# EMPLOYMENT TRIBUNALS

| **Claimant:** | | **Respondents:** |
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| Mr F San Diego | **v** | Bagshot Rehab Centre Limited (1)<br>CHD Living Ltd (2) |

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| **Heard at:** | Reading | **On:** 25 & 27 July 2022<br>& 11-13 January 2023 |
| **Before:** | Employment Judge Anstis<br>Mrs A E Brown<br>Mr G Edwards | |

**Appearances:**
**For the Claimant:** In person
**For the Respondent:** Miss L Hatch (counsel)

## WRITTEN REASONS

A. INTRODUCTION

1. These are the written reasons for the tribunal's judgment of 13 January 2023. They are produced at the request of the claimant.

2. The claimant was employed by the first respondent from 20 April 2020 as clinical deputy manager. There is a dispute about the date and circumstances in which his employment ended, but it is agreed that his employment ended in either May or June 2020, so he was employed by the first respondent for a very short period of time. It was the respondents' position that he was only actively at work for 18 days. He is an experienced and senior nurse.

3. The first respondent operates Bagshot Park Rehabilitation Centre, which is a residential home for between (at the time) 20-22 residents with high clinical needs. These are often individuals who have suffered traumatic accidents. Their average age is around 40 years old. The second respondent is the parent company of the first respondent, and also owns and operates other businesses within the care sector.

4. The claimant's claims were the subject of case management by Employment Judge Alliott on 14 June 2021. They are all claims relating to public interest disclosures. The alleged public interest disclosures were identified by EJ Alliott as follows:

*"5.4.1 On 20 April 2020 to Julia Billins and Lincoln Abraham. It is the claimant's case that a disclosure was made orally and that only he and the two named individuals were present. The particulars of the disclosure are as set out in paragraph 1 of the statement of facts in the claim form* [that is: "inadequate unplanned induction", "inadequate information on handling sharps and what to do in case of needle stick injuries", "no training provided for Caresys the patient data record software of the company" and "medication management led by physiotherapists which are not competent on medication management for nurses"]

*5.4.2 In an email dated 4 May 2020*

*5.4.3 In an email dated 14 May 2020.*

*5.5 The claimant relies on sub sections 43B(1)(b) and (d). The legal obligations relied upon as per Table 1 of the claim form and the health and safety that the claimant alleges was likely to be endangered was that of service users and other staff members."*

5. At the start of the hearing the claimant indicated that he wished to rely on a fourth, oral disclosure on 4 May 2020. We heard an application to amend his claim to include this fourth alleged protected disclosure, but refused his application to amend for reasons given orally at the time.

6. These protected disclosures are said to have given rise to six detriments described at para 5.6 of Employment Judge Alliott's order, and are also said to have been the main reason for the claimant's dismissal (or constructive dismissal). The alleged detriments are:

*"5.6.1 On 22 May 2020 the claimant found out that the duty of care for his wellbeing was breached. He asserts that … a member of staff, inappropriately contacted service user families and negatively influenced their perceptions about the claimant through defamatory statements. The claimant asserts that Ms Julia Billins was aware of this pattern of behaviour from which any reasonable person would have taken steps to protect other colleagues from suffering this kind of detriment from* [that member of staff]*. However, the claimant asserts that Julia Billins breached her duty of care for the claimant's wellbeing and deliberately failed to act on* [that member of staff's] *pattern of behaviour prior to the detriment occurring as a form of retaliation for the claimant's public interest disclosures.*

*5.6.2 Between 14 and 22 May 2020 the claimant asserts that he suffered increasing unfair scrutiny and demotion. After the public interest disclosure on 14 May 2020, Mr Kingsley Samuel Dhinakar increasingly and unfairly scrutinised the claimant's nursing*

*practice on tracheostomy despite having deemed the claimant competent on 4 May 2020.*

*5.6.3 The claimant asserts that on 22 May 2020 he found out that Mr Dhinakar had demoted him by prohibiting him from handling patients with tracheostomies without a fair disciplinary process which followed the Acas Code of Conduct.*

*5.6.4 On 23 May 2020 the claimant asserts he suffered harassment and bullying form Kingsley Samuel Dhinakar through workplace violence in the form of threats to legal and professional action and coercion to accept professional liability and forcing resignation as part of a continuing detrimental actions as retaliation for the claimant's public interest disclosure on 14 May 2020.*

