising privileges* ***or otherwise thereafter****."*

10. The Tribunal has considered carefully the very detailed and closely argued submissions of Counsel both written and oral and the evidence it heard. This evidence and those submissions are developed further below.

**Agreed matters**

11. There are some matters that are agreed, or nearly agreed. Injury to feelings is accepted as £30,000, and while the Claimant did not limit himself to that figure there was no argument put forward as to why it should be larger. The cost of earning a private income is between 20% and 25%. The loss for 2015 was agreed at £15,000 (gross – before the deduction of the 20-25% expenses). Winterbourne currently has a total fee level for work the Claimant might do of £110,000 - £155,000. There are some consultants who do £20,000 - £25,000 a year, and one at about £100,000.

**Evidence**

12. We heard evidence from the Claimant, and for the Respondent from Sarah Reynolds, a consultant obstetrician and gynecologist in Bedfordshire, Karl Hudson, its head of insurer relations.

13. The Tribunal has some observations about the evidence before it. There is no objective evidence available about the extent of private earnings of NHS consultants. The nearest there is was a report from the British Medical Journal of 20 September 2016 that there was a proposal that *"clinical staff would be required to declare their earnings from private practice and state whether they earnt (sic) less than £50 000, less than £100 000, or more than £100 000. This information would then be included on their employers' register…"* which is of very limited assistance, save that it indicates that a figure of £100,000 for private earnings is not fanciful. That was known anyway as Consultant A at Winterbourne earned at that level.

14. The Claimant had sought much disclosure of the earnings of the Respondent's consultants. The Respondent had not been willing to disclose much, even anonymised. There was a case management hearing on 22 March 2019 at which the Claimant's application for disclosure was dealt with. That application was unsuccessful for reasons that it is not necessary to go into. At paragraph 18 of the decision it is stated *"In light of the Respondent's (understandable) position within this application, it will clearly be difficult for it now to argue that the Tribunal ought to reject the Claimant's claim for lost earnings on the basis of evidential insufficiency."*

15. The Respondent does have a difficulty in giving full information. It knows what it charges for a full episode of care, where it is a package for which they bill. However often there is care provided after consultation for which

the patient is billed direct by the consultant, and likewise aftercare. The Respondent thought there might be some double counting in fees put forward by the Claimant. On day 2 of this hearing he produced a revised schedule (195C) the formulation of with the Respondent agreed. Over a 4 year period it showed Consultant A earning between £81,000 and £104,000 a year, Consultant C earning between £20,000 and £32,000 and Consultant E earning between nothing in the first year, then £11,000, £8,000 and £22,000 in the next years. One of the Claimant's colleagues had volunteered her private earnings in the last 4 years as £1,500, £17,000, £19,000 and £41,000. (All these figures are rounded.)

16. From this the Tribunal concluded that there is a vast range in private earnings. There are a variety of reasons for this, as Mrs Hudson explained. Some consultants do not want to do private work. Some want to do a lot. Some are constrained by availability of work, some by geography, as the 30 minute rule is widely regarded as an essential. Some are willing to travel and stay over when needed, some are not: some find staying over impacts adversely on the NHS role, which restricts their ability. Some find the market saturated, and so have to wait for retirements and then fill the gap. She said most consultants retire at about 60. She has a higher level of patients who seek a consultation – the *"worried well"* - than most, she thinks because she is female, but overall thinks that the private fees for obs and gynae consultants from surgery and from consultation are similar, about half and half. There are fewer operations but they pay more. Most cases are day cases and the longer the stay of a patient the more infrequent it is. Most issues with operations involve bleeding, and that is almost always soon after surgery, the likelihood diminishing as time passes after the operation. Almost all oncology work involves laparoscopy, but only about 15% of other obs and gynae consultants are expert in it. Although she is from Bedford there is no reason to think that her experience is atypical. She was a clear coherent objective and concise witness who did her best to assist the Tribunal. Although she was a witness for the Respondent she was not partisan, and her evidence was not materially challenged. It was helpful.

