# THE EMPLOYMENT TRIBUNALS

**Claimant** **Mr J Chatterjee**

**Respondent** **Newcastle upon Tyne Hospitals NHS Foundation Trust**

**Heard at** **Newcastle Hearing Centre (via CVP video link)**

**On** **22-26 November 2021 and 3, 7 & 25 February 2022**
**Deliberations in chambers on 9 & 23 March and 14 April 2022**

**Before** **Employment Judge SE Langridge**
**Members** **Mrs D Winter**
**Mr I Curtis**

**Representation:**

**Claimant** **Ms Sophie Garner, counsel**
**Respondent** **Mr Robert Gibson, solicitor**

# JUDGMENT

(1) The detriments to which the claimant was subjected by the respondent were not done on the ground that he had made protected disclosures.

(2) The claimant's claim is dismissed.

# REASONS

## Introduction

1. This hearing was originally listed for five days in November 2021 following remission to a new Tribunal by the Employment Appeal Tribunal (EAT). The purpose of the remission was to rehear evidence limited to one question, namely whether there was a causative link between the public interest disclosures made by the claimant and the detriments to which the first Tribunal found he was subjected.

2. The first Employment Tribunal heard this case over eight days in April 2017 and having given judgment, it provided written reasons on 18 September 2018. These were corrected on 11 January 2019. It found (in paragraphs 10.1–10.6 of the decision) that there had been a protected disclosure, specifically at a meeting on 17 November 2016, where "the claimant amongst others raised patient safety". It went on to find that the claimant had been subject to detriments (paragraphs 12.1–12.10). Those findings were undisturbed by the EAT's decision and were not therefore questions for this Tribunal to re-open. Regional Employment Judge Robertson expressed a provisional view to the parties on 19 February 2020 that a new Tribunal should "re-hear the remitted issue ab initio, without relying on or being bound by the evidence and findings at the original hearing". He said this approach would "require the parties to lead evidence of primary fact about the issue". It was therefore necessary to rehear large parts of the case in order to form our own view about the question of causation.

3. We approached this difficult task by adopting the first Tribunal's findings of fact and supplementing them with our own following a review of all the relevant evidence.

4. A Preliminary Hearing took place before Employment Judge Sweeney on 24 April 2020 when the issues were reviewed and directions made. The scope of this further hearing was agreed and recorded in that order as follows:

   "6.1 The claimant having made protected disclosures on 15-16 November 2016 and on 17 November 2016, and having been subjected to detriment by the acts/deliberate failures to act as set out by the employment tribunal in paragraphs 6.1 to 7.3 of their written (corrected) reasons of 11 January 2019, what was the ground on which those acts and/or failures to act were done?

   7. There was some discussion as to whether there should be a reference to a 'prima facie' case having to be established and what, if anything, was meant by reference to that phrase by the EAT in the context of this claim, in particular to paragraph 56 of the EAT judgment. In the end, however, it was agreed that the tribunal which has to consider the issue should focus on the wording in section 48(2) ERA and that the tribunal should not be constrained by any possible interpretations of what is meant by 'prima facie' case.

   8. Section 48(2) provides in very straightforward terms that it is for the respondent to show the ground on which any act or deliberate failure to act was done. That

provision, unlike section 136 Equality Act 2010, does not concern itself with notions of burden reversal upon the establishment of a prima facie case. In a section 48 complaint of this sort, it is for the claimant to establish that he made a qualifying disclosure which was protected. However, that is not an issue on the remitted hearing. He must also establish that the acts were done (or not as the case may be in the case of a deliberate failure). That is not an issue on the remitted hearing. The only issue is, for want of a better word, causation. The burden of showing the ground rests on the respondent."

5. EJ Sweeney also noted that "the findings [of fact] of the original Tribunal in paragraphs 4.1–4.20 shall remain undisturbed".

6. The parties were directed to agree an essential reading list for the Tribunal, consisting "only of those documents which we needed to read in order to gain a sufficient understanding of the background and to make sense of the evidence to be adduced". On the first day of the hearing the parties invited us to refer to their respective chronologies to identify the key documents. Navigating the extensive paperwork proved very challenging throughout the hearing and the decision-making.

7. It was not possible to conclude this hearing within the time allowed in November 2021. The bundles were extensive and amounted to over 1800 pages. This included much of the documentation from the first hearing, though only a fraction of the documents were actually essential to the determination of the claim, and many were not in date order. Witness statements from the original hearing were made available to us as well as new statements from some of the same witnesses. The claimant gave evidence on his own behalf and called a former colleague, Dr A Sorial. For the respondent we heard evidence from Mr Peter Hodgkinson (former Head of Department, Plastic Surgery), Mr Michael Clarke (Clinical Director), and Mr Andrew Welch (Medical Director). Witness statements from the original hearing were read.

8. A further complication arose during the oral evidence, when the claimant raised concerns that the respondent's witnesses were giving evidence that was materially different from evidence given at the 2018 hearing. While a legitimate point, which if true might have impact the Tribunal's assessment of the evidence, it did cause some practical difficulties for our decision-making. The claimant was invited to prepare notes of the previous cross-examination for agreement by the respondent. Ultimately the parties submitted their notes and comments as part of their submissions.

9. Having run out of time in November, the case went part-heard until the first available dates in February 2022. The fixing of those additional three days was in itself problematic and last-minute changes were made with the agreement of all involved so as to enable a member of the Tribunal to attend a funeral. A later delay was caused by a sudden bereavement affecting another member of the Tribunal, such that deliberations in chambers had to rescheduled from mid-March and concluded on 14 April. Regrettably, this caused further problems with the writing up of this judgment. An explanation and apology for the delay was provided to the parties.

## Issues and relevant law

10. The first Tribunal found as a fact that the claimant made protected disclosures within the meaning of sections 43A and 43B Employment Rights Act 1996 (the Act) on 15-16 November 2016 and on 17 November 2016. The first Tribunal held that the disclosures made fell within section 43B(1)(d), in that the claimant disclosed information which he reasonably believed tended to show that the health or safety of patients was likely to be endangered by the introduction of a new on-call rota. The Tribunal also found that the claimant met the requirement for the disclosure to be in the public interest.

11. Findings of fact were made that the claimant was subjected to detrimental treatment by the respondent on twelve occasions, in that:

    (1) At a meeting on 8 December 2016 Mr Hodgkinson suggested to nurse Jo Taylor that she should contact Mr Clarke to see how her concerns about the claimant conduct towards nurses could be taken forward.

    (2) Mr Hodgkinson escalated an issue of the claimant having allegedly shouted at nurse Hayley Nevin on 13 December 2016 to Mr Clarke. He did so without making any attempt to verify Ms Nevin's account or speak to other people present.

    (3) Mr Hodgkinson presented the above issue as one of competence as well as communication, suggesting that the claimant was out of his depth.

    (4) Mr Hodgkinson presented his concerns about the claimant to Mr Clarke as being of sufficient gravity to provide reasons to investigate the claimant and/or restrict his duties.

    (5) Mr Clarke escalated Mr Hodgkinson's concerns about the claimant to Mr Welch which included an allegation of lack of competence.

    (6) Mr Hodgkinson and Mr Clarke failed to keep a record of what was reported by Mr Hodgkinson and how the decision had been reached to initiate an investigation and/or put in place restrictions.

    (7) An investigation was initiated and restrictions were placed on the claimant's practice.

    (8) Mr Hodgkinson and Mr Clarke devised the terms of reference for the investigation, taking its scope beyond the matters that Mr Hodgkinson and Mr Clarke had initially reported to Mr Welch on 14 or 15 December 2016.

    (9) Mr Hodgkinson and Mr Clarke proposed the initial list of witnesses to the case investigator in February 2017 excluding witnesses, which included Antony Sorial, who might have witnessed or had information about the claimant's interactions with Hayley Nevin on 13 December 2016.

(10) Mr Hodgkinson and Mr Clarke withheld from Mr Lees the statement of Mr Sorial which they had in their possession from December 2016.

(11) Mr Hodgkinson and Mr Clarke failed to review the restrictions on the claimant's practice, causing him to be deskilled.

(12) The delay in progress and completion of the investigation.

12. The legal issue for this Tribunal was therefore relatively simple: to decide on what ground(s) each detriment was carried out and whether in each case that was contrary to section 47B of the Act, which provides that:

> *A worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure.*

13. Section 48 of the Act says that where there is a complaint of detriment in contravention of section 47B:

> *[…] it is for the employer to show the ground on which any act, or deliberate failure to act, was done.*

14. We also took into account the key authorities relevant to this case, which were helpfully set out in Ms Garner's written submissions and are summarised in that part of this judgment.

15. Our findings of fact are detailed (though not intended to be a comprehensive account of all the evidence considered), because ultimately this case turned on its facts. The issue for us to determine, in relation to the twelve detriments, was who was responsible for each, what mental process took place in that person's mind, and whether the protected disclosures were more than a minor or trivial contributory factor in the detrimental treatment.

16. This meant that procedurally the task was not straightforward, as the case turned so much on a complex set of facts which had been aired over two separate Tribunal hearings several years apart. Aside from the sheer volume of evidence, and the need to reopen the case but without disturbing previous binding findings, we had to navigate a path through the voluminous written and oral evidence. We then had to review the previous findings of fact, and supplement those by reference to the evidence placed before us which led to our own findings of fact. From that starting point, our task then was to draw our own conclusions as to the reason why and the possible connection with protected disclosures.

**<u>Findings of fact</u>**

17. The claimant began working for the respondent NHS Trust on 2 November 2015 after responding to a vacancy advertised on 19 April that year. The vacancy was described as a "consultant plastic surgeon with a special interest in breast reconstruction surgery" and was based in a team of 14 consultant plastic surgeons at Newcastle's Royal Victoria Infirmary. The advert stated that the post "will have a

general plastic surgery on-call commitment which will include microsurgical lower limb reconstruction and a significant commitment to hand trauma". At that time the claimant had fairly recently been appointed as a consultant working in another Trust. He was dual-qualified as a hand and breast reconstruction surgeon and was attracted by the opportunity to develop his skills in both areas.

18. Following a successful interview, the claimant joined the plastic surgery department. This was headed by Peter Hodgkinson until he resigned that post on 6 June 2017. Mr Hodgkinson reported to the Clinical Director, Michael Clarke and he in turn reported to Andrew Welch, Medical Director. Both Mr Hodgkinson and Mr Clarke were on the interview panel and supported the appointment of the internal candidate, not the claimant. They had good and close working relationship from before the claimant's arrival in the team. The department comprised several teams providing a range of plastic surgery services between them. The claimant worked in the green team which specialised in breast cancer cases. His line manager was Joe O'Donoghue. The blue team were responsible for hand surgery and its members included consultants Nick Williams and Susan Stevenson. Most of the team had two registrars allocated to work with them, except the blue team which had three.

19. The claimant's appointment was a split decision with the Chair having a casting vote. He was preferred over an internal candidate, and was made aware of this from early on. Both Mr Clarke and Mr Hodgkinson were on the panel and were in favour of the other candidate. They accepted the outcome of the appointment panel but remained affected by their disappointment that the internal candidate, whom they knew, was not successful. Mr Williams and Miss Stevenson felt the same way.

20. The respondent provided the claimant with a job description which outlined the scope of the work. From the outset of his appointment the claimant was mainly responsible for breast reconstruction work as part of the cancer team. He also dealt with hand surgery as part of his on-call trauma work, and in those cases he would follow up with some elective work where needed. That changed when a new rota was later introduced, which had the effect of limiting the claimant's hand surgery to times when he was on call only. The claimant was, however, able to carry out some additional hand surgery work in private clinics outside the Trust. In effect, this meant that the "significant commitment to hand trauma" was limited to carrying out hand surgery when on call but not doing that work in elective cases.

21. At the time when the claimant was employed, the respondent operated a "Capability Procedure to Address Concerns Regarding Competence of Medical and Dental Staff" ('the Capability Procedure'). It was updated on 26 January 2017 though not in any material respect. The following extracts from the Capability Procedure are relevant:

"**Introduction and Aims**
1.1 The aim of the Policy and Procedure is to ensure M&D staff that do not meet requirements in relation to their capability are supported to improve and, if/where necessary, action is also taken in accordance with the procedure.

1.2 This procedure is an internal framework and the Trust reserves the right to adapt it to suit the needs of each situation. It may not be appropriate to follow each stage of the steps in turn or in the time frame proposed. The Trust will take each individual case on its own merits in determining the stage or manner of dealing with concerns relating to job performance."

**Action When a Concern Arises**

"4.1.1 The management of performance is a continuous process which is intended to identify problems. Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which need not necessarily require formal investigation or the resort to formal procedures.

4.1.2 Unfounded and malicious allegations can cause lasting damage to a doctor's reputation and career prospects. Therefore all allegations, including those made by relatives of patients, or concerns raised by colleagues, must be proportionately investigated to verify the facts.

**Framework for NHS Procedures**

4.2.2 All serious concerns must be registered with the Chief Executive or Medical Director who must ensure that a case manager is appointed and must designate a non-executive member of the Board 'the designated member' to oversee the case and ensure that momentum is maintained.

All concerns should be investigated quickly and appropriately. A clear audit route must be established for initiating and tracking progress of the investigation, its costs and resulting action. However the issue is raised, the Medical Director will need to work in consultation with HR to decide the appropriate course of action in each case.

**Protecting the public**

4.3.1 When serious concerns are raised about a practitioner, the Trust must urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Part II of this framework sets out the procedures for this action.

**Involving the NCAS**

4.4 At any stage of the handling of a case consideration should be given to the involvement of the NCAS [an NHS resolution service].

**Understanding the issue and investigation**

4.5.1 The first task of the case manager is to identify the nature of the problem or concern and to assess the seriousness of the issue on the information available and the likelihood that it can be resolved without resort to formal disciplinary procedures.

This is a difficult decision and should not be taken alone but in consultation with HR and the Medical Director. The NCAS can provide a sounding board for the case manager's first thoughts.

However, it is preferable that the first approach to the NCAS should be made by the Medical Director.

4.5.2 The first stage of any NCAS involvement in a case is exploratory – an opportunity for local managers to discuss the problem with an impartial outsider, to look afresh at a problem, see new ways of tackling it themselves, possibly recognise the problem as being more to do with work systems than doctor performance, or see a wider problem needing the involvement of an outside body other than the NCAS.

4.5.3 The case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed.

4.5.4 Where it is decided that a more formal route needs to be followed the Medical Director must appoint an appropriately experienced or trained person as case investigator.
4.5.5 The case investigator is responsible for leading the investigation into any allegations or concerns about a practitioner, establishing the facts and reporting the findings.

22. From early on the claimant experienced some problems with a lack of registrars available to work with him when on call. This was a problem affecting the department as a whole. In January 2016 the claimant reported that no registrar had been scheduled for his on-call rota. Rather than appoint a locum, Mr Hodgkinson offered to provide cover himself on the grounds that "locums are expensive".

23. In the early months of the claimant's appointment extensive negotiations took place between him, Mr Hodgkinson and Mr Clarke about his job plan. This was a usual process, but both managers took against the way the claimant handled it. They were annoyed about his involving the BMA in reviewing his job plan and frustrated by the protracted nature of the negotiations at this early stage of the claimant's career. In an email dated 3 February 2016 Mr Hodgkinson said to Mr Clarke: "The red mist has lifted now and I see what he has done", referring to the claimant's latest proposed changes to the job plan.