*5.6.5 The instigation of and conclusions contained in the Section 42 Report.*

*5.6.6 The instigation of and conclusions contained in the Root Cause Analysis.*

B. THE LAW

7. We note that in a case such as this it is for the claimant to prove on the balance of probabilities that he made protected disclosures and was subject to detriments. If he does so, then s48(2) of the Employment Rights Act 1996 provides that:

> *"on* [a complaint of detriment due to protected disclosures] *it is for the employer to show the ground on which any act … was done …".*

8. In whistleblowing detriment claims, the test is whether:

> *"the protected disclosure materially influences (in the sense of being more than a trivial influence) the employer's treatment of the whistleblower"* Fecitt v NHS Manchester [2011] EWCA Civ 1190 (para 45).

9. As for dismissal, it is for the claimant to show that the reason or principal reason for his dismissal (including any constructive dismissal) is that he made a protected disclosure.

C. THE FACTS AND OUR CONCLUSIONS

**The alleged protected disclosures**

10. The claimant started work on 20 April 2020. This was around a month after the first national lockdown on account of Covid-19 had started. It was a time of fear, uncertainty and, particularly for those working in the care sector, real danger. Ms Billins told us that the first respondent had had its first death of a resident

from suspected Covid-19 shortly before the claimant started work. We also note that the claimant started work at a time of significant staff and skill shortages within the health and care sector.

11. The claimant says that he made protected disclosures to Ms Billins (and Mr Abraham) on 20 April 2020. He sets them out in the following terms in his witness statement, where he describes them as being "observations":

> *"There was no induction training as trainer was unavailable and manager not aware that he was self-isolating.*
>
> - *The in house training lead who is a physiotherapist gave me a thick pile of workbooks and was considered to be 'the induction'.*
> - *I was not given access to Care Sys (Clinical Records System) for the home.*
> - *The medication management was being led by a physiotherapist Lincoln Abraham. Medication administration is not within the purview of physiotherapy practice.*
> - *No records of medical equipment competency/self-assessment for the following medical equipment:*
>
>  *Suction machines*
>
>  *Feeding pump*
>
>  *Blood glucose monitoring machines*
>
>  *Non invasive ventilation machines*
>
>  *High Flow oxygen devices*
>
>  *Oxygen Concentrator*
>
> - *My roles and responsibilities was not clearly explained to me including my shift patterns."*

12. He says: "*I have raised these issues on the day with the lead of training Lincoln Abraham and Julia Billins the manager as a matter of importance due to health and safety implications as induction is a health and safety issue.*"

13. The first respondent agrees that the intended face to face induction was not provided as the trainer was self-isolating due to Covid-19.

14. Ms Billins does not deny that these things were said, although the way the claimant puts it makes it difficult to know in what form they were said.

15. On 4 May 2020 the claimant sent an email to Julia Billins containing the following alleged protected disclosures:

> *"I think an induction is quite important with regards to new employees starting in Bagshot Park."*
>
> and
>
> *"I have been left to my own devices in terms of getting to know our residents diagnoses, care plans, and where they are in terms of the rehabilitation journeys. I have had a focused shadowing with* [L] *regarding the daily ins and outs of nursing care and she has been a marvellous support in my first two weeks. However a proper handover should have taken place in terms of discussion of the service users clinical status. I again recommend that this should be a standard for all nurses starting in Bagshot Park."*

16. On 4 May 2020 Samuel Dhinakar certified the claimant as being fit to carry out tracheostomy work.

17. On 14 May 2020 the claimant sent an email to, amongst others, Ms Billins and Mr Dhinakar. He says this had the following protected disclosures:

> *"a.* "[H] *started a week ago however she still has not been given access to Caresys which meant she did not have a way to view the care plans for service users that she is caring for";*
>
> *b. "Yesterday ... two nurses from Kingston had turned up to be assessed for their tracheostomy competencies. However they arrived with no learning objectives and have little idea where they are in terms of their learning in management of tracheostomies …";*
>
> *c. "The situation I mentioned above however represent a failure in coordination and communication. Staff members in Bagshot Park should not have to start coming out of supernumerary without being given proper induction and proper access to our clinical records. Otherwise we are failing our service users"*
>
> *d. "Moving forward with regards to nurses coming for assessments proper due consideration should be given to their learning needs which means that they have learning objectives prior to coming in Bagshot Park for their competency assessment".*
>
> *e. "Their learning objectives should have been communicated to me prior to coming for assessment so I can reinforce their weak points and strengthen their strong points".*

*f. "All nursing staff should have Caresys access ready for them on day 1 with the company …""*

18. These alleged protected disclosures had several broad themes, so we will consider them together when considering whether any of them amounted to protected disclosures.