17. Mr Hudson is not a doctor: he is a manager, with a key responsibility for liaising with the insurers. He explained that after 2008 there was a very large reduction in corporate memberships of permanent health schemes which is only now recovering. Privately funded work pays more (as the insurers get a discount) but it is on the increase with many people choosing not to be insured but to set aside money they would otherwise pay in premiums so as to have a pot of money in case of need, or for other purposes if there is no need, relying on the NHS for anything really serious. There is a great increase in the number of competitors in the market. The Respondent is one of the biggest providers in the market, but this is at 17% not 70% (the Claimant accepted this). There are no plans to close the Winterbourne, but it is a fast moving market, and it is not a new facility, so it is not a given that it will be there for 20+ years. The new build hospitals go for a swift patient turnround to minimise expense. There is no other private hospital close to the Winterbourne. The nearest private hospitals the Claimant could work at are the Nuffield in Bournemouth and at Poole Hospital. There is a preponderance of day cases and outpatient surgery in this speciality. The figures for the Winterbourne are not easy to

read, because of one consultant who specialised in IVF, and who brought in a lot of work. He had now set up on his own, and so all that work had gone. Stripping out that effect, he agreed that the level of gynae work had remained reasonably stable over the last 4 years. He accepted that Consultant A had earned towards £100,000 or even more in a year. People in this area had a choice, as for many in Dorset the Bournemouth / Poole area was a reasonable choice. There was becoming an issue with GP referrals, as in negligence cases aggrieved patients now included a referring GP, so that GPs were now tending to suggest a list of names and making the patient choose. On line bookings at NHS hospitals likewise made the patient choose. While the Winterbourne did some NHS referral work it was only marginally profitable. It was the swift throughput new entrants who (emulating NHS procedures) who wanted such work. Again the Tribunal found Mr Hudson was a fair witness doing the best he could to assist the Tribunal.

18. The Claimant gave his evidence over most of day 1. While plainly he feels a great sense of injustice, he kept it firmly under control. On matters of fact the Tribunal found him a reliable witness, and on basic matters of fact there is remarkably little between the parties: it is what we make of the facts that is determinative, rather than there being issues of fact to resolve. The prime difficulty in fact finding is not dispute but paucity of available evidence upon which to base those findings and conclusions. The Tribunal relies on what all 3 witnesses said, and on common sense, this being *"an industrial jury".*

**Facts**

19. The evidence set out above is adopted as factually accurate.

20. There is an underlying factor in this case, which is that Consultant A was the line manager of the Claimant at his NHS hospital and a long established consultant at the Respondent. It was the actions of Consultant A that led to the Claimant making his public interest disclosures, and the consequences are set out in the liability decision in this case. Subsequently Consultant A was the subject of warnings from the NHS hospital and ultimately was dismissed by them. It appears that this was by reason of inter team relationships (that no one could work harmoniously with him, or the reverse) rather than for clinical reasons, but we expressly make no findings of fact other than to note that he was dismissed. He continues to work for the Respondent, which has taken no action of any kind as a result. Consultant A is now in his mid 60's. It appears that he now undertakes no work other than at the Winterbourne.

21. The Claimant is expert in laparoscopic techniques, with qualifications to show it.

22. The Claimant opted into and out of the NHS pension scheme twice before the matters relevant to this claim, and his contributions were returned to him.

23. The Claimant has now been promoted and his total remuneration is now well in excess of £114,000. He did not provide an exact figure. At the time

of the events it was about £100,000. Consultant A was his line manager: now he is at a level where he would be Consultant A's line manager.

24. There is no realistic possibility of private work at the Poundbury Clinic as it deals with IVF and does not have operating facilities.

25. Consultant A operated at Winterbourne most weeks, and earned his private fees working one day a week, with 4 days at the NHS hospital, which is what the Claimant works.

26. NHS consultants work on programmed activities, 10 a week at 4 hours each. If they do private work they have to offer to do one more programmed activity a week.

27. The consultant from Yeovil comes to the Winterbourne because there is not enough private work in Yeovil, which has a private wing to an NHS hospital.

28. The Greenwood project has not provided any work for the Claimant (or anyone else).

29. The expense factor for earning private fees is 23%. While the Claimant's wife acts as his secretary, the cost of insurance is 20% or so, and although the percentage diminishes with an increasing size of private practice, things such as hire of consultation rooms will inevitably mean that 20% is too low a figure.