24. When asked to explain this in his oral evidence, Mr Hodgkinson said it did not seem correct to have someone working more than they were paid, referring to the calculation of programmed activities in the job plan. He said it was unusual for a doctor to refer to the BMA as the claimant had done. He then accepted that it was not unusual to have numerous meetings, but that happened more quickly in this case, and with BMA involvement.

25. In February 2016 the department held an away day when options were put forward for managing hand trauma cases in a different way, reducing the amount of elective hand surgery and requiring more flexibility from consultants to ensure cover was in place between elective and trauma cases.

26. By July 2016 the claimant had experienced further on-call shifts without registrar support. In an email dated 15 July to Mr Clarke, he recorded a conversation in which Mr Clarke had said he should reflect on why registrars may not wish to volunteer to work additional shifts with him. This view was based on information from a colleague which Mr Clarke was not willing to share with the claimant. He had not spoken to the registrars himself. Although Mr Clarke sought to discuss this email with Mr O'Donoghue before responding, it does not seem to have been followed up.

27. In his oral evidence Mr Clarke was asked about this email and said he "did not think it would assist the claimant to report gossip". He avoided answering questions about whether he and Mr Hodgkinson had discussed the issue, eventually conceding that they had.

28. In July emails were exchanged between the claimant, Mr Clarke and Mr O'Donoghue about the claimant's request for study leave for a wrist arthroscopy course. Mr Clarke queried its relevance to the service, and felt it was outside the scope of the regular practice of the department. In reply the claimant said he wished to refresh his skills. Mr O'Donoghue expressed the view in an email to Mr Clarke that it would be an unusual skill for a member of the team to have, but supported maintaining the skills if the department wished to move in that direction. He asked what the hand surgeons thought, and in his reply dated 12 August Mr Clarke commented that "Nick [Williams] & Susan [Stevenson] were very unenthusiastic". On around 11-12 August Mr Hodgkinson made a note for Mr Clarke on a Post-It note on the approval form, saying: "Wrist arthroscopy? The dept doesn't offer this treatment. He is a breast surgeon." They were not keen for the claimant to encroach on the blue team's work.

29. An incident arose on 9 August 2016 in respect of a patient known as patient Y. Mr Hodgkinson was contacted by Matron Sue Cook in his capacity as Head of Department, as a patient with a chest wound was to be transferred to Ward 47 from the Freeman Hospital. The claimant had been managing patient Y's care in the Freeman for some weeks and had spoken to Mr O'Donoghue, his line manager, about it previously. By the time the transfer was to happen, the claimant was on annual leave, though made himself available by phone to discuss the case on 8 August. Matron Cook was concerned because she understood none of the other doctors were aware of the arrangements. Mr Williams was on call and assessed patient Y at the Freeman. He recommended further surgery in the next few days and liaised with Mr Hodgkinson about this. In response to a message from Mr Hodgkinson, the claimant phoned him during his leave and they discussed the case. Mr Hodgkinson also raised it with Mr O'Donoghue in his role as the claimant's mentor and line manager. A few days later, on 12 August, Mr Hodgkinson made a file note summarising the events. The note recorded no explicit concerns about the claimant's handling of the case. No particular action was taken about this for some weeks, when Mr Hodgkinson emailed his file note to Mr Clarke, with a copy to Matron Cook, on 21 September. It was very unusual for such a note to be made.

30. The clinical notes for patient Y show that the claimant had input into the management of the medical care on 8 August. Following the transfer to the RVI, patient Y was assessed by a consultant anaesthetist as being at "very high risk" for

surgery, and so the procedure was delayed. The claimant continued to be involved in her care on 15 August.

31. When later interviewed during the formal investigation, Mr O'Donoghue provided his account of events. He confirmed that he and the claimant had spoken frequently about patient Y, some weeks before the claimant's holiday when the transfer of the patient was arranged by staff at the Freeman. He disagreed with Mr Williams' opinion that further surgery was needed. He expressed the view that the claimant had carried out a procedure which was "pioneering and difficult", in which he was trained, and had in fact saved the patient's life.

32. The claimant's appraisal meeting took place with Mr O'Donoghue on 18 August 2016. Overall it was a positive discussion, though it also covered some problems the claimant had experienced since his appointment. It noted that Mr Clarke was involved in discussions about a "resolution process".

33. The appraisal document noted some specific points relevant to these issues:

> "Knowledge, skills and performance
>
> [The claimant] demonstrates and provides strong evidence of a very sound and up to date knowledge base and skill-set in oncoplastic breast surgery and hand/wrist surgery […] There is strong evidence that his surgical performance is of an excellent standard.
>
> "Communication, partnership and teamwork
>
> [The claimant] clearly values the contribution of all team members in a holistic approach to patient care. His level of personal involvement in patient care is very high which the nursing staff have found difficult at times. Nursing staff on the plastic surgery ward have discussed this with [the claimant]. We have discussed how to balance his anxieties associated with being a new consultant and allowing the nursing staff to provide care within their level of expertise and competency.
>
> The claimant has felt that he has been undermined on a regular basis by colleagues within the plastic surgery team (outwith the breast team) since he arrived in Newcastle. He feels this relates to his appointment. A number of examples have been discussed including a recent report by the TIG Hand Fellow that she had been instructed by one of his colleagues that she should not receive Hand Diploma Tutorials from [the claimant] (which had already been arranged) because he is a breast surgeon. [The claimant] is an approved […] national Tutor for the Diploma in Hand Surgery.
>
> In contradistinction, the claimant has felt very supported/mentored and very much regarded as an equal member of the breast team. We have discussed the issues surrounding this undermining including the non engagement of the hand surgery team with him given that he has a skill set currently unavailable to the Newcastle plastic hand surgery service (eg wrist surgery including wrist arthroscopy and microsurgical wrist reconstruction). We have discussed the pressures within the breast team and the requirements to keep the breast reconstruction waiting lists

under control while at the same time this has been balanced with a discussion about ways that he may still be able to provide a hand wrist service to NHS patients in the North East so as to utilise his training and skill sets and not become deskilled. We have also discussed coping strategies to deal with any perceived undermining.

“Maintaining trust

The claimant has the trust of his patients. He understands that he will need to do a colleague and patient feedback once during each revalidation cycle. No concerns were raised about trust in this appraisal and the claimant clearly shows respect for his patients and treats both his colleagues and patients fairly and without discrimination. No probity concerns were raised.

“General summary

It is fair to say the claimant has had a difficult start to his consultant career which he feels goes back to his appointment. (This appraiser sat on his interview panel and has been his mentor.) We have discussed issues relating to communication with ward nursing staff and his sense of being undermined by colleagues. It is very clear that [the claimant] satisfies the GMP framework set out by the GMC in all domains and an appropriate PDP has now been set for the coming year. It is hoped that his second year as a consultant in Newcastle will be much smoother and that any outstanding issues will be resolved very quickly. This appraiser has been involved in discussions with [the claimant’s] Clinical Director [Michael Clarke] to help in the resolution process.

34. On 19 August a meeting took place between the claimant and Mr Clarke which the latter noted in writing, again an unusual step The meeting began with Mr Clarke saying the claimant had been “appointed in controversial circumstances”, that it was important to move forward and that he was “being treated fairly”. The case of patient Y was discussed, and the claimant explained his clinical handling of the case. He felt that Mr Williams had voiced his criticisms of this, as they had a difference of clinical views. The claimant had involved the wound care nurses on the ward, though Matron Cook felt he should have shown confidence in them sooner.

35. Mr Clarke noted that it was “important to draw a line under this case” but advised the claimant to “reflect that it may have been better to have had more conversations with senior colleagues” about patient Y. Mr Clarke further advised the claimant of the importance of having good relations with nursing colleagues, whom the claimant felt he was having to “tip-toe around” at that time. The relationship with hand surgeons was also raised by Mr Clarke, who emphasised that the claimant was employed as a breast surgeon. The claimant accepted this, and both men agreed that the hand surgeons were not keen for him to join them. Finally, the subject of the claimant working on call without registrar cover was discussed. Mr Clarke had suggested they were avoiding being on call with the claimant, and the latter disagreed, pointing to recent positive feedback. Mr Clarke invited the claimant to contact him if he had any concerns in the future.

36. In his oral evidence Mr Clarke said he formed the impression at this meeting that the claimant "felt stressed and under pressure, unwelcome in the unit and we needed to resolve that." He did not, however, take any steps to do so.

37. The claimant made his own note of the same discussion. In this he said Mr Clarke felt he was not being treated fairly in the unit, though Mr O'Donoghue was supportive of his work and clinical abilities. The note went on:

    "[…] it was unfortunate that I was suffering due to the fact that I was appointed in the interview and that this was not my fault. He wanted to draw a line under the turbulent start I had been given. He stated that I needed to be squeaky clean to offset the unfair approach being taken with him by Mr Hodgkinson."

38. The claimant's note reflected Mr Clarke's view that his hand qualifications "may be inflaming certain members of the team who see me as trying to edge into the hand team." The claimant explained that he had been given the impression on his appointment that this was an area he could develop.

39. In the discussion about patient Y, the claimant told Mr Clarke that Mr Williams had "been shouting in the ward" that he had performed the wrong procedure, in the hearing of the patient and colleagues. Mr Clarke had not been aware of this. He did not take any steps to follow this up with Mr Williams or ward staff. The claimant's note recorded that Mr Clarke would be:

    "speaking to Mr Hodgkinson and Mr Williams to lay off me. I said that I had been made to feel most unwelcome in this unit."

40. The claimant told Mr Clarke that there had not been any row with the nursing staff. He said that it was to be expected that he would care for his patients differently, as all his colleagues on the ward had come from the unit, a point which Mr Clarke agreed with. From the claimant's point of view, any issue was being "created" and "any suggestion from the matron that there were still issues was definitely factitious", meaning contrived or untrue.

41. The claimant's note finished by saying that Mr Clarke "confirmed a line was drawn and I should be free to do my work without persecution".

42. Later in the day of that meeting, Mr Clarke emailed his note to Mr Hodgkinson, saying he would be keeping it on file. His email opened with the words:

    "You may want to read this email on Sunday night holding something alcoholic."

43. When asked during oral evidence about this comment, and whether Mr Clarke was aware that he was unhappy with the claimant and the way he worked, Mr Hodgkinson said that was not correct. He denied that the reference to "drawing a line" arose because the claimant was not getting a fair crack of the whip due to the preference for the internal candidate. Mr Hodgkinson claimed to be unclear about what he had to draw a line under, and what Mr Clarke meant by giving the claimant a "fair crack of the whip".

44. The reference to "something alcoholic" was explained by fact that there had been a difference of opinion between two senior surgeons about the clinical management of patient Y. Mr Clarke had made Mr Hodgkinson aware that Mr O'Donoghue had also disagreed with Mr Williams' assessment of patient Y and the risks of the proposed surgery.

45. About the meeting that day with the claimant, Mr Clarke said in his email to Mr Hodgkinson:

> "Justin's clearly rattled and I think we need to draw a line, forget about Siva, make sure we give him a fair crack of the whip, and see what happens…"

46. By 19 August it was clear to Mr Clarke that the claimant was unhappy and "felt picked on by Mr Hodgkinson and others". Mr Clarke explained the reference to "drawing a line" in his evidence as meaning that the department needed to resolve disagreements and "try to get the best out of the claimant". He received the claimant's appraisal outputs in October and was aware of the his concerns about interactions in the department which he "wanted to explore". He knew the claimant felt undermined. Yet the respondent did not take responsibility for tackling the problem across the team, instead focussing attention on the claimant personally.

47. In the context of these email exchanges in August, Mr Clarke conceded that he had a perception that Mr Hodgkinson found the claimant irritating. He knew that Mr Williams was not happy about the situation with patient Y.

48. At the 19 August meeting Mr Clarke had agreed that the claimant could have study leave for the wrist arthroscopy course, but would have to pay the course fees himself.

49. On 13 September the claimant sought advice from outside the hospital about the fact that he would not be allowed to provide hand surgery tutoring, despite being dual qualified. This had been discussed at his appraisal in August. He had heard that a consultant had said "he is a breast surgeon". The reply confirmed that he was indeed qualified to tutor in this field.

50. Around five weeks after making his file note of 12 August about the issue with patient Y, Mr Hodgkinson emailed it to Mr Clarke, with a copy to Matron Cook. His covering email referred to there being an issue about the clinical management of the patient and the need to "make sure that the nursing staff on ward 47 were not presented with a patient for whom the responsible consultant was on leave". He concluded:

> "Please file the attached contemporary note with your other documents."

51. No such "other documents" were disclosed in connection with these proceedings, except the file note made by Mr Clarke (on 19 August 2016) and the two notes made by Mr Hodgkinson (on 12 August and 8 December 2016). They were not in the habit of making such notes but felt the need to do so on these limited occasions. No notes whatsoever were made about events later in December 2016.

52. On 24 October Mr Clarke emailed the claimant inviting him to "have a chat" about his appraisal outputs. The claimant replied to suggest meeting on 25 November. He then overlooked the appointment as he was caught up in another meeting. He apologised and asked for another date to be arranged.

53. In the meantime, on 26 October Mr Welch had provided a pro forma reference to a private hospital on behalf of the claimant, which he annotated with the words "No issues".

54. In November 2016 the new on-call rota was introduced as discussed at the away day in February. It had been proposed by Mr Hodgkinson in order to reduce waiting lists in the department. One of its effects was that the claimant would no longer be able to carry out emergency hand work while on call, as that would be left to the hand surgeons. Around a week after its implementation the rota was discussed at a Consultant Business Meeting on 17 November. This was attended by Mr Hodgkinson, Mr O'Donoghue, the claimant, Matron Cook, Miss Stevenson and numerous others. Mr Clarke was not there. As the Head of Department Mr Hodgkinson reported on the new trauma system. Concerns were raised by several people, including Mr O'Donoghue who shared and expressed some concerns the claimant had raised with him. He had been one of the first to work on the new rota the previous week. The respondent's minutes recorded the discussion, which had been fractious, and noted that:

    "Some consultants experienced difficulties while running full elective commitments and being on-call at the same time and concerns were raised about patient safety. Mr O'Donoghue stated that it has been recognised for some time that on-call and elective commitments should be separated citing the Royal College of Surgeons' 2007 publication and guidance. In the first week of the new system it was noted that the on-call consultant had difficulty managing an elective clinic when called to manage an orthopaedic case."

55. The on-call consultant in question was the claimant. In his first week working under the new rota he had been supported by a Senior House Officer not a registrar, and had concerns about patient safety. He had discussed these with Mr O'Donoghue on 15 November and sent him the RCS guidelines about separating emergency and elective surgical care which he had researched.

56. The meeting agreed that on-call consultants should reduce their elective commitments to registrar level where possible, and attendees were reminded that the system would be trialled initially for a six month period. Feedback arrangements would be put in place.

57. The information raised by the claimant directly to Mr O'Donoghue was found by the first Tribunal to amount to a protected disclosure by the claimant. The raising of the same concerns by the claimant or on his behalf by Mr O'Donoghue at the meeting of 17 November amounted to the second protected disclosure. Another complaint raised by Mr O'Donoghue on the claimant's behalf at this meeting related to his having to leave a patient consultation to undertake emergency surgery. This was the subject-matter of the third alleged protected disclosure which the first Tribunal did not uphold, as it was not an issue about patient safety.