19. For a protected disclosure, we need disclosure of information (that is, facts), which the worker believes are made in the public interest, with such a belief being reasonably held, and with the worker tending to believe that the disclosure shows that a person has failed to comply with a legal obligation, or (more clearly relied upon by the claimant) that the health and safety of someone has been, is being or is likely to be damaged.

20. While accepting that in broad terms the claimant raised the matters he mentions with Ms Billins on 20 April 2020, without further explanation from him it is very difficult to describe these as being protected disclosures. There is, clearly, information being conveyed, but it is difficult to say that the claimant regarded these as being allegations of a failure to meet legal obligations or that health and safety of patients and others were being endangered as a result. Patient safety was a critical part of his role, and he was an experienced nurse who was taking up a management role with the first respondent. If he had believed on his very first day that circumstances were such as to endanger patients or to breach legal obligations it is hard to see how he felt this was best dealt with by way of an informal conversation with the manager. What we have in this case appears to be observations on ways the claimant felt that his induction and practices around that could be better. If there was really a fear by the claimant that this was a public interest matter of health and safety, or breaches of legal obligations, he would not have been content to mention this in passing in a casual conversation.

21. Similarly, the 4 May 2020 email is framed as a way in which things could be improved. He speaks of "*marvellous support*" from a colleague. This is not the language that a person would use if they considered that they were raising matters of public concern in relation to legal obligations and patient health and safety.

22. Much the same can be said about the email of 14 May 2020. There are observations there about better ways of doing things. To make such suggestions was part of the claimant's job. Equally, it was his job to raise the alarm (in clear terms) if he felt there were breaches of legal obligations or a risk to health and safety of patients. This is not something that should require complex interpretation or explanation in order to be understood as raising a health and safety concern. The claimant has (rightly) emphasised his commitment to patient care, but in such circumstances if he had seen a real breach of legal obligations or health and safety we would have expected him to say so in clear terms. His professional conscience would have required nothing less than that, but it does not appear in the alleged disclosures he made.

23. The alleged protected disclosures are not protected disclosures because in making them the claimant did not have a reasonable belief that they tended to show a breach of a legal obligation or that the health and safety of any individual was being endangered.

24. If these are protected disclosures, we note that they are made in the mildest possible terms, were about matters that were properly part of the claimant's managerial role, do not seem to have provoked any immediate reaction from either Ms Billins or Mr Dhinakar and were unlikely to have been of particular concern to either individual nor particularly high on their agenda in the face of the difficulties that the Covid-19 lockdown presented.

25. Since there are no protected disclosures, the claimant's claims are bound to fail. However, for the sake of completeness we will briefly address the questions of detriment and dismissal.

**The nebuliser incident**

26. On Friday 15 May 2020 a key incident in the claimant's work for the first respondent occurred. He was working on a patient with a tracheostomy, apparently taking the opportunity to train a junior colleague in the correct approach to such matters. The patient's mother was watching this via a tablet. The next day, the patient's mother sent an email to Ms Billins and Mr Dhinakar in the following terms:

> *"I am very sad that I'm having to write this email but I witnessed something yesterday that shocked me very much. I do hope my concerns won't be taken the wrong way.*
>
> *At around 11.30 yesterday morning I was speaking to* [patient's name] *on the Echo, Diego came into* [the room with his junior colleague] *to give trache training. I asked what he was doing and he informed me he was going to suction* [the patient] *I then informed him that [the patient] really never ever requires suctioning and with the sounds I could hear it sounded like* [he] *needed a neb. I then asked when he had his last neb and Diego informed me it was a 7.30. This is way too long and if you look at* [his] *charts you will see that normally he would of had one in between.*
>
> *Diego then agreed and proceeded to get a neb ready. He then told* [the junior colleague] *to place the neb over the speaking valve. From that moment my heart sank as I then had to say you never place a neb over a speaking valve and only ever use a non-fenestrated tube.*
>
> *If this is your new clinical lead training nurses how to deal with trache residents this fills me with no confidence. What if he had processed to*

> *do so over the speaking valve and* [the patient] *had blocked the tube with a secretion, he would have lost his airways.*
>
> *My conversation with Diego ended with him saying "you learn something everyday". This is something I should not of had to inform him."*

27. This was, on the face of it, a very alarming report. It is not in dispute that that putting the nebuliser over the speaking valve could have the effect of blocking air to the patient. Exactly how hazardous that might have been depended on the extent of any secretions – but it was clearly a worrying report.

