EMPLOYMENT TRIBUNALS

CLAIMANT: **Dr Pippa Stallworthy**

RESPONDENT: **South West London & St George's Mental Health NHS Trust**

HELD AT: **London South (by CVP)** **ON: 13-23 November 2023**

BEFORE: **Employment Judge Hart, Mrs Hilary Carter, Mr Kieron Murphy**

REPRESENTATION:

Claimant: **Mr Patel (counsel)**
Respondent: **Miss Owusu-Agyei (counsel)**

RESERVED JUDGMENT ON LIABILITY (CORRECTION)

The Judgment of the Tribunal is that:

1. The claims for detriment on the grounds of making a protected disclosure do not succeed and are dismissed.

2. The claim for automatic unfair dismissal on the grounds of making a protected disclosure does not succeed and is dismissed.

3. The claim for constructive unfair dismissal succeeds.

4. Remedy to be determined at a Remedy Hearing.

REASONS

INTRODUCTION

1. This is the unanimous judgment of the tribunal panel in relation to the Claimant's claims for whistleblowing (detriment and automatic unfair dismissal) and constructive dismissal. The Claimant's contract terminated on 27 November ~~2021~~ 2019.

THE HEARING

2. We attended the hearing in person, the parties and their witnesses attended by CVP. Both parties were represented by counsel. They are both thanked for their assistance and representation during the hearing.

3. It was agreed at the outset of the hearing that the following reasonable adjustments were to be put in place: regular breaks (every hour) and providing the Claimant with sufficient time to absorb and consider questions. On application by the Claimant's representative, following the completion of the Claimant's evidence it was agreed to reduce the number of breaks due to pressure of time.

4. We were provided with the following documents:
   - 4.1 A joint agreed hearing bundle of 1615 pages, the references to page numbers in this judgment are to the pages in this bundle.
   - 4.2 A witness statement bundle.
   - 4.3 An agreed chronology, cast list, reading list and agreed list of issues.
   - 4.4 An updated schedule of loss.

5. The Claimant gave evidence on her own behalf, and called Ms Kerry Young and Dr Helen Kennerly as witnesses. The Respondent called Ms Siobhan Woolett, Ms Tracy Lynn, Dr Ian Petch, Dr Stuart Adams, Ms Bola Ogundeji, Mr Lincoln Murray, Ms Vanessa Ford and Mr Simon Wylie as witnesses.

6. The hearing was originally listed for 7 days. The parties proposed a timetable of day 1 for preliminary applications and tribunal reading, days 2-3 for the Claimant's evidence; days 3-6 days for the Respondent's evidence; and day 7 for Dr Young to give evidence followed by submissions, panel deliberation and judgment. It was clear from the outset that this timetable allocated insufficient time for panel deliberations and judgment. The time allocated for evidence could not be reduced since Dr Young was abroad and only returned to the UK on that day. We therefore agreed to sit for a further 2 days to deliberate with judgment reserved. During the hearing a further ½ day was lost due to technical computer problems on the Claimant's side. This was resolved by the Claimant attending the offices of her instructing solicitors. It was agreed with the parties to increase the sitting day and have shorter breaks to make up the time.

7. On completion of the evidence both parties provided helpful written submissions, supplemented by oral submissions. Judgment was reserved.

CLAIMS / ISSUES

8. The hearing had been listed to determine liability only. The claims and issues to be determined had been agreed by the parties in advance of this hearing. They were re-formulated prior to submissions and are attached to this judgment (Appendix).

9. In closing submissions the Claimant's counsel was specifically asked to identify what disclosures the Claimant was relying on. This was because the contemporaneous evidence did not support the description of the disclosures in the

list of issues. The disclosures that the Claimant is relying on are set out in the findings of fact below. We did not agree with the Respondent's submissions that the Claimant should only be permitted to rely on the disclosures identified in the list of issues since the list of issues are not pleadings.

10. In relation to a number of detriments, the Claimant failed to identify the persons involved merely stating "and others" or "and / or relevant decision maker(s)". Where those others have not been identified by the Claimant in her evidence or in closing submissions, we do not make any findings and have removed these phrases from the headings in this judgment.

Administrator and building works

11. The Respondent objected to the tribunal taking into account the Claimant's evidence of the pressures on her caused by managing the TSS administrator and / or the by the building works. It was submitted that these issues had not been pleaded or included in the list of issues, had not been subjected to mutual disclosure, not referred to in the Respondent's witness statement and had only been raised by the Claimant's counsel on the 7th day of the hearing at the end of Mr Wylie's cross examination. It was therefore submitted that any finding on this matter would be partial and a breach of the overriding objective. The Claimant submitted that both these issues had been pleaded albeit not explicitly referred to in the list of issues.

12. We found that these two issues were referred to in the pleadings. The Amended Grounds of Claim had stated that the Claimant "was left to manage staff with performance and behavioral management issues" which was a reference to the administrator [**p. 32 para 4**]. It also stated that the Claimant had set out her concerns about the building works in her resignation letter dated 27 August 2019 [**p. 46 para 44**). Whilst not specifically referred to in the list of issues, the issues included "working long hours" (issue 11.1.2) and "not putting in place measures of support" (issue 11.1.3). The Claimant provided evidence about the management of the administrator and the building works in her statement which was not challenged by the Respondent. Further, the Claimant's counsel had cross examined both Ms Woollett and Mr Wylie on these issues, albeit only lightly. Taking the above into consideration we considered that the matters had been pleaded and sufficiently explored before us to enable us to make factual findings, to the extent that these issues were relevant.

ANONYMITY ORDER

13. The Respondent applied for an anonymity order in relation to Dr X, the Claimant did not oppose the application. We agreed to hold part of the hearing in private in order to consider the application.

14. The Respondent's application was that a single person be referred to as Dr X orally during the hearing, in any paperwork available to the public (namely hearing bundle and witness statements) and in any written judgment. The application was made under rule 50 of the ET (Constitution and Rules of Procedure) Regulations 2013 on the grounds that it was both "necessary in the

interests of justice" and "in order to protect the Conventions rights of any person", in this case Article 8 (right to respect for private life).

15. Rule 50 (privacy and restrictions on disclosure) provides that:

    "(1) *A Tribunal may at any stage of the proceedings, on its own initiative or on application, make an order with a view to preventing or restricting the public disclosure of any aspect of those proceedings so far as it considers necessary in the interests of justice or in order to protect the Convention rights of any person or in the circumstances identified in section 10A of the Employment Tribunals Act [which is a provision in relation to confidential information].*

    (2) In considering whether to make an order under this rule, the Tribunal shall give full weight to the principle of open justice and to the Convention right to freedom of expression."

    Thus the rights of any individual seeking a restrictive reporting order must be weighed against the fundamental principle of open justice and freedom of expression. There are three separate grounds upon which such a derogation can be made: where it is necessary interests of justice (which concerns consideration of common law principles such as the administration of justice), in order to protect a convention right (in this case Article 8) and to protect confidential information (not applicable in this case): **Clifford v Millicom Services** [2023] ICR 663 (CA).

16. In considering this application we took into account that parties cannot consent to a derogation from the principle of open justice, this is a matter for determination by the Tribunal. Further a derogation from the principle of open justice is not discretionary decision.

17. In relation to the first ground, we concluded that it was not "necessary in the interests of justice" to anonymise Dr X's identity. There was no evidence submitted by either party that publication of Dr X's name would have any impact on the administration of justice or any other common law principle. For example there was no evidence that she was at risk of serious harm if she was named or that any party or witness would refuse to participate in these proceedings.

18. In relation to the second ground, we found that publication of Dr X's name would interfere with Article 8 (the right to private and family life). We considered that publication would affect her reputation, professional standing and career prospects. In so doing we took into account that Dr X was a psychologist and worked in a profession where criticism of clinical skills could affect her relationship with colleagues and patients. We then went on to consider whether any interferences with Dr X's Article 8 rights could be justified giving full weight to the principle of open justice and the convention right of freedom of expression. We concluded that it could be justified for the following reasons:

    18.1 Dr X was not a party or a witness to these proceedings. We considered this to be a relevant and significant factor in this case: **TYU v ILA Spa Ltd** [2022] ICR 28 (EAT).

    18.2 Dr X had not consented to being identified during these proceedings.

18.3 Dr X was not accused of subjecting the Claimant to any detriment arising out of her disclosures.

18.4 The derogation being sought related to a peripheral matter and open justice would not be compromised if Dr X's identity was not made public. The central issue in this case was whether the Claimant had made a protected disclosure. Whilst a number of the Claimant's disclosures concerned Dr X's clinical abilities, these concerns were unproven and the issue for the tribunal to determine was whether the Claimants' belief that Dr X posed a risk to patient safety was objectively reasonable not whether her belief was in fact true. Therefore there was no public interest in knowing the name of Dr X, her identity did not affect the proceedings or the impact of any judgment.

19. Taking all the above into account we concluded that a minor derogation from the principle of open justice could be justified in order to protect the article 8 convention rights of Dr X. We therefore ordered that:

19.1 Dr X be anonymised, during the hearing both orally and in any documentation; and

19.2 Dr X be anonymised in the written reasons accompanying any judgment.

FINDINGS OF FACTS

20. We have only made findings of fact in relation to those matters relevant to the issues to be determined. Where there were facts in dispute we have made findings on the balance of probabilities. We confirm that we have taken into account all the documentation and evidence before us and if something is not specifically mentioned that does not mean that we have not considered it as part of our deliberations.

Claimant's appointment and the Traumatic Stress Service

21. On 25 February 2009 the Claimant (Consultant Clinical Psychologist), commenced employment with the Respondent, a large NHS trust, as Clinical Lead for the Traumatic Stress Service (TSS) on a 1.0 Working Time Equivalent (WTE) contract [**p. 124**]. She led a team of 3 WTE psychologists, supported by a full-time administrator and a part-time assistant psychologist. It was a small team and there was always pressure on the service. At the time of the commencement of these events the other two psychologist were Dr Sharif El-Leithy (Principal Clinical Psychologist) and Dr Abigail Pain (Clinical Psychologist), both on 1.0 WTE contracts.

22. The TSS was an outpatient psychology and psychotherapy service. It assessed and treated adults with complex post-traumatic stress (PTSD), arising from a traumatic event in adulthood. It accepted referrals from secondary mental health services across the Respondent trust. It had strict criteria and did not treat people with co-morbid substance misuse problems, those at significant risk of harm to themselves or at risk from / to others, those with psychotic symptoms, people with adverse psychosocial circumstances and people with PTSD primarily due to a traumatic event in childhood [**p. 667**]. If a person presented with psychotic symptoms, they would be *"advised to have treatment for their psychotic symptoms first, since assessing for PTSD*

can exacerbate psychotic symptoms and associated risks".

Respondent's organisational structures and management

23. The Respondent was split into 5 "service lines": community adult, inpatient service, specialist service, child and adolescence service and forensic service. The heads of these service lines would attend monthly executive meetings with the Chief Executive Officer, Director of Nursing, and other senior managers to discuss issues including the demand pressures on their services and funding. The Respondent's mental health services were funded through a block grant provided by the Clinical Commissioning Group ("commissioners"). Applications for additional funding was by means of a report setting out the demands and pressures on a particular service (Demand Pressure Report). The person responsible for negotiating with the commissioners on behalf of the Executive was Mr David Ince, Associate Head of Contracts.

24. TSS was one of 33 teams situated in the community adult service line. The Head of Service Delivery was Ms Gillian Moore, the Deputy Head of Service Delivery was Mr Simon Wylie and the Clinical Director was Dr Stuart Adams (consultant psychiatrist). The Claimant had three different types of supervisor / manager:
    24.1 An operational manager, who was the Claimant's line manager and responsible for budgetary decisions. It was not disputed that over the 10 year period the Claimant had 15 different managers. In 2018 this was Mr Shaun Hare (Locum Service Manager) who left around the end of January 2019. Mr Wylie then took over the role on or around the end of May 2019. There was no-one acting as operational manager between the end of January and the beginning of June 2019.
    24.2 A professional supervisor, who was responsible for discussing service issues including staffing and pressures on the service. From August 2018 this was Ms Siobhan Woollett (Consultant Clinical Psychologist), Head of the Adult Community Service Line with whom the Claimant had monthly supervisions. Ms Woollett's professional supervisor was Dr Petch, Head of Psychology and Psychotherapies.
    24.3 An external clinical supervisor, who was responsible for discussing the Claimant's cases. Throughout the Claimant's employment with the Respondent this was Dr Helen Kennerley (Consultant Clinical Psychologist) who the Claimant met monthly.

SIREN and Quality Performance Reports

25. The Respondent had in place a monthly self-reporting system to enable teams to raise safety concerns called SIREN. It used a traffic light system of "red" (significant safety concerns), "amber" (some concerns but not safety critical) and "green" (no significant safety concerns). The Heads of Service Line Delivery would provide the Executive with monthly Quality and Performance Reports (QPR) which included a summary of the SIREN reports for all the teams in their service line, along with other Key Performance Indicators. This was to provide a comprehensive picture of clinical risk. Every three months the Executive was required to conduct a "deep dive" into those teams marked as "red" or "amber" with the aim of comprehending underlying causes and aiding team managers to formulate strategies to address the identified issues. The SIREN reports were

used by the Respondent to justify bids for additional funding from the commissioners, we therefore considered, contrary to the Respondent's submission to the contrary, that these reports carried considerable weight.

26. The TSS SIREN reports showed red for the first time in January 2019 [**p. 750**]. Thereafter the TSS SIREN reports were all "red" until September 2019 [**p. 750, 871**]. The reports were completed jointly by the Claimant and Dr El-Leithy [eg. **p. 427**].

27. The January 2019 QPR for the community service line identified 10 teams showing red; some of whom had been showing red for a number of months [**p.348-349**]. Under *"interpretation of scores and action following review*" it was recorded for TSS "*review of administration systems and deeper dive into operational systems and waiting times*" [**p. 350**]. The same action was recorded in the February 2019 QPR [**p. 371**]. The March, May and June 2019 QPRs recorded *"review of administration systems and deeper dive into operational systems and waiting times <u>is required</u>*" (our emphasis)" [**p.397, 540, 578**]. The July and August 2019 QPRs recorded "improvement plan now in place" (we note that this is not in fact accurate since work on the improvement plan was only commenced on or around 1 August 2019 and was not completed until October 2019). They also recorded "full review <u>will be undertaken</u> into administrative systems / operational systems and waiting times / team dynamics and culture and team effectiveness" (our emphasis) [**p. 640-641; 750**]. By August 2019 there were only 5 teams now showing red. The September 2019 QPR recorded that a "service review was now in progress in recognition of increased demand and subsequent high RTTs [referral to treatment]…." [**p.750**].

28. Dr Adams was present at the monthly executive meetings when the QPRs were discussed. He stated that discussions were taking place "at high level" about all the red SIREN reports, and that the narrative in the QPRs was limited and did not "necessarily reflect the discussions that were taking place". He stated that Ms Moore was "keen to address and put a plan in place" and that "things were happening". His evidence lacked detail as to what was discussed, what was agreed and when these discussion took place. We were not provided with any notes of these discussions, or even emails referring to such discussions taking place (in contrast with the emails we saw regarding the discussions that took place from September 2019). We also noted that when referring to these discussions, Dr Adams stated that the Executive were trying to address "issues with staffing in the operational manager team" and "having the right people in place to support". These comments are consistent with the fact that there was no operational manager in place until June 2019 (and that there was some confusion as to who was to become the manager – see below). We therefore found on the basis of the QPR entries and the chronology set out below that there were no discussions at executive level about how to address the demand pressures on the TSS prior to September 2019 and find that the discussions that Dr Adams was referring to prior to June 2019 related to changes in the management structures.

Policies and procedures

29. The Respondent had the following relevant policies:

29.1 Recruitment and Selection Policy [**p. 138-163**]. Under the heading "Fixed Term Contract to Permanent" it provided that:

"10.4 When a vacancy is filled with a fixed term contract and the same role becomes permanent, the manager has to follow a new internal recruitment process.

10.5 Staff working on a fixed term contract will be given a chance to apply and HR will follow a fast -tracked recruitment process"

29.2 Managing and Implementing Change Policy [**p. 164-187**]. This provided a framework for managing change. Under "definitions" it provided that:

*"**Slotting In** means the process by which Staff At Risk are confirmed into a post in a new staffing or management structure which is similar to their current post and where that individual is the only contender for that post. Slotting in may occur where a post is in the same band as the individual's current post or where it remains substantially the same with regards to job content, responsibility, band, status and requirements for skills, knowledge and experience.*

***Staff at Risk** means staff whose posts may potentially be redundant as a result of organisational change if suitable alternative employment cannot be found"* [**p. 168**]

The policy set out the process to be followed when a member of staff is at risk of redundancy, the details of which are not relevant to this determination.

29.3 Whistleblowing – Raising Concerns at Work Policy [**p. 188-205**]. This included the provision under the hearing "5. Policy Specifics" that "*As soon as a whistleblowing concern is received by a member of the Trust, it is expected that the receiver will have up to 3 working days to refer the concern (s) to the relevant Executive Director and the Director of HR" [**p.197**]*

29.4 Grievance Policy and Procedure [p. **253-268**]

Dr X

30 Between 1 April 2009 and 9 May 2017 Dr X had been employed in the Respondent's Improving Access to Psychological Therapies (IAPT) Department as a Highly Specialist Counselling Psychologist (Band 8A) on a 0.4 WTE contract. This post was made redundant on 13 February 2017 and she was put "at risk" of redundancy. In her IAPT role Dr X had worked 1 day a week in the TSS as CPD. On 12 May 2017 Dr X was employed in the TSS as a Clinical Psychologist (Band 7 but on a protected band 8a salary) on a 1 year 0.3 WTE contract [**p. 299; 1506**]. On 16 April 2018 Dr X was employed in the TSS as a Locum Highly Specialist Clinical / Counselling Psychologist (Band 8A) ("the locum role") on a 1 year 0.4 WTE contract [**p. 301; 302-309; 1609-1615**]. This post was to provide cover for Dr Pain who was on maternity leave, with the remaining 0.6 WTE covered by another locum, Dr Parker. For both TSS locum posts Dr X went through a

competitive selection process and was interviewed by the Claimant and Dr El-Leithy. On both occasions she had been successful albeit the second choice. Dr El-Leithy was Dr X's supervisor. The Claimant's professional dealings with Dr X was limited to supervisions when Dr El-Leithy was on leave and team meetings. Prior to 2019 the Claimant had raised no concerns about Dr X's practice.

Chronology of events

31 In 2010 the Claimant had supported a patient's complaint against a GP for failing to identify potentially fatal symptoms; this resulted in a GMC investigation against the GP the outcome of which is not known. In supporting this complaint the Claimant was following the advice of her managers at the time. The GP then complained to the Respondent who conducted a "serious untoward incident" investigation into the Claimant. Such investigations are usually reserved for investigating patient deaths and assaults. This resulted in a letter of apology to the GP and an amendment to the Respondent's whistleblowing policy.

32 On 14 May 2018 the Claimant was signed off sick for 9 weeks with "work related stress" and "stress at work" (see GP notes dated 14 May and 27 June 2019 respectively [**p. 326; 327**]). The Claimant stated that at the time she was under "enormous pressure" from work and that this affected her mental health. Prior to going off sick, she had raised concerns with her professional supervisor about resourcing and management and expressed a loss of confidence in the Respondent's ability to improve / resolve issues internally [**p. 322-325**]. In May 2018, a locum, Katheryn Munroe, was brought in on a supernumerary basis on a 1 year 0.6 WTE contract to cover the Claimant's absence.

33 On 31 July 2018 the Claimant returned to work [**p. 328**]. Her health was discussed with Ms Woollett in her supervisions on 21 August and 25 September 2018, during which the Claimant stated that she was "feeling much better" [**p. 330; 335**]. There is no reference to the Claimant's health recorded in any subsequent supervision notes. Ms Woollett stated that in supervisions she discussed with the Claimant how to manage her workload including delegating tasks to other members of staff, not accepting research work and reducing teaching work. The Claimant did not deny these discussions. However we accept the Claimant's evidence that by the beginning of 2019 she had delegated the responsibility for supervision, teaching and training to Dr El-Leithy, and had delegated as much as she could. This was confirmed by Dr Kennerly since it had been discussed with her in her clinical supervisions. Further we accept the Claimant's evidence that she was not doing teaching or research and noted that Ms Woollett, in cross examination, merely referred to the Claimant having "lots of discussions with people about research".

34 In addition to her clinical work the Claimant was managing an administrator who had significant performance and behavioral issues. Her evidence was that this took up an inordinate amount of her time. Ms Woollett accepted that this had been raised with her in supervisions and there are references to HR and management involvement in a number of the supervision records including March, April, May and July 2019 [**p. 405; 444, 529 and 599]**.

35 The number of referrals to TSS fluctuated monthly, with the overall annual numbers averaging 140 (for the financial years of 2013/14 to 2017/18): [**p. 360**]. However in the year 2018/19 the number of referrals increased by around 35% and in January 2019 was predicted to increase to 198 persons from 147 in 2017/18 [**p. 360**]. We accept that the actual amount was slightly lower at 193, and that this then reduced to 132 in the year 2019/20 and 102 in the year 2020/2021 [**p. 1509-1512**]. This reduction appears to have started around January 2019 but was more significant from August 2019 [**p. 1509-1512**]. However at the beginning of 2019 the increase in referrals in the previous months was such that Mr Hare agreed to support the Claimant's request for funding from the commissioners for the TSS for an additional 1.0 WTE Band 7 or 8a. On 4 January 2019 the Claimant emailed Mr Hare providing him with information about the increase in referrals and stated that she was attempting to manage this temporarily by switching a day from providing treatments to assessments but that this meant that the wait for treatment was longer, "leading to dissatisfaction from patients and is not sustainable" [**p.359**]. On 17 January 2019 Mr Hare forwarded this email to Ms Moore [**p. 358**] and informed her that he was having discussions with the Claimant about how to ensure that the service was receiving appropriate referrals. An example of the Claimant addressing this is her email dated 6 February 2019 responding to an objection from the IAPT service following a request for more information in order to determine if a referral was appropriate [**p. 379**].