58. Mr Clarke did not accept that there was any suggestion than the new rota created a risk to patient safety. He had not been at the meeting on 17 November and he said Mr Hodgkinson did not bring any such issue to his attention. He did not see the minutes until they were circulated on 17 January 2017. That day, Mr O'Donoghue emailed the consultant team, including Mr Hodgkinson and Mr Clarke, to request an amendment to reflect omissions from the minutes which did not record the RCS document that had been discussed, "nor has it recorded some of the other serious incidents I mentioned". Mr Clarke made enquiries as to the identity of the minute-taker but no action was taken to amend the minutes. As far as he was concerned, in the period before the minutes were received, no safety issues had arisen.

59. Mr Hodgkinson expressed the view that while he did not share the concerns raised at the 17 November meeting, he accepted that others had the right to express them. He also felt it was too early to judge the success of the new on-call rota until it had been trialled for six months as agreed.

60. On 5 December 2016 the claimant emailed Mr Clarke asking when it would be convenient to meet about the appraisal, and by a reply the following day the latter proposed putting the meeting back to January 2017. On 15 December the claimant emailed with some suggested dates, though in the event the meeting was superseded by events.

61. On 8 December Mr Hodgkinson met with Sister Taylor and Matron Cook on the ward, and made a file note. This recorded that concerns had been raised by Sister Taylor about the claimant's care of patients. Mr Hodgkinson noted that the concerns had been "ongoing for many months" and discussed at previous meetings. The respondent had made no notes of any previous discussions. In his later witness statement for the first Tribunal Mr Hodgkinson reported that Sister Taylor's categorised her concerns about the claimant as "undermining behaviour, lack of professional respect and management strategies that were significantly different" to other breast consultants. He said "it was felt that matters ought to be escalated to the Clinical Director" Mr Clarke by the two nurses.

62. At a staff meeting on 9 December Mr O'Donoghue raised an issue with the new rota in the claimant's absence, at his request. He felt that plastic surgeons should not be combining on-call work with elective clinics as it was disruptive to patient care. The minutes noted that he had discussed this with Mr Hodgkinson and referred to the NICE guidelines which suggested the two should not be combined.

63. On Tuesday 13 December 2016 an issue arose on ward 47 concerning the care of patient X. The claimant was responsible for the management of the patient and had left instructions that the wound dressing should not be changed until his return from theatre. He explained his rationale for this, which was to avoid exposing the wound more than once a day. Some nurses did not agree with the claimant's decision. They became concerned because patient X was showing symptoms of infection and were worried about him developing sepsis. The respondent's sepsis protocol was already being followed, and tests done. Unable to reach the claimant, Sister Taylor took steps contrary to his instructions, and changed the dressing after speaking with Matron Cook.

64. Dr Sorial was on duty when the claimant returned to the ward and witnessed an exchange between him and the nursing staff when the claimant questioned the fact that the wound had been re-dressed in his absence. Some nurses were visibly upset by the disagreement. They had legitimate concerns about patient X, given his high temperature and the possibility of infection. He said they had already started the 'sepsis 6' guidelines, taken blood and obtained test results.

65. Nurse Nevin later complained to Sister Taylor about the claimant shouting at her in front of the patient. Both the claimant and Mr Sorial disputed this account, but a difficult conversation did take place and it was not in dispute that some nurses were upset.

66. This incident brought matters to a head due to the involvement of Mr Hodgkinson. The claimant was described as "reprimanding" nurse Nevin, causing her "extreme upset and distress". These were his words and he in turn was relying on a report from Sister Taylor. Mr Hodgkinson and Matron Cook suggested that Sister Taylor raise her concerns with Mr Clarke. They expressed their "high level of support" for her and "all the nurses" on ward 47. Mr Hodgkinson said he felt he had "no choice" but to report it to the Clinical Director, because he himself was not the claimant's line manager. In his evidence Mr Hodgkinson denied advising the nurses to go to Mr Clarke about the communication issues but rather he "invited them" to do so.

67. This suggestion amounted to detrimental treatment towards the claimant, instigated by Mr Hodgkinson with the support of Matron Cook ('Detriment 1'). ET linked this together with detriment 2.

68. Sister Taylor provided a witness statement for the first Tribunal and attached to it several documents including a note about the events of 13 December. Her statement outlined some general differences between the way the claimant liked to work as distinct from the rest of the team on the ward, though it fell far short of accusing the claimant of bullying or anything similar. The incident on 13 December had occurred after she left the ward at the end of her shift. Sister Taylor was not therefore a direct witness to what happened. She relied on a phone call from nurse Nevin on the evening of 13 December, in tears. She made a note and said this was some time in the days after the incident, as she was so concerned, yet she did not produce it to anyone at the respondent until making her formal witness statement. The date when the typed noted was created was 27 September 2017, many months afterwards. It dealt with the clinical issues with patient X but made no record of the telephone call from nurse Nevin later that evening.

69. Mr Hodgkinson had a long conversation with Sister Taylor on the evening of 13 December followed by discussions with senior nurses on 14 December. This led him to suspect there was a clinical concern, though he did not review the clinical records or speak to the other consultant surgeons involved in the care of patient X, Ms Arshad and Mr Fearon. Both were later spoken to informally by Mr Clarke, though neither was asked to provide a written statement.

70. Mr Hodgkinson conceded that neither Matron Cook nor Sister Taylor had been present during the exchange with nurse Nevin. Mr Hodgkinson then had "a long

meeting" with Mr Clarke" on 14 December though later said he couldn't remember it being long. He made no note of this or any of the other discussions.

71. The following day, Wednesday 14 December, Dr Sorial visited ward 47 to ask how the nurses were. This is something he would expect to do. Mr Hodgkinson was there in conversation with Sister Taylor. Matron Cook was also there. Mr Hodgkinson requested that Dr Sorial provide a "note of events". He did not ask for an account of the clinical concerns or the risk to patient safety. Although in his evidence Mr Hodgkinson denied asking Dr Sorial to email him this statement, we did not accept that evidence. He said "I didn't want him to make a statement. It was a panicky response to an email I didn't want", meaning his forwarding of the email to Mr Clarke.

72. No records of the discussions between Mr Hodgkinson, Sister Taylor or Matron Cook were made. The information given to Mr Hodgkinson verbally about what had happened was provided only by the aggrieved nursing staff and he did not take any steps to investigate it with nurse Nevin directly, or with the claimant. No others were asked to provide a statement.

73. In oral evidence Mr Clarke said he spoke to Mr Hodgkinson on 14 December. He accepted that Mr Hodgkinson's concerns were not based on first hand knowledge of patient X, but the reference to the claimant's competency related to wider concerns. He said it was "primarily a nursing issue", though he felt that competence includes communication. When asked about the claimant taking on work outside his capability, when the only live issue was communication, Mr Clarke said that Mr Hodgkinson had voiced concerns and that he himself was not taking a view whether the claimant was competent or not.

74. Mr Clarke accepted that the conversation with Mr Hodgkinson was wider than whether the claimant had shouted at a nurse. He claimed not to have discussed restrictions with Mr Hodgkinson. He and Matron Cook expected him to do something because of the patient safety issue. He was aware that the claimant and Mr Hodgkinson did not get on. He did not think he was aware of the claimant raising concerns about the on call rota. We find that he did have knowledge of the general discussion on 17 November as a result of his briefing from Mr Hodgkinson, and knew that some consultants including the claimant had concerns about patient safety.

75. At some point on 15 December Mr Hodgkinson spoke to Mr Clarke about the issues and the latter then spoke to Mr Welch. The purpose of the conversation with Mr Welch was to obtain his authorisation to restrict the claimant's duties and remove him from the on-call rota. Mr Clarke's evidence to this Tribunal was that he was not then contemplating a formal investigation, but we did not find that credible. Mr Welch's oral evidence at the first hearing was that the decision had effectively been made by then. We agree. He also said that this conversation had been a lengthy one, yet neither he nor Mr Clarke made a note of it.

76. Much time was taken up during this hearing to try and understand the precise sequence of events that took place on Thursday 15 and Friday 16 December 2016. We have attempted to set out our detailed findings of fact on this sequence, though

the task was beset by inconsistencies and a total lack of any record-keeping on the respondent's part.

77. In oral evidence Mr Clarke said he had two conversations with Mr Welch, one at around 6pm on Thursday 15 December and the other at around 3pm on Friday 16 December. In the first conversation he expressed his concerns about issues raised with him by Matron Cook and Mr Hodgkinson. He did not contact Mr O'Donoghue before taking matters to a more senior level.

78. Mr Clarke said he had spoken to Mr Fearon and Ms Arshad by the time of the second conversation with Mr Welch and informed him of this. Both had been in surgery with the claimant but not witnesses to the interaction on the ward. Contrary to the respondent's previous case, Mr Clarke accepted that he spoke to Ms Arshad on the morning of 16 December. He did not remember her raising issues about nursing staff.

79. Ms Arshad provided a witness statement for the first Tribunal about receiving a message to call Mr Clarke on Friday 16 December. Before doing so she spoke to Mr Fearon, who told her Mr Clarke was investigating events relating to the claimant's involvement with patient X. After that she spoke to Mr Clarke and explained what had happened. He asked her specifically if she felt the claimant was "out of his depth". She said the first operation had not gone as well as expected, but she put this down to fatigue and stress. She felt the claimant had not had sufficient support. In this context, she agreed with what Mr Clarke put to her about the claimant being out of his depth, as she did not know what was causing him difficulties. In response to a direct question about whether the claimant had been undermined at work, she told Mr Clarke that she felt the nurses in the team did not accept his management plan, which she felt was a logical one. Mr Clarke did not ask her to make a written note of events.

80. When later interviewed in the investigation, Mr Fearon was not asked about being contacted by Mr Clarke on 16 December, and by the time he made a witness statement for the first Tribunal he had no such recollection. We accept, however that Mr Clarke did speak to Mr Fearon. Mr Clarke's evidence was that this happened at lunchtime on 15 December in person on ward 20. He too was not asked to put anything in writing.

81. Mr Clarke accepted that he did not keep a note of the conversations with Mr Fearon and Ms Arshad, but during his oral evidence he said they were saying the claimant was "stressed, isolated, out of his comfort zone and unsupported". He rang Mr Welch with his concerns. Mr Welch suggested that Mr Clarke arrange a meeting with the claimant, but Mr Clarke used the fact that the claimant had missed the appraisal appointment to suggest that he would not be willing to attend a further meeting with him. This was a misrepresentation of the case, but it persuaded Mr Welch to arrange a meeting between the claimant and himself.

82. When asked about this issue during cross-examination, it was suggested that Mr Clarke did not give Mr Welch the whole picture in implying that the claimant would not attend a meeting with Mr Clarke himself. In reply, he said "I accept that the claimant emailed me to try and rearrange", which did not address the question put

to him. He accepted that there was nothing urgent about the proposed meeting about the appraisal, saying it had been a long-standing problem almost from the outset. He had tried to resolve the claimant's concern about being undermined at the 19 August meeting, but then received the appraisal outputs in October. He was also concerned that the claimant appeared to be suspicious and mistrustful of him.

83. Mr Clarke had been involved in restricting duties on one previous occasion since becoming Clinical Director in 2016. Unlike Mr Hodgkinson, he accepted in evidence that he wanted Mr Welch to authorise the claimant's removal from the rota. Mr Welch advised him to speak to the claimant himself, but he said he had not attended the previous meeting, giving the impression that he did not think the claimant would attend this one even though there was nothing to suggest that was the case. On being challenged about this, he sidestepped responsibility and said simply that he had been "stating a fact".

84. In his written evidence Mr Welch referred to his conversation with Mr Clarke on around 15 December when the latter indicated there were "competency concerns" regarding the claimant. Mr Clarke relayed that Ms Arshad and Mr Fearon had separately indicated that the claimant was "out of his depth" and working on his own, suggesting that these two sources were independent of each other and ignoring the fact that these were the words Mr Clarke used in his direct questions to them. Working relations with nursing staff were "strained to the point of breakdown". Mr Welch felt that the claimant's request to bring a companion to the meeting suggested he was not keen to attend. If he "insisted" on bringing a representative, he could do so in the course of the investigation meetings.

85. Mr Clarke emailed the claimant at 18:13 on 15 December, copied to Mr Welch's PA, with the subject line "meeting tomorrow at 5.30". The content consisted only of the following:

> "The medical director, Andy Welch, wants to see both of us in his office at 5.30 tomorrow. Please confirm that you can come."

86. On 16 December at 14:29 the claimant replied (cc to Mr Welch) saying:

> "I am sorry I am unable to make that. Please can I defer this to a suitable time next week.
>
> I would like to bring someone to accompany me to the meeting. Could you please let me know what information you require so I can prepare in advance."

87. By this stage the claimant felt that some of his colleagues were against him, and he was understandably worried about what was happening.

88. On 16 December at 15:06 Dr Sorial emailed Mr Hodgkinson with his statement about the events of 13 December. He prefaced his message with the words "as requested". He outlined the support he had given the nurses looking after patient X, and that they had completed the 'sepsis 6' protocol together. He described the management of the wound dressing, and named two other doctors who had been present with the claimant when he reviewed the wound later. He noted:

> "During the review the nursing staff had voiced some concerns regarding the fact the dressings were not taken down earlier and that they believed Mr Chatterjee had said they could not take the dressings down without his permission.
>
> Mr Chatterjee was explaining to the nursing staff the rationale for this (so as not to expose the open wounds and fracture site more than once a day) at the bedside while he reviewed the patient's leg. There was some discussion between the nursing staff and Mr Chatterjee about this rationale at the patient's bedside."

89. Dr Sorial did not mention any raised voices, though he did feel that things "could potentially have been handled more positively".

90. At 16:03 on 16 December, Mr Clarke replied to the claimant's request to defer the meeting with the benefit of more information about it. Rather than agree to the claimant's request, he stated:

> "Sorry you aren't able to make the meeting today as it would have been helpful to have had a discussion face to face rather than by email and I've been away from the Trust today. I have to advise you that you are not take on any joint cases with specialties other than plastic surgery until further notice and are not to be on the on call rota until further notice. There are some concerns which we need to look into to inform a plan of how to take things forward and what support you will need. The Medical Director will be asking Mr Tim Lees to investigate these concerns and you will be able to bring a colleague or union representative to any meeting he asks you to attend. More detail will follow in due course."

91. Mr Welch said in evidence that he took the decision to investigate and put the claimant on restricted duties, partly because he failed to attend the requested interview.

92. On Monday 19 December at 14:16 Mr Hodgkinson forwarded Dr Sorial's statement to Mr Clarke, saying, "I asked him to send this to you but he sent it to me instead". Dr Sorial's statement was not emailed to Mr Lees until March 2017, but it was neither discussed with any witness nor included in his report.

93. In oral evidence Mr Welch provided further detail about the rationale behind his decision. He was influenced in his views about competency by the information relayed to him by Mr Clarke, though he accepted that this was not later borne out by the investigation. Mr Clarke gave him a "full run down" of his concerns. He set out all the information he had, which was a "significant" amount. It involved the management of patient X and chronic issues about trust between the claimant and his colleagues. Mr Clarke had not made him aware that Ms Arshad had disagreed with the nurses and provided them with national guidelines to explain the rationale for the wound management. He was also not aware that Dr Sorial had not supported the allegation that the claimant had shouted.