28. It is not necessary for us fully to recount the subsequent investigative steps taken by the first respondent, but we note that in later investigations, the claimant's junior colleague said "*clinical lead explained to me which tracheostomy cannula to use for nebuliser,* [the patient's] *mum overheard this and said 'not to use that cannula in any circumstances'. Therefore clinical lead didn't use and used correct cannula. Diego apologised and said "you learn something new every day*". In his reflections on the incident the claimant said:

> *"As a very experienced nurse I recognised this strong sense of participation and have sought to encourage it for it will be important to foster trust in the long run. Thus when she mentioned the nebuliser, my approach was to be kind, cooperative, and listening and agreed to give the nebuliser right there and then. I am also by intuition directed at that moment to ask question to impart the feeling of respect towards their deeply held vested interest to the service user. However I asked a passive question during that time which was as far as I can recall was: 'Shall I place the nebuliser on top of the tracheostomy like so?' knowing that the speaking valve was still on. I am fully aware and will be changing the inner cannula to a non fenestrated one before I administer. But as long as I continually impart that sense of respect to their contribution to the service users ... Thinking this may give the potential for some teaching if the family member answered wrongly. Looking back it was not right for me to ask the passive question as this was not effective towards the service users relative. However the family member was correct when she said do not give the nebuliser over the speaking valve. 'The family member said I can give you a lesson on how to manage the tracheostomy'. Which I took to be a sign of high confidence and sought to further strengthen by saying: 'One can learn something new everyday'. I then proceeded to change the inner cannula into a non fenestrated one and left the room to allow time for the nebuliser to be administered."*

29. There has thus never really been any dispute that the incident occurred in much the same manner as originally alleged by the patient's mother. The only point that arises from the claimant's reflective statement was his position that this was done to encourage the mother's participation in her son's care and in an

attempt to generate some sort of teachable moment. That was not how it was seen by the mother.

30. The claimant was off sick the following Monday. Ms Billins discussed the incident with Mr Dhinakar to gain his clinical views on the matter. She replied that morning to the patient's mother saying there would be a "*thorough investigation*" and also that "*I will raise this as a safeguarding and inform CQC*". She did that the same day by way of a statutory notification under reg 18(2) of the Care Quality Commission (Registration) Regulations 2009. This was described as a possible incident of neglect. The account given by the patient's mother was recorded on the form, but without giving the name of any of the clinicians involved (including the claimant). This initial notification recorded that "*Investigation is underway but key people are not working until the end of the week.*" She notified Surrey MASH of a "*near miss incident that could have become a serious safeguarding*", in similar terms.

31. Although not alleged as a detriment, much of the claimant's questioning of the respondent's witnesses was to the effect that this initial notification was unnecessary and an overreaction. We disagree. We note that Ms Billins was following the principle of avoiding delay. She had not spoken to the claimant about the incident but that was because he was not at work. We also note that she made the referral in guarded terms. It was always clear that this was about a "near miss" rather than a risky event actually occurring, and she had avoided naming the claimant. If this was (as the claimant saw it) a malicious attempt to get him into trouble, Ms Billins could have gone much further. As it was, we see this initial notification as being entirely appropriate and professional.

**The alleged detriments**

32. The first alleged detriment was something the claimant had considerable difficulty explaining to us. It is agreed that a colleague told another patient's relatives about the incident. It is also agreed that this breach of confidentiality was one of the reasons why that colleague was later dismissed. It is accepted by Ms Billins that she knew the colleague was friendly with those particular relatives, but she said that did not mean that there was an obvious risk of a confidentiality breach.

33. The problem with the claimant's claim is that he says that Ms Billins deliberately failed to prevent the breach because of his whistleblowing. That is, at best, far-fetched. He later explained that he had been appointed to his role in preference to this colleague and that as such he was particularly vulnerable to her gossiping about him. We simply don't see that Ms Billins should have foreseen this problem, nor that, if she had, any failure to prevent it was anything to do with what the claimant had done.