36 In addition to the significant increase in referrals, in December 2018 Dr El-Leithy reduced his hours to 0.8 WTE and Dr Pain returned from maternity leave on a 0.6 WTE contract. Mr Hare agreed that the hours released could be combined to create a 0.6 WTE Highly Specialist Clinical/Counselling Psychologist Role on Band 8a ("the substantive role"). The job description and person specification for this post was identical to the 0.4 WTE locum role that Dr X had been employed on. Both were on grade Band 8a, both job descriptions required the post holder to undertake clinical duties and non-clinical duties including teaching, training and supervision, service development and research. The person specifications for both posts required as essential "doctoral level training in clinical/counselling psychology" and as desirable "knowledge of the theory and practice of specialised psychological therapies in specific difficult to treat groups (e.g. personality disorder, dual diagnosis)" [p. **120 and 306].**

37 On 23 January 2019, Ms Moore emailed Ms Tracy Lynn (HR Business Partner) and Mr Hare about the termination of Dr X's fixed term contract due to expire on 20 April 2019 and referred to the Respondent's responsibility towards Dr X [**p. 365**]. She stated, "*we could have a post in TSS so need to know our position straight away".*

38 On 28 January 2019 Dr X emailed Ms Lynn asking if she would be entitled to be redeployed into the substantive role without an interview since she had already been interviewed twice for the locum roles. [**p. 362**]. Ms Lynn forwarded the email to the Claimant for her advice. In a subsequent telephone discussion, the Claimant informed Ms Lynn that the post should be externally advertised and that Dr X should not be slotted in.

39 On 6 February 2019 the Claimant met with Dr X to explain her reasons for

wanting the post to be externally advertised [**p. 375-376])**. These were
(1) that the post was 0.6 or 0.7 WTE and that Dr X was currently working on a 0.4 WTE;
(2) that the locum role was primarily clinical whereas the substantive role included supervision, training, service development and research; and
(3) that TSS was seeing an increase in the proportion of people with psychotic symptoms, neurodevelopmental disorders, head injury and / or dementia, and that she would be looking for the postholder to have skills and experience in assessing and treating people with these co-morbidities.

The Claimant informed Dr X that she could apply for the post and that *"since she has been successful at interview, twice, she is clearly in a very strong position, and Sharif [Dr El-Leithy], who is her clinical supervisor and manager speaks highly of her work*" [**p 376**].

40 The Claimant emailed Ms Lynn informing her of the discussion with Dr X. Ms Lynn responded to the Claimant's email the next day and asked:
(1) whether Dr X gave an indication as to whether she could increase her hours;
(2) whether Dr X expressed any interest in undertaking the other non-clinical aspects of the role; and
(3) whether Dr X was able to train to attain the new skills and experience identified by the Claimant [**p. 376**]?

41 On 7 February 2019 the Claimant responded to Ms Lynn's questions stating that Dr X was considering increasing her hours but that her other concerns remained. That she did not know whether Dr X wanted to do, or could do, the non-clinical aspects of the role. On training, she stated that it would "take years" to develop clinical skills of working with people with psychotic symptoms, neurodevelopmental disorders, head injury and / or dementia, and that this was not something that the TSS could teach [**p. 377**]. The Claimant had come to this view based on her experience that this was not normally covered in counselling psychology training; she did not in fact know what training Dr X had done. Nevertheless the Claimant concluded her email stating that Dr X *"is in a strong position as she knows the service and her clinical supervisor is positive about her work*".

42 The Claimant expressed similar views in an email on 8 February 2019 to Ms Woollett, copied to Dr El-Leithy **[p.386-387]**. She again concluded that "*we all think highly of the work that she [Dr X] has done and will support her through the redeployment process whether to this or any other post*". The Claimant was due to go on annual leave and expected the recruitment process to commence in her absence since it had been agreed with HR that the post would be externally advertised.

43 Ms Lynn's evidence, which we accept, was that whilst she could advise the Claimant on HR matters, she was not an expert on what was required of the role and therefore deferred to the Claimant's greater expertise. However she was concerned about Dr X's employment rights, both as a member of staff on a fixed term contract where the role was being made permanent under the recruitment and selection policy, and as a staff member who was 'at risk' of

redundancy who should be 'slotted in' to a post which was substantially the same under the Managing and Implementing Change Policy. Ms Lynn therefore raised the matter with Ms Woollett.

44 Ms Woolett discussed the Claimant's position with her clinical supervisor, Dr Petch. His view was that since Dr X was already working in the same role as a locum for 2 years without any concerns about her practice she should be slotted in. Ms Woollett also spoke to Dr El-Leithy in his capacity as Dr X's supervisor, and he informed her that he had no concerns regarding Dr X being slotted in or her competencies.

45 On 17 February 2019 Dr X emailed Ms Woollett (copied to the Claimant and Dr El-Leithy and others) setting out her position that she should be slotted into the substantive role under the Respondent's Managing and Implementing Change policy [**p. 390**]. She stated that the clinical population issues that the Claimant had referred to could arise in any clinical service. She also stated that tasks such as supervision and service development were part of her other role in the IAPT.

46 On 5 March 2019 Ms Woollett informed the Claimant by email that having consulted Ms Lynn and Dr Petch she was proposing that Dr X should be slotted into the post. This was because Dr X was employed under the same job description as the post that the Claimant wanted to advertise, she had 2 years' service and there had been no concerns expressed about her skills and performance over that time. Further that whilst the Claimant may have different expectations of the permanent post she would need to have a plan through supervision and training etc. to enable Dr X to fulfil these expectations [**p. 402**]. Ms Woollett did agree that it was in the interest of service for the post to be 0.6 WTE not 0.4 WTE.

47 Separately to the issue of Dr X, the Respondent had submitted to the commissioners a Demand Pressure Report dated 13 February 2019 setting out the case for funding for the additional 1.0 WTE post for the TSS including the *"significant increase in referrals this year that had resulted in placing additional pressures on the existing staff within the service"* [**p. 439-443**]. The report stated that doing nothing would result in patients waiting longer to access treatment, increasing crisis episodes and slowing recovery. The TSS Demand Pressure Report for TSS was one of 13 bids submitted to the commissioners for extra funding [**p. 437**]. On 5 March 2019 Mr Ince emailed clinical directors and others including Ms Moore, Dr Adams and Mr Wylie reporting on the conversation between the Executive and the Commissioners on the bids **[p. 435-436**]. They were informed that not all the bids could be funded in 2019/20, and were to be split into the highest and lower priorities. As a result of this process the TSS's bid was not identified as the "highest priority", and was therefore unsuccessful. Neither the Claimant nor Ms Woollett were party to these discussions or copied into these emails. The Claimant thought that commissioners had not been asked to provide funding, she was wrong about this. We consider that this was a misunderstanding on her part caused by the fact that at the time she did not have an operational manager.

48 On 12 March 2019, following her return from annual leave, the Claimant emailed Dr Petch (copied to Ms Woollett) stating that she was "extremely concerned, and indeed, unhappy" about the proposal to slot Dr X into the role and requested a meeting [**p. 401**]. A meeting took place the same day. There are no notes of this meeting, and the Claimant did not provide any evidence as to what was said.

49 On 15 March 2019 the Claimant sent a lengthy email to Dr Petch, copied to Ms Woollett and Dr El-Leithy [**p. 413-418**]. In the email the Claimant reiterated her view that that the two roles were different in that locums were not expected to carry out the non-clinical elements of the role and therefore these elements had not been assessed when interviewing for the locum position. In relation to Dr X, the Claimant stated that she was the second choice in the last locum interview process. She referred to the increase in demand on the TSS coupled with the more complex presentation of patients, particularly in relation to psychosis and provided 4 examples (none of which related to Dr X). She then stated: *"Clearly, the primary issue here is patient safety. However, I am also aware that, in the event of death, or other serious incident, I, and the Trust have to be able to able to justify our practice. I am concerned that "slotting in" someone who may have no training in assessing or treating psychosis and who, to our knowledge, may have encountered psychosis and complexity and risk in the context of her IAPT post, it is most unlikely, that she has experience of treating people with these. Clearly, this could be more fully assessed in some way":* **DISCLOSURE 1.**

50 The Claimant acknowledged that Dr El-Leithy did not share her view. Whilst he agreed that Dr X's non-clinical skills had not been assessed in the locum interviews, he was concerned about assumptions being made on the basis of Dr X's counselling psychology qualifications, which the Claimant accepted as a "fair point". Dr El-Leithy's position was that any areas where Dr X was less strong could be managed within the team. The Claimant commented: *"I would have made the same points at any time in this post, but to do this now, when the service is under such extreme pressure seems to me, frankly unjustifiable. As regards the areas of relative skill weakness being "managed" within the team, while a laudable aspiration, with respect, I disagree. I think it is unrealistic, especially when so much of my time is already spent managing the difficulties in relation to the administrator"* [**p. 417**]: **DISCLOSURE 1**.

51 The Claimant's oral evidence before us was that she thought Dr El-Leithy's view of Dr X's abilities were similar to her own, but that he was reluctant to express this to her. She based her view on comments that he had made in relation to Dr X such as she was "not the easiest person to supervise" and that she was "not present in meetings". She asked Dr El-Leithy to provide her with written feedback, but he had failed to provide this information in a timely manner and she concluded that this was deliberate. We considered that the Claimant was wrong in her interpretation of Dr El-Leithy's view and that his non-response was deliberate for reasons that will become apparent below.

52 In the same email the Claimant referred to the 35% increase in referrals and that the TSS was "*seriously struggling to manage*". The Claimant wrote that Dr El-Leithy agreed that the service was unsustainable at the current level and that without an increase in resource, the service would need to alter the inclusion criterion or the

practice in some other way. Ms Woollett in cross-examination confirmed that she was aware that Dr El-Leithy agreed with the Claimant that the position was unsustainable.

53 On 19 March 2019 the Claimant had a supervision meeting with Ms Woollett [**p. 405**]. In relation to Dr X, it was recorded that the "post will be advertised". In relation to the demand pressures on the TSS it is recorded that the Claimant expressed concern regarding lack of clear management causing difficulties with communication on activity and targets. There was also a discussion about how to manage the increase in demand, which included:
(a) spending more time on assessment (but this resulted in a dilemma due to increasing treatment waiting list);
(b) continuing to work on reducing inappropriate referrals including to stop accepting cluster 8 referrals (i.e. those with unstable personality disorders and at higher risk of self-harming); and
(c) stop taking people who have already had a treatment in the service. [We accept the Claimant's evidence that this would have required senior management approval]).

At the same meeting the Claimant reported that she *"has been working very long hours before and after leave; Will aim to address this to get better work life balance. Siobhan [Ms Woollett] to monitor for Pippa's welfare*" [**p. 406**]. It is recorded that this was to be actioned by Ms Woollett.

54 On 20 March 2019 Ms Lynn emailed Dr X to inform her that the substantive role was to be advertised externally [**p. 407, 412**]. Dr X responded requesting a copy of the grievance procedure and the timescale for raising a grievance [**p. 421**].

55 On 21 March 2019 Dr Petch had a further discussion with Ms Moore and Ms Lynn. He then emailed the Claimant informing her that Dr X was considering taking out a grievance and that refusing to slot Dr X into the substantive role put the Respondent in a weak position legally because the posts were "sufficiently similar" to be considered suitable redeployment [**p. 411**]. He also stated that if the Respondent externally advertised the post and invited Dr X to apply then *"it would mean we are implicitly saying it could be suitable for her".* In evidence Dr Petch stated that the issue was not whether Dr X was the best person for the job but whether she could do the job competently and safely.

56 On 27 March 2019 the Respondent extended Dr X's contract (due to end on 31 March) by 6 weeks to enable the Claimant to have a meeting with Dr X and her union representative about the suitability of the substantive role [**p. 431-432**].

57 Meanwhile in relation to the demand pressures on the TSS, the SIREN report for March 2019 included the comment: "*team operating under severe pressure due to demand substantively exceeding capacity and no operational manager in post*" [**p. 430**].

58 On 9 April 2019 Mr Ince emailed the clinical directors and others, including Ms Moore, Dr Adams and Mr Wylie setting out the next stage in the Respondent's demand pressure work, which included conducting a quality impact assessment

(QIA) "*for all the services which you identified as being under demand pressure*" [**p. 433-434**]. Therefore this included the TSS. Mr Ince explained that the purpose of the QIAs was to enable the trust to "*make a risk assessment of each of the pressure areas. These will then facilitate discussions about how to allocate the limited MH [mental health] funding, available in the contract, across the list of pressures, while keeping patients safe and maintaining quality*". He also stated that QIAs "*will also signal to commissioners any mitigating actions we may need to take related to outcome and performance measures, for unfunded pressure. For example relaxing waiting times or control of referrals*". He proposed that QIAs be developed during April. We find that no QIA was done for the TSS.

59 On 16 April 2019 in supervision with Ms Woollett, the Claimant continued to raise concerns about the lack of clear management and the increase in demand and had a similar discussion as previously about how to manage this increase [**p. 444-445**].

60 On 24 April 2019, the Claimant accompanied by Ms Lynn met with Dr X and Dr X's union representative to explain her decision to externally advertise the substantive post with reference to a document titled "Traumatic Stress Service Contextual Service Information: The distinction between the Locum and Substantive TSS 8a posts" [**p. 952- 957**]. This document repeated the same points in relation to the increased complexity of patients and gave the same 4 examples of serious risk issues in relation to psychotic symptoms. The Claimant then wrote:

"Clearly, the primary issue here is patient safety. However, I am also aware that, in the event of death, or other serious incident, I, and the Trust have to be able to able to justify our practice. I am concerned that "slotting in" someone who may have no training in assessing or treating psychosis and who, to our knowledge, may have encountered psychosis and complexity and risk in the context of her IAPT post, it is most unlikely, that she has experience of treating people with these. Clearly, this could be more fully assessed in some way.

I have some concerns about [Dr X's] skills in this area, since there are two cases I have been involved with, where she had conducted assessments (one in IAPT and one in TSS) where serious longstanding psychotic symptoms were not identified (clients [A] and [B]). Given the recent examples above, this is not a theoretical risk" [**p.954**]: **DISCLOSURE 2a.**

In relation to the non-clinical elements of the role, the Claimant accepted that Dr X had some supervision experience in her IAPT role but expressed concern about her ability to supervise more complex cases, and stated that the other non-clinical skills were either "untested and / or absent".

61 At this meeting the Claimant also provided a revised job description for the post, along with commentary as to how Dr X did not meet the criteria of this revised job description [**p. 958-967**]. This had not gone through any formal process and we find that the Claimant did not have authority to unilaterally change the job description.

62 Following the meeting Dr X emailed Ms Lynn stating that she wished to raise a grievance and on the 30 April 2019 Dr X submitted a formal grievance over the

Respondent's failure to follow its internal Managing and Implementing Change policy by slotting her into the substantive role [**p. 446-447; 451-464**].

63 The decision to externally advertise the post was paused to enable the grievance to be determined. The Respondent's HR proposed going straight to stage 2 of the grievance process which involved a panel hearing and decision with a right to appeal [**p. 449**]. In her email dated 30 April 2019 Ms Lynn wrote that the purpose of the hearing was two-fold: (1) to "reduce the risk" should Dr X submit a claim by demonstrating that the Respondent had conducted a formal process and (2) *"it is also good for Pippa to be accountable to formal procedures due to her decision making at present*". We accept Ms Lynn's evidence that the procedures she was referring to was the recruitment and selection policy and Dr X's employment rights.

64 On the 9 May 2019 Dr X's contract was further extended to 9 August 2019 [**p. 478 - 479]**.

65 On 16 May 2019 Dr El-Leithy wrote a letter in support of Dr X, as her supervisor [**p. 483-488**]. He specifically requested this only be disclosed to Dr X's union representative, HR and the grievance panel and not to any other party without his explicit consent since the Claimant was his clinical and professional supervisor and there was "some sensitivity" about him supporting Dr X. In the letter he stated that he was happy with the quality of Dr X's clinical work and professional standards. He was impressed by her commitment to developing her specialist PTSD competencies and her progress in this respect, that she had fitted in well with the team and become a core and valued team member. He then stated that with 4 exceptions no concerns had been raised with him either during the period of her CPD placement or her two part-time locum positions. These exceptions were:

65.1 A difficult patient that Dr X had seen in 2016 who had become angry and left the room and refused to work with Dr X. The patient had been transferred to Dr El- Leithy and been discussed with Dr X in supervisions. Dr El-Leithy wrote that "*I did not think that there was an issue around your competence, and you were open to reflecting and learning from the encounter in terms of managing difficult therapeutic interactions".*

65.2 In April 2019 the Claimant raised a general concern in relation to Dr X's ability to assess and manage psychotic symptoms in the context of her perception of an increase in these presentations and her assumptions about Dr X's training and experience in this area. Dr El-Leithy wrote that "*I felt that, if there was indeed an issue, it was one for the service as a whole, given that a number of the clinicians had struggled with psychosis presentations that arose at assessment and / or had interrupted treatment".* He felt that this could be addressed through supervisions and he had agreed with Dr X to have this as a standing item.

65.3 In April / May 2019 the Claimant had raised with him concerns in relation to two patients that Dr X had historically assessed and had not identified the presence of psychotic symptoms. [These are the same two patients that the Claimant had referred to in the TSS Contextual Service document].

65.4 Patient A was assessed by Dr X in January 2016. [We find that this was before Dr X was employed as a locum by TSS and therefore arose during her CPD]. The patient had since been under the care of TSS and received two episodes of treatment with core members of the team including the Claimant. During this treatment the patient had informed the Claimant that she had presented with psychotic symptoms (hearing voices) when she was assessed by Dr X. Dr El-Leithy wrote *"I have reviewed the case records in detail, and also recall the case from our supervisory discussions. I am entirely satisfied that there were no indications of psychotic symptoms during your assessment, or indeed present in other records of encounters with health professional at the time. Indeed none were identified by the specialist registrar who subsequently assessed her in March 2016*". He concluded that there was no evidence that Dr X had failed to identify psychotic symptoms because these had only emerged later. He also stated that Dr X had made entirely appropriate referrals at the time and that he had informed the Claimant of his view. [The Claimant confirmed this in her evidence].

65.5 Patient B was assessed by Dr X in her role as IAPT in December 2017 and referred to the TSS. The Claimant assessed the patient in late 2018 and was informed by the patient that she hears voices. The patient was seen by a specialist registrar in November 2018 who concluded that the experiences were not psychotic in nature. Dr El-Leithy wrote that he had reviewed Dr X's original assessment report and referral and "*felt it was comprehensive and of a high standard relative to what is typically undertaken at step 3 in IAPT services*" and concluded that Dr X had not inadequately assessed the patient. In an email dated 20 October 2019 the Claimant agreed with Dr El-Leithy stating *"I would not expect an IAPT assessment to include assessment of hallucinations or other possible psychotic symptoms*" [**p. 843**]. [The Claimant confirmed this view in her evidence].

Dr El-Leithy concluded that in relation to the management of risk/safeguarding issues that Dr X was a "safe pair of hands" that she sought consultations and supervisions on risk issues appropriately and managed them effectively and documented her work in detail: [**p. 486**].

66 He further stated that Dr X had been allocated the full range of band 8a caseload, the only restriction was being able to complete treatment within 1 year (due to the fixed term nature of her contract), but that this had not excluded many cases since the average treatment course was 20 sessions [**p. 486-487]**. Further that he did not consider any gaps in Dr X's learning would significantly impair her ability to carry out all the duties of a band 8a role to a high standard [**p. 487**]. Finally whilst the non-clinical elements of the role had not been tested in interview they did form part of the consideration at shortlisting and were a relatively small part of the role.

67 Dr El-Leithy was well respected in the profession and has recently co-authored a book "Working with Complexity in PTSD". Dr Young was aware of his reputation and agreed that he was an expert in training people and giving advice

on how to deal with patients presenting with complex PTSD. She agreed he was a "safe pair of hands" to supervise a counselling psychologist to address any gaps in their knowledge.

68 Dr El-Leithy's letter was sent to the grievance panel on 20 May 2019 [**p. 500-501**]. In a pre-hearing meeting on 22 May 2019 Ms Ogundeji advised Dr Petch and Dr Adams that they could not take it into account because it could not be disclosed to the Claimant. The letter had however been read by both Dr Petch and Dr Adams and we find that that it did form part of their consideration since they both refer to it in their statements and oral evidence.

69 On 21 May 2019 the Claimant attended a supervision with Ms Woollett [**p. 502**]. The Claimant was informed that Ms Melissa Ellison was to become the operational manager from 3 June 2019 (in fact Ms Ellisson did not take up the role). It was noted that Ms Munroe was due to leave and that "there will be a gap and will put pressure on the service". It was further noted that "Pippa [the Claimant] working long hours as very busy – need to address".

70 Dr X's grievance hearing took place on the 22 May 2019 [**p. 504-509**; **p. 1597-1601**]. The panel was Dr Adams as chair and Dr Petch as professional advisor, with Ms Bola Ogundeji (Head of Business Partnering and Resourcing) present in an advisory capacity. The Claimant attended to present the management case supported by Ms Lynn. In advance of the hearing the panel were provided with Dr X's grievance and accompanying timeline, the Claimant's TSS Contextual Service Information Report and proposed job description [**p. 492-493**]. No minutes were taken. We are surprised about this given that this was a formal hearing attended by HR personnel. We found the recollections of all the witnesses as to what was said at this meeting to be poor. The Claimant had made notes in advance of the hearing which set out the points she intended to make with reference to the TSS Contextual document and amended Job Description [**p.504-505**]. In the absence of evidence to the contrary we accept that this reflected what she said at the meeting and that she relied on the same disclosure as that made at the informal meeting on 24 April 2019 (**DISCLOSURE 2b**). The Claimant claimed that she had brought with her the anonymised case files for patients A and B, but that she was not given the opportunity to share this with the panel. This was denied by the Respondent. However Dr Petch said in cross examination that the Claimant's request had been refused because the Claimant had had ample chance to provide this evidence in advance of the hearing. We therefore find that the Claimant did ask to adduce this evidence and that her request was refused.