94. Mr Welch was not aware of Mr Clarke telling Mr Hodgson earlier in the year that they had to "draw a line" over past issues. He initially told Mr Clarke that they should have a discussion with the claimant, but this was not possible on 15 or 16 December.

95. Mr Welch claimed that the proposed meeting on 16 December was to be a fact-finding exercise to get the claimant's views on the concerns raised, and that he had no outcome in mind. We did not accept that explanation. When asked about going straight from the proposed informal meeting to a formal investigation, only because the meeting could not happen on that date, he replied, "It was partly because we had to bottom out the on-call arrangements for the weekend. There was also the impression that the claimant was not keen on meeting in the short term and that was important too. They were minor restrictions only and not uncommon. If there were acute concerns about patient safety, we cannot sit around and wait to the following week. If there had been an opportunity to speak to the claimant, the decision might have been different."

96. In answer to Tribunal questions Mr Welch said it was "fairly uncommon" to impose restrictions on practice and it had happened less than 10 times in his nine years at the hospital. He said "the bar is reasonably high, the threshold for restricting someone". We accepted this evidence and rejected Mr Welch's previous remark that restrictions were not uncommon as an attempt to downplay their significance to the claimant.

97. Mr Welch said he was unaware of the email exchange in which the claimant asked for more information and to be accompanied to the meeting. He made the decision following the telephone call with Mr Clarke when he was told that the claimant would not be attending the proposed meeting, so restrictions were put in place until they could discuss it further. Neither he nor any other witness checked to see when the claimant would next be on call.

98. Accordingly, Mr Welch went ahead with restrictions and a formal investigation in the face of information that was not yet verified, and in the absence of any discussion with the claimant based on the information Mr Hodgkinson and Mr Clarke provided him. In defending this on cross-examination, Mr Welch said, "I have to believe senior colleagues and why shouldn't I?"

99. Mr Welch conceded that there had been no discussion about taking an informal route prior to the investigation. He described it as a "question of pragmatism over process".

100. He said the claimant's competence was put in doubt because Mr Hodgkinson had presented the issue about patient X in this way, as well as being about communication. He and Mr Clarke had suggested to Mr Welch that the claimant was "out of his depth" and presented their concerns as being of sufficient gravity to warrant an investigation and a restriction of the claimant's duties. This was the subject-matter of Detriments 3, 4 and 5 as found by the first Tribunal.

101. We find that although it was Mr Welch's responsibility as Medical Director to authorise the appointment of the case investigator, he was encouraged in that decision by the steps already set in motion by Mr Hodgkinson and Mr Clarke which were in turn influenced by their strong antipathy towards the claimant.

102. Contrary to the Capability Procedure, the respondent:

- Took no steps to support the claimant to improve his capability.
- Took no steps to support the claimant to improve his clinical skills (if that were felt necessary) as a result of the incident with Patient X on 13 December.
- Did not consider any informal remedial or supportive action before problems were deemed to be serious.
- Did not consider the possible motives of the staff raising concerns about the claimant's handling of Patient X, in light of the known risk of causing lasting damage to his reputation and career.
- Did not consider whether the investigation and restriction of duties was proportionate.
- Did not ensure that the concerns were investigated quickly or appropriately.
- Did not create a "clear audit route" – or indeed any records whatsoever – for initiating the investigation.

103. On this last point, the first Tribunal found that "the appalling lack of record keeping" to show how the decision was made disadvantaged the claimant as he was unable to challenge the motivation of the respondent's witnesses. This amounted to Detriment 6 . The fact of the investigation being initiated, restrictions being placed on the claimant's practice and alongside this a lack of progress with the investigation formed the subject-matter of Detriment 7 as found by the first Tribunal.

104. In oral evidence Mr Welch accepted that there was no audit trail contrary to the Capability Procedure, conceded that he had no excuses for it and said it should have happened.

105. On 22 December the claimant met with Mr Welch to discuss the situation. He said Mr Hodgkinson was acting against him and that he felt the investigation would not be fair. The subject-matter was touched on by the claimant's email to Mr Welch on 30 December enclosing some data in the form of a Word document and Excel spreadsheet (neither of which was available to the parties to present to the Tribunal). The email also provided the claimant's appraisal outcomes and referred to "the issues we discussed that I have been facing since being appointed here".

106. In his witness statement Mr Welch said the claimant came to see him on 22 December for an informal discussion. The claimant said he felt picked upon because of the issues surrounding his appointment, but not because he had raised patient safety issues. In oral evidence Mr Welch said he had spoken to the claimant many times, and although the question of raising patient safety concerns was mentioned in his conversation with Occupational Health in January 2017, the claimant never raised such concerns with Mr Welch directly. The claimant did tell Mr Welch when they met on 22 December that he felt victimised but did not connect this to his raising patient safety concerns. Mr Welch had not seen the minutes of the meeting of 17 November when he made his decision as these were not circulated until January

2017. He was completely unaware of any live issue about patient safety caused by the new on-call rota. Any concerns would have been discussed at director level by all senior clinicians concerned. We accepted this evidence.

107. In December the claimant was signed off sick with a chest infection and he never returned to work after that. His sickness continued due to the anxiety and pressures caused by the investigation.

108. On 12 January 2017 the claimant wrote to Mr Welch with his concerns about the investigation. He thanked Mr Welch for opening up a direct line of communication, and reiterated his desire to return to work as soon as possible. He felt this was subject to a resolution of the circumstances. The claimant referred to the considerable stress and anxiety he and his family were under. He said "I am still not clear what the complaint or concern is that has led to the email I received on 16th December". He offered to meet Mr Welch at any time with a view to resolving matters quickly. This offer was not taken up and instead the formal investigation was left to run its course over many months.

109. On 18 January the claimant was assessed by Occupational Health whose report was issued on 23 January. It was sent, on the claimant's instructions, only to Mr Welch and the HR advisor, Tracy Mitchell. The report advised that the claimant was experiencing a reaction to:

> "ongoing concerns he has in relation to the working relationships within his directorate which he fears may be, at least in part, related to having raised patient safety concerns.
>
> Meantime he is able to meet with yourself to review the workplace concerns which, if resolved, would enable him to return."

110. Mr Welch did not arrange any meeting with the claimant, and neither he nor Ms Mitchell took any steps to review with him the ongoing restrictions on his practice. When asked about this during his evidence, Mr Welch said he understood that it related to the claimant's sickness absence, though the Occupational Health report of 23 January did say he was fit to attend meetings. He conceded that it was overlooked. Had the claimant return to work the restrictions would have been reviewed immediately.

111. On 27 January Mr Welch exchanged emails with the investigator, Mr Lees (Clinical Director and Consultant Vascular Surgeon), and Ms Mitchell, about the next steps. Nothing had been done in the weeks that had elapsed since Mr Lees was named in Mr Clarke's email to the claimant on 16 December. Mr Lees replied to say he had "heard a bit about this from [redacted name] and Mike Clarke" but he was not sure what to do or who else to speak to other than the claimant. Mr Welch said Ms Mitchell was to brief him. She replied confirming that she would draft terms of reference for the investigation.

112. On 7 February Ms Mitchell contacted the claimant by email, following receipt of a letter from Occupational Health. She confirmed that Mr Welch had asked Mr Lees to "look into the workplace issues raised within the Directorate and on that basis it

would be inappropriate for him to meet with you to discuss your concerns separately”.

113. Draft terms of reference were emailed by Mr Clarke to Ms Mitchell on 28 February. He began by referencing patients X and Y, then set out 9 items for the investigation to establish:

100.1 The range and efficiency of clinical activity and procedures carried out by [the claimant].

100.2 If these are within the normal range of a consultant plastic surgeon (with a special interest in breast surgery).

100.3 Whether [the claimant's] role in the management of patient X (jointly with orthopaedics) and patient Y with cardiac was appropriate.

100.4 Whether when managing patients (within the directorate or jointly with another directorate) [the claimant]:

- keeps colleagues appropriately informed
- seeks advice when it is appropriate to do so

100.5 Whether [the claimant's] working relationships with senior and junior colleagues are professional and constructive, and if not what can be done to improve them

100.6 Whether junior medical and nursing staff perceive the claimant] as bullying and undermining them.

100.7 The circumstances surrounding [the claimant] allegedly shouting at a member of nursing staff regarding patient X.

100.8 Whether [the claimant] is safe to be on call as consultant plastic surgeon to the major trauma centre.

100.9 Does [the claimant] have insight into his clinical and surgical ability?

114. A further point was added, as to whether the claimant was operating in the private sector while on sick leave. The respondent had no evidence that this was the case.

115. In mid-February an initial list of witnesses’ names was provided to a member of the HR team by Mr Hodgkinson and Mr Clarke. It included themselves, Mr O’Donoghue, Matron Cook, Sister Taylor and nurse Nevin, as well as Miss Stevenson and Mr Williams from the hands team. Other medical staff who were involved in the case of patient X were not on that list, namely Dr Sorial, Mr Fearon and Ms Arshad. Mr Lees treated this as a starting point and added to the witness list as the interviews progressed. After seeing the original list of names, the claimant proposed that additional people be interviewed, including Dr Sorial and Mr Fearon. Both were interviewed in connection with patient X.

116. On 1 March Mr Clarke emailed Ms Mitchell and Mr Lees sharing some questions he had been thinking about, in relation to the terms of reference, namely:

    - Is [the claimant] safe to be on call?
    - Is he effective and productive enough to function adequately as a consultant in this trust?
    - Why isn't he discussing / handing over complex patients with colleagues?
    - Are relations with junior medical and nursing staff sufficiently bad as to constitute a threat to patient safety?
    - What is it about this post? Prior to his appointment there was a turnover of 5 or 6 locum and substantive consultants over the past five years – at least one of whom had some trenchant things to say about the support she was given. How does that feed into [the claimant's] situation and is it resolvable?
    - Is there a probity issue?

117. Mr Clark also indicated he would send his "collection" of emails relating to the claimant separately. The emails provided to this Tribunal were but a handful.

118. The first Tribunal found that Mr Hodgkinson and Mr Clarke devised the terms of reference and took its scope beyond the matters they had reported to Mr Welch on 14 or 15 December 2016. This was the subject-matter of Detriments 8 and 9**.** In upholding these two detriments, the first Tribunal also found that Mr Hodgkinson and Mr Clarke proposed the initial list of witnesses to the investigator in February 2017 and that this excluded witnesses, such as Dr Sorial, who might have witnessed or had information about the claimant's interactions with nurse Nevin on 13 December 2016.

119. Professor Julia Newton, Associate Medical Director, was appointed as the case manager under the Capability Procedure, to oversee the case. On 6 March she wrote to the claimant confirming the investigation under the Capability Procedure & setting out the terms of reference. These adopted the wording established by Mr Clarke at the outset, with a number of changes leading to a total of 12 Items. The substantive changes were as set out below.

120. The concern about "efficiency" was removed from Item 1 and formed into a new Item 3, which read:

    > "Whether the time taken to complete [procedures] is within the normal range of a consultant plastic surgeon (with a special interest in breast surgery)."

121. Item 6, in which Mr Clarke had referenced "bullying", was reframed as Item 7:

    > "The perception of [the claimant's] interactions with junior medical and nursing staff."

122. The original Item 8, questioning whether the claimant was "safe" to be on call was reworded (now Item 9) to say:

    "Whether [the claimant] has the appropriate clinical skills and competences to operate safely as Consultant on call to the major trauma centre."

123. The original Item 9 (about the claimant's insight into his abilities) became Item 10:

    "What is the claimant's perception of his clinical ability including his surgical skills?"

124. Two additional points were added, both deriving from Mr Clarke's email to Ms Mitchell of 1 March with his additional questions. These were:

    "11 Whether the claimant has had sufficient and appropriate support as a new consultant in the Directorate.

    12 Whether the claimant has undertaken private practice during his current period of sickness absence."

125. The broader question posed by Mr Clarke in the above email ("What is it with this post?") was not directly included in the investigation remit.

126. The claimant was invited to a meeting with Mr Lees on 9 March in order to begin the investigation formally. A completion date within 4 weeks was identified as an aspiration, in keeping with the Capability Procedure, though Professor Newton also indicated that "the timescale may be a challenge". No explanation was provided to the claimant for why it took nearly 3 months for the investigation to get underway formally.

127. The interviews with colleagues who worked with the claimant presented a generally positive picture of him, with several people acknowledging the difficult start he had had in joining the department. One senior Sister felt the plastics team was "difficult to get into, with some very strong personalities". Another breast surgeon felt some empathy with the claimant because he had himself "felt similar when he came up to Newcastle; it felt insular and fixed in its ways".

128. The claimant was described as having good relationships with colleagues and liked by juniors. A fellow plastic surgeon described the claimant as "a very very decent guy and a good surgeon".

129. Beyond the report from nurse Nevin, none of the claimant's colleagues had ever heard him shout. He was considered to be quiet, conscientious, calm and not one to lose his temper. A senior Sister said he was "pleasant to the nurses" though he often talked about how he would do things differently in previous posts. A fellow breast surgeon who worked closely with the claimant said that the idea of the claimant shouting at nursing staff was "the most surprising thing he had ever heard", and was "massively outwith his personality".

130. A number of colleagues felt the claimant was sometimes slower in his pace of work, which could cause tension in the team, but no other reason was put forward for why registrars might not want to be on call with him. He was not the only slow surgeon and as a less experienced consultant, he had yet to establish himself. A registrar commented that the claimant had "his own ideas about things and wanted to keep all his own patients". He said that relationships with colleagues were "not brilliant" and he did not believe that communication was the claimant's strong point.

131. In his interviews with Mr Lees, Mr O'Donoghue expressed in unambiguous terms his views about the department, saying it was divided and badly led, subject to favouritism and that the claimant had been subjected to "sustained bullying". Mr O'Donoghue felt the claimant was "an acceptably slow operator" and "ultra-cautious" in his work. He referred to a covert investigation whereby a colleague had to report back to Mr Hodgkinson about a surgery carried out by the claimant. He gave some detail about what he described as "the strangest of recruitment experiences" when the claimant was appointed.

132. Patient Y was discussed, and Mr O'Donoghue confirmed that he and the claimant had spoken frequently about the case, some weeks before the claimant's holiday when the transfer of the patient was arranged by staff at the Freeman Hospital. Mr O'Donoghue disagreed with Mr Williams' opinion that further surgery was needed. He expressed the view that the claimant had carried out a procedure which was "pioneering and difficult", in which he was trained, and had in fact saved the patient's life. He also had no difficulty with his management of patient X.

133. Mr O'Donoghue told Mr Lees that "Mr Hodgkinson in particular has an agenda and it has to stop". He reiterated his and others' concerns about the new on-call rota which Mr Hodgkinson implemented in the face of disagreement and concerns about patient safety. This was in the general context of how Mr Hodgkinson treated others in the department, and he did not suggest that the claimant was singled out in this respect.

134. Mr O'Donoghue told Mr Lees that Mr Hodgkinson and Margaret Gray had been looking through patient X and Y's notes, "examining them closely" and were critical, which he believed highly inappropriate. It was Ms Gray who had suggested the claimant was carrying out private practice during his absence.