34. Detriment 5.6.2 relates to Mr Dhinakar unfairly scrutinising the claimant's nursing practice. As with the first detriment, we had some difficulty in understanding the claimant's case on this. Following the incident, for a time Ms

Billins said that the claimant should not undertake work on tracheoscopies. That is understandable given the possible risks. In response to points the claimant had made about difficulties in training others Mr Dhinakar had offered to train them himself. We see nothing wrong with this. During the course of this hearing the claimant sought to extend this allegation to include Mr Dhinakar's investigation of the incident, but we do not see anything wrong with that. If the claimant's case is that Mr Dhinakar's certification of him on 4 May 2020 should stand forever as an entitlement to work on and train people on tracheoscopies, that must be wrong.

35. The claimant accepts that 5.6.3 was an action carried out by Ms Billins, not Mr Dhinakar. If this can be changed to allege the detriment against her, we do not see anything wrong with it. It was an appropriate precaution.

36. The detriment at 5.6.4 concerns a meeting held on 23 May 2020, at which the claimant, Mr Dhinakar and Ms Billins were present.

37. This was described by Mr Dhinakar as an informal meeting to discuss various issues around tracheoscopy practice. Ms Billins took notes, although they do not record the particular point at issue.

38. Both sides describe this as a difficult meeting that descended into argument. Mr Dhinakar put it this way in his witness statement:

> *"The aim and purpose of the informal meeting on 23 May 2020 was reflective and to provide patient information and guidance, nothing more. It was not to discuss the safeguarding referral. I explained that investigations surrounding the complaint were ongoing and no conclusions had been arrived at. I can confirm that the meeting was not disciplinary related. Given the nature of the meeting the Claimant was not offered the right to be accompanied by either a work colleague or trade union representative. Its aim was to bring the Claimant up to speed on matters since he had been off sick and also in relation to the session with nurses that had taken place on 19 May 2020. I also wanted to ensure that he felt comfortable with undertaking tracheostomies and to qualify the training he had already received and with a view to this being resumed by him on 23 May 2020, if he felt comfortable in doing so. The Claimant had only recently commenced employment and I wanted to ensure that he had all the necessary support in place as he continued in his role.*
>
> *The Claimant used the meeting to explain his position and that he wanted to involve the patient's family during the treatment to show he was confident. The Claimant was not provided with any information that related to the incident on 15 May 2020 as this was not the purpose of the meeting which I reiterated to him.*

*The Claimant became argumentative about the approach taken in making the safeguarding referral and proceeded to then criticise the First Respondent business and became scathing of the management and made comments on how poorly Bagshot Park was run and made referenced to the most recent CQC report. The Claimant stated that as a physiotherapist I should spend more time on the "floor" and that the tracheostomy policies were not correct without providing further information.*

*I can confirm that the Claimant was advised during the meeting on 23 May 2020, that if he did not want to discuss the matters further with me, the matter could be referred as an alternative option to the RCN/NMC for an independent mediation or adjudication. This was not a threat and was with a view to achieving a resolution to resolve any issues the Claimant had and to ensure that he along with staff that had attended the meeting earlier on 19 May 2020 could practice safely going forward. During the conversation it also came to light that he had assisted or provided intervention for a tracheostomy patient, which was in my opinion concerning as he had not, as I understood followed a reasonable management decision to refrain from tracheostomy care until we had the opportunity to speak at that meeting.*

*In order to move away from these points and to try to facilitate a conversation with the Claimant, I also asked him about the clinical reasoning, following my walkaround that morning, in relation to the clinical intervention of the tracheostomy again with the purpose to ensure that he felt comfortable in undertaking the practice of tracheostomies. The Claimant again became agitated but my rationale behind this was not to question his ability but with a view to ensuring there was sufficient support in place to enable him to undertake his role and as he was within his probationary period.*

*I can confirm that I was not forcing the Claimant to tend his resignation and did not say the service would be fine without him as has been alleged. The Claimant then proceeded to say that he had "had enough" and has seen too many bad things at Bagshot, left the meeting and typed his letter of resignation."*

39. The claimant remembers things differently:

*"The meeting started at around 12:00 with myself, Julia Billins, and Samuel Dhinakar in attendance. At the start Samuel Dhinakar brought up the email I sent on 14 May 2020. He mentioned that he did not mean for there to have any issues but still I sent raised concerns and included the regional director as a recipient. Samuel Dhinakar then added that we were not here to discuss the safeguarding referral for the events on 15*