71 On 24 May 2019, the Claimant emailed Dr Adams (copied to Dr Petch and Ms Ogundeji) with further representations regarding slotting Dr X into the substantive post [**p.520**], stating:

"…as Clinical Lead for the service, I need to put in writing my concerns regarding clinical risk. As you can see from the incidents regarding the high-risk Fulham patient, although I have great respect for Sharif's [Dr El-Leithy] clinical skills and risk management, I take a more conservative approach to risk, hence escalating it to you. This may, in some measure, account for the difference in

relation to the 'slotting in' issue.
….
Given this, if the panel decides that [Dr X] should be slotted into the TSS post, I need a statement from you in writing, as Clinical Director of the Community Service line stating that I have raised my concerns about [Dr X's] skills, training and experience in relation to psychosis and risk, and explained the implications of this for her role in this service. If I have to attend a coroner's court, I then have evidence that I have done my utmost to alert all relevant people to the risk, and been overruled.": **DISCLOSURE 2c.**

The Claimant also referred to the 35% increase in demand and that this had placed TSS under "safety critical levels of pressure" and that she had been working "*between 11 and 13 hours every day since Christmas, to try and manage the work safely, ensure CQC requirements are met and resolve the recruitment issues*" [**p. 520**].

72 The Respondent was concerned that this email could be construed as interfering with the grievance process since the panel had yet to reach a conclusion and it had not been copied to all parties. Dr Adams emailed the Claimant informing her of this and also informing her that if she had any concerns about any aspect of the service or safeguarding issues she should consider using the relevant escalation process through the service line (i.e. her manager) [**p.519, 522-523**]. The Claimant apologised stating that it was not her intention to compromise the integrity of the process [**p.522**].

73 In relation to the Claimant's working hours in evidence Dr Petch agreed that the Claimant's email referring to working long hours did raise "alarm bells". However, he confirmed that he did not discuss it with the Claimant. We found that he gave inconsistent evidence as to whether he had any discussions with Ms Woollett: he initially stated he did not discuss it with her due to "delegated responsibility", but then stated he did discuss it with her in May 2019 or thereafter but he had no specific recollection of the conversation. This discussion was not referred to in his witness statement and was not referred to by Ms Woollett in her evidence. Dr Adams' evidence was also inconsistent. In his witness statement he claimed that he was "unaware" of her the Claimant's working hours despite having been the recipient and responder of the email. He stated that had he been informed "*he would have immediately requested her clinical and operational line managers address the situation.*" (statement para 45). We find that neither Dr Petch nor Dr Adams made any attempt to have a discussion with the Claimant about her long working hours nor did they take any steps to ensure that this issue was addressed by her line managers.

74 On 30 May 2019 Dr X's grievance was upheld [**p.525-527, 528**]. The panel found that Dr X's locum role and the substantive role were "similar" and therefore should be treated as a suitable alternative employment. The reason for this decision was (in summary):

- the two job descriptions were the same;
- no evidence had been presented to support the Claimant's concerns of Dr X's clinical competence and other clinical work;
- 60-70% of the substantive role was clinical work and that any gaps in non-

clinical skills could be addressed over time;
- the length of time that Dr X had been in the locum role and her previous experience with the IAPT service; and
- Dr X's continuous service with the Respondent.

The outcome letter proposed a meeting between Dr X and the Claimant to discuss any support that Dr X or the Claimant may need to address the Claimant's concerns around patient safety and the need to fulfill the non-clinical aspects of the role. It also proposed that "*where there are service concerns that are not precipitated by one factor, I recommend that the Service Lead escalates to the Head of Service and relevant Senior Management Teams through the appropriate channels."* Dr Adams' view was that the issues raised by the Claimant in relation to increased risk were systematic and not attributable to any one individual, and were outwith the scope of the grievance. It would require reviewing the SIREN reports and utilising the clinical and operational management structures in place at the time.

75 On 31 May 2019 the Claimant had a supervision meeting with Ms Woollett [**p. 529**]. She stated in relation to the outcome of the grievance that she was still processing it.

76 The SIREN report for May 2019 stated that: "*there are serious issues of understaffing to manage the volume of referrals + of appropriate treatment cases leading to long waits for treatment and patient complaints*" [**p. 534**].

77 On or around 10 June 2019 Dr X asked the Claimant if she could do the post as a 0.4 WTE rather than 0.6 WTE. The Claimant responded that it would not be possible to split the post further since it would result in having someone for one day per week, which was unworkable [**p. 552**]. In the same email she asked Dr X for information about her training needs.

78 On 12 June 2019 the Claimant emailed Dr Adams, Dr Petch and Ms Ogundeji [**p. 554-556**], stating that:
"I have a number of serious concerns regarding the panel's decision relating to patient safety and the need for the Traumatic Stress Service ("the Service") to have the requisite skill set and experience for the created permanent vacancy to deal with level of risk presented by our highly vulnerable patient population. I feel that the panel in their decision has failed to appreciate the significant risks involved and I am not satisfied that the panel has given sufficient weight to the concerns about patient safety. I feel that the Trust's focus has been to comply with its Managing and Implementing Change Policy rather than consider the needs of the Service.

I would also make clear that my concern arises from the need to ensure that we have the right level of experience and skill set for the role, rather than the individual. My concerns are not focused on issues concerning [Dr X's] performance but what the requirements are for the role we have available. The panel in its decision has entirely ignored this point.
….
Nonetheless, I had already presented evidence regarding the risk profile of the

Service, such that 44% of patients I, personally, have assessed most recently, reported voices telling them to commit particular actions. 33% of those patients reported that their voices were telling them to kill or harm themselves. I am well aware of the debate around whether such anomalous perceptual experiences do, or do not constitute psychotic phenomena, but this is irrelevant here, since regardless of the label, there is evidence that such experiences increase clinical risk.
…
In respect of [Dr X], when she joined the Service, neither of the locum posts were considered similar for her to be slotted into. Additionally, she was not the preferred candidate on either occasion but was offered work on the basis that the preferred candidate did not want to work all the available hours. Whilst [Dr X] worked as a locum, she worked for the first year-in as a Band 7 0.3 WTE and the second year as Band 8a 0.4 WTE. This means that she has only one year of 0.4 Band 8a experience in this service. I do not believe that this experience means that she has the requisite and relevant experience now to be slotted into the permanent role.
….
I am aware of two examples where [Dr X] did not identify that patients were hearing voices telling them to kill themselves, which, as indicated above, we are increasingly being required to do." **DISCLOSURE 3.**

In addition the Claimant stated that the TSS was "struggling with the volume of work", the Claimant referred to feeling totally unsupported and requested that she be sent a copy of the whistleblowing policy.

79 The same day Dr Petch, Dr Adams and Ms Ogundeji met to discuss the Claimant's email [**p. 553-554**]. They did not agree with the Claimant's view that slotting in Dr X posed a risk to patient safety. In relation to the pressures on the TSS, Dr Petch suggested that Dr El-Leithy should be approached to see if he shared the Claimant's concerns. Dr Adams then emailed the Claimant informing her that the grievance process had concluded. He proposed that she meet with Ms Woollett and Mr Wylie "*to explore how your team is set up to assess referrals, allocate work, manage risk across the team and escalate risk appropriately through the service line"* [**p. 558**]. [This is evidence that by 12 June 2019 Mr Wylie had taken on the operational manager role. Prior to taking on the role Mr Wylie had little involvement with TSS, he was aware of the increase in demand pressure but not aware of the red SIREN reports].

80 On 14 June 2019 Dr Adams informed the Claimant that he would forward her concerns about team safety to Mr Wylie and Ms Woollett and suggest that she meet with them. He then did so asking them to meet with the Claimant to "*look at the way the team approaches / manages risk*" [**p. 564**].

81 On 13-14 June 2019 the Claimant took study leave to attend an International Trauma Conference in Rotterdam [**p. 530; 551**], this was followed by a period of annual leave with her returning on 7 July 2019 [**p. 939**]. We accept the Claimant's evidence that she was a delegate and not a presenter at this conference.

82 On 18 June 2019 Dr X emailed Ms Lynn stating that due to unforeseen

circumstances she was no longer able to do 3 days pw but could do 2 days pw, and enquired as to her employment position [**p. 565**]

83 On 26 June 2019 Dr El-Leithy emailed Ms Moore and Ms Wylie, copied to the Claimant, about the "demand and capacity issues in the TSS" [**p. 566-568**]. He stated that this was having "*a detrimental impact on our ability to deliver a safe, effective or efficient service"* and that these issues had been raised previously in July 2018, January 2019 and consistently in the SIREN reports. He set out the demands on the service and that new referrals and those awaiting assessment "*will breach the 18 week target from now on and indefinitely*". He provided detailed calculations explaining how based on current staffing levels, even if the TSS closed to new referrals for 12 months there was ***"****more than 15 months' worth of work outstanding*". He stated that the "*situation is unsustainable without additional long term resource changes or very significant changes to our referral criteria".* He proposed *"closing the service to new referrals for at least 4 months, restricting access to patients who have already had at least one credible course of treatment delivered locally, regardless of severity or complexity and permanently increase the establishment of at least 1 WTE".* He then stated: *"It is also important to remind you that beyond normal burnout, the nature of the work undertaken in the service has a specific risk for secondary traumatisation of staff. This risk is typically mitigated by careful management of workload and casemix. The demand pressures mean that we are no longer able to do this, and it is inevitable that staff will suffer harm as a result."*

84 On 28 June 2019 Mr Wylie responded to Dr El-Leithy's email (copied to the Claimant, Ms Woollett and Ms Moore), thanking him, stating that this was "*very helpful as discussed*" and that it will assist with the overall review of the TSS [**p. 566**].

85 The SIREN report for June 2019 stated that: "*the situation has further deteriorated since the last SIREN entry and is now safety critical. The fact that we received no response to the previous SIREN entries – including 4 consecutive high risk flags – speaks volumes as to the value of SIREN as a the Trust clinical governance tool* (sic)" [**p. 572**].

86 On 8 July 2019, having returned from annual leave, the Claimant emailed Mr Wylie referring to the change in the management arrangements and requested a meeting "fairly quickly" [**p. 582**]. We find, on the basis of this email chain, that the Claimant and Dr El-Leithy had not been informed that Mr Wylie was taking on the operational manager role until 18 June 2019 [**p.582-583**].

87 On 18 July 2019, sometime before 8:48am the Claimant telephoned Mr Lincoln Murray, a Freedom to Speak Up Guardian employed by The Guardian Service Limited. This is an independent organisation providing a confidential service to staff working in the NHS who wish to raise concerns (including whistleblowing concerns). A guardian's role is to assist a member of staff to formulate their concern and can forward that concern to the relevant trust. A guardian has no investigatory powers, forms no view on the merits and cannot provide advice. A concern forwarded by the guardian service carries no additional weight than if

submitted by a member of staff.

88 Following the telephone conversation with Mr Murray, the Claimant sent an email to him attaching a letter detailing her concerns [**p. 585-586**], and stated that:

"*The first issue relates to the "slotting in" of [Dr X], Locum Counselling Psychologist in the Traumatic Stress Service to the substantive Band 8a 0.6 WTE Clinical / Counselling psychology post, on the basis that she does not have the skillset required to protect patient safety.. My particular concern is that the placing of someone under the Managing Change Policy, takes precedence over patient safety*": **DISCLOSURE 4.**

"There are now additional responsibilities for the team in relation to implementing Trauma Informed Care across the Trust, which must surely include the needs of those with PTSD to childhood trauma, and the new diagnosis of Complex PTSD, it is imperative that all staff in the service meet all the requirements set out in the Job Description for the new post": **DISCLOSURE 5.**

"Secondly, Sharif El-Leithy, Principal Clinical Psychologist and I, have been raising concerns about the demand pressures on the service using the Trust's online Clinical Governance tool, SIREN, which uses a "traffic light" service risk rating system. We have flagged the service as "red" i.e. at risk, and at safety-critical levels, for four months without ever receiving a response. Since there have been no management meetings for five months – and, indeed, a lack of clarity regarding who holds operational management responsibility for the service – there has been no opportunity to raise these concerns in managerial meetings. I enclose a copy of the SIREN submissions, for your reference": **DISCLOSURE *6.***

89 In the same email the Claimant stated that she was unable to attach the Trust's whistleblowing form and that she would be "*sending a hard copy as well as supporting documentation, as discussed*". She further stated that she was only able to print off the most recent SIREN report but was happy to provide copies of the previous submissions once she had worked out how to retrieve them [**p. 592**]. At 3:34pm Mr Murray emailed the Claimant stating "*I will forward this to the Director of Nursing as discussed*" [**p. 592**]. At 4:22pm Mr Murray emailed the Claimant providing her with his postal address [**p. 590**]. The Claimant responded at 4:41pm stating "*ah, okay have addressed envelope but not sent yet, but I can correct that*" [**p. 590**]. At 5:24pm the Claimant emailed Ms Jennifer Birch (assistant psychologist) asking her to print off 3 copies of the relevant SIREN submissions [**p. 593**].

90 We accept Mr Murray's evidence that he never received the hard copy of the Claimant's whistleblowing form and supporting documentation. Mr Murray had no actual memory of the Claimant's case since he has dealt with 4-500 cases since 2019, therefore he relied on the contemporaneous entries on his database record. The Claimant stated in evidence that she had a clear memory of addressing the envelope but not of posting it, but she had a small desk and would have realised if she had not posted it. On the basis of the documentary

evidence we find that the Claimant did not put a hard copy in the post on 18 July 2019 because she was waiting for further information.

91 On 19 July 2019 the Claimant had a joint supervision meeting with Ms Woollett and Mr Wylie [**p. 599-600**]. We accept the Claimant's evidence that this was the first meeting that she had with Mr Wylie; Mr Wylie's evidence that there had been other unspecified meetings prior to this date was vague and not corroborated by any documentary evidence. During the meeting the Claimant stated that the redeployment of Dr X meant that the TSS would be "unsafe" and that she had "got employment law advice – suggested whistleblowing policy". In relation to the service review it is recorded that Mr Wylie stated that "*due to difficulty with capacity and demand it would be a good time to review what the commissioners want, how appropriate are the targets, recommend ways of dealing with demand etc. Simon will lead on this*" [**p. 599**]. The Claimant was informed that the review of TSS would not include her concerns about Dr X, since this decision had already been made.

92 On 20 July 2019 Mr Murray closed the Claimant's case file. It is recorded on his database that the reason the file was closed was because the Claimant had "*decided to write to HR*" [**p. 605**]. Mr Murray informed us that it was not unusual for the person contacting his service to change their mind and submit the concern themselves. Mr Murray stated he believed he was informed of this by telephone since his database recorded that 2 telephone calls had taken place [**p. 604**]. Although the dates of the phone calls were not recorded, since the first phone conversation was on the 18 July, it was likely that the second conversation was on the 20 July 2019 (the date the file was closed). The Claimant had no recollection of any subsequent telephone conversation, but we note that the Claimant made no further contact with the Guardian Service after this date and that she did subsequently raise her complaint with Ms Ford (who at the time was the Director of Nursing). We therefore find that the Claimant did inform Mr Murray that she would submit her whistleblowing concerns herself and that this was the reason he closed the file without forwarding her concerns to the Respondent.

93 On 22 July 2019 the Claimant emailed Mr Wylie and Ms Woollett regarding Dr X only being able to work 0.4 WTE stating this would be untenable due to the increasing fragmentation of the service [**p.606**]. Neither Ms Woollett nor Mr Wylie provided any response to this email. Ms Woollett forwarded the email to Mr Wylie and others asking whether it impacted on the redeployment of Dr X [**p. 606**], and did not receive a response to this query. Ms Woollett accepted before us that this was not an ideal situation given the resource issues at the time, and that it would be difficult to recruit to a 0.2 WTE post. She thought that the released funds could be used e.g. to increase the hours of another post or to employ locums.

94 On 25 July 2019 the Claimant emailed Mr Wylie to arrange a meeting to discuss TSS service issues that required urgent attention and could not wait until completion of the service review [**p. 623**]. She stated that one of the issues was that Dr X's contract was due to expire on or around 9 August 2019 and that Dr X would need to know what was happening as did the service. Mr Wylie responded on the 29 July 2019 suggesting a meeting to start work on the

improvement plan in relation to the following issues: staffing, administration, information governance, environmental issues, demand and capacity, policy update for TSS and adherence to trust policy to enhance safety and managing service e.g. lone working, risk assessment etc. [**p. 622**]. It was clear from this email that there was no improvement plan already in place and that the Respondent was only just starting work on formulating a plan. Mr Wylie stated in evidence that prior to the formulation of the improvement plan there had been "months of preparation" to understand the pressures on the service. We do not accept his evidence. He was not involved in those discussions and we have received no documentation of such work. His evidence runs contrary to the entries in the QPRs and the sequence of events set out above and below.

95 On 29 July 2019 Dr X was provided with a 0.4 WTE contract for the substantive post [**p. 608-619**]. Neither the Claimant nor Ms Woollett were consulted about this decision [**p. 624, 629**]. Ms Lynn explained that the reason she did not consult the Claimant was because time was running out since Dr X's fixed term contract due to expire in mid-August. It is unclear who made the decision to appoint on a 0.4 WTE. Ms Lynn stated that she had spoken to Ms Ogundeji who had informed her that management would need to manage the reduced hours. Ms Ogundeji denied that she had made this decision stating it was not her decision to make. We find that this was a miscommunication with Ms Lynn believing a decision had been made when it had not.

96 On 30 July 2019 the Claimant emailed Ms Vanessa Ford, the then Director of Nursing [**p. 624-625**], stating that:

"I have been raising patient safety concerns regarding the "slotting in" of the locum psychologist, [Dr X] into the substantive TSS 8a role for over six months. I have made it clear that the role requires a highly experienced clinician and my concerns are that Dr X does not have the appropriate training and experience. I have detailed my concerns on numerous occasions and particularly the requirement for need to be able to work with people experiencing visual and auditory hallucinations, which are an important indicator of clinical risk. Assessment is a key part of the substantive role and 33% of the people I have assessed recently as part of our routine assessment process report command hallucinations telling them to kill themselves.

As a Counselling Psychologist, she would not routinely be trained to assess or treat people experiencing these symptoms which is, as indicated, an essential skillset for the role. In support of my concerns, there is evidence as outlined in the grievance process referred to below, that she has missed command hallucinations in two cases seen in this service": **DISCLOSURE 7.**

Furthermore, despite it being accepted that we required the post holder to work for 3 days a week, Dr X has been given a two-day contract which will impact on the ability of the team to provide consistent cover as we will need to find another person to cover the other day. Again, this was decided without any prior discussion with me": **DISCLOSURE 8.**

"*Having taken advice, I have raised this, and the fact that we submitted four*

consecutive "red" SIREN submissions without a response, as a whistleblowing issue. Had there been any management meetings during those months, I would, of course, have discussed the patient safety issues with them, but there were none. There was an interim manager and then a lack of clarity as to who actually held managerial responsibility for the service. I have had no meaningful response to either the concerns raised below or to my whistleblowing concerns" [The "concerns raised below" was a reference to the email of 12 June 2019 which formed Disclosure 3, which the Claimant attached]: **DISCLOSURE 9.**

The Claimant concluded that *"since my primary duty, ethically and professionally, is to protect the safety of the patients in my service, my position is rapidly becoming untenable*". She requested an urgent response.

97 Ms Ford forwarded this email to Ms Janice Allen, her PA, to acknowledge receipt and obtain "the background" [**p. 624; 628**]. Ms Allen then emailed Ms Ogundeji, Dr Adams, Dr Petch, Mr Wylie and Ms Woollett for an update [**p. 632**].

98 Dr Petch stated, with reference to the 30 July 2019 email, that in his view the Claimant appeared to be unable to work with her operational and professional lead. That he considered there was an "*unwillingness or inability to knuckle down and be clear about the issues and address them*" and that it seemed to be a further attempt to block the redeployment of Dr X. He denied that he saw the Claimant as a troublemaker "*but someone showing lack of judgment*" since she was continuing to raise patient safety issues without providing any evidence.

99 On 31 July 2019 Ms Ogundeji responded to Ms Allen, copying in Dr Adams, Dr Petch, Mr Wylie and Ms Woollett [**p. 631-632**]. She attached the grievance outcome letter and stated that the panel found no compelling evidence that the posts were different and that there was no evidence to support the Claimant's subjective view that Dr X's performance or ability was inadequate. She referred to the Claimant not accepting this decision. She also stated that the Claimant had been informed that if she had legitimate service concerns these should be raised with the service line senior team. Ms Ogundeji concluded that: "*I strongly suggest that the SL [service line] leadership meet with Pippa including the head of profession to look into her concerns and perhaps get her to re-think her approach. If there are reasons why she feels someone is a risk, she needs to evidence it and follow the Trust's procedures and if there are service concerns that require intervention of additional sessions, again, there is a process for her to propose it rather than to appear to be penalising one member of staff for the issues".* Ms Ford's evidence, which we accept, was that Ms Allen failed to forward this response to her.

100 On 1 August 2019 Ms Ford became the Acting Chief Executive Officer.

101 The same day the Claimant met with Mr Wylie to discuss the formulation of an improvement plan [**p. 646-647**], there were no notes of this meeting but there was a subsequent exchange of emails. Mr Wylie provided a short bullet point summary of "*where we are in terms of Improvement Plan and progress going forward*" [**p. 651**]. The Claimant responded on 6 August 2019 stating, "*I also*

said that …." and proceeded to set out points that she had made [**p. 650**]. We do not consider these emails to be inconsistent, Mr Wylie was setting out action points whereas the Claimant was setting out a record of the issues she had raised at the meeting. In his evidence Mr Wylie could not recall if the Claimant had made these points, we find that she did since Mr Wylie did not dispute at the time the Claimant's account set out in her email and the points she raised are consistent with her previous statements. We therefore find that the Claimant said:
:

- That she believed that the TSS was "*clinically unsafe*" for three reasons.