135. The interviews with Mr Fearon and Dr Sorial were brief and confined to the issues relating to patient X. Mr Fearon spoke of the clinical handling of the surgery by the claimant and Ms Arshad, which he felt was satisfactory overall though he was not aware of the detail. Dr Sorial spoke about the interaction between the claimant and the nurses on 13 December, saying the claimant had not been aggressive or raised his voice. He said it had been an uncomfortable conversation in front of the patient and he felt that the situation could have been handled better both on the part of the claimant and the nurses.

136. The negative comments about the claimant came from the people who had been instrumental in bringing about the investigation, namely Mr Hodgkinson, Mr Clarke, Matron Cook and Sister Taylor. Nurse Nevin also gave an account of the incident of 13 December, the only direct witness to this other than the claimant and Dr Sorial.

137. Mr Hodgkinson felt the claimant's slowness impacted negatively on others in theatre, due to surgeries overrunning into the evening. On the ward, nurses sometimes felt the claimant was being critical of them, because he liked to do things differently from his colleagues. He also failed to delegate at times. Mr Hodgkinson gave few if any examples of particular concerns. He said there had been "several discussions" with nurses on Ward 47 about the claimant and one discussion with the claimant about this, which Mr O'Donoghue conducted. He provided his file note of 8 December 2016 in this context. No other records were referred to.

138. Patient Y was discussed. When the Freeman made contact about the transfer, no one on Ward 47 or among the medical staff knew about the patient, whose surgery the claimant had carried out some weeks earlier. Mr Hodgkinson did not have any detailed knowledge of the case of patient X, except that a nurse had ended up in tears that day.

139. Mr Hodgkinson said the claimant had "difficult professional relationships" with consultants and some of the nurses. He "gained the impression" that some trainees did not want to be on call with the claimant, and they had been talked down to. No examples were given.

140. Mr Clarke's interview with Mr Lees was summarised in a brief record, reflecting that he felt other colleagues were better placed to answer some questions, including about working relationships. On this subject he had nothing to contribute himself. On the subject of patients X and Y, Mr Clarke similarly felt that this was best addressed by others. He did comment that he understood the claimant to have been "very helpful and attentive" in his management of patient X and that he and others had pulled together on the best way to manage the patient's injuries. He qualified this by saying, "however it emerged on hearsay that [the claimant] had been out of his depth." Mr Clarke said he had phoned Mr Welch to discuss his concerns, but did not identify where his information came from, nor make any mention of Mr Hodgkinson's role in the initiation of the investigation.

141. Mr Clarke sent Dr Sorial's statement to Mr Lees by email on 9 March. He did not refer to it in his interview because he did not think it was important. He felt he was a very junior doctor present at an altercation, but not in any position to judge competency issues. Mr Clarke was not particularly concerned about the issue with nurse Nevin. In oral evidence to the Tribunal he said:

    "If we restricted the duties of everyone who made a nurse cry, we'd get nothing done".

142. Matron Cook told Mr Lees that working with the claimant "had not been the easiest of relationships and he hadn't had the easiest of times". She described issues with the claimant wanting to retain control over his work and linked this to his unhappiness with the new on-call rota. On patient X, she felt poor communication had led to poor management of the situation. She had authorised Sister Taylor to redress the wound and the claimant had taken out his annoyance on nurse Nevin and had "shouted at her". Matron Cook had not, however, been a witness to this interaction on the ward.

143. Sister Taylor was asked about the claimant's performance and said he was slow, but this was based on "hearsay". She said his clinical competence and results were good, though he had very different ways of working than other consultants. Her own communications with the claimant had broken down after around 6 months following a discussion between them about their different ways of working. This was in around summer 2016. As for working relationships generally, she said the claimant was "from out of the area and didn't really fit in".

144. Sister Taylor was asked about the alleged shouting on 13 December. She had gone home at the end of her shift and did not witness the incident itself. She had left instructions for colleagues to deal with the dressing as she was concerned about sepsis. She felt the claimant was mistrustful of colleagues for no reason. Nurse Nevin had phoned her in tears to relay that the claimant had shouted at her.

145. Staff Nurse Nevin gave her own account to Mr Lees about this event. She had regular interactions with the claimant on the ward but not in theatre. She felt he could be "obstructive" and nurses did not feel he had confidence in them. Patient X had been cared for by the claimant and Ms Arshad. There was a disagreement about leaving the wound dressings in place, as she wanted to take them down due to oozing and a spiking temperature. The claimant was due back on the ward around 5pm but by then Sister Taylor had instructed her to change the dressings. When the claimant turned up, she said he "went ballistic, slagging me off" and shouted. He followed her afterwards to try and explain why he needed to access the wound himself.

146. The claimant set out a detailed written 'Case Summary' which Mr Lees incorporated into his report. In it he referred to the new rota implemented in November 2016. The changes meant that the claimant would not be able to cover hand trauma cases, which would be done only by the hand surgeons. He felt the rota was "pushed" in despite concerns regarding patient safety raised from some consultants, and furthermore that continuing elective commitments while being on-call was at odds with the national guidance from the Royal College of Surgeons. He referred to the meeting of 17 November 2016 when he disclosed safety concerns and referred colleagues to the RCS guidelines. The claimant did not in this part of his document alert Mr Lees to any connection between the raising of these concerns and the fact of the present investigation.

147. The claimant made Mr Lees aware of numerous problems affecting his position within the plastic surgery team, giving specific examples. He said it began with the decision on his appointment and continued thereafter. One example was the "covert investigation" of his practice, by reference to a surgery carried out in October 2016. He said Mr Clarke had asked a colleague to investigate this, but the only concern was the length of time the surgery had taken.

148. On 16 December the claimant had contacted Mr O'Donoghue after receiving the invitation to the meeting. He was unaware of it and advised the claimant to contact Mr Fearon, which he did. Mr Fearon said he was happy with the claimant's care and told him that Mr Clarke had rung him that morning to ask if the claimant had shouted. Mr Fearon had responded to Mr Clarke saying he knew nothing about any "row" on

the ward. Mr Fearon had told Mr Clarke that it was a complex case. He felt that Mr Clarke was asking "leading questions" about whether or not this surgery was something the claimant should be doing. Mr Fearon shared with the claimant his suspicion that there was "a political agenda" going on.

149. The claimant also alerted Mr Lees to what he felt was "an atmosphere of intimidation", giving an example of Mr Hodgkinson shouting loudly at a colleague at a consultant meeting. Others had warned the claimant to be "extremely careful" regarding Mr Hodgkinson as he was "very dangerous" and could try to damage him. He was also warned not to get caught between Mr Hodgkinson and Mr O'Donoghue as the former would "crush" him.

150. One section of his Case Summary was headed "Not treating all equally". The claimant linked this to a culture of different rules and regulations being applied within the department. He referred to a range of issues, including job planning, access to waiting list initiative work, the management of study leave and variable clinical standards being set. He did not say he was being treated unequally because he had raised patient safety concerns.

151. In the conclusion to his 38 page document the claimant said he felt the unit was dysfunctional, that he was aware of the difficulties in recruiting to the post he had taken up, and that there were "no concerns with my clinical decision-making or ability at my appraisal output in October 2016". He went on:

> "Since arriving in the Trust I believe I have suffered undermining and bullying often in a very subversive manner. However I can't help but feel that since I have expressed concerns about patient safety in the department their attacks have escalated …".

152. It was also on 9 March that Mr Clarke emailed his "records" about his contact with the claimant and "emails others have sent to me about him" to Mr Lees. The list of attachments included Dr Sorial's statement, the appraisal outputs and some emails about the claimant's job plan. The relevance of the latter was not explained.

153. It was alleged at the first hearing of this claim that Mr Hodgkinson and Mr Clarke withheld from Mr Lees the statement of Mr Sorial which they had had in their possession from December 2016. The first Tribunal upheld this as Detriment 10.

154. Detriment 11 was upheld on the basis of the respondent's failure to review the ongoing restrictions on the claimant's duties during the lengthy investigation. The respondent did not dispute that no such review had taken place, though sought to explain it by reference to the claimant's continuing sickness absence.

155. The delay in progress and completion of the investigation was found to be Detriment 12. The first Tribunal concluded that the delay was detrimental as the claimant was unable to return to work until it was completed, and may have been deskilled.

156. It is not in dispute that the investigation took a considerable amount of time to conclude. The first formal interviews conducted by Mr Lees were on 9 March 2017 when he met with Mr Hodgkinson, Mr O'Donoghue and Mr Clarke. Other interviews

continued in late March and early April, with others taking place in May, June and July. These included interviews with Mr Fearon on 15 June and Mr Sorial, the final witness to be seen, on 14 July. The claimant attended two interviews, on 10 and 19 May 2017. Ms Arshad was not interviewed before leaving the respondent in March 2017 after working three months' notice.

157. Emails were exchanged on 8/9 June between Mr Welch and the MDDUS about the fact that the restrictions on the claimant's practice had not been reviewed every 4 weeks as required. Queries were also raised about why it was necessary for the specific restrictions to be put in place. In reply, Mr Welch said it was expected that:

> "… the investigation will be completed in the near future at which time the restrictions, which were never formalised, would be reviewed."

158. He went on:

> "The restrictions have not been reviewed to date due to their informal nature, but had [the claimant] been at work, clearly would have been."

159. Mr Lees' investigation report was finalised on 23 July 2017. He had conducted a thorough investigation and interviewed 28 witnesses. In summary, Mr Lees concluded that the claimant was slow and meticulous in his work, reluctant to delegate, and gave the impression he trusted no-one. He concluded that the claimant was safe to operate and he had no clinical concerns. That report was sent to Professor Newton for review on 24 July and on 28 July it was emailed to the claimant.

160. It later emerged when Mr Fearon gave a written statement for the first Tribunal hearing that on 1 August 2017 the claimant had phoned him. He made a note of the conversation and the claimant's comment that:

> "… the history of his hostility that he has been receiving in the hospital is due to himself getting a job over a local trainee"; and that he had been "under the spotlight since he has been appointed".

161. Following her review of the report and appendices, Professor Newton raised some points of clarification with Mr Lees on 5 September. He replied on 15 September to answer her three questions:

    a. What is your understanding for the rationale for the change in the on-call rota?

    b. Was there any sense it was introduced inappropriately and in particular was there any evidence that [the claimant] was singled out in any way?

    c. Did the new rota make things better or worse and has it led to any occasions of concern for patient safety?

162. The gist of Mr Lees' reply was that the new rota was introduced following discussions at an away day meeting, to help reduce waiting lists for breast surgery

and ensure that hand surgeons were always available for emergency cases. He was aware that the claimant, Mr O'Donoghue and other colleagues had raised objections to the change. Mr Lees did not feel it was inappropriate to introduce the new on-call rota, but acknowledged that there had been "clear concerns" expressed about patient safety. On the question of the claimant being singled out, he said the breast surgeons felt particularly disadvantaged by the new rota and so he did not believe the claimant was singled out. He referred to the importance of monitoring the effects of the change and its impact of patient safety, not least because of a serious risk that Mr O'Donoghue had identified to him.

163. The final formal step in the investigation was a letter from Professor Newton to Mr Welch dated 29 September setting out recommendations arising from the investigation. In this letter 14 terms of reference were identified, being the 12 items in Professor Newton's letter to the claimant of 6 March, plus an additional two issues:

"13 The circumstances surrounding the appointment of [the claimant].

14 The circumstances surrounding the change on the plastic surgery on call rota with particular reference to hand trauma surgery."

164. Professor Newton summarised the 24 findings and conclusions in Mr Lees' report. On Item 13 she referred to the split decision on the claimant's appointment, which was felt to be "reflective of long term division within plastic surgery". The scope of the claimant's work was felt to be something to be dealt with through the job planning process. His pace of work was felt to be slower than other consultants, and while not an issue of patient safety it did need to be addressed.

165. The cases of patients X and Y were referred to. In both cases the clinical outcomes had been "good or at least not unexpected". There were differences of opinion about the claimant's management of the cases, some critical and others not. The report had confirmed that the claimant did have the skills and competencies to operate as a consultant in a major trauma centre (Item 9). It was recommended that the restrictions on his practice be lifted.

166. On the subject of working relationships, it was concluded that some were good and others were a cause for concern. "Mistrust and poor communication exists." Recommendations for team building and mutual cooperation were made. The incident on 13 December with nurse Nevin was described as "an uncomfortable exchange", a conclusion Mr Lees reached after reviewing differing accounts of it. The outcome was that both the claimant and the nurse were to be reminded that it should not have taken place in front of the patient.

167. The investigation concluded that the claimant had a very positive perception of his competencies and needed encouragement to reflect on his practice, with the help of a new mentor.

168. Overall, the outcome of the investigation was favourable to the claimant except insofar as he needed to improve his self-reflection and contribute to the building of better working relationships. Several of the recommendations made clear that there were issues for line management to follow up, but no formal steps were needed.

169. Although the new on-call rota was supposed to have been reviewed after 6 months, it was not. On 9 October 2017 its implementation was confirmed at a further away day meeting. It was felt, on balance, to be worth continuing with even though its problems were recognised.

170. On 20 October 2017 the claimant resigned from the respondent Trust to take up another position elsewhere in the NHS.

**Submissions for the claimant**

171. For the claimant, Ms Garner summarised the relevant law by reference to s.47B Employment Rights Act 1996 ('the Act'), prohibiting detrimental treatment of a worker "on the ground that" he has made a protected disclosure. Section 48 of the Act requires the employer to "show the ground" on which the detrimental treatment was done.

172. We were referred to other authorities, including *Harrow London Borough v Knight* [2003] IRLR 140, where it was said that a mere 'but for' test (ie but for the disclosure, the respondent would not have carried out the conduct in question) is insufficient: it has to be shown that in some way the disclosure 'motivated' the respondent into perpetrating the act of detriment.

173. In the key case of *Fecitt v NHS Manchester* [2012] IRLR 64 (CA), Elias LJ stated:

*"45. In my judgment, the better view is that s.47B will be infringed if the protected disclosure materially influences (in the sense of being more than a trivial influence) the employer's treatment of the whistleblower."*

*"50-51 I entirely accept that where the whistleblower is subject to a detriment without being at fault in any way, tribunals will need to look with a critical – indeed sceptical – eye to see whether the innocent explanation given by the employer for the adverse treatment is indeed the genuine explanation. The detrimental treatment of an innocent whistleblower necessarily provides a strong prima facie case that the action has been taken because of the protected disclosure and it cries out for an explanation from the employer."*

174. Ms Garner also referred us to the EAT judgment in the present case (paragraphs 33-35) in which HHJ Auerbach summarised the salient points arising from the body of authorities:

*"33. Firstly, it will not necessarily follow, from findings that a complainant has made a protected disclosure, and that they have been subjected to a detriment, alone, that these must by themselves lead to a shifting of the burden under Section 48(2). The Tribunal needs to be satisfied that there is a sufficient prima facie case, such that the conduct calls for an explanation.*

*34. Secondly, if the burden does shift in that way, it will fall to the employer to advance an explanation, but, if the Tribunal is not persuaded of its particular explanation, that does not mean that it must necessarily or automatically lose. If the*

*Tribunal is not persuaded of the employer's explanation, that may lead the Tribunal to draw an inference against it, that the conduct was on the ground of the protected disclosure. But in a given case the Tribunal may still feel able to draw inferences, from all of the facts found, that there was an innocent explanation for the conduct (though not the one advanced by the employer), and that the protected disclosure was not a material influence on the conduct in the requisite sense.*

*35. […] material influence is indeed, the test which the Tribunal should be applying.*

175. Ms Garner suggested that we might find it useful to follow the *obiter* suggestion of Eady HHJ (as she was then) in the case of *Western Union Payment Services UK Ltd v Anastasiou* EAT 0135/13 to consider and establish the chain of causation on the facts, where – as it is submitted in this case – there is an organisational culture or chain of command such that the final actor might not have personal knowledge of the protected disclosure, but where it nevertheless still materially influenced his treatment of the complainant.