*May 2020 as there is a separate legal repercussions against me towards that.*

*Sam then went on to bring up issues he identified on 13 May 2020 with the service user he complained about. He said that these issues were omissions that I had to accept liability for. He continued to pursue these allegations by reading on a piece of paper he called evidences. I did not accept the coercion to accept liability as I felt that there should have been a root cause analysis first to determine the root cause of what's happened and also to ascribe blame on me alone is unfair.*

*At this point Sam now mentioned the incident on 15 May 2020 and said that he has two witness statement from the nurses who were on shift with me on 15 May 2020 alleging misconduct. ... I was not given a copy of these prior to the meeting neither was I informed that the meeting was to take this accusatory nature.*

*Sam then motioned that he sits in GMC fitness to practice meetings and he could easily refer me to a fitness to practice hearing if I do not accept liability on what he called omissions of care. I challenged him that because he was not nurse with him judging my nursing career and threatening it with professional actions is unfair and that he may have some blind spots. He said that he has gone on night shift plenty of the time before with nurses whilst they were given medications so he knew what it is like to be a nurse. I reiterated that this was not enough for him to be able to claim enough competency to judge a registrant who is part of a profession he is not a part of. I have cited an example of the CQC report of the home which gave poor leadership reviews as multiple nurse managers in the past continue to leave the home in short periods of time spent in the post. I pointed out that this will continue to leave as long as nurses are not given the opportunity to perform their duties according to how they were trained and not be micromanaged by a member of another profession. At this point Sam said he has had enough and said I only had two options at that point one is either to submit a resignation effective immediately or face a fitness to practice hearing at the NMC.*

*I felt that my psychological safety was compromised at this stage due to Sam's threats of legal and professional actions. I suggested that submission of a resignation letter was the most appropriate way forward given the threats and coercions.*

*I went to the closest computer station to write my resignation letter when Sam approached me and said that after I have signed my letter I can leave and that they will be fine without me. I printed and submitted my letter of resignation outlining victimisation, coercion, and threats as the reason for leaving. I left the building at around 13:00."*

40. A particular difficulty with Mr Dhinakar's account is that it does not accord with his original version of events, as given during the course of the grievance investigation, where he says:

> *"During the meeting FSD was heard to say that he had 'had enough' and that he had made up his mind that he had seen too many bad things at Bagshot and knew it was not going to work. Sam explained that in response to this he had told FSD that he should resign if he felt that way or take part in a Fitness to Practice Hearing. Sam felt he had no option other than to say this as FSD had become argumentative in the meeting and would not listen to him. Sam explained that FSD was slandering the company and so Sam told FSD that someone else should decide what should happen.*
>
> *Sam said he did not mean this to be threatening, but just a way to resolve the issues and in no way was he forcing FSD to tender his resignation. Sam said that at no point did he tell FSD that 'the service would be fine without him'.*
>
> *At this point in the meeting, Sam said FSD left the office and went to a computer where he typed his resignation letter."*

41. The account given in the grievance meeting seems to be closer to the truth to us. It is the one that was given nearer the relevant time. It is consistent with two clear points: that by that time the claimant was disenchanted with management and various practices at the first respondent, and also that he resented being answerable (as a nurse) to a physiotherapist (Mr Dhinakar). The claimant did say that he had had enough, and in return Mr Dhinakar said that he should resign if he felt that way. The claimant was not listening to or properly discussing the matter with Mr Dhinakar. Mr Dhinakar spoke of a referral to a fitness to practice hearing, though we have some doubts about whether this was actually what was meant, since no particular professional misconduct had been identified at this stage. This was a "heat of the moment" argument, and it may be that Mr Dhinakar intended to refer to the adjudication by the RCN that he had in mind. However, he did use the words "fitness to practice". Questions of resignation only arose after the claimant said he had had enough, and this discussion arose due to the argument that occurred in the meeting, not due to anything the claimant said on 20 April or 4 or 14 May 2020.

42. As for 5.6.5, the instigation of a section 42 report is done by the local authority, once they have considered the initial report. Strictly speaking the section 42 report is also prepared by the local authority, although we understand that the claimant's allegation that the conclusions are a detriment are allegations that the conclusions of Ms Billin's internal investigation (subsequently provided to the local authority for the purposes of their report) was a detriment.