- "*1. The skillset of [Dr X], who has been slotted in to the 8a role, does not meet the needs of the service, as previously discussed*": **DISCLOSURE 10**.

- "*2. The further fragmentation of the team by dividing the 0.6 WTE into 0.4 and a vacant 0.2 WTE when the service is already overly fragmented, making clinical and management continuity almost impossible":* **DISCLOSURE 11.**

- "*3. The increased volume of demand for the service without additional capacity or management support as to how this can be managed within the existing resources, since we have been told that we cannot close the waiting list"*: **DISCLOSURE 12.**

102 We also find that the Claimant stated that she had raised these issues verbally, in writing and via whistleblowing but received no meaningful response. That Mr Wylie had responded that her *"concerns had been heard, even though they had not been agreed with, that there was no additional resource and that was the Trust's position and that we would need to try and work within the existing resource*". We note that this comment appears to have been made in the context of a discussion about the Claimant's concerns about slotting in Dr X. The Claimant informed Mr Wylie that her position was untenable [**p. 650-652**].

103 In his action points Mr Wylie had recorded *"establishment and skill mix – Dr X 0.4 – how can we maximise support? Sharif [Dr El-Leithy] – leaving to take up new post – can we look overall to secure 1 x WTE for service going forwards?"* [**p. 651**]. This was a reference to the fact that Dr El-Leithy's post was 0.8 WTE and therefore could be combined with Dr X's 0.2 WTE to create a 1.0 WTE contract. Following the meeting Mr Wylie had emailed Ms Ogundeji informing her that Dr X would be working 0.4 WTE as established and that "*Going forward as part of our overall Improvement Plan look to see how we use other vacant sessions to build up to another WTE x 1. We will factor this in now as Sharif is leaving …."* [**p. 646-647**]. We find on the basis of this evidence that at the 1 August 2019 meeting the 0.2 WTE issue was resolved without any further fragmentation of the service.

104 On 6 August 2019 the Claimant emailed Mr Wylie stating that she had also raised with him that she had been working between 11-13 hours a day "every day since Christmas" which was neither sustainable nor safe [**p. 652**]. In evidence, Mr Wylie accepted that the Claimant had raised this and said that he

had responded that he did not expect her to work over her normal hours and that it was not good for her health. He recalled that at the meeting the Claimant was *“very anxious generally about the service”.*

105 In his evidence to us, Mr Wylie expressed the view that the Claimant’s long working hours was because she was failing to manage her workload, taking much longer to complete her clinical work than her colleagues and spending too long on assessments. He formed this view from discussions with unspecified others on unspecified dates, including Dr Petch. However Dr Petch did not corroborate this evidence. Dr Petch’s evidence was that he ”*could not determine whether these long hours that he heard about from time to time were a choice or a necessity or based on writing very long reports for courts*”. We note that Ms Woollett also referred to the Claimant spending too much time writing detailed clinical reports but provided no details. The Claimant denied that she spent longer on her clinical work than her peers stating her practice had not changed and that prior to 2019 she had been able to manage her clinical practice. We noted that there was no evidence that this was ever raised with the Claimant in supervisions, and we have seen no reference to this in any email or other documentation. Therefore we accept the Claimant’s evidence that this was not the cause of the increase in her workload.

106 On 9 August 2019, having received no substantive response from Ms Ford, the Claimant sent a follow up email as to when she could expect a response [**p. 660**]. The same day Ms Allen forwarded Ms Ogundeji’s response to Ms Ford. Ms Ford accepted that there was some confusion as to what should happen next. Ms Ogundeji had suggested the leadership team meet with the Claimant whereas Ms Allen was awaiting a draft response to send to the Claimant on Ms Ford’s behalf. Ms Ogundeji stated that it was not her understanding that she was to draft a response to her email and that this would not have been appropriate as she was part of the grievance panel.

107 On the same day the Claimant had a further meeting with Mr Wylie (**p.657**), we were not provided with any evidence from either the Claimant or Mr Wylie as to what was discussed, but we find that this was a continuation of the discussions on the improvement plan, since the August 2019 supervision notes refer to the Claimant conducting a review of the referral criteria and discussing it with Mr Wylie [**p. 687-688**].

108 On 12 August 2019 Ms Ford responded to the Claimant with an apology confirming that she had read the original email and had made enquiries with executive colleagues and “will be in touch shortly” [**p. 677**]. The same day Ms Ford emailed Ms McKenna (Chief Operating Officer) and Ms Foulkes (Executive Director of Human Resources) asking whether the recommendations by Ms Ogundeji had been followed up so that she could respond to the Claimant [**p. 712-713**]. Ms McKenna responded that she did not know but would make enquiries and emailed Dr Adams and Ms Moore [**p. 710-713**].

109 On 13 August 2019 that Claimant attended supervision with Ms Woollett. The notes recorded that the Claimant was awaiting response from Ms Ford in relation

to the redeployment of Dr X, that Dr El-Leithy's post was being advertised in October as 1.0 WT and that Mr Wylie was leading on the wider service review [**p. 678-679**]. At this meeting Ms Woollett recalled discussing with the Claimant how she was managing her professional working relationship with Dr X to which the Claimant responded that she had a good working relationship with Dr X and that they had been out to lunch. Ms Woollett could not recall if she also discussed the Claimant's workload and stress. We accept the Claimant's evidence that she was not asked.

110 On 14 August 2019 Dr Adams responded to Ms McKenna and Ms Moore informing them that the Claimant had met with Mr Wylie and Ms Woollett and that she was working with Mr Wylie to develop an improvement plan [**p. 711**].

111 On 15 August 2019 the Claimant complained about noisy building works due to take place outside the TSS that day [**p.715**]. This email followed a previous email from the Claimant dated 8 August 2019 stating that 11 days was insufficient notice of any building works and that the service may have to close [**p.655]**. Her concern was that the noise could cause flashbacks of trauma for some patients and that without proper notice to implement plans to adjust the service patients would need to be cancelled. Mr Wylie was copied into these emails and could not recall if he responded. He was aware of the Claimant's concerns since he had attended meetings with the Claimant and the Estates Modernisation Program team to discuss and look at solutions. He denied that it had a particular impact on the Claimant or the TSS in general and said that the service did not have to close at any point. Ms Woollett accepted that the Claimant had raised her concerns regarding noisy building works in her May 2019 supervision, but denied that this impacted on the Claimant's workload since she had delegated this issue to Dr El-Leithy.

112 On 19 August 2019 Dr X provided the Claimant with a breakdown of her training and experience [**p. 717-718**]. This included attending workshops on schizophrenia and assessment of psychotic symptoms. The Claimant's view was that attending workshops was insufficient whereas Dr Petch's view was that this training was "highly relevant". He did not agree with the Claimant that Dr X needed extensive training on assessment of psychotic symptoms, since the purpose of the TSS was to treat PTSD not psychosis. Further, being able to recognize the symptoms of psychosis in order to refer to a different service was not unique to TSS but required of all those working in mental health services; since Dr X had worked in IAPT she would have that experience. We prefer the view of Dr Petch to that of the Claimant. Dr Petch was a consultant clinical psychologist with 33 years of experience of working in a range of services dealing with patients presenting with complex conditions including psychosis. This included a year working with the Claimant in the TSS. His professional responsibilities included teaching and training on how to assess psychotic disorders. In addition, his view was consistent with the views of Dr El-Leithy.

113 On 20 August 2019 Dr El-Leithy wrote to the Claimant setting out the developmental feedback he had provided to Dr X in relation to her skills and abilities. This letter largely repeated the views expressed in his letter of support for Dr X's grievance [**p. 719-725**].

114 On 23 August 2019 Ms Ford emailed Ms Allen to chase a response from Ms Foulkes and Ms McKenna [**p. 728-729**].

115 On 27 August 2019 the Claimant resigned with three months' notice. In her resignation letter to Mr Wylie she stated that she had lost all *"trust and confidence in the Trust as a result of its continual failure to address my concerns regarding issue of patient safety and its neglect in providing proper resource for the TSS, its failures to abide by its own procedures and obligations including ignoring the whistleblowing concerns that I have raised and its lack of regard regarding its own obligations to me as an employee"* [**p. 729-732**]. She stated that the patient safety concerns were (1) the slotting in of Dr X and (2) the "massive pressure" on the service of managing the increase in referrals "without an increase in proper resource for about a year". She stated that she had raised her concerns at every level, exhausted all options and felt ignored at all stages. She concluded by stating that "*in my opinion the fact that both I and the service are on our knees is largely due to systematic management failure*". She did not hold Mr Wylie responsible for this failure and stated, "*I am grateful for your assistance with some of the other pressing issues in the service*", and expressed a willingness to be involved in the review of the service which was to take place.

116 Both Dr Kennerley and Dr Kerry Young (Clinical lead of the Woodfield Trauma Service in Central and North West London NHS Foundation Trust, a similar service to the TSS, and who acted as an unofficial mentor for the Claimant), confirmed that they were aware of the Claimant's concerns in relation to the slotting in of Dr X and the demand pressures on the TSS. They were also aware that she was working very long hours. Dr Kennerly stated that prior to her resignation the Claimant was "*visibly more stressed at each supervision meeting*" and gave accounts of poor sleep and deterioration in her mood. Dr Young stated that that for most of 2019 she was very worried about the Claimant, her mood was clearly suffering, she as having trouble sleeping and said she was regularly working until really late in the evening.

117 On 29 August 2019 Dr Victoria Hill (acting Clinical Director for Community Services), emailed the Claimant and others to check the data on long waiters (those on waiting lists for more than 52 weeks) [**p. 740-741**]. The Claimant responded on 30 August 2019 stating that "*The number of long waiters should come as no surprise to senior management, since I had been raising the treatment waiting times with our various managers for years. Indeed, the last 5 SIREN reports had been red on this basis, amongst others*". She informed her that Mr Wylie was conducting a review of the service which included 'capacity issues' but did not know the timeframe for this [**p. 738-740**]. Dr Hill responded stating that she will discuss "urgently" with Mr Wylie on his return from leave the next week and "*we do need to conduct a service review, given the increase in the referrals and TSS caseload*" [**p. 737**]. Her response supports our finding that prior to this point there had not been discussions at executive level about how to address the demand pressures on the TSS.

118 The TSS SIREN report for August 2019 included the comment "*ward / team is under significantly more stress than usual and struggl....*" [**p. 744**].

119 On 3 September 2019 the Claimant attended a conference returning on the 9 September 2019 [**p. 651**]. We accept the Claimant's evidence that she was a delegate and not a presenter at this conference.

120 On 4 September 2019, Dr Hill emailed Mr Wylie informing him that Ms Ford had asked her to write a brief position statement to get approval for a short period to stop referrals and to approve locum cover [**p. 762**]. Later that day Dr Hill sent a position statement with recommendations for consideration by the Executive [**p. 1533-1535**]. This referred to the increase pressure on the TSS caused by 33% increase in referrals over the last 12-18 months, the disruption in administrative support as a result of admin capability issue which was being addressed via HR processes, the resignation of the two senior member of the team, that the team had no team manager but is being operationally managed by Mr Wylie and that Mr Wylie was conducting a review of the service with Dr Petch and had produced an improvement plan [**p. 1535**]. The recommendations included:

(a) executive approval "*to close to referrals for a period of 4 months and then review";*

(b) executive approval *"to employ a locum / agency psychologist to provide treatment to the long waiters within the service"; and*

(c) "Review the contract / service agreement and propose that access to TSS is restricted to only those patients who have already had at least once credible course of treatment…"

Ms Ford asked Ms Hill to add a recommendation that the Executive have a more detailed discussion about the clinical model, to which Ms Hill responded that this issue was already part of the planned review of the service "*as we know that demand is outstripping capacity*" [**p. 1546**].

121 On 5 September 2019 Ms Ford emailed Ms Foulkes regarding no response having been provided to the Claimant following her emails of the 30 July and 9 August 2019 and expressing concern that since the Claimant had handed in her notice the Respondent could be vulnerable [**p. 765**]. Ms Foulkes responded that the issues were "a bit broader" than the recruitment process and advised that the Claimant be informed that the matter had been passed to her and that she would discuss with Ms Mardon (Assistant Director of HR and Ms Ogundeji's line manager) "*who is best placed to carry out the fact finding investigation*" [**p. 764**]. Ms Ford asked Ms Allen to email the Claimant with her apologies for the time lag and to inform her that Ms Foulkes would be dealing with her concerns [**p.764**]. Ms Ford in evidence stated that she had checked her emails and was not sure that Ms Allen sent an email to the Claimant. We accept the Claimant's evidence that she received no email from Ms Ford after 12 August 2019.

122 On 11 September 2019 Dr Hill emailed Mr Wylie, Ms Moore and Dr Petch stating that following initial discussions with the commissioners it would be "a challenge" to get them to agree to close the TSS to new referrals. Further the commissioners only agreed that locums / agency staff could be employed "*to cover the staffing gaps (but not to cover the backlog of work)*". She stated that this would not address the current backlog / long waiting list *"so we need further thinking on this – a change in the current model to quicken the assessment /*

treatment timeline without diluting quality? A real challenge" [**p. 772-773**]

123 On 17 September 2019, Mr Ogundeji emailed Ms Ford referring to the Claimant's resignation, among other things, and stated that she had been in touch with the service leads in relation to what they are doing to manage the service concerns raised by the Claimant and the Claimant's perception of them including *"whether anything can be done to change her mind*" [**p. 774**]. Ms Ogundeji then added the comment "*not that I am sure they will want her to change her mind as they also have some other concerns about the service*". We accept Ms Ogundeji's evidence that this was a reference to a separate issue, unconnected to the patient safety concerns that the Claimant had raised.

124 On 25 September 2019 Mr Wylie sent the TSS Improvement Plan to the Claimant [**p. 777-783**]. This identified 7 aims including patient safety aims of timely interventions, robust risk management and manageable caseloads. The recommended actions included a review of the current establishment with a view to recruit another WTE psychologist. It also proposed to "cease all new referrals to TSS to enable recovery" but this was amended on 7 October 2019 to a comprehensive analysis and review to be conducted before closing to new referrals [**p. 811**].

125 On 10 October 2019 the Claimant met with Mr Wylie to discuss the improvement plan and on 14 October 2019 the Claimant thanked Mr Wylie for the meeting and provided him with detailed comments on the aims and actions suggested in the plan [**p. 820-823**]. On 15 October 2019 Mr Wylie responded thanking the Claimant for her comprehensive response [**p. 827**].

126 In a separate discussion with Dr El-Leithy, Mr Wylie had proposed in an email dated on 17 October 2019 (copied to the Claimant) that the TSS needed a "*comprehensive review going forwards*" since the "*current model is not sustainable with our demand, resource etc*" [**p. 852**].

127 On 4 November 2019 the Claimant was signed off sick with depression [**p. 887; 888**].

128 On 11 November 2019 the Executive submitted another Demand Pressure Report for the TSS requesting an additional 2.0 WTE Band 8a psychologists to match the level of demand for the service [**p. 889-895**]. It stated that referrals had continued to increase since the previous bid and that the risk of not funding the service to meet demand included longer waiting times for treatment resulting in *"slower recovery, longer duration of sessions to achieve recovery* and *"the increased risk to patients and their families arising from untreated PTSD"* [**p.890**]. It also referred to the knock on impact on other services if PTSD was not treated. A year later, in October 2020 the commissioners agreed to fund two additional full time band 8A Clinical psychologists. Mr Wylie accepted that this bid was made in recognition of the fact that there was not sufficient staffing in the TSS and that this was only resolved after the Claimant had resigned.

129 The Claimant's employment terminated on 27 November 2019.

130 Ms Woollett in her evidence referred to a computer printout of the annual leave that the Claimant had taken during her employment with the Respondent [**p.938-941**]. Her evidence was that in 2018 the Claimant took 35 days annual leave and in 2019 42 days annual leave (of which 4 days was unpaid). The Claimant did not challenge this evidence. We accept that she took this leave in order to manage her mental health.

131 The Claimant contacted ACAS on 24 February 2020 and the ACAS Early Conciliation Certificate was issued on the 24 March 2020 [**p. 1**]. On 23 April 2020 the Claimant submitted her ET1 [**p. 2**].

THE LAW

PUBLIC INTEREST DISCLOSURES

132 In order to be a protected disclosure under Part IVA of the Employment Relations Act 1996 (ERA 1996) the disclosure must satisfy two conditions:
(a) it must be a qualifying disclosure made in accordance with s 43B(1) ERA 1996; and
(b) it must be made in accordance with one of the six specified methods in s 43C-H ERA 199.

133 Section 43B(1) of the Employment Relations Act 1996 (ERA) defines a qualifying disclosure as:
"…. any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show one or more of the following—
….
(b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,
…
(d) that the health or safety of any individual has been, is being or is likely to be endangered…."

Thus in order for a disclosure to be a qualifying disclosure:
(a) there must be disclosure of information;
(b) the worker must reasonably believe that the information tends to show one or more of the specified wrongdoings (in the Claimant's case this is a breach of legal obligations and / or endangering health and safety); and
(c) the worker must reasonably believe that the disclosure is made in the public interest.

134 A disclosure of information is required to be more than an allegation in that it must have sufficient factual content and specificity such as is capable of tending to show a specified wrongdoing: **Kilraine v London Borough of Wandsworth** [2018] ICR 1850 (CA). It is a matter for the evaluative judgment of the tribunal in the light of all the facts of the case (paras 35-36). The communication of an opinion can amount to a disclosure of information: **McDermott v Sellafield Ltd and Oth** [2023] IRLR 639 (EAT). Two or more communications can be read

together; it is a question of fact for the tribunal whether to do so in any particular case: **Norbrook Laboratories (GB) Ltd v Shaw** [2014] ICR 540 (EAT); **Simpson v Cantor Fitzgerald Europe** [2020] EWCA Civ 1601 (CA).

135 In assessing whether the worker had a reasonable belief of one or more of the specified wrongdoings, the tribunal must assess (a) whether the worker subjectively believed that the information tended to show that wrongdoing and (b) whether objectively that belief was reasonable. Professionals can be held to a different standard then laypeople as to what it is reasonable for them to believe: **Korashi v Abertawe Bro Morgannwg University Local Health Board** [2012] IRLR 1 (EAT). The example given in **Korashi** was that a consultant surgeon disclosing medical wrongdoing would be expected to check the medical records whereas a lay person making the same disclosure would not. A belief may be reasonable even if it is wrong: **Babula v Waltham Forest College** [2007] ICR 1026 (CA).

136 Where failure to comply with a legal obligation is relied upon, save in obvious cases the Claimant must identify the source of the legal obligation: **Blackbay v Ventures Ltd (t/a Chemistree) v Gahir** [2014] ICR 747 (EAT); **Eiger Securities LLP v Korshunova** [2017] ICR 561 (EAT).

137 We accept the Claimant's submissions, not disputed by the Respondent, that we should adopt the reasoning applied in a disability discrimination context and that "likely" means "could well happen": **SCA Packaging Ltd v Boyle** [2009] ICR 1056 (HL).

138 Whether a disclosure has been made in the public interest will depend on the circumstances of the case: **Chesterton Global Ltd v Nurmohamed** [2018] ICR 731 (CA). The essential point is that the disclosure has to serve a wider interest than the private or personal interest of the whistleblower. The Court of Appeal provided guidance as to the factors to be considered which included: the numbers in the affected group, the nature of the interests affected and the extent to which they were affected, the nature of the wrongdoing and the identity of the alleged wrongdoer.

139 In order to be a protected disclosure a qualifying disclosure must be made to a specified person, such as an employer (s 43(C)(1)) or an employer designated entity (s 43(C)(2)). Section 43(C)(2) covers disclosures to a designated confidential whistleblowing helpline where the helpline is run by a third party organization: **Brothers of Charity Merseyside v Eleady-Cole** (EAT 0661/01).

DETRIMENT

140 Under section 47B ERA 1996 a worker has the right not to be subject to any detriment by "any act, or any deliberate failure to act" by an employer done on the grounds that he had made a protected disclosure. In relation to a failure to act the wording of the statue implies a conscious decision.

141 Detriment is not defined under the act but is understood to mean some form of disadvantage, to be assessed from the view point of the worker (**Shamoon v**

Chief Constable of the Royal Ulster Constabulary [2003] ICR 337 (HL). An unjustified sense of grievance cannot amount to a detriment: **Jesudason v Alder Hay Children's NHS Foundation Trust** [2020] EWCA Civ 73 (CA).

142 The burden of proof is on the Claimant to prove a protected disclosure and detriment. The burden then shifts on the Respondent to prove that the worker was not subject to a detriment on the grounds that she had made a protected disclosure (section 48(2) ERA 1996). Section 47B is infringed if the protected disclosure materially (i.e. more than trivially) influences the employer's treatment of the whistleblower: **Fecitt and Ors v NHS Manchester (Public Concern at Work intervening)** [2012] ICR 372 (CA)

JURISDICTION

143 The time limit for submitting a claim to a tribunal is three months beginning with the date of the act or failure to act to which the complaint relates or, where that act or failure is part of a series of similar acts or failures, the last of them (Section 48(3) ERA 1996. Where an act extends over a period the "date of the act" means the last day of that period. A "deliberate failure to act" is to be treated as done when it is decided on or when an employer does something that is inconsistent with doing that failed act or might reasonably be expected to do the failed act (Section 18(4) ERA 1996).

144 A series of similar acts or failures is distinct from an act extending over a period of time (continuing act): **Arthur v London Eastern Railways Ltd t/a One Stansted Express)** [2007] ICR 193. An act extending over a period may arise where there is an underlying rule, practice, scheme or policy which connect the acts. A series of similar acts may arise where there is a connection between the acts themselves, some link which makes it just and equitable for them to be treated as part of a series of similar acts.

145 The Tribunal has discretion to extend time in the Claimant's failure for such further period as the tribunal considers reasonable in a case where is it satisfied that it was "not reasonably practicable" for the claim to be presented within time.