## Conclusions

30. We take first and shortly the claim for **pension loss**.

    a. We consider that the argument of the Respondent that the personal circumstances of the Claimant which mean that he was not able to contribute 13% of his income into his pension scheme is not a reason to award compensation when he was deprived of the opportunity to earn that 13% at the Respondent's hospital is irrefutable. What is the cause of the Claimant not being in the scheme? It is that he cannot afford it even when earning over £100,000 a year.

    b. Even if we are incorrect about this there is another point not put to us by Counsel for the Respondent. It is that the Claimant now earns about 13% more now than he earned then. If he could not afford it then, he can now. He has no ongoing loss, as he can now afford to pay in to the scheme. We do not consider that we should adjourn the decision to invite representations on this point since we would not have awarded any sum under this heading in any event.

    c. The Respondent's double counting point is also correct, as if the contributions are awarded as part of the loss of income, and the pension loss as well, the effect is a contribution free pension.

    d. The Tribunal raised the possibility that there might be the

opportunity to buy back years of service, which the Claimant will be able to fund when he receives compensation. The Claimant thought not for defined benefits, although this could be done on a defined contribution basis. The effect of that is simply to invest money on a tax efficient basis rather than to reduce any loss. We assume that to be correct, but for the two reasons given it is not germane to our decision.

31. Future loss: principles.

    a. Any suggestion that the Claimant is in some way *"damaged goods"* with some sort of reputational damage or someone under some sort of cloud or that he would be regarded with suspicion on the *"no smoke without fire"* principle by referring GPs is wholly unfair. As Counsel accepted this could not be thought likely from the time that the Claimant was promoted. In any event all that GPs would have known at the time was that the Claimant was not currently accepting private work. He works full time, with 2 children now 4 and 2, and this was 2015: there could have been many reasons why the Claimant was not working privately, such as new children, and no reason why GPs should know he was having difficulty at work. This is plainly a submission with no weight at all, as Consultant A has been not investigated, but disciplined, and then dismissed, but yet has continued to earn very substantial sums in private practice with the Respondent.

    b. There is a virtuous circle with working as an NHS consultant, as there is contact with GPs who may then refer private patients. It should not be overstated for the reasons given by Mr Hudson.

    c. Consultant A is still earning over £80,000 a year despite now having no NHS connection, and so it is plainly possible to build (or at least maintain) a large private practice without an NHS connection

    d. The level of work at the Winterbourne for a consultant is not driven only by work referred by insurance, as personal referrals can be highly significant (such as the IVF consultant).

    e. The Claimant's expertise in keyhole surgery is likely to make him a desirable choice for private gynaecological work, as it is preferred by patients (and their partners) and only about 15% of consultants can offer this option. Notwithstanding Mr Hudson's point, this is a highly significant factor.

    f. The 30 minute rule is not one to be stretched – it is regarded as binding, and there is no hospital within 30 minutes of the Claimant's home or the NHS hospital.

    g. There would be no point in doing only consultations, as those consulting do so on the basis that the person being consulted can operate if needed.

h. The number of operations is in inverse proportion to the number of operations. The number of operations, particularly for a surgeon using laparoscopic techniques, that require an overnight stay is small, most being out patient of day cases.

i. It is not unreasonable to expect the Claimant to travel to Bournemouth or Taunton to work. He cannot avoid the obligation to mitigate his loss by asserting damage to family life. He has no right to work a couple of minutes from home, and so to be compensated for what he could have earned if he cannot now do so.

j. The Claimant could realistically expect to limit his case load to day cases only. While this might limit his earnings somewhat it would only be in a few cases that he would have to decline to operate, as most cases are outpatient or day surgery cases.

k. It is not unrealistic for the Claimant to undertake other cases if he wished, and to stay overnight on. Friday night (he working Monday – Thursday for the NHS) if he wished to do cases involving overnight stays.

l. One of the consultants works in Bournemouth and at the Winterbourne. As it is possible to combine NHS practice in Bournemouth with private work in Dorchester, logically the same is possible the other way round.

m. Consultant A is likely to retire in the near future. Mrs Hudson said that Consultants tend to retire at 60 and Consultant A is in his mid 60's. This has two consequences. The Tribunal considers that there would have been the opportunity to step into Consultant A's shoes sooner rather than later (so increasing his potential earnings). Secondly the Claimant's assertion that he will work until he is 70 is not one the Tribunal can accept (even if the Claimant has a financial imperative that may lead him to continue work when others might stop).