176. Ms Garner made submissions on the facts, the detail of which is not repeated here. In summary, she doubted the respondent's witnesses' credibility on a number of key issues of fact, and suggested that their evidence had during this hearing "drifted away" from that given to the first Tribunal. Her submissions dealt with the early stages of the claimant's employment, covering issues between the claimant and Mr Hodgkinson about the job planning negotiations, the lack of registrar cover, his email referring to the "red mist" having lifted, and Mr Clarke's email about needing to move on and give the claimant a fair crack of the whip". She reminded us that the first Tribunal has already made findings about Mr Hodgkinson's antipathy towards the claimant. He perceived that the claimant had challenged his authority on a number of occasions, including the meeting of 17 November 2016. Following this, Mr Hodgkinson escalated matters after the 8 December ward meeting. There was no explanation for why things were precipitated at this point.

177. By the time Mr Hodgkinson and Mr Clarke acted together in mid-December, they both had an agenda, which was to curtail the claimant's activities and fire a shot across his bows. It was submitted that it was Mr Hodgkinson's request to Mr Clarke to seek a restriction on the claimant's duties, for the simple reason that this removed the possibility of him raising further concerns about the rota, including whether it adhered to patient safety guidelines. Mr Hodgkinson saw the claimant as a troublemaker and the time line showed the final act of 'troublemaking' was the raising of the patient safety issues on 17 November 2016. The claimant had relied on RCS guidelines and said that these were not being adhered to by Mr Hodgkinson or his plastic surgery team. This led to the salient protected disclosure and was *a material part of* Mr Hodgkinson's motivation in instigating and then participating with, the report to Mr Clarke in December 2016.

178. Ms Garner invited us to go beyond the acknowledged antipathy and look at why it existed and whether the protected disclosure was a matter that was a material (ie more than trivial) influence on the decision-making in relation to each detriment.

179. On the question of Mr Clarke's awareness of the protected disclosure having been raised, it was submitted that he had a close working relationship with Mr

Hodgkinson, as evidenced by the tone of their email communications. Mr Clarke agreed in cross-examination that, that following departmental consultants' meetings at which he had not been present, he would get a debrief from Mr Hodgkinson if "something significant" had been discussed.

180. Ms Garner took us through the detriments as found by the first Tribunal. She said the latest issue regarding the on-call rota was a further irritant to Mr Hodgkinson, who wanted the claimant removed from a position from which further criticism of the rota could be made. The patient X issue provided a sought-for excuse to take this agenda forward. The protected disclosure was therefore a material influence on Mr Hodgkinson's decision to take this particular step, at this particular time. Mr Hodgkinson's evidence was equivocal before both this and the first Tribunal as to whether he was raising an issue of competence or communication. Similarly, the Terms of Reference grew significantly and were expanded to include all possible complaints that Mr Hodgkinson had made previously against the claimant. It was a wide-ranging list of issues that was effectively a condemnation of the claimant's entire working practice, not just his communications. By his own evidence Mr Clarke stated he did not have much day to day contact with the claimant. He was not a plastic surgeon. It follows, on the balance of probabilities, that he gathered the information necessary in reliance upon Mr Hodgkinson.

181. By the time the matter reached Mr Welch, the course of action that had already been decided by Mr Hodgkinson and Mr Clarke after their "lengthy meeting" on 15 December was in train. The outcome that Mr Hodgkinson wanted was acted upon by Mr Clarke and Mr Welch. Mr Clarke told Mr Welch what restrictions were requested, which suggestion – in all likelihood – came from PH. The information that Mr Clarke gave to Mr Welch was inaccurate in two respects: the first was that he had already spoken to two orthopaedic surgeons; the second was that the claimant had previously refused to attend a meeting with him. It was Mr Clarke's motivation – pushing Mr Hodgkinson's agenda to take action against the claimant – that gave rise to the decisions to start the investigation and place restrictions on him.

**Submissions for the respondent**

182. Mr Gibson addressed the facts of the case in his submissions for the respondent. He said that at its most basic level, the Tribunal should consider which of two scenarios had occurred, on the balance of probabilities. The first was that Mr Hodgkinson had conducted a campaign to discredit the claimant, fuelled by his disclosure of 17 November 2016 about patient safety concerns, and had therefore 'persuaded or coerced or conned' a cohort of healthcare professionals to behave dishonestly and participate in a campaign for improper reward. The second scenario was that Mr Clarke and Mr Hodgkinson had reached a tipping point where professional relations between the claimant and some medical and nursing staff were so bad, and the claimant's insight so poor, that legitimate concerns about the risk to patients led to an investigation and restriction of practice (however shoddily that investigation might have been conducted).

183. He said the claimant's case is that right from the date of his appointment Mr Clarke and Mr Hodgkinson were intent on undermining him. He did not doubt that the

claimant genuinely believed this. However, the respondent felt this was a mistaken belief, and that proper analysis of the events in question showed no such improper motive by either Mr Clarke or Mr Hodgkinson.

184. Mr Gibson referred to the job planning discussions and submitted that these were typical of the 80 such discussions Mr Clarke has every year with consultants. There is compromise on both sides.

185. The tutoring on the hand diploma course was something the claimant was suitable to carry out, but the consultant who made the remark about this was Mr Williams and it had nothing whatsoever to do with Mr Clarke or Mr Hodgkinson. As for the wrist arthroscopy course, Mr Hodgkinson's view was summed up on his Post-It note: "Mike wrist arthroscopy. The department doesn't offer this treatment. He is a breast surgeon". This is not to say the claimant does not have hand trauma skills, but that is not the substantive post for which he was engaged.

186. He submitted that Mr Clarke and Mr Hodgkinson played no part in the nursing issues other than it was raised with them. The handling of the situation with patient Y and the emails in August 2016 show a mindset that recognises a problem and is genuinely concerned to improve working relationships and get the best out of the claimant. It is not a malign or hostile viewpoint and certainly not one influenced by any disclosure.

187. Mr Hodgkinson's response to the patient Y issue was that it "was entirely about the clinical management of a patient to try to ensure the best outcome was achieved for the patient, to make sure the nursing staff on Ward 47 were not presented with a patient for whom the responsible consultant was on leave and to avoid problems for the Trust". That indicated his mindset and was also entirely true.

188. Mr Clarke was worried about poor consultant relations; Mr Hodgkinson was worried about poor communications. Both were concerned that this created patient safety risks.

189. Referring to the Lees report Mr Gibson drew attention to the variable state of professional relationships between the claimant Chatterjee and colleagues, which began with the claimant perceiving he was not welcome on the unit. The report stated: "Early concerns surrounding this were not dealt with and [the claimant] has felt increasingly threatened and has developed a defensive persona. There is a perception amongst some nursing and medical staff that he wishes to do everything himself due to a lack of trust in other professionals. This has spiralled into a situation of mistrust and poor communication, compounded by existing tensions between some of the other consultants."

190. As a result of the 17 November meeting, the respondent pressed forward with the 6 month trial of the new on-call rota, reducing the on-call consultants' elective commitments to a registrar level so that if the consultant is called away the registrar can manage. Feedback on the new system would be gathered and a further meeting would then make a decision. In short, the discussion led to a form of resolution.

191. Mr Gibson said there was no evidence that Mr Hodgkinson ever raised the discussion at the 17 November meeting subsequently at any forum. It was striking that there was no mention of the meeting again anywhere. That is consistent with Mr Hodgkinson not recalling the claimant had spoken and believing that a resolution to the issues raised had been reached. Mr Clarke was clear he had no knowledge at all about protected disclosures made by the claimant. He was not at the consultants' meeting. There was no reference to the claimant speaking in the minutes. There was no mention to him of any protected disclosures on the part of Mr Hodgkinson. Mr Clarke was not aware of any patient safety issues raised by the claimant and it never factored into his thought processes at all.

192. As for the events of 8 December 2016, he suggested that Mr Hodgkinson referred the nurses to Mr Clarke as Clinical Director because he was perhaps mindful of Mr Clarke's email of 19 August 2016. He had already raised the nursing concerns the claimant's appraiser and could not really take it any further.

193. Turning to 15/16 December, he submitted that the first conversation alerted Mr Welch to a problem and resulted in him wanting to meet with the claimant to listen to what he had to say. The second conversation was to decide upon a way forward once the claimant refused to attend. As a result, Mr Welch removed him from the on-call rota, restricted his practice, and commissioned an investigation. His mindset was that the on-call rota was the exact time when a consultant could find himself in a difficult situation without support. His sole motive was protecting patients and any protected disclosure by the claimant played no part in his decision. Neither Mr Welch nor Mr Clarke knew about it.

194. Mr Gibson reminded us that reasonableness is not the test. It is the thought processes of the decision makers, all three of whom could not have been clearer. It was about working relationships and Patient X. Protected disclosures did not factor in anybody's mind.

195. We were invited to accept there was a longstanding nursing concern, and it had nothing to do with any protected disclosure, about which Sister Taylor was wholly unaware. Mr Hodgkinson's concern was a breakdown in working relationships between the claimant and the nursing staff on Ward 47. Having already raised these matters previously with Mr O'Donoghue, it was entirely consistent of Mr Hodgkinson now to refer the nursing staff to Mr Clarke with their concern. Mr Hodgkinson was not the claimant's line manager, such a referral was not disproportionate and it was not motivated by a patient concern raised by the claimant, which Mr Hodgkinson did not recall.

196. The investigation was a fact-finding exercise. Mr Hodgkinson had no part in the terms of reference. Mr Clarke had some input after the first draft had been formulated by Ms Mitchell. He was asked to articulate the concerns he had raised. But the terms of reference are those of Mr Welch not Mr Clarke. Ms Mitchell had no knowledge of any protected disclosure, and she drafted terms of reference based on what Mr Welch told her. He conceded that the restrictions should have been reviewed but were not. The reason for this was the claimant's absence on grounds of ill health, not any protected disclosure.

197. In conclusion, Mr Gibson submitted that the series of perceived wrongdoings relied on by the claimant did not all involve Mr Hodgkinson. Where they did, his actions were nothing more than robust management of fairly low-grade matters, such as the job planning, tutoring, funding for wrist arthroscopy training and events involving patient Y. Furthermore, these events pre-dated any disclosure. He acknowledged that the claimant had a genuine but mistaken belief that Mr Hodgkinson and Mr Clarke set out to undermine him, but they did not.

## Conclusions

198. The starting point for this Tribunal was to consider the statutory provisions of the Employment Rights Act 1996 (the Act). Section 47B prohibits detrimental treatment at work "on the ground that" a worker has made a protected disclosure. Section 48 requires the employer to show the "ground" on which the acts (or omissions) were done.

199. We were satisfied that the nature and amount of detrimental treatment to which the claimant was subjected demonstrated a sufficient prima facie case calling for the respondent to explain its actions. It was then necessary to consider whether the reasons the respondent had in its mind, through the actions of Mr Hodgkinson, Mr Clarke and/or Mr Welch, had a material and more than trivial influence on the treatment.

200. Applying the key principles from the case law, we considered the explanation put forward by the respondent, which was essentially the same explanation as at the first hearing, namely that it had concerns about the claimant's competence and his working relationships with colleagues which warranted the steps taken. It was open to us to decide that we were persuaded by that explanation, or to reject it. If the latter, this would not automatically lead to a finding in the claimant's favour, as a third option was available. We could find on the evidence that there was another explanation, an 'innocent' cause of the treatment which even if unreasonable or improper might not be an unlawful breach of section 47B of the Act.

201. In assessing the evidence of the mindset of the respondent's three witnesses, we also assessed their credibility. Our focus was on the oral evidence given by Mr Hodgkinson, Mr Clarke and Mr Welch, as their motives were under scrutiny. The first Tribunal had already found that the claimant was subjected to numerous detriments by reference to the actions in which they all played a part.

202. We found that there were many difficulties in accepting the respondent's witnesses' explanations for the detriments, though in some areas we found their responses credible. We weighed up what they said to us, how this related to the limited contemporaneous records, and the claimant's submissions about a potential shift in their evidence between the two Tribunal hearings.

203. We felt there was both clear evidence of the antipathy found by the first Tribunal and clear evidence that the respondent's explanation for its actions were not as stated by Mr Hodgkinson and Mr Clarke. They claimed to be justified in instigating a formal process, which required Mr Welch's authorisation, because of doubts over the claimant's clinical competence and his working relationships, especially with nurses.

We are clear in our minds that the real reason for the claimant's treatment was this general antipathy. This took hold in such a way as to enable Mr Hodgkinson and Mr Clarke to use their concerns about day to day issues in the department in a manner that was prejudicial and hostile to the claimant. We do not challenge the legitimacy of some of the concerns themselves, but in a healthy and well-managed workplace we would not expect management to respond to them as they did here. The causes of concern could and should have been proactively managed across the team, without singling out the claimant as if he were the only cause of difficulties, and nothing about the evidence justified the formal escalation of events in December 2016 at a speed which even the respondent could not explain.

204. Although this mindset was not something the respondent was willing to admit, the evidence in support of it was striking. Contrary to Mr Gibson’s submission that the claimant had no insight and saw everything as the fault of others, we find that the same could be said of the respondent. The claimant was asked to reflect on his communication and relationships with colleagues, but at no point did the respondent do the same. The department knew there was a problem recruiting to and retaining consultants to the claimant's post, yet from the outset held him wholly responsible for all the problems.

205. The only evidence the respondent could give us to show that it had tried and failed to take informal action was that Mr O’Donoghue was asked to raise communication and nursing issues in the claimant’s appraisal. No sooner had he done so, than Mr Hodgkinson and Mr Clarke were exchanging exasperated emails with each other which belied their true intention to find a constructive way forward. They did not investigate any other members of staff whose own behaviour may have contributed to the problems, nor even was that in their contemplation.

206. In his oral evidence Mr Clarke would not accept that he had a “good” working relationship with Mr Hodgkinson, but rather that they had a “functional” working relationship. This belied the tone of the emails they exchanged, and we had no doubt that they had a close and friendly working relationship.

207. Our findings of fact and our sceptical assessment of the respondent's witnesses might lead the claimant to expect a finding in his favour. However, having examined carefully the evidence as a whole we cannot agree that the ground on which he was treated badly was that he raised patient safety concerns in November 2016. The evidence pointed strongly towards the antipathy beginning on his appointment and it manifested itself throughout his time with the respondent. The origins of the detrimental treatment pre-dated the protected disclosure by some time, and even the claimant’s theory was that his controversial appointment lay behind it. He had a suspicion – both valid and understandable – that his treatment arose from the protected disclosure, but the evidence as a whole does not support this.