CONSTRUCTIVE DISMISSAL

146 Section 95(1)(c) of the ERA 1996 provides that there is a dismissal when the employee terminates the contract, with or without notice, in circumstances such that he or she is entitled to terminate it without notice by reason of the employer's conduct. In order to claim constructive dismissal the Claimant must satisfy the tribunal that the Respondent had committed a repudiatory breach of contract, that she resigned in response to that breach and did not otherwise waive or affirm the contract.

147 The Claimant relies on the implied term of trust and confidence. This is defined as the implied term that the employer shall not without reasonable and proper cause conduct itself in a manner calculated or likely to destroy or seriously damage the relationship of confidence and trust between employer and employee: **Malik v Bank of Credit and Commerce International SA** [1997]

IRLR 462 (HL). This requires tribunals to consider (1) whether the Respondent behaved in a way that was calculated or likely to destroy or seriously damage the trust and confidence between the Claimant and the Respondent; and (2) whether it had reasonable and proper cause for doing so**.** The legal test requires looking at the circumstances *objectively* — i.e. from the perspective of a reasonable person in the Claimant's position, whether the contract breaker has clearly shown an intention to abandon and altogether refuse to perform the contract: **Tullett Prebon plc v BGC Brokers LP** [2011] IRLR 420 (CA).

148 The approach to be applied to a final straw cases is set out in the Court of Appeal case of **Omilaju v Waltham Forest London Borough Council** [2005] ICR 489**,** at paragraphs 19-22**.** In particular, Dyson LJ noted that the last act need not itself be a breach of contract, it need not be unreasonable or blameworthy, nor does it need to be of the same character as the earlier acts. However it did need to add something to the breach even if what it added was relatively insignificant. An entirely innocuous act on the part of the employer cannot be a final straw.

149 An employee is not justified in leaving employment just because an employer has acted unreasonably: **Bournemouth University Higher Education Corporation v Buckland** [2010] ICR 908 (CA). This case is also authority (obiter) that a long notice of 5 months did not affirm thee contract where a university professor did not wish to disrupt his students' studies by leaving during the academic year.

150 Section 103A ERA 1996 provides that an employee will be regarded as unfairly dismissed if the reason (or, if more than one, the principal reason) for the dismissal is that the employee made a protected disclosure. This includes where an employee has been constructively dismissed. In determining the reason for dismissal the tribunal may only take into account those facts that were known to the Claimant at the time of her resignation: **W Devis and Sons Ltd v Atkins** [1977] ICR 662 (HL).

151 Alternatively, section 98(4) ERA 1996 provides that an employee will be regarded as unfairly dismissed if the reason (or if more than one the principal reason) for dismissal was for a potentially fair reason. This includes some other substantial reason (SOSR) of a kind such as to justify the dismissal, such as a breakdown in working relationships. The burden of proof is on the employer to establish the reason. It is then for the tribunal to determine whether the dismissal was fair or unfair having regard to all the circumstances and the equity and substantial merits of the case. In considering fairness tribunals should apply the "range of reasonable responses" test: **BHS v Burchell** [1978] IRLR 379 and **Post Office v Foley** [2000] IRLR 827.

DISCUSSION AND CONCLUSION

PUBLIC INTEREST DISCLOSURES – PRELIMINARY ISSUES

Jurisdiction

152 The Respondent's primary position was that any complaint of detriment prior to

25 November 2019 was out of time. This was because the latest date of any act / deliberate failure to act was 25 September 2019 (the date that the Claimant was provided with the improvement plan). The Respondent disputed that the acts or failures were continuing acts. Further the Claimant had provided no evidence that it was "not reasonably practicable" for her to submit the claims in time, indeed there was evidence to the contrary in that the Claimant had sought legal advice prior to her meeting with Ms Woollett and Mr Wylie on 19 July 2019.

153 The Claimant denied that the claims were out of time stating that they were all continuing acts on the basis that the Respondent applied a policy (a) to retain Dr X for the substantive role and / or (b) not supporting the Claimant which commenced in March 2019 to the date of the Claimant's dismissal. Alternatively the detriments were a series of similar acts / failures, namely forcing the Claimant to work long hours which extended to 27 November 2019. If the claims were out of time then it was "not reasonably practicable" for her to submit them in time due to actively seeking to resolve matters internally and her poor health.

154 The issue of jurisdiction only applied to the detriment claims and then only if we found that the Claimant was subjected to a detriment on the grounds that she had made one or more protected disclosures. Therefore we decided that jurisdiction should be determined after we had reached our conclusions on disclosure and detriment. This would enable us to determine this issue based on what we had actually found rather than what we might find.

Breach of a legal obligation

155 In relation to the alleged wrongdoings, the Claimant relied on both a breach of a legal obligation and endangering health and safety. The legal obligation relied upon by the Claimant was the Respondent's "duty of care to its patients". The Respondent submitted that a reference to general common law was not sufficiently obvious and therefore the Claimant had failed to identify the legal obligation with refence to the **Blackbay** case.

156 We consider that "duty of care to patients" is sufficiently obvious to constitute a legal obligation, as "duty of care" is a specific legal obligation under tort. However, it was unclear to us to what extent, if at all, this wrongdoing differed from endangering health and safety of patients and the Claimant relied on the same facts and reasons in relation to both alleged wrongdoing. We considered that the nature of the disclosure more properly fitted into the endangering of health and safety, and that the breach of a legal obligation does not add anything to the claim.

WAS THERE ONE OR MORE QUALIFIED DISCLOSURES?

DISCLOSURE 1: On 15 March 2019 informing Dr Petch by email that she considered that there was severe risk regarding patient safety if Dr X was "slotted in" to the substantive post because she lacked the knowledge, skill, training and experience to fulfil that role effectively and safely? (**Issue 6.1.1**)

157 The disclosure relied upon is set out at paragraphs 49-50.

Was this a disclosure of information?

158 The Respondent submitted that this disclosure did not connect the slotting in of Dr X with patient safety. The reference to "patient safety" in Disclosure 1 was made in connection to the four examples of risk issues that could arise from patients presenting with more complex presentations, with whom Dr X had no involvement. The Claimant submitted that the email should be read as a whole and that the reference to "patient safety" was made in connection to her concern about slotting in Dr X because she may not have the requisite training and experience of treating patients with psychosis. We agreed that read as a whole the email was suggesting that slotting in Dr X was a risk to patient safety, and note that the paragraph stating that "Clearly, the primary issue here is patient safety ….." then goes on to express the Claimant's concerns about slotting in Dr X.

159 In our view the contents of the email was an expression of an opinion, since the Claimant merely stated that Dr X "may" not have the training and was "most unlikely" to have the experience of treating patients with psychosis; not that she did not in fact have this training or experience. Further the Claimant provided no factual basis for her assumptions. We noted that a disclosure may be one of mixed facts, allegations and opinions and that these categories are not mutually exclusive. In considering this issue we took into account the following:

159.1 The opinions expressed by the Claimant should be considered in the context of someone who is an experienced professional and team leader whose opinion should not be ignored.

159.2 The Claimant disclosed facts in relation to the increased risk of patients, which supported her opinion that the service required someone with sufficient experience for the role.

159.3 The Claimant's opinion in relation to Dr X's training was based on her knowledge of the training of counselling psychologists, her interactions with Dr X in supervisions and team meetings and her interpretation of her conversation with Dr El-Leithy.

159.4 The Claimant stated that Dr X's non-clinical skills had not been tested in interview and that she had not been the first choice.

Whilst we agree with the Respondent that the factual detail was limited, we consider that taken as a whole, there is sufficient specificity to constitute a disclosure of information.

Did the Claimant believe the disclosure was made in public interest and was that belief reasonable?

160 We accept that the Claimant genuinely believed that the disclosure was made in the public interest, her disclosure related to patient safety and was not a private or personal matter. We consider that this belief was reasonable since the subject matter related to patient safety, which obviously affects the public in general and engages public interest. Further the NHS is a public sector employer and the public have an interest in how it is managed.

Did the Claimant believe the disclosure tended to show endangerment of health and safety of patients and / or breach of a legal obligation and was that belief reasonable?

161 We consider that the Claimant genuinely believed that slotting in Dr X endangered the health and safety of patients and / or was a breach of the duty of care towards patients. She specifically referred to the "primary issue" being "patient safety" and to the possibility of death, or other serious incident. The Claimant has been consistent in her belief, both in her written representations to her employer and in evidence before us. The fact that she had those concerns is supported by the evidence of Dr Young and Dr Kennerly, who both confirmed that she discussed her concerns with them.

162 However, we do not consider that the Claimant's belief was reasonable. We accept it was not necessary for the Claimant's belief to be true, but on the facts of this case we conclude that the Claimant had no reasonable basis for her belief. In particular we took into account:

162.1 The locum and substantive roles were identical on paper; with the same job description and person specification. It was therefore illogical to consider that Dr X was suitable for the locum role but not the identical substantive role.

162.2 Dr X had been in the TSS locum post for 2 years and there had been no complaints or concerns raised in relation to her clinical practice over this period. We do not accept that it was reasonable for the Claimant to believe that Dr X's assessments of patient A and B raised patient safety concerns and prefer the conclusions of Dr El-Leithy in his letter of support.

162.3 The Claimant was a senior manager and in a position to check the qualifications, training and experience of Dr X; she should have made enquiries instead of making assumptions on the basis that Dr X's professional training as a counselling psychologist rather than a clinical psychologist. The Claimant accepted in her email of the 15 March 2019 that Dr El-Leithy had expressed a concern about the Claimant's objections being based on assumptions and she had accepted that this was a "*fair point*". Therefore it was unreasonable for the Claimant to continue with her assumptions, without making further enquiries.

162.4 The Claimant was aware that Dr El-Leithy did not share her view. He was Dr X's clinical and professional supervisor and had greater knowledge of Dr X's skills and abilities than the Claimant. It was unreasonable for the Claimant to dismiss his view and continue to believe that Dr X posed a risk to patient safety.

162.5 It was not reasonable for the Claimant to assert that Dr X had no experience of dealing with high risk patients. Dr X had been a Band 8a Highly Specialist counselling psychologist in IAPT since 2009, she had also been working in TSS for 2 years (albeit on a 0.4 WTE contract). Dr El-Leithy confirmed in his letter of support that Dr X had been allocated

the full range of TSS Band 8a caseload. Further Dr Petch's evidence was that assessing psychotic symptoms is not unique to the TSS and required of all those working in mental health settings. Given the considerable length of time that Dr X had been working in mental health, either in IAPT or TSS, it should have been obvious to the Claimant that she was likely to have experience of dealing with high risk patients. Further and in any event Dr X also informed the Claimant of this in her email of 17 February 2019.

162.6 There was no evidence that there were any significant gaps in Dr X's non-clinical knowledge of experience. Indeed there is evidence to the contrary in that supervision and service development had formed part of Dr X's role in IAPT. She also had a doctorate and therefore did had research skills and experience. But even if there had been a gap in Dr's X's non-clinical skills and knowledge, there was no evidence to believe that this would give rise to any concerns about patient safety. The mere fact that these elements of the role had not been tested in interview does not make the appointment of Dr X unsafe. We also accept that this was a relatively minor part of the role

162.7 The Claimant's position was contradictory since she had repeatedly stated that Dr X could apply for the post if it was externally advertised and that she was in a "strong position" and would be supported if she applied. This implied that Dr X would be suitable for the role, and was not a risk to patient safety.

162.8 We agree with the Respondent that it is immaterial whether Dr X could have been offered other suitable posts. Nor do we consider that it is relevant whether or not the Respondent was correct in its interpretation of its Managing and Implementing Change and / or Recruitment and Selection policies. We accept the Respondent's evidence that this was a complicated situation and that Dr X had previously been put "at risk" of redundancy, and that she was on a fixed term contract in a post that was to be made permanent. We accept that HR genuinely believed that the policies applied in Dr X's case and that she should be slotted in. There is no evidence to suggest Dr X was slotted in for any other reason than an attempt to safeguard her employment rights and comply with the Respondent's policies.

162.9 Dr Kennerley and Dr Young both stated they considered the Claimant's concerns in relation to Dr X to be well founded. However their views were based on what the Claimant informed them and therefore are partial and not independent. Further, although Dr Young ran a similar service for a different NHS trust, she accepted in cross examination that that her service had different referral criteria, treated those with more complex conditions than TSS and that she had not been provided with the job description for the Band 8a role in the TSS. Moreover she agreed that Dr El-Leithy was well respected in the profession and that he was a "safe pair of hands" to supervise a counselling psychologist to address any gaps in their knowledge. We therefore did not conclude from their

evidence that the Claimant's belief was reasonable.

163 Taking all the above into consideration we consider that the Claimant's belief that Dr X posed a risk to patient safety was not reasonable. Accordingly we conclude that Disclosure 1 was not a qualifying disclosure.

DISCLOSURE 2:

164 The Respondent submitted that in the list of issues the Claimant sought to rely on a 5 week period without properly specifying what was being disclosed and that her witness statement merely stated that she raised the same issues without providing any further detail. We agree that this was unsatisfactory. However we felt sufficiently able to consider this matter based on the oral evidence given and the documents in the bundle. We separated the disclosures into a disclosure made at the informal meeting on the 24 April 2019 (disclosure 2a), the disclosure made at the grievance hearing on 22 May 2019 (disclosure 2b) and the disclosure made in the Claimant's email of 24 May 2019 (disclosure 2c).

DISCLOSURE 2a: On 24 April 2019 informing Ms Lynn, Dr X and Dr X's union representative that the service could not ensure patient safety if Dr X was slotted in to the substantive role because she did not have the required skills, knowledge and training **(Issue 6.1.2)**

165 The disclosure relied upon is set out at paragraph 60.

Was this a disclosure of information or an allegation?

166 This repeated the same points as the 15 March 2019 email to Dr Petch, and for the same reasons as set out above we accept that this was a disclosure of information.

167 In addition the Claimant referred to "some concerns" regarding Dr X's clinical skills" and the two cases where in her view Dr X had failed to identify psychotic symptoms and identified the names of the clients. She also addressed Dr X's supervision experience. Therefore this disclosure contained some factual matters as well as an expression of an opinion.

Did the Claimant believe the disclosure was made in the public interest, and was that belief reasonable?

168 We accept that the Claimant genuinely believed that the disclosure was made in the public interest and that her belief was reasonable for the same reasons as disclosure 1 (see above).

Did the Claimant believe the information tended to show endangerment of health and safety of patients and / or breach of a legal obligation and was that belief reasonable?

169 We accept that the Claimant genuinely believed that the information tended to show the identified wrongdoings for the same reasons as disclosure 1 (set out above). She also specifically referred to two patients as evidence in support of her concerns. We accept that she genuinely believed that these were examples

of Dr X failing to identify psychotic symptoms based on what the patients had informed her and her own assessment.

170 In so far as the information repeated the same belief as disclosure 1, we did not consider the Claimant's belief to be reasonable for the reasons set out above.

171 In relation to the additional information regarding the 2 patients we also conclude that the Claimant's belief was not reasonable. We took into account the following considerations:

171.1 The Claimant formed her belief purely on what she was told by Patient A. She maintained her belief despite being informed by Dr El-Leithy that he had conducted a detailed review of the case records and that there was no evidence that the patient had presented with psychotic symptoms to Dr X or any of the other health professionals (including the specialist registrar) treating her at the time. Dr El-Leithy recalled discussing the case with Dr X in supervisions and expressed the view that Dr X had made appropriate referrals at the time, which the Claimant did not dispute. We do not consider it reasonable for the Claimant to accept the patient's account without any corroborative evidence as to whether what the patient was saying was true, particularly in the face of evidence to the contrary. We do not agree with the Claimant that the assessment by the specialist registrar should be discounted solely because it was for a shorter period of time (20 minutes as opposed to 1½ hours for TSS).

171.2 The Claimant accepted that Dr X's assessment of Patient B was done in her IAPT role and that she would not have expected an IAPT assessment to include assessment of psychotic symptoms. It was therefore unreasonable for the Claimant to continue to rely on this example as evidence that Dr X posed a risk to patient safety.

171.3 In any event, both these examples were historic and did not occur in the course of Dr X's locum role in TSS (one was in her capacity as IAPT and the other when doing CPD).

171.4 We are troubled that the Claimant only expressed having "some concerns" about Dr X's clinical skills in April / May 2019, and that this was only being raised in the context of justifying her view that Dr X was not suitable for the substantive role. She did not raise them with Dr X or Dr El-Leithy at the time that she first became aware of them. Further, these "concerns" are contrary to previous statements that the Claimant had made in relation to Dr X being in a strong position if she applied for the role and her statement in the 8 February 2019 email that "*we all think highly of the work that she has done*".

172 We therefore conclude that the Claimant's belief that Dr X posed a risk to patient safety was not a reasonable belief. Accordingly we conclude that this disclosure was not a qualifying disclosure.

DISCLOSURE 2b: On 22 May 2019 inform Dr Adams, Dr Petch and Ms Ogundeji that the service could not ensure patient safety if Dr X was slotted in to the substantive role because she did not have the required skills, knowledge and training **(Issue 6.1.2)**

173 The disclosure relied upon is set out at paragraph 70. For the same reasons as set out above we accept that this was a disclosure of information. The Claimant did not specifically rely on anything stated in her pre-hearing note as a disclosure and therefore we do not take that into account other than as evidence that she did refer to the TSS Contextual service document and her revised job description.

174 We did not consider that this disclosure was a qualified disclosure for the same reasons as set out above in relation to disclosures 1 and 2a.

DISCLOSURE 2c: On 24 May 2019 inform Dr Adams, Dr Petch and Ms Ogundeji by email that the service could not ensure patient safety if Dr X was slotted in to the permanent Role because she did not have the required skills, knowledge and training **(Issue 6.1.2)**

175 The disclosure relied upon is set out at paragraph 71. We considered that the email dated 24 May 2019 should be considered in conjunction with any disclosure to the grievance hearing. The information was provided to the same people, Dr Adams, Dr Petch and Ms Ogundeji. We did not consider that this email conveyed any additional information, rather it restated the Claimant's previous concerns.

176 Therefore We did not consider that this disclosure was a qualified disclosure for the same reasons as set out above in relation to disclosures 1 and 2a and 2b.

DISCLOSURE 3: On 12 June 2019 inform Dr Adams, Dr Petch and Ms Ogundeji by email that she had serious patient safety concerns with regard to the decision in Dr X's Grievance Outcome to slot Dr X into the substantive role **(Issue 6.1.3)**

177 The disclosure relied upon is set out at paragraph 78. This disclosure largely repeated the Claimant's concerns already made in her previous disclosures. The Claimant provided no additional factual information in support of her concerns. We conclude that this was not a qualified disclosure, for the same reasons as disclosures 1 and 2.

DISCLOSURE 4: In a letter dated 18 July 2019 inform Mr Murray that she had serious and significant patient safety concerns relating to the "slotting in" of Dr X in the TSS, to the substantive role, on the basis that she did not have the skillset required to protect patient safety **(Issue 6.1.4)**

178 The disclosure relied upon is set out at paragraph 88. The Claimant's case was that this disclosure was substantially the same as Disclosures 1, 2 and 3. We conclude that this was not a qualifying disclosure, for the same reasons as set out above.

DISCLOSURE 5: In a letter dated 18 July 2019 inform Mr Murray that given the new diagnosis of Complex PTSD and the new requirements for the TSS (and those working across the Trust) in relation to implementing Trauma-Informed Care she felt it surely must be imperative, in order to ensure patient safety, for the appointee to the Role to meet all of the requirements set out in the Job Description for the Role, and Dr X did not meet the requirements **(Issue 6.1.5)**

179 The disclosure relied upon is set out at paragraph 88. The Claimant submitted that this disclosure was substantially the same as Disclosure 3. We conclude that this was not a qualified disclosure, for the same reason as set out above.

DISCLOSURE 6: In a letter dated 18 July 2019 inform Mr Murray that both she and Dr El-Leithy had been raising concerns about risks to patient safety caused by the demand pressures on the TSS service using the Trust's online Clinical Governance tool, SIREN, which uses a "traffic light" service risk rating system **(Issue 6.1.6)**

180 The disclosure relied upon is set out at paragraph 88.

Was this disclosure of information?

181 We accept that this disclosure was a disclosure of information. In particular, the Claimant referred to the following alleged facts: that the SIREN reports for the TSS had been flagged as "red" (i.e. risk was at safety critical levels) for 4 months, that there had been no response to these reports, that there had been no management meetings for 5 months and that there was a lack of clarity as to who was the operational manager.

Did the Claimant believe the disclosure was made in the public interest, and was that belief reasonable?

182 We accept that the Claimant genuinely believed that the disclosure was made in the public interest and that her belief was reasonable for the same reasons as disclosure 1 (see above).

Did the Claimant believe the disclosure tended to show endangerment of health and safety of patients and / or breach of a legal obligation and was that belief reasonable?

183 We considered that the Claimant genuinely believed that there was a risk to patients arising out of the rise in demand pressure on the TSS. The Claimant had first raised this issue with her then line manager Mr Hare towards the end of December 2018 and provided information to support a bid for additional funding on 4 January 2019.

184 We consider that the Claimant's belief was reasonable. There is considerable evidence that the TSS was experiencing an increase in demand pressure and that this posed a risk to patient safety (see constructive dismissal below). Her belief was supported by Dr El-Leithy (see SIREN reports and 26 June 2019 email) and the Respondent (see Demand Pressure reports of March 2019 and November 2019). Moreover, we have found as a fact that there was a four month gap in the operational management between January 2019 and June 2019. Further we accept, from the Claimant's point of view, that there had been no response to the red SIREN reports until 19 July 2019 for the reasons set out

below. Therefore we consider it was reasonable for the Claimant to believe that the Respondent was ignoring the safety critical pressures on the TSS and that the health and safety of patients was endangered and / or that the Respondent was in breach of its duty of care towards patients.

185 Therefore we conclude that this was a qualified disclosure.

DISCLOSURE 7: In an email dated 30 July 2019 inform Ms Ford that she had significant and serious patient safety concerns regarding the slotting in of Dr X to the substantive role when she did not have the requisite knowledge and training to carry out that role while ensuring patient safety. The Claimant copied in Dr Adams, Dr Petch, Ms Ogundeji, Mr Wylie and Ms Woollett **(Issue 6.1.7)**

186 The disclosure relied upon is set out at paragraph 96. This disclosure repeated information contained in disclosure 3. The panel concluded that this was not a qualified disclosure, for the same reason as disclosure 3.