n. It is not a sound basis for assessing loss to assume that the Winterbourne will continue as it is for the next 20 years or more: there has to be the risk that it will not. There is probably a higher risk that the Winterbourne will close, as Mr Hudson spoke of a substantial reduction in the number of hospitals run by the Respondent. However two of the likely reasons for the Respondent ceasing at Winterbourne are that they sell it to another provider or that a competitor has opened up. In the first case the Claimant might be able to work for the company that took over (though perhaps not if Teresa Starling was tupe'd over). In the second example the Claimant could go and work for the competitor. The Tribunal put that risk at 5%, and reduce compensation accordingly, as any loss would then be for a supervening reason.

o. The Claimant assumes that his health will permit him to work full time as an NHS consultant and earn £100,000 in addition in private practice: this is hard work, and it is no certainty that the health of

the Claimant will permit this. There must be a chance that this is not going to be possible. There is no evidence on which to base this, and the Tribunal again takes 5% as the best it can do: making the total deductions to 10%.

p. While the income of Consultants varies year on year, all we can do it take what we think is the average likely figure.

**Application of the principles to the Claimant**

32. The Claimant would have stayed at Winterbourne as long as he was working and it was still operational. His speciality of laparoscopy would have led to a successful long term career as a private consultant, until the age of 65.

33. Consultant A is likely to retire fully in the next few years, and the Claimant was likely over the next few years to achieve earnings of £100,000 a year. The starting point is the figure of £15,000 in 2015. Others earn between £20,000 to £25,000 a year. Over the 5 years from 2015 to 2020 the Claimant would have increased his private income from £15,000 to £50,000 a year, and after the retirement of Consultant A to £100,000. Consultant A's fee income is now declining, so that would be a steady progression from £50,000 and £100,000, over the 5 years from 2020 - 2025.

34. Taxation and grossing up was considered in the hearing. We are grateful to both Counsel for taking a pragmatic approach. The Claimant's earnings are all going to be at 40%, as he is now above the figure where there is a regressive tax rate as allowances are lost, and he is not far short of the 45% tax band of £150,000. All his award will be taxed at 45% for this reason. We will award it all gross for that reason. While there may be a small amount by which the tax is higher for the portion of each year's income to £150,000 from the present figure, the Claimant was content for there to be no adjustment for tax, and this must be right, for we have decided that mitigation of loss would soon take the Claimant to an income at £150,000 or above, so all the compensation would be taxed at that rate. It seems unlikely that tax rates for the well off will fall, so the Claimant may well pay less tax by getting compensation taxed at 45% this year than if he gets it as the years go by. There is no rational basis to do other than order it gross.

35. The schedule of loss, and the counter schedule, each consider the effect of inflation, at varying rates, to increase any award. We raised the fact that there is a discount rate for personal injury of -0.75% because it is impossible to find safe investment with a return at the rate of inflation, low that that is. There is no longer a discount for early payment in such cases, but an enhancement. This is so complex a subject and the possibility of error of principle so large, that the Tribunal decided that in this case the fairest way to approach the calculation was to make no allowances for interest, inflation or discount rate. It will be for the Claimant to make what decisions he wishes for the investment or spending of the Tribunal's award and whether he is better or worse off that will be the result of those decisions. It would be different if the Claimant were a minor or

incapacitated, but he is fully able to take such decisions.

36. There are a variety of different years used – calendar, financial, and the Respondent's own financial year. As this calculation is an art not a science, there is a real danger of overcomplex arithmetic obscuring principle. We will use the years of the Claimant's age. He was born on 24 October 1973, which is near the end of the calendar year, so we will start from 01 January following: so in 2015 he is taken to be 41 all year.

37. The Claimant will, one way or another, make a private practice. We think, over time there is no reason why he cannot get to £35,000 a year. We take account of the fact that it will be the more difficult in another area with no GP connection, and that distance may constrain the amount of time he can spend working. With day cases we do nto see why he cannot operate every week on his day doing private work as does Consultant A. The operations do not take all day, so if he operated in the mornings and had clinics in the afternoons the 24 hours he would need to be within 30 minutes of the patient would be over by lunchtime the day after the operations, even for someone who had to stay overnight.