208. Although much of the treatment predated the protected disclosure and it may therefore be said the chain of causation is broken, we scrutinised the evidence for signs that there was an escalation in the antipathy which might be explained by the protected disclosure in November 2016. Certainly, there was an escalation of events but no change in the respondent's mindset; and we found no causal link between the protected disclosure and what followed. The one area where we felt

the respondent's witnesses were most credible was that the raising of patient safety concerns was not in their minds when their actions were taken in December 2016. They were simply a continuation of the negative mindset already formed, as evidenced by the documents from August 2016. On the one hand, Mr Clarke wished to draw a line and give the claimant a fair crack at the whip, but in the next breath he and Mr Hodgkinson were expressing privately their exasperation with the claimant. He was an outsider, who liked to work in a particular and meticulous way, he took advice outside the organisation and quoted national guidelines to support his approach. He inadvertently drew attention to the fact that some colleagues were not following such guidelines, and they found this an irritant.

209. The evidence as a whole about the antipathy towards the claimant was strong enough to displace any unlawful reason having factored into the respondent's motives. If the safety concerns about the new on-call rota played any part in the chain of events, it was trivial and not material to the steps taken.

210. We noted also that in their second statements the respondent's witnesses had an opportunity to explain their reasons for acting as they did against the claimant. They did not offer any new information or present a positive case. They chose not to provide innocent explanations for their conduct, despite the findings of the first Tribunal, for example by admitting to their antipathy. However, the evidence has brought us to the conclusion that this was not a case where the protected disclosure had any material bearing upon the case. It formed part of the general narrative but was not retained in the minds of Mr Hodgkinson or Mr Clarke when they took their concerns to Mr Welch in December 2016.

211. Having set out those general conclusions, we shall deal with aspects of the detail of the case.

212. There is no doubt that the claimant was experiencing problems at work from an early stage. He found himself working on call without the required support of a Registrar on a regular basis, and had little if any support from Mr Hodgkinson about this. Instead, the respondent sought to present the issue to the claimant (and this Tribunal) as if it were a case of registrars not wanting to work with the claimant specifically. However, there was no evidence to support this, and such evidence as we did have suggested there was a department-wide problem. Neither Mr Hodgkinson nor Mr Clarke had even spoken to the registrars about this.

213. There were similarly two sides to the job planning negotiations. On the one hand, we were told that it was quite usual for these discussions with consultants to be protracted, but what seems to have irked Mr Hodgkinson is that the claimant embarked on this course at an early stage after joining the department. The fact that he went to the BMA for guidance also made him unpopular, even though he was perfectly entitled to do so. The fact that a “red mist” had descended upon Mr Hodgkinson in February 2016 was an overreaction by someone who was predisposed to be critical of the claimant's actions.

214. Mr Clarke sent his email records to Mr Lees about the job plan, though the relevance of these to the terms of reference was far from clear to us. What did strike us, however, was the way these records reinforced the obvious hostility displayed by

Mr Clarke and Mr Hodgkinson to the claimant's attempts to negotiate his job plan, despite this not being an unusual event.

215. A similar attitude was apparent from the way the claimant's requests for study leave and tutoring in hand surgery were dealt with. The claimant was specifically recruited to perform hand surgery alongside his main role as a breast surgeon and had a legitimate expectation that this would feature in his work. In this respect too he was rebuffed by his senior colleagues. It is not difficult to infer that Mr Williams, who also opposed the claimant's appointment and was later critical of his handling of patient Y, shared this negative view of the claimant.

216. The animus towards the claimant was about more than communication issues or differences in clinical practice, as illustrated by the tone of the communications involving Mr Hodgkinson and Mr Clarke in connection with the claimant's study leave, his job plan, and their emails to each other. They found the claimant awkward, difficult to work with, and felt he did not fit in. Matron Cook and Sister Taylor were of the same mindset. They did not, however, have any knowledge or involvement in the subject-matter discussed at the consultants' meeting on 17 November.

217. On the claimant's part there appeared to be an element of defensiveness about how he was being treated by colleagues, because he knew from an early stage that a number of his senior colleagues did not want him in the team. This undoubtedly fed into the claimant's lack of trust of his colleagues and it would be unsurprising for this to have had a negative impact on working relationships. The fact that the key actors in the steps taken against the claimant all felt he should not have been appointed to the job was in our view the root cause of all the problems. Through the extensive evidence we reviewed, including the claimant's, this ran like a thread clearly through the whole narrative. It reinforced our belief that the claimant was subjected to detrimental treatment – without good reason – but at the same time it displaced any notion that the protected disclosures played any part in the minds of Mr Hodgkinson, Mr Clarke or Mr Welch.

218. We appreciate also that the claimant made his own contribution to the problems because he had a particular way of working, which was meticulous and perhaps over-cautious by comparison with some of his colleagues. That said, it was not his responsibility but the respondent's to create a healthy working environment in which all personalities and approaches could an flourish.

219. One colleague who supported and mentored the claimant was his line manager Mr O'Donoghue. The record of the appraisal he conducted on 18 August 2016 shows a positive picture overall, with some areas for reflection. No doubt was expressed about the claimant's clinical competency, and his surgical performance was said to be "of an excellent standard". His reluctance to delegate to nurses was discussed and Mr O'Donoghue encouraged the claimant to allow them to demonstrate their skills and experience. This was at the heart of the incident on 13 December with patient X.

220. The appraisal took place only days after the issue with patient Y arose on ward 47, which was mainly an issue about communication. There was also a difference of clinical opinion between the claimant and Mr Willams about the treatment, though

the claimant's approach was later vindicated by Mr O'Donoghue and in Mr Lees' investigation.

221. The appraisal noted that the claimant felt undermined by some colleagues "since he arrived in Newcastle. He feels this relates to his appointment." The undermining was linked to a discussion about his desire to carry out some hand or wrist surgery, though Mr O'Donoghue impressed upon him the need to balance this against the priority of clearing waiting lists for breast surgery patients. Coping strategies were discussed and a personal development plan put in place for the coming year. In other words, there were areas the claimant had to work on, but this was in train. Mr Clarke was said to be involved in a "resolution process", though in fact no such steps were taken.

222. The General Summary of the claimant's appraisal stated:

> "It is fair to say the claimant has had a difficult start to his consultant career which he feels goes back to his appointment."

223. The appraisal therefore documented a discussion about problems which already existed, and recorded the claimant's own view that the causes went back to his appointment. This of course predated the protected disclosure made on 17 November.

224. The 19 August meeting between the claimant and Mr Clarke had the appearance of being an exercise in offering support, as well as allowing Mr Clarke to express his concerns about the management of patient Y during the claimant's absence on leave. Mr Clarke opened the meeting by referring to the "controversial circumstances" of his appointment (something which he noted, but which Mr Hodgkinson was inexplicably reluctant to acknowledge on cross-examination). The claimant's own note of this meeting referred to the fact that he "was suffering due to the fact that I was appointed in the interview", reflecting the view he had expressed at his appraisal. The very fact that Mr Clarke made a file note of this meeting was highly unusual and perhaps anticipated the need to produce evidence at a later date.

225. Mr Clarke's note about the handling of patient Y showed that this had been addressed at an informal and low level. The claimant was simply advised to reflect on the need for better communication with senior colleagues. No concerns were expressed then that there had been any risk to the patient or that the lack of communication might have impacted on clinical competence. The reference provided by Mr Welch in October identified no concerns at all about the claimant's competence.

226. The fact that the claimant felt he had to "tip-toe around" nursing staff was also revealing of the mutual problems in their communications. Following the later incident with patient X, it became clear that both Mr Hodgkinson and Mr Clarke had a close working relationship and a "high degree of trust" in Matron Cook and Sister Taylor. The nursing staff who were most instrumental in the escalation of events at the end of the year shared the attitude of these two senior colleagues towards the claimant. They saw him as an outsider who did things differently, and they were not

receptive to his clinical approach. They had liked and got on well with the internal candidate.

227. At the 19 August meeting Mr Clarke offered speak to the claimant if he had further problems, in an apparent effort to try and resolve the issues. This reflects Mr O'Donoghue's note to that effect at the appraisal. Any appearance of a supportive attitude towards the claimant was, however, undermined by Mr Clarke's email to Mr Hodgkinson later that day, suggesting he "may want to read this email on Sunday night holding something alcoholic."

228. His email summed up the root causes of the problems the claimant was experiencing, when Mr Clarke said "Justin's clearly rattled and I think we need to draw a line, forget about Siva, make sure we give him a fair crack of the whip, and see what happens…" It was unsurprising that the claimant was "rattled". The need to forget about the unsuccessful internal candidate was also revealing this many months after the appointment. The need to give the claimant a "fair crack of the whip" implied that he had not been given this courtesy previously, and it was the respondent as much as the claimant that needed to work to make things better.

229. Before the next set of concerns arose in December 2016, the protected disclosure was made at the meeting of 17 November. We conclude that Mr Hodgkinson was irritated by this challenge to the new rota which he had championed, and that he knew the claimant had raised (directly or through Mr O'Donoghue) concerns about patient safety. That said, the evidence about this meeting showed that the claimant was not the only person to be concerned. The meeting was divided and others expressed their disagreement. Nothing in the evidence persuaded us that Mr Hodgkinson left that meeting with any change of attitude towards the claimant. If he noticed the claimant's contribution to the debate, it was a passing moment and we accepted his oral evidence to this effect. Any irritation or anger towards the claimant simply formed part of an overall series of occasions when Mr Hodgkinson was similarly averse to the claimant's approach. We also accepted that the outcome of the meeting was a resolution of the debate – for the time being at least – in that the new trauma system would be trialled for six months.

230. We are in no doubt that Mr Clarke was also aware of this discussion and the concerns raised at around the time of the meeting. Although reluctant to make a direct concession on the point, he did accept on cross-examination that he would have been briefed by Mr Hodgkinson if anything significant had been discussed. Clearly this was significant. Again, we do not believe this led to any change of attitude towards the claimant. Generally, there was no evidence to suggest that the respondent's mindset towards the claimant, already negative and hostile, became more so after the protected disclosures were made.

231. The next series of incidents affecting the claimant took place between 8-16 December 216. On 8 December Mr Hodgkinson had a discussion on the ward about the claimant with Matron Cook and Sister Taylor. His note of the concerns they shared ended with an expression of the "high level of support" for Ms Taylor and all the nurses on the ward. At no time was any expression of support, even in less glowing terms, afforded to the claimant, nor was there any recognition from medical

staff that that he may have different but acceptable ways of working as a relative newcomer into the department.

232. By supporting Ms Taylor to take her concerns to Mr Clarke, the Clinical Director, Mr Hodgkinson knew that he would have the latter's support for taking matters further, and at the same time he was seeking to distance himself somewhat from responsibility. By the time the issue relating to patient X occurred on 13 December, those involved in the discussion a few days earlier were already intent in taking matters to a more senior level.

233. During cross-examination Mr Hodgkinson was reminded that Sister Taylor's evidence was that it was he who advised her to take her concerns to Mr Clarke. Mr Hodgkinson avoided the question when it was put to him, by saying Matron Cook was the line manager. When asked by the Tribunal about the claimant's line management, Mr Hodgkinson gave very unsatisfactory evidence which seemed designed to distance himself from the picture. He said Mr Clarke had previously suggested Mr O'Donoghue take over as his line manager and mentor, so he devolved that role on Mr Clarke's advice. He was unclear about whether this was from the outset of the claimant's appointment or later, but that was certainly the position by August 2016. Mr Hodgkinson had a line management role for some administrative purposes such as training. When asked why he did not then take the issue about the nurses to Mr O'Donoghue as the line manager, he replied, "Good point. I felt Mr Clarke as the most senior person needed to be aware". That was not an answer.

234. The incident on ward 47 on 13 December amounted to a difference of clinical opinion. Both the claimant and Mr Sorial felt that the situation was under control, though the nurses were understandably concerned by the patient's symptoms. They were an experienced team and their concerns were genuine. The claimant was clear in his mind about his rationale, and followed clinical procedures. Although he explained this to the nursing staff at the end of the day, they disagreed with his approach and felt it was different from what they had been used to seeing from other surgeons in the department.

235. The evidence provided by Dr Sorial, which we found reliable, was that sepsis protocols were already being followed. The difference of opinion between the nurses and the claimant about the wound dressing and the interaction with nurse Nevin were the issues that prompted the escalation of pre-existing concerns.

236. The respondent's evidence was somewhat contradictory on the question whether the concerns were about the claimant's clinical competence or his relationship with nurses. Had competence been a central issue, at the very least the clinical notes and statements from Mr Fearon and Ms Arshad would have been obtained. Mr Hodgkinson and Mr Clarke also ignored the fact that the claimant had attempted to explain his rationale to nurses, who were clearly not receptive to a different way of working.

237. We noted a shift of emphasis in Mr Hodgkinson's written evidence between making his first and second witness statements. In the first, he did not treat the incident on 13 December as having particular significance. He was made aware of it by Sister

Taylor. The issues were portrayed as a breakdown in relationships between the claimant and the nursing staff, inappropriate behaviour by reprimanding a nurse in a public setting, and causing her "extreme upset and distress". He said he would have contacted the claimant personally to discuss it, if he had been the line manager, but since he was not, he took it to Mr Clarke. Although he had raised some issues with Mr O'Donoghue in the past, he did not do so on this occasion and had no explanation for that.

238. In his second witness statement Mr Hodgkinson treated the concerns raised on 8 December as a "nurse led issue" about working relationships. He also said it was the incident as a whole that he took to Mr Clarke, "specifically patient care and concerns about patient safety". This time he felt that it was not a matter for discussion with a line manager, but something that needed to be looked into. He said, "I would accept it was serious enough to warrant an investigation as in some form of inquiry process."

239. In his first witness statement Mr Clarke similarly presented the incident involving patient X as primarily an issue about the interaction between the claimant and nurse Nevin. He said Mr Hodgkinson had voiced to him "additional concerns" about the claimant's competence. Although he could not comment on the claimant's competence, not being a plastic surgeon himself, he was aware that others had formed the view that the claimant was struggling. This was, however, based on nothing more than Mr Hodgkinson's opinion and the views he himself had solicited from Mr Fearon and Ms Arshad in response to the direct questions he put to them.

240. In his second statement Mr Clarke said this was not mainly to do with the alleged shouting at nurse Nevin, and that what had happened with patient Y also impacted on his mind. He felt the claimant was not communicating well with the team and that there was also a patient safety issue.

241. We agree that in principle the respondent was entitled to be concerned about the communication and relationship issues, though we would find it surprising if that were unusual in a busy and hard-pressed NHS team. Indeed, Mr Clarke himself commented that: "If we restricted the duties of everyone who made a nurse cry, we'd get nothing done". However, imposing a restriction on duties and embarking on a formal investigation of this kind was, even on the respondent's own case, a very rare step to take. It should have been a last resort but clearly the respondent had a greater interest in escalating the issue than resolving it.

242. It is the speed and urgency of the actions taken, and the formality of them, which caused us great concern.

243. As for other alleged changes in the respondent's oral evidence, we considered these but were not persuaded that there was any substantive alteration which had a bearing on our decision. For example, there was a question about when Mr Clarke and Mr Welch spoke, and whether this was on 16 December for the first time or on two occasions. Having reviewed the submissions and the two sets of witness statements, we felt that even if the claimant's point had merit, it did not assist us overall. This was because we came to our own conclusion that Mr Hodgkinson and Mr Clarke did have an agenda and were not entirely reliable in their evidence, even

though we were also quite satisfied that the agenda was not related to a protected disclosure.