DISCLOSURE 8: On the 30 July 2019 inform Ms Ford by email that she had concerns about Dr X having been appointed to the substantive role for only 2 days per week when in fact the TSS needed a permanent member of staff in the role 3 days per week and that this would impact on the ability of the team to provide consistent cover and therefore meet demands and ensure safety of patients and staff **(Issue 6.1.8)**

187 The disclosure relied upon is set out at paragraph 96.

Was this disclosure of information?

188 We accept that this was a disclosure of information, since the Claimant specifically referred to the factual decision to appoint Dr X for 2 days instead of 3 days, stating that the team required the postholder to work for 3 days and that the decision would impact on the ability of the team to provide cover. Further that this had been done without consulting the Claimant.

Did the Claimant believe the disclosure was made in the public interest, and was that belief reasonable?

189 We accept that the Claimant genuinely believed that the disclosure was made in the public interest and that her belief was reasonable for the same reasons as disclosure 1 (see above).

Did the Claimant believe the information tended to show endangerment of health and safety of patients and / or breach of a legal obligation and was that belief reasonable?

190 We considered that the Claimant genuinely believed that this was an issue of concern. She had raised this issue on a number of occasions, see emails of 6 February 2019, 10 June 2019, 22 July 2019 and in the meeting with Mr Wylie on 1 August 2019. However it was not clear from this disclosure that she specifically considered that this was a patient safety issue since she only referred to the decision resulting in difficulties in providing consistent cover and that she had not been consulted. However read in conjunction with previous emails it was clear that she was concerned about a 0.2 WTE post having limited time to do clinical work given that they would need to attend training,

supervision and team meetings.

191 We agree that appointing Dr X on a 0.4 WTE rather than 0.6 WTE contract may have potentially fragmented the service; it was a small team and it would be difficult to recruit someone for a 0.2 WTE (1 day a week) post. We also note that Ms Woollett accepted that it was not an ideal situation and neither Ms Woolett nor the Claimant had been consulted about the decision. We have carefully considered whether it was reasonable for the Claimant to believe that this would endanger health and safety of patients and / or breach the legal duty of care to patients. We accept that it may reduce the capacity of the team to provide clinical assessments and treatment leading to longer waiting lists, and that this could have a consequential impact on patient safety.

192 On the other hand we note that on 25 July 2019 the Claimant had emailed Mr Wylie to arrange an urgent meeting to discuss the date that Dr X was starting and that he had responded on the 29 July agreeing to meet on the 1 August 2019 and indicated that this discussion would include staffing. We agree with the Respondent that it was premature to raise this as a patient safety concern given that discussions were ongoing. It was not being proposed that the staffing establishment of TSS be reduced by 0.2 WTE, and until discussions had taken place as to how to manage the released funds, it was unreasonable for the Claimant to believe that this would have any impact on patient safety. Further whilst we accept that the possibility of further fragmentation of the service was not optimal we did not consider that this issue alone endangered the health and safety of patients or breached any legal obligation since there were other options available to the Claimant and Dr X would merely be continuing to work the same hours that she was already working in the locum role.

193 Therefore we conclude that taking all the circumstances into account, that the Claimant's belief that this endangered health and safety and / or was a breach of a legal obligation was not reasonable and that this was not a qualified disclosure.

DISCLOSURE 9: By email on 30 July 2019 inform Ms Ford that she had submitted four consecutive "red" SIREN reports flagging patient safety issues without any response and that she had been unable to raise the patient safety concerns with management directly because there had not been any management meetings for around six months **(Issue 6.1.9)**.

194 The disclosure relied upon is set out at paragraph 96. This disclosure was similar to disclosure 6, and we accept that it was a qualified disclosure for the same reasons.

DISCLOSURE 10: At a meeting on 1 August 2019 inform Mr Wylie that she believed that the TSS was currently clinically unsafe because Dr X had been slotted into the substantive role when she did not have the required skillset and there was no evidence that this lack in skills and knowledge could be managed by the service within the current resources, especially with the ever-increasing demand on the service and increased volume of work **(Issue 6.1.10)**

195 The disclosure relied upon is set out at paragraph 101. This disclosure is the same as disclosures 1, 2, 3, 4 and 7. We do not conclude that it was a qualified disclosure for the same reasons.

DISCLOSURE 11: At the meeting on 1 August 2019 inform Mr Wylie that Dr X being appointed to the substantive role for only 2 days per week rather than the 3 days the post required caused further fragmentation to the team and compromised patient safety **(Issue 6.1.11)**

196 The disclosure relied upon is set out at paragraph 101. This disclosure is the same as disclosure 8. We do not conclude that this was a qualified disclosure for the same reasons.

DISCLOSURE 12: At a meeting on 1 August 2019 inform Mr Wylie that she had concerns around the safety of the service because of the increase in workload without any corresponding increase in resource and support **(Issue 6.1.12)**

197 The disclosure relied upon is set out at paragraph 101. This disclosure was similar to disclosure 6, and we accept that it was a qualified disclosure for the same reasons.

WAS IT A PROTECTED DISCLOSURE? (Issue 7)

198 It was not disputed in relation to disclosures 1-3 and 7-12 that they had been made to the Claimant's employer.

199 In relation to disclosures 4-6, we consider that these had been made to an employer designated entity, namely the Guardian Service Ltd. The Respondent's "Whistleblowing – raising concerns at work policy" specifically named the Guardian Service as an organisation that employees can use to raise concerns [**p. 188-205**]. Such disclosures are treated as a disclosure to an employer under s. 43C(2) ERA.

200 We have found that disclosures 6, 9 and 12 were qualified disclosures and since they were made to the Claimant's employer or an employer designated entity we conclude that they are protected disclosures.

DETRIMENTS – WHAT DID THE RESPONDENT DO / NOT DO? (Issue 8)

201 Where the Claimant relies on failures to do things rather than a positive act, we note that in order to be a detriment under section 47B ERA 1996 an omission has to be deliberate; negligence is not sufficient.

DETRIMENT 1: From 15 March 2019 did Dr Petch and /or Ms Woollett refuse to or alternatively fail to properly investigate or take action to address the serious concerns relating to patient safety the Claimant had raised? **(Issue 8.1)**

202 The Claimant accepted in evidence that Dr Petch had considered what she had told him, whether these raised patient safety concerns, whether there was any evidence to support those concerns and reached a decision which was

communicated to her. This had included a discussion with Ms Moore and Ms Lynn on the 21 March 2019, which was communicated to the Claimant by email the same day. The fact that Dr Petch disagreed with the Claimant that slotting in Dr X posed a risk to patient safety does not mean that he failed to properly investigate her concerns. Therefore we conclude that Dr Petch had not failed to properly investigate the Claimant's patient safety concerns in relation to slotting in Dr X.

203 Further, having completed that investigation, we do not consider that Dr Petch was under any duty to take action in relation to the Claimant's patient safety concerns since her concerns were not reasonable. In any event, on the facts the Respondent intended to advertise the post externally (see March 2019 supervision notes and Ms Lynn's email to Dr X dated 20 March 2019), therefore there was in fact no failure to address the Claimant's concerns.

204 The Claimant made no specific submissions in relation to any failure by Ms Woollett to investigate or take action following the Claimant's disclosure. In any event Ms Woollett had already investigated the Claimant's concerns by speaking to the Claimant, Dr Petch, Dr El-Leithy, Dr X and Ms Lynn (see for example email of 5 March 2019). Having conducted those enquiries Ms Woollett had not agreed with the Claimant that Dr X posed a risk to patient safety. The Claimant had not disclosed any information that required further investigation. Since there was no duty on Ms Woollett to conduct any further investigation, there was no deliberate failure to investigate.

DETRIMENT 2: From 15 March 2019 did Dr Petch and / or Ms Woollett create oppressive environment by ignoring impact on the Claimant and effect having to work in a service which she believed was clinically unsafe and the effect that was having on the Claimant's mental and physical health? **(Issue 8.2)**

205 In relation to the Claimant's concerns about Dr X, we do not consider that Dr Petch or Ms Woollett were under an obligation to consider the impact on the Claimant of working in a service which she believed was clinically unsafe in circumstances where that belief was not reasonable. Therefore we do not conclude that they deliberately ignored her concerns. The Claimant had not specifically stated that her concerns in relation to Dr X were impacting on her mental and physical health, and there was no reason for Dr Petch or Ms Woollett to consider that the Claimant's unreasonable belief that slotting Dr X into the substantive role was "clinically unsafe" would have this impact. Dr X had been working in the TSS in the same role for two years without any concerns being raised, and Dr El-Leithy her supervisor had no concerns about her competence to do the role.

206 In relation to the Claimant's concerns about the demand pressures on the TSS, we consider that from the beginning of 2019 the Claimant was working in an "oppressive environment" since she was having to work extremely long hours which was having a detrimental impact on her health (see constructive dismissal below). However, in the 15 March 2019 email the Claimant had not made any reference to the impact on her personally, merely stating that Dr El-Leithy and herself agreed that the TSS was "unsustainable at the current level".

At the subsequent March 2019 supervision the Claimant had only referred to working long hours before and after leave. Consequently we do not find that the respondent deliberately ignored the impact of these pressures on the Claimant from the 15 March 2019.

207 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 3: From between 24 April 2019 and 31 May 2019 did Ms Lynn, Dr Adams, Dr Petch and / or Ms Ogundeji refuse to or alternatively fail to properly investigate or take action to address the serious concerns relating to patient safety the Claimant had raised? **(Issue 8.3)**

208 The patient safety concerns that the Claimant had raised on these dates related to the slotting in of Dr X. We do not consider that Ms Lynn or Ms Ogundeji were under any obligation to properly investigate these concerns since they were not decision-makers. Ms Lynn had been appointed as the HR representative to support the Claimant in presenting the management case in response to Dr X's grievance. Ms Ogundeji had been appointed as the HR representative to support the grievance panel in an advisory capacity only. Therefore it was not their role to investigate, or take action to address, the Claimant's concerns. Since there was no duty on Ms Lynn or Ms Ogundeji to investigate, there was no deliberate failure to investigate.

209 We agree that Dr Adams and Dr Petch did not investigate or take action to address the Claimant's concerns, but that was because their role was to investigate Dr X's grievance and the issues that she had raised (this was not a hearing to determine the Claimant's grievance). The Claimant had objected to Dr X being slotted into the substantive role and therefore was attending to present the management case. The onus was on the Claimant to explain the rationale for her objections and to provide the panel with any evidence that she relied upon. It appeared to us that the Claimant misunderstood her position and her role, and that she was expecting the grievance panel to investigate matters that were outside their remit, as opposed to making a decision based on the evidence before them. Therefore we do not find that Dr Adams and Dr Petch were under a duty to investigate the Claimant's concerns and therefore there was no deliberate failure to investigate.

210 We did not consider it unreasonable for the Respondent to refuse to permit the Claimant to adduce new evidence in the form of the case files for patients A and B at the hearing since she could, and should, have provided these in advance. Adducing them at the hearing meant that Dr X was not in a position to respond. In any event Dr El-Leithy had conducted a review of the case records and did not agree with the Claimant's conclusions. Therefore we do not consider that these records would have had any significant bearing on the decision made.

211 Further, we accept that Dr Adams and Dr Petch did not act on the Claimant's concerns, this was because they did not share the Claimant's view that Dr X posed a risk to patient safety. She had been working in the role for 2 years

without concerns and the Claimant had failed to adduce cogent evidence that Dr X did not have the skills or experience to deal with complex patients or that any skill gaps could not be address through supervision and training. They were entitled to reach that view based on the views of Dr El-Leithy and the views of Dr Petch who was in a position to comment on the expectations of the role. However Dr Adams and Dr Petch did not ignore the Claimant's concerns but proposed a mechanism to enable her concerns to be addressed. This was that the Claimant and Dr X meet to discuss what support they may need to address the Claimant's concerns around patient safety and the non-clinical aspects of the role (see grievance outcome 30 May 2019). We considered that this was a reasonable approach for the Respondent to adopt.

212 Finally we consider it reasonable for Dr Adams and Dr Petch not to take into account the Claimant's email of 24 May 2019, given that representations from one side could have been seen as outwith the grievance procedure and undermining the grievance process. The Claimant accepted this at the time because she apologised. In any event this email did not add to the information already before the panel.

213 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 4: From 24 April 2019 and / or 31 May 2019, did Ms Lynn, Dr Adams, Dr Petch and / or Ms Ogundeji create an oppressive environment for the Claimant by ignoring the impact of having to continue working in a service which she believed was clinically unsafe and the effect that was having on the Claimant's mental and physical health? **(Issue 8.4)**

214 We do not consider that Ms Lynn, Ms Ogundeji, Dr Petch and / or Dr Adams deliberately ignored the impact of working with Dr X on the Claimant for the same reasons as detriment 2. In addition, neither Ms Lynn nor Ms Ogundeji were decision-makers, but only present in an advisory capacity.

215 In relation to the demand pressures on the TSS, we do not consider that from the date of the grievance hearing on 22 May 2019, Dr Adams or Dr Petch were under any obligation to address the environment that the Claimant was working in. We have heard no evidence that she had informed them of her hours of work or that she considered that of this was affecting her health. However, we do consider that they were under an obligation to address this matter following receipt of her email dated 24 May 2019 in which she referred to her long working hours in order to manage the volume of work safely. In response, Dr Adams proposed a mechanism to enable the Claimant and Dr X to be supported and address any patient safety or non-clinical concerns that the Claimant had raised (see grievance outcome on 30 May 2019). Therefore we do not conclude that Dr Adams and Dr Petch deliberately ignored the impact on the Claimant. Although we consider that this response was inadequate (see constructive dismissal), it is evidence of an intention that this issue be addressed through the proper channels, and therefore was not a deliberate omission.

216 Therefore we do not conclude that the Respondent subjected the Claimant to

this detriment.

DETRIMENT 5: From 12 June 2019 did Dr Adams, Dr Petch and Ms Ogundeji refuse to or alternatively fail to properly investigate or address the serious patient safety concerns the Claimant had raised? **(Issue 8.5)**

217 We find that Dr Adams, Dr Petch and Ms Ogundeji did not refuse or fail to properly investigate the Claimant's concerns in relation to slotting in Dr X. The issue of slotting in Dr X had already been formally considered and determined through the mechanism of a grievance hearing and the Claimant had no right of appeal since she was on the management side. The Claimant's disclosure conveyed no further information and in such circumstances the Respondent was under no duty to conduct any further investigation and it was reasonable for them to consider the matter as closed.

218 In fact the Respondent did not just brush the Claimant's concerns under the carpet. Dr Adams, Dr Petch and Ms Ogundeji met to discuss the email following which on 12 June 2019 Dr Adams emailed the Claimant. Although the Respondent considered the issue of slotting in Dr X had been concluded, it was proposed that the Claimant meet with her managers to discuss her concerns in relation to the risk on TSS more generally. Dr Adams then forwarded the Claimant's concerns to Mr Wylie and Ms Woollett. We consider that this was a good response by the Respondent, given that the Claimant had raised a number of concerns about the pressures on the TSS and we agree that it was appropriate to seek to address these matters through the line management (service line) structure. In addition it was decided to approach Dr El-Leithy to ascertain if he shared the Claimant's concerns. Again we consider that this was a good response by the Respondent

219 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 6: From 12 June 2019 did Dr Adams, Dr Petch and Ms Ogundeji create an oppressive environment for the Claimant by ignoring the impact of having to continue working in a service which she believed was clinically unsafe and the effect that was having on the Claimant's mental and physical health? **(Issue 8.6)**

220 We do not consider that Dr Petch and Dr Adams deliberately ignored the impact of working with Dr X on the Claimant for the same reasons as detriments 2 and 4.

221 In relation to the demand pressures on the TSS, we do not find that Dr Petch and Dr Adams deliberately ignored the impact on the Claimant since they propose a meeting with her manager and agree to canvass the views of Dr El-Leithy. The delay in having the meeting was in part due to the Claimant being on leave.

222 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 7: From 18 July 2019, did Mr Murray and /or the relevant decision maker(s) at the Respondent who should have liaised with Mr Murray (or who, if they did liaise with Mr Murray, should have taken action) refused to or alternatively failed to properly investigate or address the serious patient safety concerns the Claimant had raised, in direct contradiction of NHS whistleblowing policy? (**Issue 8.7)**

223 We accept that Mr Murray did not investigate or address the Claimant's concerns in relation to slotting Dr X into the substantive role. However we find that this did not subject the Claimant to any detriment. To the extent that the Claimant claims that she was not provided with any substantive response to her concerns from Mr Murray, we note that it was not his role to do so, he was merely a conduit and had no investigatory or advisory powers.

224 We accept that the Respondent also did not investigate or address the Claimant's concerns, this was because Mr Murray did not send them the Claimant's concerns having been informed that she no longer wanted to use their services. The Respondent's decision-makers cannot be expected to liaise with Mr Murray in relation to concerns of which they were unaware, therefore this failure was not deliberate.

225 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 8: From 18 July 2019 did Mr Murray and /or the other relevant decision maker(s) at the Respondent who should have liaised with Mr Murray (or who, if they did liaise with Mr Murray, should have taken action) refused to or alternatively failed to properly investigate or address the serious patient safety concerns the Claimant had raised **(Issue 8.8)**

226 We accept that neither Mr Murray nor the Respondent investigated or addressed the Claimant's concerns in relation to Dr X not meeting all the requirements of the job description. However we find that this did not subject the Claimant to any detriment for the same reasons as set out for detriment 7.

DETRIMENT 9: From 18 July 2019 did Mr Murray and /or the other relevant decision maker(s) at the Respondent who should have liaised with Mr Murray (or who, if they did liaise with Mr Murray, should have taken action) refused to or alternatively failed to properly investigate or address the serious patient safety concerns the Claimant had raised around demand pressure on the service and lack of resource?

227 We accept that neither Mr Murray nor the Respondent investigated or addressed the Claimant's concerns in relation to demand pressures on the TSS. However we find that this did not subject the Claimant to any detriment for the same reasons as set out for detriment 7.

DETRIMENT 10: From 30 July 2019 did Ms Ford and the other individuals included on the Claimant's email refuse to or alternatively failed to properly investigate or address the serious patient safety concerns the Claimant had raised? **(Issue 8.10)**

228 We do not conclude that Ms Ford deliberately failed to investigate the

Claimant's concerns in relation to Dr X, since on receipt of the Claimant's email she initiated an investigation by asking Ms Allen, her PA, to obtain "the background". Ms Ogundeji provided a response to Ms Allen on 31 July 2019 setting out the background to Dr X's grievance and attaching the grievance outcome letter. We consider that this was a sufficient response in relation to the Claimant's concern about slotting in Dr X. Since the issue had been addressed through a formal grievance we do not consider that the Respondent was under any obligation to conduct any further investigation into the matter. We note that Ms Ogundeji did not address the Claimant's concerns relating to Dr X being appointed to work 2 days a week. This was an omission on her part. However, for the reasons set out in disclosure 8, we do not consider that it was clear that the Claimant was raising patient safety concerns such as to put the Respondent on notice that this issue was one that required investigation or a response.

229 We also do not conclude that Ms Ford deliberately failed to investigate the demand pressures on the TSS; we took into account that:

229.1 Ms Ford immediately requested background information and that Ms Ogundeji responded "strongly" suggesting a meeting with the service line leadership and head of professions to look into the Claimant's concerns (more generally). Unfortunately Ms Ogundeji's email response to Ms Allen dated 31 July 2019 was not immediately forwarded to Ms Ford.

229.2 Following the Claimant's chasing email of the 8 August 2019, Ms Ford was forwarded Ms Ogundeji's email and on the 12 August 2019 she emailed the Claimant apologising and stating that she had made enquiries and "will be in touch shortly".

229.3 The same day Ms Ford emailed Ms McKenna and Ms Foulkes asking whether Ms Ogundeji's recommendations had been followed up. They responded that they did not know and emailed Dr Adams and Ms Moore.

229.4 Dr Adams responded to Ms Mckenna on the 14 August 2019 stating that the Claimant had met Mr Wylie and Ms Woollett and was working with Mr Wylie to develop an improvement plan. It appears that this email was not forwarded to Ms Ford since she then chased her PA for a response on 23 August 2019.

229.5 On the 5 September 2019 Ms Ford again chased Ms Foulkes for a response to be informed that the matter was "a bit broader" than the recruitment process. This appears to be an acknowledgement that there was a need to consider the demand pressure concerns that the Claimant had raised. Ms Foulkes proposed a fact finding investigation. Unfortunately the Claimant was not informed of this. Also by this date she had resigned so no investigation was put in place, although work on the service review and improvement plan continued, which lead to the demand pressure issues being addressed.

Therefore whilst we agree that this matter was not in fact investigated, there

was no evidence that Ms Ford deliberately ignored or refused to investigate the Claimant's concerns. We consider that Ms Ford made appropriate enquiries and intended to investigate and that the failures were administrative rather than a deliberate omission, and then overtaken by events.

230 We did not consider that Dr Adams, Dr Petch, Mr Wylie, Ms Woolett or Ms Ogundeji were under any obligation to investigate the Claimant's concerns since they were only copied into the email. Therefore they did not deliberately ignore or fail to investigate the Claimant's concerns. The Claimant did not request a response from them and there is no evidence that she chased them for a response. Ms Ogundeji and Mr Ward did respond to Ms Ford's enquiries.

231 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 11: From 30 July 2019 did Ms Ford and the other individuals copied in on the Claimant's email at the Respondent create an oppressive environment for the Claimant by ignoring the impact of having to continue working in a service which she believed was clinically unsafe and the effect that was having on the Claimant's mental and physical health? **(Issue 8.11)**

232 In relation to the Claimant's concerns about Dr X, we do not consider that Ms Ford was under an obligation to consider the impact on the Claimant of working in a service which she believed was clinically unsafe, in circumstances where that belief was not reasonable.