38. We accept that the Greenwood project has not been successful – as it involves little other then a fee to be dealt with in the same way and in the same place as an NHS patient but without the wait it is easy to see why. If you are going to pay, you might as well have all the trimmings like a private room, good food and visits whenever you like. The Claimant has lost out by something over £3,000 by reason of the insurance premium required. It was not sought to recover this (and it would not have been possible) but that the Claimant spent this much (when he does not have spare cash) indicates that he was committed to making it work.

39. In short, and with some adjustments, we consider that the submission of Counsel for the Claimant has a simplicity and directness that is simply irrefutable. It is that Consultant A is in his mid 60's. While he is earning a little less now (perhaps by reason of ceasing NHS work) he is still earning towards £100,000 a year. When he retires, as he is likely to do soon, there will be a gap for the Claimant to fill. He is eminently suited to do so with his laparoscopy skills and connection to local GPs and there is every reason to think that he would step into Consultant A's shoes and be very successful in a private practice in the well off area of Dorset around Dorchester, where there may be a defined catchment area but also no competition.

40. We accept the submission that it is not realistic to require the Claimant to relocate. Consultants relocate around the country to progress to consultant status and then tend to stay put. Mrs Reynolds' evidence was confirmatory of this, and that it was the consultant status that opened the door to lucrative private practice.

**Calculations**

41. We calculate gross then apply the necessary adjustments.

42. For 2015 it is accepted that the figure should be £15,000. This is subject

only to the 23% deduction for expenses, so **£11,550**.

43. For the years from 2020 onwards for 5 years we decided that the Claimant's income would grow from £15,000 to £50,000 a year. The average is £35,000 a year, so £175,000, less 23% = **£134,750**.

44. From 2020 to 2025 we decided the Claimant's income would rise from £50,000 to £100,000. That is an average of £75,000 for 5 years, so £375,000, less 23% = **£288,750**.

45. Until the claimant is 65, 2039, is 14 years at £100,000, so £1,400,000, less 23% = **£1,078,000**.

46. We decided that mitigating loss from 2020 would lead in 5 years to an income of £25,000 a year (the sort of figure the other consultants earn) in 5 years and in another 5 years to £35,000 a year.

47. For the first 5 years that is £25,000 x 5 = - £125,000 less 23% = **£96,250**.

48. For the next 5 years it is the midpoint of £30,000 x 5 = £150,000, less 23% = **£115,500**.

49. For the rest of his career, 14 years at £35,000 is £490,000, less 23% = **£377,300**.

50. Accordingly, the losses are

    a. 2015 - £11,550.
    b. 2016 – 2020: £134,750 - £96,250 = £38,500.
    c. 2021 – 2025: £288,750 - £115,500 = £173,250.
    d. 2026 – 2039: £1,078,000 - £377,300 = £700,700.

51. The total future loss to which we apply reduction is the figure from 2021. This is £873,950. We reduce this by 5% to take account of the possibility that the Claimant may not be able to work until age 65. That reduction is £43,698, taking the figure to £830,252, to which we add the figures for 2015 of £11,550, and 2016-2020 of £38,500. The total loss of earnings we award is therefore **£880,302**.

52. We have not made any reduction for the possibility that the Winterbourne may be closed by the Respondent, because it might be taken over by another operator, or may have closed because of the opening of a competitor, for whom the Claimant might work.

**Injury to feelings**

53. The Tribunal adopt the figure of **£30,000** suggested by both parties. As it was suggested by both there was no objective evidence or oral evidence, and no cross examination on the subject. There is no basis on which the Tribunal can or should do otherwise than adopt the figure.

**Aggravated damages**

54. The Claimant seeks an additional £20,000 in aggravated damages. Aggravated damages are for high handed or malicious actions that may worsen the injury to feelings. They remain compensatory not punitive. There is the danger of two awards for the same actions, or compensation for injury to feelings being duplicated. There is guidance on Commissioner of Police of the Metropolis v Shaw [2012] IRLR 291 and in HM Land Registry v McGlue (UKEAT/0435/11). The injury to feelings award accepted by the Respondent is high (with the figure well within the upper band, from 05 April 2019 £26,300 to £44,000 and originally £15,000 to £25,000.

55. There is no right to an apology, and it is not usual to award aggravated damages when a Respondent does not do so. It can occur, such as in HM Prison Service v Salmon [2011] IRLR 425 and in BT v Reid [2004] IRLR 327.