244. The evidence from Mr Hodgkinson and Mr Clarke about the claimant's relationships with colleagues was entirely one-sided, and even though they knew of the difficult circumstances of his appointment, they closed their minds to the possibility that others might have been responsible for creating a hostile working environment. The respondent's actions presupposed that the problems between members of the nursing staff and the claimant were caused by him and did not take account of the potential differences of clinical opinion, nor did it have any regard to the difficulties in relationships created by the decision to appoint the claimant instead of the internal candidate preferred by some in the department.

245. The Capability Procedure expressly envisages that at an early stage informal steps might be explored with a view to finding a resolution quickly and before problems become serious. Mr Clarke was tasked with that as an outcome from the claimant's appraisal, yet he did nothing and was content to await a follow up discussion with the claimant in January 2017.

246. The respondent took no particular steps to support the claimant to improve his capability, in keeping with the aims of the Capability Procedure, beyond Mr O'Donoghue's guidance as illustrated by the appraisal. While there had apparently been some informal conversations about the need to improve working relationships, these were at unspecified dates and entirely undocumented. Furthermore, those conversations were conducted in the full knowledge that some of the claimant's colleagues were hostile to his appointment and his manner of working. Not one of the respondent's witnesses asked HR to facilitate an informal process, for example through workplace mediation or the involvement of the NCAS. Such a step would have been apt in an environment where a wider problem was known to exist in the department.

247. The Capability Procedure also identifies the need for proportionality and the potential for "lasting damage to a doctor's reputation and career prospects" if allegations are unfounded or malicious. We find that the decision to investigate in this case was far from proportionate. Those who were instrumental in the initiation of the process clearly had a negative attitude towards the claimant, by which we mean Matron Cook, Sister Taylor, Mr Hodgkinson and Mr Clarke. The latter two used their positions to persuade Mr Welch to go along with their agenda.

248. When asked about the process for dealing with interactions within the team, Mr Hodgkinson confirmed that this does happen regularly and arises sometimes with new consultants until things settle down. The process would start informally with guidance from mentors to help understand the team approach. The next stage would also be informal, through encouragement and support from the mentor in particular. "If all else fails", it would escalate to the Clinical Director. When asked about the cause of the escalation he replied that "concerns about patient safety are paramount".

249. The respondent's failure to follow its own Capability Procedure in a number of substantive and procedural respects is concerning in a case alleged to justify action being taken at the highest possible level.

250. Rather than raise the matter informally with the claimant in the first place, as Mr Welch seems to have contemplated initially, all three managers chose to move with undue haste to a formal investigation. Despite this being an exceptional step to take, they made no records whatsoever of their decision-making.

251. Originally Mr Welch had wanted Mr Clarke to meet with the claimant, but within 24 hours the decision to go ahead formally was made even though nothing had changed. No one had checked when the claimant was next scheduled to work on call. The respondent was even able to identify a named investigator in Mr Lees. This seems to reflects a frustration with the claimant borne of many months of hostility. The fact that the claimant wanted a companion to attend the meeting with him, and information about its purpose, was entirely reasonable, though not in Mr Welch's mind.

252. The evidence upon which the decision was made was virtually non-existent. It relied on Mr Hodgkinson's views about the claimant, as he had gathered no evidence except the opinions of the two senior nurses. He did not review the clinical notes of patient X, or speak to the other consultants involved in his care. He did not even speak to nurse Nevin about her account of 13 December, nor did he approach the claimant, or refer his concerns to Mr O'Donoghue as the line manager.

253. At some point, but only after the discussions with Mr Welch had been initiated, Mr Clarke did speak to Mr Fearon and Ms Arshad. Although he made no note, during his oral evidence he recalled they were saying that the claimant was "stressed, isolated, out of his comfort zone and unsupported". 'Out of his comfort zone' is not the same as out of his depth. These conversations then fed into his discussion with Mr Welch, by which time the concerns about communication had broadened out to concerns about competency. In presenting this view to Mr Welch, Mr Clarke relied on Ms Arshad and Mr Fearon as separately indicating that the claimant was "out of his depth". This was disingenuous, because it was Mr Clarke who put those words into their mouths through his leading questions.

254. When asked during oral evidence about the restriction on the claimant's duties Mr Hodgkinson said it was "not in my control or my decision. I'm aware of it". In reporting the issues to Mr Clarke, he claimed that he wanted improvement in communication on the ward, thereby distancing himself again from what was happening. He believed the investigation was put in place by Mr Welch and when asked about capability issues being raised he said, "That's what it turned into", as if it was not initially about that. He said the restrictions were Mr Welch's decision and the aim was not to remove the claimant from the rota but to develop and encourage better relationships.

255. Mr Welch's evidence was that he took the decision to investigate and restrict the claimant's duties, partly because he failed to attend the requested meeting. We reject this explanation as being not credible. There was no suggestion that the proposed meeting on 16 December had any purpose or intent to resolve or influence

the situation. Contrary to the impression the respondent's witnesses sought to give us, this was not a case of the respondent seeking to avoid formal steps, if only the claimant had attended the meeting with Mr Welch. Rather, Mr Hodgkinson and Mr Clarke always intended to restrict the claimant's duties and prompt an investigation, and they went to Mr Welch to authorise this. We conclude that the only purpose of meeting the claimant that day was to have told him this news in person. Furthermore, Mr Welch's decision was based on information given to him by two senior colleagues whom he believed he could trust. However, Mr Clarke wrongly led him to believe that the claimant would refuse to attend a meeting

256. Mr Welch's concession that there had been no discussion about an informal route contradicted his evidence that if the claimant had attended the planned meeting, the result might have been different. His description of it being a "question of pragmatism over process" showed a surprisingly casual approach to such a serious decision.

257. As for the rationale for the restrictions, Mr Welch contradicted himself again in his evidence, initially saying they were minor restrictions only and "not uncommon". In response to Tribunal questions he then said it was "fairly uncommon" to impose restrictions on practice and it had happened less than 10 times in his nine years at the hospital.

**258.** The interviews Mr Lees later conducted with Mr Hodgkinson and Mr Clarke support our conclusions that there was little or no evidence warranting the decision made on 16 December. Mr Hodgkinson had no knowledge of substance about the patient X case. The brevity and content of Mr Clarke's interview showed again a desire to distance himself from questions about working relationships. The only example of concern he referred to was the "hearsay" comment about the claimant being out of his depth. In the end, the investigation vindicated the claimant.

259. Turning to the conduct of the investigation, we find that Mr Clarke's evidence was unreliable on the subject of the terms of reference being drafted by Ms Mitchell. The email correspondence makes clear his direct involvement and the fact that he had "questions" he wished to be answered. We would find it surprising for Mr Hodgkinson not to be involved to some extent, given his close involvement in the situation, and found his attempt to challenge this unconvincing. Ms Mitchell could only have drafted the terms of reference on instruction from management, as only they would have knowledge of the areas of concern. In principle we do not have a problem with their having some input, but the fact that Mr Clarke's words were adopted with very little change (except to tone down, for example, his mention of "bullying") did not give confidence in the independence of the investigation's remit. Likewise, both Mr Clarke and Mr Hodgkinson were invited to, and did, name relevant witnesses. It was not inherently improper for them to do so, but their partiality was demonstrated by the omission of Dr Sorial's name.

260. Our conclusions about the particular items in the original terms of reference are as set out below.

261. Items 1 and 2 relate to the range of clinical activities carried out by the claimant. Their inclusion speaks to an antipathy towards him, being expressed in

unnecessarily broad terms which have to do with his job role and not his competence. It also reflects the Post-It note attached to the request to attend the wrist arthroscopy course, a sense that the claimant was reaching beyond his remit and should confine himself to breast surgery notwithstanding the original need for trauma hand work while he was on call. It also suggests, along with the other evidence of the views of Miss Stevenson and Mr Williams, that they were unhappy at the prospect of the claimant encroaching upon their work.

262. What items 1 and 2 do not speak to is any question about the claimant's capability. His qualifications and experience in hand surgery were in no way in doubt. Those questions had no place in a formal investigation nor warranted a restriction of duties.

263. Items 3 and 4 relate to the management of patients X and Y. These questions were in principle legitimate but it was wholly disproportionate to initiate a formal investigation under the Capability Procedure. This is clear from the outcome of the appraisal in August and the fact that all managers were satisfied with the informal discussions about patient Y.

264. Item 5 relates to the claimant's working relationships. This makes clear that the respondent was treating the claimant as cause of the problem, and ignores the hostility towards the claimant's appointment, which Mr Hodgkinson and Mr Clarke well knew to to be a significant factor. They were quite entitled to be concerned about the state of relationships within the team, but a neutral instruction to the investigator would have been framed in terms of an examination of relationships in the team. We note that the evidence we saw showed an absence of problems on wards other than ward 47, nor issues between the claimant and numerous other colleagues. Even Mr Clarke questioned the dynamics of the team when posing the question, “What is it about this post?”. Clearly the possibility that some other members of the team were contributing to the problem was not to be the focus of the investigation.

265. In a similar vein, Item 6 was expressed in a very partisan way, using the red flag of alleged “bullying” – a word not used by the staff members themselves but chosen by Mr Clarke. It was not neutral as would be expected and was correctly removed.

266. Item 7 was the allegation that the claimant had shouted at nurse Nevin on 13 December. This was of course something the respondent had to look into, though it was disproportionate to do so by subjecting the claimant to scrutiny under the Capability Procedure. We can see no reason why this issue (which must surely arise from time to time in a busy and pressurised hospital environment) should be the subject of such a formal investigation.

267. Items 8 and 9 asked whether the claimant was safe to be on call as a consultant plastic surgeon to the major trauma centre, and whether he had insight into his ability. They overlap with Item 3, in that it is legitimate to ask questions about a surgeon’s competence, including his own insight into any problems. The problem in this case is that to express the concern as being about whether the claimant was safe to practice was an unwarranted escalation of the communication issues that were at the heart of the cases of patients X and Y. We have no difficulty with the respondent's case that poor or unclear communication can overlap with issues

about competency, but in August there was no serious concern about patient Y and in December the main cause of complaint was the “nurse-led” issues.

268. Other aspects of the conduct of the investigation formed part of the detriments upheld by the first Tribunal. Initially Mr Welch had made himself available to talk to the claimant, who availed himself of this on several occasions. Once the formal investigation was commissioned, this changed and in February Ms Mitchell emailed the claimant to say it was no longer appropriate for then to meet. While this is understandable in the midst of a formal process, it also had the effect of reinforcing the legitimacy of the investigation to the exclusion of all other avenues for an informal resolution of the problems with workplace relationships.

269. The respondent conceded that the restrictions on the claimant's practice should have been reviewed but were not. Mr Welch said this was due to the claimant's ongoing sickness absence, but we found this explanation weak. The claimant's ability to return to work was by this time directly affected by the existence and duration of the investigation. It is difficult to see how the respondent could have expected the claimant to return to duties until the formal investigation was completed.

270. The length of the investigation was criticised, but we find that in a complex case involving many witnesses this is unsurprising. However, by the same token the respondent could have been expected to undertake regular reviews in order to assess the impact on the claimant, his ability to maintain his clinical skills, and the predictable adverse effect on his health.

271. Stepping back from the detail of the events, we agree with the first Tribunal that there was an appalling lack of record-keeping by the respondent in this case. We accept that it may not be realistic to make file notes of all discussions, but the absence of any records whatsoever of the decision made on 16 December and its rationale is quite remarkable. The career and reputation of a consultant surgeon was at stake, and this merited not only careful thought and consideration, but also an evidence-based decision.

272. As indicated above, we concluded that Mr Hodgkinson’s evidence was not wholly reliable, but we are of the view that his lack of frankness arose from his antipathy towards the claimant which began from the moment of his appointment. This was coupled with his own defensiveness about his role in the detrimental treatment which was attributable to dislike, but not to protected disclosures. If the challenge to his new on-call rota played any part, it was but a minor and trivial contribution to the overall relationship where by Mr Hodgkinson among others was annoyed whenever challenged by the claimant.

273. While we do not uphold the claim that there was a causal connection between the protected disclosures and the detrimental treatment, we are forced to conclude that the respondent brought the consequences, in the form of this claim, upon itself. It did so firstly by subjecting the claimant to an unwarranted level of hostility, by taking out on him their grievance about the fact of his appointment, and by acting in concert against him in a way which does not show the medical profession in a positive light. All of this was exacerbated by the woeful lack of record-keeping which we find

extraordinary in the context of a formal procedure which is very rarely invoked and has such damaging potential consequences for the doctor at its centre.

274. Finally while we have focussed closely on the mindset and motives of the respondent's witnesses, we have also had regard to the wider evidence and the claimant's own perception of the cause of his treatment. When Occupational Health wrote their report in January 2017, they relayed that the claimant was experiencing a reaction to:

 "ongoing concerns he has in relation to the working relationships within his directorate which he fears may be, at least in part, related to having raised patient safety concerns.

275. In his written submission to Mr Lees he gave an example of poor treatment by reference to the "covert investigation" of his practice, an event which predated the protected disclosure as it arose in October 2016. In his notes on "Not treating all equally, the claimant referred to a range of issues, including job planning, access to waiting list initiative work, the management of study leave and variable clinical standards being set. This too is consistent with the cause of the difficulties experienced by the claimant being significantly broader-based than the fact of his having made a protected disclosure.

276. The highest the claimant could state his case was set out in the conclusion to his document:

 "Since arriving in the Trust I believe I have suffered undermining and bullying often in a very subversive manner. However I can't help but feel that since I have expressed concerns about patient safety in the department their attacks have escalated …".

277. In Mr Fearon's written record of his conversation with the claimant on 1 August 2017, he recorded the claimant's view that:

 "… the history of his hostility that he has been receiving in the hospital is due to himself getting a job over a local trainee"; and that he had been "under the spotlight since he has been appointed".

278. We are in no doubt that the claimant believed this to be true, but even his own conviction in the cause or causes of his detrimental treatment lack conviction.

279. In summary, we conclude that the original cause of the detrimental treatment started with the claimant's appointment. That pre-dated the protected disclosures by some time and did not form any causal link with the patient safety concerns raised. That issue formed part of the overall narrative, but to Mr Hodgkinson it was at best a minor annoyance. We did consider whether there was an escalation of the adverse treatment after the disclosures, but concluded that this was not borne out by the evidence. The trigger for the most serious of the detriments were the complaints by nurses about the case of patient X which when picked up by Mr Hodgkinson and Mr Clarke led to a snowball effect in the events which followed.

280. Not only the claimant but others were concerned about the new rota, but we are satisfied that this was not in the respondent's mind when they dealt with events in December 2016. By then they felt the rota was working well. The debate on 17 November was quickly forgotten and superseded by other events. We therefore find that the disclosures played no part in the respondent's thinking, but even if they did form part of the background, this was a minor and trivial feature. The claimant genuinely believed that it played a part but he lacked conviction in this explanation for the way he was treated, and he did fairly acknowledge that there were other significant causes of his treatment.

SE Langridge
**Employment Judge Langridge**

**JUDGMENT SIGNED BY EMPLOYMENT JUDGE ON**

**30 August 2022**

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