233 Further and in any event in relation to the Claimant's concerns about Dr X and the demand pressures on the TSS, we do not find that Ms Ford deliberately ignored the impact on the Claimant, since she took immediate steps to investigate in order to address the Claimant's concerns (see above). Whilst we conclude that more could and should have been done, the failure was not deliberate but due to administrative failures.

234 For the same reasons as detriment 10 we do not consider that Dr Adams, Dr Petch, Mr Wylie, Ms Woolett or Ms Ogundeji deliberately ignored the impact on the Claimant. They were only copied into this email and therefore not expected to respond. Although for the reasons set out under constructive dismissal we consider that the Respondent should have done more to address the workload pressures on the Claimant, we consider that this was due to a lack of care (negligent) rather than deliberate.

235 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 12: From 30 July 2019 did Ms Ford and the other individuals copied in on the Claimant's email (deliberately or negligently) failed to put measures in place or make provision for additional resource to support the Claimant? **(Issue 8.12)**.

236 We accept the Respondent's submissions that negligence is not sufficient to make a finding of a deliberate omission.

237 In relation to the appointment of Dr X for 2 instead of 3 days, we do not consider that there was an obligation on the respondent to make provision for additional resources, in circumstances where the Claimant's concerns were premature. Therefore there was no deliberate failure to put in place such resources. In fact, on 1 August 2019, two days later, the Respondent agreed to combine the 0.2 WTE from Dr X's post with the 0.8 WTE from Dr El-Leithy's post to make a 1.0 WTE post removing the need for additional resources to support the Claimant.

238 In relation to the demand pressure on the TSS, for the same reasons as detriment 11, we do not consider that there had been any deliberate failure by Ms Ford to put in place measures or additional resources to support the Claimant from 30 July 2019 onwards. Following receipt of the Claimant's email Ms Ford took active steps to make enquiries and we have found that any failure to act was due to administrative errors.

239 For the same reasons as above we do not consider that Dr Adams, Dr Petch, Mr Wylie, Ms Woolett or Ms Ogundeji deliberately ignored the impact on the Claimant. They were only copied into this email and therefore not expected to respond. Further and in any event we accept that from 19 July 2019 the Respondent was seeking to address the demand pressures on the TSS, and that this led to discussions with the Claimant about an improvement plan from 1 August 2019. Whilst we are concerned about the lack of urgency after 19 July 2019 (see constructive dismissal), nevertheless the steps that Mr Wylie and others took over this period do not support a conclusion that there was any deliberate failure to put measures in place or make provision to provide additional resource to support the Claimant.

240 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 13: From 30 July 2019 did Ms Ford and the other individuals copied in on the Claimant's email force the Claimant to continue to work extremely long hours for extended periods due to the Respondent's and Ms Ford's failure to adequately resource the service? **(Issue 8.13)**.

241 In relation to the appointment of Dr X for 2 instead of 3 days, we do not consider that this decision forced the Claimant to work extremely long hours for the same reasons as detriment 12. The Claimant's concerns were premature and resolved 2 days later.

242 In relation to the demand pressure on the TSS, we do not consider that the Respondent's failure to address the workload pressures on the Claimant was deliberate for the same reasons as detriments 11 and 12.

243 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 14: From 1 August 2019 did Mr Wylie refuse to or alternatively fail to properly investigate or address the serious patient safety concerns the Claimant had raised? **(Issue 8.14)**.

244 From the List of Issues (issue 10.9) and the Claimant's closing submissions, this detriment only relates to the failure to investigate slotting Dr X into the substantive role. We do not consider that Mr Wylie was under any obligation to investigate this concern since this issue had already been determined through the grievance process and it was not his role to re-investigate, in the absence of any new information. Therefore we do not consider that Mr Wylie deliberately refused to investigate and we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 15: From 1 August 2019 did Mr Wylie create an oppressive environment for the Claimant by ignoring the impact of having to continue working in a service which she believed was clinically unsafe and the effect that was having on the Claimant's mental and physical health? **(Issue 8.15)**.

245 From the List of Issues (issue 10.9) and the Claimant's closing submissions, this detriment only relates to the impact of slotting Dr X into the substantive role. Since we have found that the Claimant's patient safety concerns in relation to this decision were not reasonable we consider that Mr Wylie was under no obligation to consider the impact on the Claimant arising from those concerns. Although the Claimant referred to her position "rapidly becoming untenable", she did not specifically state that her concerns in relation to Dr X were impacting on her mental and physical health. There was no reason for Mr Wylie to consider that the Claimant's unreasonable belief, that slotting Dr X into the substantive role was "clinically unsafe", would have this impact. Therefore Mr Wylie did not deliberately ignore the impact on the Claimant and we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 16: From 1 August 2019 did Mr Wylie ignored the specific patient safety concerns the Claimant had raised regarding the appointment of Dr X to the substantive role and when setting out the required actions and desired outcomes for the Service in the TSS Improvement Plan, he or they omitted any reference to the concerns raised about Dr X not having the skills and knowledge to properly assess patients so as to ensure patient safety? **(Issue 8.16)**

246 Since we have found that the Claimant's patient safety concerns in relation to the decision to slot Dr X into the substantive role were not reasonable we consider that there was no obligation on Mr Wylie to address these in the improvement plan or at all. Indeed it would not have been appropriate to include any reference to Dr X in the improvement plan given that there was no objective basis for the Claimant's concerns. Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 17: From 1 August 2019 did Mr Wylie fail to respond to concerns raised by the Claimant regarding lack of resource and staffing within the TSS in a timely manner in that he failed to produce the TSS Improvement Plan or alternatively failed

to send a copy to the Claimant until 25 September 2019, nearly a month after the Claimant had been forced to resign from her post? **(Issue 8.17)**

247 We have found as a fact that the improvement plan was provided to the Claimant on the 25 September 2019. We accept that it would have taken some time to draft and do not consider that the period between 1 August to 25 September was unreasonable. We note that a draft of the plan had been sent to the Executive on 3 September 2019, we do not know why it was not also sent to the Claimant at this point, but from the documentation it was provided to the Executive in the course of an internal discussion at senior level and an approach to the commissioners to pause referrals and provide additional funding. We do not consider that there was any deliberate failure to involve the Claimant in this process.

248 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 18: From 1 August 2019 did Mr Wylie exclude the Claimant from decision-making and discussions that fed into the TSS Improvement Plan in that the Claimant was not asked to provide any further input into the improvement plan, despite being the Clinical Lead of the Service and the named "Action Owner" in relation to several required actions in the Plan (**Issue 8.18**).

249 There is no evidence that from the 1 August 2019 Mr Wylie excluded the Claimant from decision-making and discussions on the improvement plan. Indeed there was at least one further meeting on 9 August 2019 and the 13 August supervision records refer to the Claimant's ongoing involvement. The Claimant was sent a draft of the improvement plan on the 25 September 2019 and attended a meeting to discuss the plan with Mr Wylie on the 10 October 2019, following which she sent him her comments by email on the 14 October 2019. In her email she thanked Mr Wylie for the meeting and stated that it was helpful. Mr Wylie responded thanking her for her comprehensive response. Consequently, we do not consider that the Claimant was excluded from discussions on the improvement plan after 1 August 2019, even after her resignation on 27 August 2019.

250 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 19: From 1 August 2019 did Mr Wylie fail or refuse to take concrete steps to put measures in place or make provision for additional resource to support the Claimant and other staff of the TSS, despite what the TSS Improvement Plan stated? **(Issue 8.19)**.

251 The Respondent did not fail or refuse to take concrete steps to put measures in place etc. in relation to the decision to appoint Dr X for 2 instead of 3 days. Indeed quite the opposite since on 1 August 2019, Mr Wylie agreed to look to secure 1.0 WTE "going forwards" by combining the 0.2 WTE from Dr X with the 0.8 WTE as a result of Dr El-Leithy's resignation. Therefore there was no

reduction in resources and no further fragmentation of the TSS staffing resource, and the Claimant was not put at a disadvantage by this decision.

252 In relation to the demand pressures on the TSS, we do not find that there was a deliberate failure to make provision for additional measures or resources to support the Claimant. This is because there is positive evidence that from 1 August 2019 Mr Wylie was actively working on an improvement plan to address the demand pressures on the TSS. Whilst we are concerned about the lack of urgency nevertheless the steps that Mr Wylie took over this period do not support a conclusion that there was any deliberate failure to put measures in place or make provision to provide additional resource to support the Claimant.

253 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DETRIMENT 20: From 1 August 2019 did Mr Wylie force the Claimant to continue to work extremely long hours for extended periods due to the Respondent's failure to adequately resource the service **(Issue 8.20)**.

254 We do not consider that there was pressure on the Claimant to work long hours as a result of the decision to permit Dr X to work 2 instead of 3 days per week, since the Respondent was going to use the 0.2 WTE to re-create a 1.0 WTE post. This potentially reduced the pressure on the Claimant in that the service would be less fragmented and the person recruited to the 1.0 WTE was likely to have at least equivalent, if not greater, knowledge and experience to Dr X.

255 In relation to the demand pressure on the TSS, we do not conclude that Mr Wylie deliberately ignored the impact on the Claimant. On being informed that the Claimant was working long hours at the meeting on the 1 August 2019 he informed her that this was not expected and that it was not good for her health. Whilst we consider this response was inadequate (for the reasons set out under constructive dismissal) we do not find that it was deliberate.

256 Therefore we do not conclude that the Respondent subjected the Claimant to this detriment.

DID THE RESPONDENT SUBJECT THE CLAIMANT TO A DETRIMENT (Issue 9)

257 We note that this issue is to be considered from the point of view of the Claimant. Had we found that the Respondent had done an act or deliberate omission, then we would have accepted that was a detriment since the Claimant genuinely believed that the Respondent was failing to address her patient safety concerns, and therefore her claims cannot be dismissed purely on the basis of an "unjustified sense of grievance".

CAUSATION (Issue 10)

258 The Respondent's decision-makers denied that the Claimant's disclosures had materially influenced their acts and deliberate omissions. We note that the reason for an act / deliberate omission may be unconscious. Therefore, in the

absence of overt evidence we considered the Claimant's case that an inference should be drawn that the Respondent does not react kindly to whistleblowing complaints. In so doing we considered the following evidence:

258.1 The investigation of the Claimant for a "serious untoward incident" in 2010: We are not able to conclude without any corroborative evidence, that this was an "overblown reaction" by the Respondent to the GP's complaint as the Claimant submitted. Even if it was, that does not mean that 9 years later the Respondent will adopt the same approach and we have received no evidence to suggest that any of the same persons were involved. Therefore we draw no inference from this incident.

258.2 Dr Petch's attacks on the Claimant's character (that the Claimant did not appear to be able to work with the operational and professional managers to resolve her issues and showed "an unwillingness or inability to knuckle down and be clear about the issues and address them"): We did not consider that this was evidence of a mindset that did not take kindly to whistleblowing allegations. Rather it was a comment on the Claimant's continued failure to accept the decision of the grievance panel and her continued belief that slotting in Dr X was a risk to patient safety without any reasonable basis for that belief. Further, whilst we accept that the Claimant's concerns about the impact of the increase in demand pressures on the TSS were reasonable, we agree with the Respondent that the Claimant's various disclosures and representations lacked detail and focus (in contrast to the detail provided by Dr El-Leithy in his email of the 26 June 2019). Therefore we draw no negative inference from these comments.

258.3 Ms Lynn's email of 30 April 2019 stating *"it is also good for Pippa to be accountable to formal procedures due to her decision making at present"* [**p.449**]: Read in context we do not interpret this email as evidence that Ms Lynn saw the Claimant as a troublemaker. Ms Lynn was merely referring to this as one of two reasons for moving to a formal stage 2 panel grievance hearing, the other being to reduce the risk of a claim from Dr X. As the person who had made the decision that Dr X should not be slotted into the role, it was self-evident that the Claimant would have to be accountable for this decision. Therefore we draw no negative inference from this comment.

258.4 Ms Ogundeji's email of 17 September 2019 referring to the Claimant's managers having other concerns about the service: We accept Ms Ogundeji's evidence that this was a reference to a separate issue, which was nothing to do with her whistleblowing concerns. Indeed we note that this comment was made in the context of a discussion about persuading the Claimant not to resign. Therefore we draw no negative inference from this comment.

259 All the whistleblowing disclosures relating to the slotting in of Dr X and / or her appointment on a 2 day (0.4 WTE) contract have been found to be based on an unreasonable belief and therefore unproven, in any event we have found no associated detriment arising from the concerns that the Claimant raised. If we

are wrong about that we also find that the Claimant was not subjected to any detriment on the grounds of having made a protected disclosure. The Claimant's concerns were investigated and addressed, as much as was reasonably required in the circumstance and there is no evidence that the Respondent ignored the Claimant's concerns. The pressures on the Claimant which led to a deterioration in her health were caused by the increase in demand on the TSS and her workload (see below) and not her disclosures regarding Dr X.

260 On the other hand we have found that the whistleblowing disclosures about the demand pressures on the TSS are protected disclosures, but still not found an associated detriment. If we are wrong about that then:

260.1 There is no evidence that Mr Murray's failure to investigate or forward the Claimant's concerns to the Respondent was on the grounds that she had made a protected disclosure (issue 10.6). It was solely because (a) he was waiting for the hard copy to be posted to him which he never received and (b) he then closed the files on being informed by the Claimant that she would be submitting her concerns directly to the Respondent.

260.2 There is no evidence that Ms Ford's failure to investigate or take action in relation to the Claimant's concerns was on the grounds that she had made a protected disclosure (issue 10.8). She did not ignore the Claimant's concerns, but instead took them seriously and initiated steps to investigate in order to provide a response. The failure to respond is attributable to administrative and communication failures not any protected disclosure.

260.3 There is no evidence that the other decision-makers (Dr Petch, Dr Adams, Mr Wylie, Ms Woollett and Ms Ogundeji) failed to investigate or take any action to address the Claimant's concerns was on the grounds that she had made a protected disclosure (issue 10.8 and 10.9). By 19 July 2019 the Respondent was beginning to put in place steps to investigate and address the concerns that the Claimant was raising about the demand pressures on the TSS. The failures to address the Claimant's concerns primarily occurred prior to this date (see constructive dismissal) and therefore pre-dated any protected disclosures on this issue. Whilst we have found that from 19 July 2019 the Respondent did not act with sufficient urgency, there is no evidence to suggest that any failure was because the Claimant had made a protected disclosure.

261 Therefore had the Claimant proved that she had made both a protected disclosure and been subjected to an associated detriment, we would not have found that there was any direct evidence that the disclosure materially influenced the detriment, and would not have drawn any inferences for the reasons set out above.

JURISDICTION - TIME LIMITS (DETRIMENT CLAIM ONLY) (Issues 2-5)

262 Since we have found that the Respondent did not subject the Claimant to a detriment on the grounds that she had made a protected disclosure it was not necessary to consider whether the claim was submitted in time.

CONSTRUCTIVE UNFAIR DISMISSAL

Was the Claimant dismissed (Issue 11.1)?

Did the Respondent continually fail to address the serious concerns the Claimant raised regarding patient safety and the under-resourcing of the TSS, as set out in the Claimant's disclosures? **(Issue 11.1.1)**

263 In our view there was considerable evidence that the Claimant did repeatedly raise concerns regarding patient safety and the under-resourcing of the TSS, in particular:

263.1 In December 2018 / January 2019, the Claimant discussed with Mr Hare, her operational manager at the time, submitting a bid to the commissioners for extra funding due to the 35% increase in referrals in 2018/2019.

263.2 The Claimant submitted 8 "red" SIREN reports between January and August 2019 indicating "significant safety concerns". These included comments such as: the TSS was under "severe pressure" (March 2019); the understaffing was "leading to long waits for treatment and patient complaints" (May 2019), the situation had further deteriorated and was "now safety critical" (June 2019) and that the "ward / team is under significantly more stress than usual and struggl…" (August 2019).

263.3 The Claimant discussed with Ms Woollett in the March and April 2019 supervisions how to reduce the demand pressures on the TSS.

263.4 The Claimant emailed Dr Petch and Ms Woollett on 15 March 2019 stating that the TSS "was seriously struggling to manage".

263.5 The Claimant emailed Dr Adams, Dr Petch and Ms Ogundeji on 24 May 2019 stating that the TSS was under "safety critical levels of pressure".

263.6 The Claimant emailed Ms Ford and others on 30 July 2019 referring to the 4 consecutive red SIREN reports and lack of response.

263.7 The Claimant informed Mr Wylie on the 1 August 2019 that the TSS was "clinically unsafe" due to the significant increase in workload and under-resourcing.

264 The Claimant's patient safety concerns were shared by others, including:

264.1 Mr Hare, who supported the Claimant's bid for extra funding for an extra 1.0 WTE (band 7) post in January 2019.

264.2 The Executive, who submitted Demand Pressure Reports to the commissioners for funding for extra staff stating that doing nothing would result in patients "waiting longer to access treatment, increasing crisis episodes and slowing recovery" (February 2019) and that that longer waiting times would lead to "slower recovery" and increased the risk to patients and their families from untreated PTSD (November 2019).

264.3 Dr El-Leithy, who agreed the 8 red SIREN reports between January and August 2019, and confirmed to Ms Woollett in or around March 2019 that the position was unsustainable. See also his email of 26 June 2019 that the demand and capacity issues in the TSS were having a "detrimental impact on our ability to deliver a safe, effective and efficient service".

264.4 Dr Hill, who on learning that the data on long waiters was accurate, and following a discussion with Mr Wylie, recommended the drastic action that TSS be closed for referrals for 4 months, that a locum be employed to address the long waiters and that the criteria for access to the service be reviewed and further restricted. When these recommendations were rejected by the commissioners she stated that without additional resourcing or agreement to close TSS to referrals, the model would need to change and that it would be a challenge to do this without diluting quality (email dated 11 September 2019). Mr Wylie also referred to the need for a "comprehensive review going forwards" and the model needing to change in his email of 17 October 2019.

265 Whilst we accept that the monthly number of referrals fluctuated and started to reduce from January 2019, this did not relieve the pressure since as Dr El-Leithy explained in his email of the 26 June 2019, even if the TSS accepted no referrals for 12 months the service still had more than 15 months' worth of work outstanding. Indeed the request for 2 extra posts in November 2019 suggests that the pressure on the service had increased since March 2019.

266 In relation to whether the Respondent had failed to address the Claimant's concerns we considered that the picture was more mixed. We took into account the following:

266.1 That Mr Hare and the Executive had supported the Claimant's bid for additional funding and that the commissioners had been asked for this funding in March 2019, along with 12 other services. The commissioners did not agree to fund all the bids but instead asked the Executive to identify those services which were of the highest priority. We accept that it was permissible for the Respondent not to include the TSS in the "highest priority" group. No doubt difficult choices had to be made between competing services under pressure and we have been provided with no evidence from which to draw any adverse conclusion from the allocation. We also accept that the Respondent did not then ignore this issue and that it submitted a further bid for 2 x 1.0 WTE Band 8 posts in

November 2019, which was ultimately successful in 2021.

266.2 On 4 April 2019 Mr Ince had proposed conducting QIAs in order to risk assess the demand pressures and identify mitigating actions that the Respondent may need to take to address unfunded pressures on the service. It was clear from this email that this was to be done for all the services identified as being under demand pressure and not just those in the "highest priority" group. This was not done for the TSS.

266.3 We did not accept Dr Adam's evidence that there were high level discussions about how to address the demand pressures on the TSS between March 2019 to September 2019. We also did not accept Mr Wylie's evidence that there had been months of preparation and discussion prior to the formulation of the improvement plan. The QPR entries and the internal email exchanges at the end of August and September 2019 suggest that high level discussions only appear to have taken place after the Claimant had resigned. These discussions included a position paper with recommendations, discussions with the commissioners and discussions at Executive level about changing the model. There is no evidence that this was being discussed prior to September 2019, although we do accept that things were beginning to move after 19 July 2019 with the proposal to conduct a service review and then work on formulating an improvement plan from 1 August 2019.

266.4 The Claimant had had no response from management to the "red" SIREN reports until her supervision meeting on 19 July 2019. The discussions that the Claimant had with Ms Woollett in her March and April 2019 supervisions focused on what action the Claimant could take to manage the demand on the TSS rather than any support that the management could provide. This was of limited assistance since the Claimant had already taking action to shift the emphasis from treatment to assessment, and in any event this was only a short term solution since it would result in longer waiting times for treatment (which is what occurred). Further the Claimant had already taken steps to reduce inappropriate referrals (see March 2019 supervision record, Hare's email of 17 January 2019 and the Claimant's email of 6 February 2019). In any event this did not address the pressure the service was already under. The Claimant could not change the referral criteria or service model, temporarily close to new referrals or hire locums / agency staff without approval from senior management and the commissioners.

266.5 We accept that Dr Adams responded to the Claimant's concerns in her email dated 24 May 2019, suggesting that the Claimant escalate to the service lead. However at the time the Claimant did not have a line manager to whom to escalate. Further we accept that the Respondent responded to the Claimant's concerns in her email dated 12 June 2019, by suggesting a meeting with Ms Woollett and Mr Wylie and sought the views of Dr El-Leithy. However, no meeting was then arranged until 19 July 2019. Although the Claimant was on leave for most of this period, it was left to the Claimant to request a meeting on her return on 8 July

2019.

266.6 We accept that Mr Wylie did respond to the Claimant's concerns in the supervision meeting on 19 July 2019 by proposing a review and on 29 July 2019 emailed the Claimant to start work on the improvement plan. We also accept that from 1 August 2019 Mr Wylie did commence work on an improvement plan in consultation with the Claimant and that there had been at least one further meeting with the Claimant on the 9 August 2019, and that she was provided with a draft on the 25 September 2019.