56. In this case the reason advanced is partly pre and partly post decision actions of the Respondent.

    a. It was the CEO of Winterbourne who was largely responsible for the detriment (and the 2 members of the Tribunal who sat on the liability hearing considered the wording of that decision a model of judicial discretion, meaning that they agree that that conduct was significant). When a person at the top of the management hierarchy discriminates against a whistleblower it is a matter of moment.

    b. That treatment was found to be deliberate.

    c. The Respondent's solicitors wrote to the Claimant's solicitor after the judgment, in particular a letter of 24 March 2017 (277). This refers to an account given to the GMC about the claimant as being factual and accurate (Consultant A had lodged a complaint about the Claimant to the GMC, and was supported by a letter from Ms Starling, which complaint was dismissed as not disclosing a matter in respect of which an allegation should be laid before the GMC's fitness to practise committee). It said that Ms Starling would not be apologising nor writing to the GMC about the matter. There was no on going relationship and so no action whether reference acknowledgement or announcement was necessary or advisable, and nor was it their practice. It was made clear that notwithstanding the considerable criticism of Ms Starling in the decision there was no action, disciplinary or otherwise to be taken.

    d. When Consultant A was disciplined (which was never the case with the Claimant) the Respondent took no action, a sharp distinction to the way the Claimant was treated. He had been allowed to continue completely unaffected by his dismissal by the NHS, which was an even starker difference in treatment.

    e. The Tribunal noted that the Claimant had settled his claim against the Dorset NHS Trust for no payment at all, but on the mutually

expressed understanding that both parties would work at a positive future working relationship.

57. The settlement of the other claim was, of course, 2 years after the liability decision in this claim, and after 2 years more experience of the Claimant's surgical work, but nonetheless it shows the Claimant to be a reasonable man, an impression of this Tribunal as was the recollection of the Claimant's conduct at the 2016 hearing. It was not down to him that the problems arose, but we accept the thrust of Counsel's submission that the consistent approach of the Respondent has been to admit nothing, apologise for nothing, remedy nothing, and to close ranks. On advice some matters of remedy have been accepted for this hearing and the Tribunal takes this into account. However the Tribunal also takes into account that the Respondent sought to portray the Claimant as someone who had reputation that was perhaps not all it should be and that this would affect his earning for the rest of his career. It was the Tribunal that pointed out that it was impossible to think so given the substantial promotion. This contention of the Respondent was itself part of and indicative of the continuing denigration of the Claimant by the Respondent showing why aggravated damages are appropriate.

58. Approaching this head of claim with caution, and giving full weight to the submissions of Counsel for the Respondent, the Tribunal did think that the combination of pre and post detriment matters do result in additional injury. The quantum claimed on behalf of the Claimant would give rise to overcompensation (it is not that the higher paid a person is the more the damages should be), and the Tribunal awards £10,000 aggravated damages.

59. Adding these together:

    a. Loss of earnings: £880,302
    b. Injury to feelings: £30,000
    c. Aggravated damages: £10,000

    The total is **£920,302**.

60. Finally we have reviewed all this holistically. We note the variance in consultant's incomes, and the variety of reasons why this is so. We note that the Claimant asserts that he cannot travel because he wants time with his family, but that £100,000 of income additional to being a full time consultant with a commitment of 40 (or 44) hours a week will undoubtedly take a lot of earning: but also that he has skills that will be in demand, and that Consultant A has been earning such sums for years. We have looked at the fluctuations in the overall income at Winterbourne for such services, but are satisfied that the figures show a consistency that makes this determination a realistic assessment. We have noted the Respondent's business concerns, but it is Mr Hudson's job to be aware of such concerns, and to deal with them. There is the likelihood of continued demand for gynecological private care in the area, and there is a steady reduction in procedures available on the NHS. Overall, we consider the award we have made is not overgenerous to the Claimant so as to be unfair to the Respondent, nor unfair to him by the making of unrealistic

expectations. If there was no Winterbourne Hospital the Claimant would have to do as we have suggested he should, and given his desire to have such a practice and his need for the income, if there was no Winterbourne he would have done similar to our indication of what he should do in mitigation. There are always ways to market a professional's services, particularly when the professional has, as does the Claimant, a particular skill that will appeal to patients of GPs, and is not widely available.

Employment Judge

_____

Date 28 May 2019