43. The conclusion that the claimant objected to was "*On examination of the evidence the allegation is upheld that Diego "suggested" that the nebulizer be placed over the speaking valve.*" The claimant was in some difficulty in suggesting to us what was wrong with this conclusion, since all of those present, including him, agreed that this was essentially what happened. The claimant went on to say that the problem was in Ms Billins saying that the allegation was "upheld" when the relevant allegation was one of neglect or abuse.

44. We do not accept this. Ms Billins is clear what her conclusion was, and it was a correct conclusion. We also note that if she had wanted to disadvantage the claimant she had every opportunity in this report to emphasise any supposed wrongdoing by him, or its possible consequences. Instead, she has downplayed the incident by simply keeping to the basic (and essentially agreed) fact that the claimant had suggested that the nebulizer be placed over the speaking valve. Ultimately on receipt of this the local authority determined that no further action should be taken. This is not the actions of an individual who wanted to retaliate against the claimant for any protected disclosures.

45. The root cause analysis was a document prepared by Mr Dhinakar. We do not see that any objection can be made to its instigation. There was bound to be something of this nature arising from the incident, and we were impressed by Mr Dhinakar's approach, which seemed genuinely to be looking for learning points and not to penalise any particular individual. The root cause analysis is a detailed and measured document. The "root causes" are identified as:

> *"- Distraction and pressure perhaps with mother being on video call*
>
> *- Lack of adequate knowledge of care plan and rationale for tracheostomy care for patient …*
>
> *- Lack of rationale and reasoning for not having mother come off the video call before care being delivered (if an argument arises that there was added pressure and anxiety of being watched by a relative)."*

46. We do not see anything wrong with that.

47. The claimant has spent considerable time working through the detail of various procedural documents, some of which seemed to have at best an indirect relevance to the procedures that the respondent had to operate. He has sought to address the detail of what might amount to a "theoretical risk", "natural justice" or a "never event". It is clear that his professional pride makes it very difficult for him to accept any linkage between his name and allegations of "abuse" or "neglect". Those do not appear to be suitable descriptions of the incident in question, but they are the terms that have to be used when a safeguarding referral is to be made. We consider the first respondent acted properly in making this referral. We note that no action was taken against the

claimant. We also note that the patient's relative felt so strongly about the matter that she made an NMC referral, though no action was taken as a result of that. No disciplinary action of any sort was taken by either the first respondent, the local authority or the claimant's regulator. We understand the claimant's sensitivities about the possible effect on his professional reputation, career and possibly also his immigration status in the United Kingdom, but the respondent has demonstrated in this case that none of these alleged detriments were affected by what the claimant said on 20 April 2020 or in the emails of 4 and 14 May.

**Termination of employment**

48. There is, finally, the question of dismissal.

49. The claimant submitted a resignation letter. This was not accepted. Again, this hardly shows that either respondent was taking this action with a view to dismissing or subjecting the claimant to detriments. It is the respondents' position that the claimant's resignation was not accepted pending resolution (or lack of resolution) of his grievance. There is some practical attraction to that argument, but it is not a good legal one. Ms Hatch refers to authorities on heat-of-the-moment resignations, but we do not see anything in that to suggest that a resignation can be held by the employer and acted on several weeks later.

50. There is no meaningful legal concept of an employer not accepting a resignation. It is as meaningless as an employee not accepting a dismissal. An employer can ask an employee to reconsider their resignation, and may give them time to do that, but such a resignation will only not be effective if then withdrawn by the employee, in which case there then is no resignation, there is not a resignation held in abeyance. In this case we find that the claimant did withdraw his resignation. He thus remained employed. The first respondent's purported acceptance of his resignation amounted to a dismissal.

51. Since his claim of unfair dismissal appears to be based only on constructive dismissal, a decision that he was actually dismissed means that claim cannot succeed. We have also found that there were no protected disclosures. For the sake of completeness, we record our finding that the principal reason for the claimant's dismissal was not what he said on 20 April nor his emails on 4 and 14 May. It was, as Ms Lazell said, because the respondents were not willing to pay compensation to the claimant, because he had refused any alternative role and because it was obvious (as he later admitted) that he would not return to Bagshot Park. It was because of that, not because of any protected disclosures

**Employment Judge Anstis**
**Date: 22 February 2023**

Sent to the parties on: 23 February 2023
For the Tribunal Office