267 What we find concerning is that there was a lack of urgency, following the unsuccessful bid for more funding in March 2019, to address the risk to patient safety of the unfunded increase in demand and put in place mitigating actions as had been proposed by Mr Ince in his email of the 9 April 2019. It took until 19 July 2019 for the Respondent to meet the Claimant and propose a "service review", then it was not until 1 August 2019 that Mr Wylie had his first discussion with the Claimant in relation to what would be covered by the improvement plan. Whilst these discussion were a positive development; such a process would take time and no immediate action was being proposed or taken to relieve the pressure on TSS. This lack of urgency can be contrasted with Dr Hill's response on 29 August 2019 on becoming aware of the data on long waiters. She stated that she would discuss the matter of service review into increase referrals and TSS caseloads "urgently" with Mr Wylie. It seems to us to be these events that lead to her position paper and the drastic recommendations referred to above. The Respondent provided no explanation as to why no such recommendations had been made at any point prior to the Claimant's resignation. Particularly given that Dr El-Leithy had recommended closing to new referrals and changing the access criteria in his email to Ms Moore and Mr Wylie on of the 26 June 2019 and that the Claimant had raised this issue in the 1 August 2019 meeting with Mr Wylie.

268 We therefore conclude that the Respondent did fail to address the serious concerns the Claimant raised regarding patient safety and the under-resourcing of the TSS.

<u>Did the Claimant have to work extremely long hours for extended periods despite her mental and physical health suffering from stress and anxiety caused by the Respondent's failure to address the serious safety concerns that she had raised and despite the Respondent's knowledge that the Claimant had previously suffered with work related stress and anxiety? **(Issue 11.1.2)**</u>

269 We accept that the Claimant had previously suffered with work related stress and anxiety since she had been signed off work by her GP for 9 weeks for this reason in mid-2018. The GP sick notes were provided to the Respondent at the time and discussed in supervision meetings. We therefore consider that the Respondent had knowledge of the Claimant's vulnerability in this respect.

270 We also accept the Claimant's evidence that she was working extremely long hours over an 8 month period in 2019. Her evidence is supported by:

270.1 Dr Young's and Dr Kennerly's evidence confirming that the Claimant had told them she was working long hours.

270.2 The March and May 2019 supervision notes that record the Claimant informing Ms Woollett that she was working long hours before and after her annual leave.

270.3 The Claimant's email of 24 May 2019 to Dr Petch and Dr Adams stating that she had been working between "11-13 hours every day since Christmas".

270.4 The Claimant informing Mr Wylie at the 1 August 2019 meeting and by email of the 6 August 2019 that she had been working 11-13 hours a day "every day since Christmas".

270.5 The Claimant reporting that she and the TSS were struggling to manage the increase in demand. For example, she referred to "struggling with the volume of work" (12 June 2019 email), that her position was becoming untenable (30 July 2019 email and 1 August 2019 meeting), that the "ward / team is under significantly more stress than usual and struggl…" (August 2019 SIREN) and that "both I and the service are on our knees" (resignation letter).

Although the Claimant's clinical caseload had not increased, because there was a limit to how many patients could be seen in a day, it was clear from this evidence that the Claimant was working extremely long hours over an 8 month period. We considered that the hours she was working was excessive. We took into account that this was the NHS and that all staff are under pressures at work, and that staff in senior positions often choose to work above their normal working hours from time to time, and that to some extent this is a normal expectation of a leadership role. However, on the facts of this case, the Claimant's working hours had become unacceptable, both in terms of the amount and duration.

271 Further there was significant evidence that there was an obvious deterioration in the Claimant's mental and physical health over that period, in particular:

271.1 In the contemporaneous documentary evidence the Claimant referred to "struggling with the volume of work" (12 June 2019 email), that her position was becoming untenable (30 July 2019 email and 1 August 2019 meeting), that the "ward / team is under significantly more stress than usual and struggl…" (August 2019 SIREN) and that "both I and the service are on our knees" (resignation letter). This all suggests that she was suffering strain from the considerable pressure that she was under.

271.2 Both Dr Kennerly and Dr Young describe noticing that the Claimant was becoming increasingly stressed; they were worried about her and noted that her mood was suffering and she was having trouble sleeping.

271.3 Mr Wiley accepted that the Claimant came across as very stressed about the service generally at his meeting on the 1 August 2019.

271.4 We consider that must have been clear to the Respondent that the Claimant had lost perspective in relation to her unreasonable objections to slotting Dr X into the substantive role. We consider that her persistence, in the face of contrary views from Dr El-Leithy and senior managers, was an indicator of a deterioration in her mental health. Further not only does she persist in her objections but also ratchets up her concerns about Dr X over the 8 month period; starting with no expression of concern about her clinical ability and being supportive of her applying for the role in February 2019, to stating that she had “some concerns” with reference to two patients in April / May 2019 to stating that Dr X “represents a serious risk to patient safety” in August 2019 (resignation letter).

272 Contrary to the submissions by the Respondent, we concluded that the Claimant’s long hours was not a choice. It was unreasonable for the Respondent to expect the Claimant to manage the dramatic increase in demand pressures on the TSS without additional funding or taking any mitigating steps to reduce those pressures. The Respondent knew about the increase in demand, that this would impact on patient safety and that the Claimant was working extremely long hours. Ms Woollett and Mr Wiley’s merely advising the Claimant not to work such long hours, without discussing how this could be done was unhelpful and meaningless. TSS was a small team and the Claimant had already delegated as much as she could. In such circumstances it was likely that the Claimant would feel under pressure to work longer hours in order to maintain a safe service. We were particularly concerned that:

272.1 Ms Woolett took no steps to address the Claimant’s long hours despite it being recorded that she would monitor the Claimant’s welfare (March 2019 supervision) and “need to address” (May 2019 supervision).

272.2 At the 13 August 2019 supervision Ms Woollett only enquired into the Claimant’s relationship with Dr X, and did not ask her about her own health or workload despite the Claimant having previously raised that she was working long hours.

272.3 The response of Dr Adams and Dr Petch following receipt of the 24 May 2019 email was inadequate. Whilst they suggested the Claimant raise her concerns through the service line, they took no steps to ensure this happened. This was despite Dr Petch admitting it raised “alarm bells” and Dr Adams stating that had he been aware he would have immediately requested her clinical and operational line managers to address the situation.

272.4 The response of Mr Wylie following the Claimant referring to her long working hours at the meeting on 1 August 2019 meeting and her email of 6 August 2019 was also inadequate, Other than to tell her not to work above her normal hours, he took no steps to address the pressure on

the Claimant. Whilst we accept that by this date the Respondent was starting to put in place a mechanism to address the demand pressures on the TSS through an improvement plan, this was likely to take time to put in place and to have an effect. We are concerned that nothing more was done to relieve the pressure on her in the interim.

We consider that the Respondent's failure to provide support or to address the Claimant's long working hours was a breach of their duty of care towards her and therefore negligent. Just because she was a relatively senior employee, that does not mean turning a blind eye to someone working extremely long hours, particularly where they had a known vulnerability to work related stress. It was this failure that created an oppressive working environment for the Claimant.

273 We did not find that the Claimant's long hours was due to any personal failure to manage her clinical practice. She was not spending longer on assessments or writing longer reports than her peers. Her practice had not changed and no concerns had been raised with her at any point. She could not delegate more, and was not doing any teaching or research at this point. Further we do not accept that engaging in discussions with her peers about potential research is the same as conducting research and it is unlikely that any discussions would have been of any significant length. In any event we accept the point made by Dr Kennerly that it is important to maintain a balance of activities and not just concentrate on clinical work and consider it unreasonable for the Respondent to expect the Claimant not to engage in any research given that it is part of her job description. Whilst we accept that the Claimant did spend time on writing documents and preparing evidence to support of her decision regarding Dr X, this would have been occurred around the time of the grievance hearing in April / May 2019, it does not explain the continuation of her long working hours after the conclusion of this process.

274 In relation to the other pressures on the Claimant, we did not consider that the time she spent managing the administrator was a significant factor. We accept that managing this employee would have taken considerable management time, and was part of her overall workload, but it was part of a normal managerial role. With the exception of a reference to this issue in the 15 March 2019 email (in the context of setting out the general demands on the service), the Claimant did not raise this as a specific concern in any of her disclosures or allege that this was contributing to her excessive hours, and did not refer to this issue in her resignation letter. Further we considered that she was receiving HR support since this is referred to in supervision meetings with Ms Woollett.

275 Nor did we consider that the disruption caused by the building works was a significant factor. Whilst we sympathise with the considerable disruption that such works cause and that this contributed to her stress levels, again this is not an unusual situation. We also accept Ms Woollett's evidence that Dr El-Leithy led on this and Dr Wylie's evidence that he attended meetings to help to resolve the disruption caused. Further, this was not raised by the Claimant in any of her disclosures and contrary to her pleaded case the building works was not referred to as a factor in her resignation letter.

276 Therefore we conclude that the Claimant did have to work extremely long hours for extended periods despite her mental and physical health suffering from stress and anxiety caused by the Respondent's failure to address the serious safety concerns that she had raised and despite the Respondent's knowledge that the Claimant had previously suffered with work related stress and anxiety.

Did the Respondent not put in place measures to support the Claimant and the team despite saying that it would? (issue 11.1.3)

277 The Respondent submitted that the Claimant had failed to particularise this allegation, and that it was not appropriate for the Claimant to only provide particulars in closing submissions. We note that the Respondent had raised this issue in the Grounds of Resistance and Amended Grounds of Resistance 33(c) [**p.66; 109 – para 33(c)]**, however this request was not pursued on day 1 of the hearing when the list of issues was discussed. The two measures that the Claimant identified in closing were addressed in evidence by both parties. We therefore concluded that we could consider this issue.

278 The Claimant in closing submissions submitted that there was a "significant overlap between this allegation and those above" and the measures relied upon was the failure to provide support with the Claimant's workload, hours and stress (covered by issue 11.1.1) and the failure to provide support with the underlying demand / capacity issues (covered by issue 11.1.2). To the extent that there was an overlap, we do not repeat the findings set out above, and we do not consider that this was an additional failure by the Respondent which added to any breach of contract.

279 On the two specific measures identified by the Claimant's written closing submissions we find as follows:

279.1 The failure to secure funding from the commissioners in March 2019: We have found that the Respondent did attempt to secure this funding and that it was permissible for the Respondent to select for funding "higher priority" services. Therefore this is not an example of failing to put in place measures to support the Claimant and the team despite saying it would.

279.2 The failure by Ms Woolett and Mr Wylie to take tangible steps "for a significant period of time" to deal with the demand pressures in the light of the recommendation in Dr Adams' email of 12 June 2019: This recommendation resulted in the joint meeting on 19 July 2019, where it was agreed to set up a service review, followed by the 1 August 2019 meeting to discuss the improvement plan. The delay between 12 June to 19 July was primarily due to the Claimant being on leave. We do not consider that there was any significant delay between 19 July to 1 August. From August, work was done by both the Claimant and Mr Wylie on the development of the improvement plan. In relation to the lack of urgency this is addressed above, we do not consider that this was an additional failure by the Respondent to put in place measures of support despite saying that it would.

Did the failure to address the serious patient safety concerns that the Claimant raised breach the implied term of trust and confidence? (Issue 11.2)

280 We consider that the failure to address the under-resourcing of the TSS, between the unsuccessful bid for funding in March 2019 and the supervision meeting on 19 July 2019 was sufficiently serious to damage the relationship to trust and confidence. The Claimant had been raising these issues repeatedly from January 2019 in SIREN reports, supervision meetings and various emails to senior managers. The Respondent knew that this was likely to impact on patient safety because this had been referred to in the Demand Pressure Report submitted to the commissioners in or around February 2019. Further it knew that it should be putting in place a QIA and considering mitigating actions as it was advised of this by Mr Ince on 9 April 2019. The QPRs in March, April and June 2019 all referred to the need for a deeper dive into operational systems and waiting times.

281 Whilst we accept that these matters do take time to address, given the urgency of the situation, and the potential for patient harm caused by longer waiting times and untreated PTSD conditions, it was unacceptable for the Respondent to not commence a service review and / or engage in discussions with the Claimant until 19 July 2019. Although the Claimant was on leave between 13 June and 8 July 2019, this work should have been commenced prior to her going on leave and in any event did not prevent Mr Wylie and others starting this process in her absence.

282 We consider that situation started to change when Mr Wylie proposed conducting a service review at the supervision meeting on 19 July 2019 and started work on an improvement plan from 1 August 2019. Thereafter there is evidence, albeit limited, of ongoing discussions between Mr Wylie and the Claimant and in her resignation letter the Claimant expressed gratitude for his support with some of the pressing issues in the service. Whilst we considered that the Respondent was still not treating the matter was sufficient urgency, and had not as yet put in place any measures to relieve the pressure on the TSS concerns, it was at least looking into the issue with a view to identifying solutions. It was reasonable for this process to take some weeks. Therefore at the point that the Claimant resigned the Respondent were not in breach of the implied term of trust and confidence since the failure was not a continuing one.

283 However, we consider that after 19 July 2019 there was a lack of urgency to address the Claimants concerns, in contrast with the actions of Ms Hill when she became aware of the long waiters on 29 July 2019. This lack of urgency when combined with the failure to address the Claimant’s excessive working hours cumulatively gave rise to a breach of the implied term of trust and confidence (for the reasons set out below).

Did the failure to address the Claimant’s extremely long hours etc breach the implied term of trust and confidence? (Issue 11.2)

284 We do not consider that the Respondent intended to destroy or seriously

damage the relationship of trust and confidence with the Claimant. This is because we have found when considering detriment that none of the failures were deliberate. We then deliberated as to whether the failure address the Claimant's long hours of work over an 8 month period was sufficiently serious in our view to be likely to destroy the relationship of trust and confidence, taking into account all the surrounding circumstances.

285 We consider that the pressure on the Claimant was excessive. It was not just the normal pressure caused by working in an under-funded service, but pressure caused by a drastic and sudden 35% increase in referrals in 2018/19. The TSS was a small service and had limited capacity to cope with this increase. As the team leader the Claimant would inevitably come under the most pressure. At the same time there was no operational manager in post to assist in relieving that pressure. As we have set out above the Respondent were aware of the demand pressure on the TSS and that it was impacting on the Claimant's working hours and her health. The Respondent would not have sought additional funding from the commissioners for one and then two additional posts in March and November 2019, if this pressure was not significant.

286 Given that the Claimant was reporting that she was working very long hours, we were alarmed that the Respondent did not to enter into any meaningful discussion with the Claimant about how she could relieve that pressure and reduce her hours. In particular, we were concerned that the Respondent did not seek to understand why she was working such long hours, given that her clinical caseload had not increased. Nor did they put in place any mechanism to monitor her hours of work and / or the impact on her health. We found this concerning given that the Claimant had previously been off work with work related stress the previous year and that the deterioration of her health in 2019 was "obvious". We did not consider that Ms Woollett and Mr Wylie telling the Claimant not to work above her normal hours was a sufficient response, given the pressure she was under at the time of which they were aware. We also consider Dr Adams and Dr Petch telling the Claimant to raise her concerns via the service line to be inadequate given that Dr Petch admitted it raised alarm bells. As stated above this was a failure of the duty of care towards the Claimant and therefore negligent.

287 We consider that the Respondent's inaction was such that it was likely to damage the relationship of trust and confidence. It left the Claimant to struggle on her own, working excessive hours without support for 8 months. We did not consider that this was remedied following the 19 July 2019 supervision meeting or the 1 August 2019 improvement plan meeting. The Claimant's long working hours was not discussed at the 19 July 2019 meeting. Whilst the Claimant raised this as an issue at the 1 August 2019 meeting, Mr Wylie did not refer to this in his summary of what was agreed at the meeting and did not take any steps to address other than to tell her not to work such long hours. Ms Woollett at the 13 August 2019 supervision did not ask the Claimant about her workload or health, merely enquiring about her relationship with Dr X. It was this cumulative failure that we considered damaged the relationship of trust and confidence

288 Further, or alternatively we considered that the failure to address the Claimant's extremely long hours should be considered in the context of the failure to address the serious concerns that the Claimant had raised regarding patient safety and the under-resourcing of the TSS until 19 July 2019 and the lack of urgency thereafter. It had taken the Respondent 4 months to put in place a mechanism to discuss the red SIREN reports following the failure to secure funding in March 2019, and whilst discussions did occur from 19 July no action was proposed until after the Claimant had resigned. Again it was this cumulative failure that we considered damaged the relationship of trust and confidence.

289 We do not accept that the Respondent had "reasonable and proper cause" for the above failures. Mr Ince had advised that a QIA be conducted in order to identify the risk to unfunded services and Dr Hill recommended taking drastic actions in her position statement, and then when this was not agreed proposed that the treatment model may need to change. We considered that these recommendations were examples of the steps the Respondent should have been considering from March 2019, following the Claimant's unsuccessful bid for additional funding, to address the pressure on the Claimant and the TSS.

290 Further, or alternatively we consider the failure by Ms Ford to respond to the Claimant's 30 July 2019 email to be a last straw. Whilst this failure does not constitute a breach of the implied term of trust and confidence since it was due to an administrative error. Nevertheless it was not an innocuous act, it is a significant step for an employee to write to the then Director of Nursing with whistleblowing concerns. The Claimant had asked for an urgent response. All she received was an acknowledgment on 1 August 2019 and then after chasing, a holding response on the 12 August 2019. No meaningful response had been provided by the date of her resignation on 27 August 2019. In conjunction with the Respondent's previous failure to respond to the Claimant's patient safety concerns prior to 19 July 2019 and lack of urgency thereafter and / or ongoing failure to address the Claimant's workload we conclude that this was the last straw leading to a breach of the implied term of trust and confidence.

Did the Claimant resign in response to the breach (i.e. was the breach of contract a reason for the Claimant's resignation)? (Issue 11.3).

291 It was not disputed that the Claimant had resigned. The reason for her resignation included the failure to address her patient safety concerns and neglect in providing a proper resource for the TSS. In the letter she referred to being under massive pressure and that she was on her knees. We therefore conclude that she was resigning, at least in part, in response to the breach i.e. the underfunding of TSS and the consequential pressure on her (which included working long hours and a deterioration in her health). The fact that the Claimant also resigned due to her concerns about Dr X does not mean that the breach was not the reason; it is sufficient that it was part of the reason.

292 Her concern regarding the underfunding of TSS repeated concerns that she had raised with the Respondent throughout 2019, we accept that those concerns were genuine. We heard evidence from Dr Kennerly that the Claimant was a conscientious and committed practitioner who was proud of the service

that she ran. It is unlikely that she would have resigned had she not felt pushed by the Respondent's failure to address her concerns.

293 We do not accept the Respondent's submissions that the reason the Claimant resigned was because she had received Dr El-Leithy's letter which clearly did not support her position. We did not consider that this was the trigger for her resignation, his letter merely sets out in more detail what he had already told her in March 2019 (as set out in her email of the 15 March 2019).

294 We also do not accept the Respondent's submission that the Claimant resigned because she did not wish to work with Dr X. She never said this and in response to Ms Woollett's enquiries at the supervision on 13 August 2019 the Claimant stated that relations were good and that they had been for lunch. If the Claimant really felt she could not work with Dr X she would have resigned at the end of May 2019 in response to the grievance outcome decision.

Did the Claimant affirm the contract before resigning? (Issue 11.4)

295 The Claimant resigned on the 27 August 2019, within a month of the meeting on the 1 August 2019 where she raised that she was working long hours to manage the volume of work which was neither sustainable nor safe. It was reasonable for her to wait a few weeks following this meeting to see if the Respondent would take any concrete steps to relieve the demand pressures on the TSS and / or her workload. During this period she had a supervision meeting during which no enquiry had been made as to her workload or her health. Further or alternatively, in relation to the last straw incident she resigned within 2 weeks of chasing a response from Ms Ford. It was reasonable for the Claimant to wait for a response before resigning. There is no evidence that the Claimant by words or actions affirmed the contract during this period. Indeed the opposite since she chased Ms Ford in relation to the lack of response to her "whistleblowing concerns" on the 9 August 2019.

296 We do not consider that resigning with 3 months' notice affirmed the contract. The statutory provision permits resignation with notice. Further there were significant reasons for the Claimant giving notice in that she cared about the service and the patients that she served and she was willing to stay on to enable a smooth transition despite her unhappiness with the Respondent's actions. This was to her own detriment since her health deteriorated over this period to the extent that she went off sick with depression on 4 November 2019.

What was the reason or principal reason for dismissal? (Issue 12)

297 We do not consider that the reason or principle reason for the breach of contract was that the Claimant had made a protected disclosure. Whilst the Respondent failed to address the Claimant's concerns about the under-resourcing of the TSS there was no evidence to suggest that this was because she had made a protected disclosure. We have found that the failures were due to poor management structures, including the lack of an operational manager between January and June 2019, which meant that the issue was not properly addressed following the failed bid in March 2019. We do not accept that inferences should

be drawn from the 2010 investigation, Dr Petch's comments or the comments by HR personnel (Ms Lynn and Ms Ogundeji) for the reasons set out above.

298 We accept the Respondent's submission that the potentially fair reason for the Claimant's dismissal was some other substantial reason (SOSR), namely a breakdown in the relationship between the Claimant and Dr X. However we did not consider that the Respondent had acted reasonably in all the circumstances in treating this as a sufficient reason to dismiss the Claimant. This was because there was no evidence that there was an actual breakdown in the relationship or that the Claimant was refusing to work with Dr X. The Claimant had been very careful throughout to state that she had nothing personally against Dr X. Her objections related to what she perceived as Dr X's skillset and her clinical practice, and she had stated in her email of 8 February 2019 that she would support Dr X in applying for the position if advertised externally. Further she had confirmed in the August 2019 supervision that she had a good professional relationship with Dr X. We do not consider that it was within the range of responses to dismiss the Claimant in such circumstances. Moreover the evidence suggests that the Respondent did not consider that the relationship had irretrievably broken down. They were content for the Claimant to work her notice and even had an internal discussion as to whether anything could be done to change the Claimant's mind (see Ms Ogundeji's email of 17 September 2019).

CONCLUSION

299 We conclude that the Claimant was not subjected to any detriment or unfairly dismissed because she had made one or more protected disclosures, however we do find that she was constructively dismissed and that dismissal was unfair.

Employment Judge Hart
Date: 9 February 2024