EMPLOYMENT TRIBUNALS

Claimant:		**Respondent:**
Dr Neil Garrard	v	Lewisham and Greenwich NHS Trust

Heard at: London (South) (via CVP)

On: 30 September & 2-4 October 2024; 7 October 2024 (in Chambers); 15 January 2025 (Judgment AM only)

Before: Employment Judge Fredericks-Bowyer
Tribunal Member Goodden
Tribunal Member Dengate

Appearances
For the claimant: In Person
For the respondents: Ms D van den Berg (Counsel)

JUDGMENT

1. The claimant was unfairly dismissed.

2. The claimant's claim that he was treated less favourably because of his sex and his sexual orientation is not well-founded and is dismissed.

3. The claimant's claim that he was treated less favourably because he was a part-time worker is not well-founded and is dismissed.

4. Remedy is to be determined at the hearing listed 15 January (PM only) and 16 January 2025, following the hand down of this judgment.

WRITTEN REASONS

Introduction

1. This judgment is to be handed down in the morning session of the hearing on 15 January 2025. It may seem an unorthodox approach to adopt this practice in the Employment Tribunal, but the pressures of work in the Tribunal means that I could not be certain that a reserved judgment would be promulgated ahead of the listed remedy hearing.

2. By directing hand down in this way, I am sure that the parties have the judgment. The parties can then reflect on their positions in relation to remedy on the morning of 15 January 2025, before the remedy hearing properly takes place on the afternoon of 15 January 2025 and over the full day on 16 January 2025.

3. The claim arises from an allegation of sexual misconduct levelled against the claimant by a patient. The respondent considered that the claimant committed the misconduct and dismissed him. He says that the respondent made assumptions based on him being an ostensibly heterosexual male which meant he was presumed to have committed the misconduct. He also says that the respondent did not do everything it would have done to support restrictions on his practice if he had been a full time worker.

4. We consider that the dismissal was unfair. There was a failure to carry out a reasonable investigation in circumstances where the claimant had been accused of a serious criminal offence which could have lasting career impact. The dismissal decision was infected with a previous matter which should have been discarded. This was recognised on appeal, but the appeal unreasonably failed to alter the infected decision to dismiss.

5. We were not with the claimant on his allegations of discrimination.

The hearing

6. The hearing took place via Cloud Video Platform over four days. The Panel then met for a day in chambers to deliberate on the issues. This judgment has been prepared following that day of deliberations. I am sorry that the judgment has taken some time to produce following deliberations. This is, again, a feature of Tribunal and judicial workload over the autumn and early winter, particularly in the London (South) region.

7. The claimant represented himself at the hearing and gave evidence in support of his claim. He also produced a supplementary bundle which ran to 1,323 pages. He was able to rely on the documents we were shown in this bundle. In the usual way, we have not considered documents we were not take to in evidence or submissions. The claimant's witness statement ran to 87 pages. He was cross examined only on the parts which were directly relevant to the issues in the claim, and that was the relevant evidence for us in any event.

8. The respondent was represented by Ms van den Berg, a barrister, and called evidence from: (1) Dr Elizabeth Aitken (former Chief Medical Office and Responsible

Officer at the respondent); (2) Sophie Gayle (Associate Director of Corporate Affairs at the respondent); (3) David Knevett (Deputy Director of Finance at the respondent); and (4) Dr Vanessa Purday (current Chief Medical Officer and Responsible Officer at the respondent).

9. We had access to a core bundle of documents which ran to 847 pages. Page references in this judgment are references to that bundle unless the number is identified as 'supplementary', in which case it is a reference to the claimant's supplementary bundle of 1,323 pages. It is unusual to be presented with over 2,000 pages of material for a five day claim with narrow issues like this one, but the Panel was not overly inconvenienced because the bundles were in entirely electronic form which could be page and word searched for the material being referred to.

The List of issues

10. The list of issues was initially set out by Employment Judge Sudra at a hearing on 4 December 2023. The claimant withdrew claims and did not pay a deposit order in respect of others, meaning they were struck out. The parties therefore agreed a trimmed list of issues for this hearing, which was confirmed at the start of the hearing. We only need to decide the issues which were in dispute.

11. The issues were –

11.1. ***Unfair dismissal –***

11.1.1. *What was the principal reason for dismissal? The respondent says the reason was conduct. The Tribunal will need to decide whether the respondent genuinely believed the claimant had committed misconduct.*

11.1.2. *Was it a potentially fair reason?*

11.1.3. *If the reason was misconduct, did the respondent act reasonably or unreasonably in all the circumstances, including the respondent's size and administrative resources, in treating that as a sufficient reason to dismiss the claimant? The Tribunal's determination whether the dismissal was fair or unfair must be in accordance with equity and the substantial merits of the case. It will usually decide, in particular:-*

11.1.3.1. There were reasonable grounds for the belief;

11.1.3.2. At the time the belief was formed the respondent had carried out a reasonably investigation;

11.1.3.3. The respondent otherwise acted in a procedurally fair manner;

11.1.3.4. Dismissal was within the range of reasonable responses.

11.1.4. The claimant alleges that his dismissal was unfair because:-

11.1.4.1. The respondent appears to have relied upon an unrelated, unproven and uncorroborated allegation relating to a complaint against the claimant made by Patient A in or around March 2021;

11.1.4.2. The respondent did not instruct their own medical expert for the disciplinary hearing nor did they request the claimant's expert, Professor Cowan, attend the disciplinary hearing;

11.1.4.3. The respondent failed to follow a fair procedure before dismissing the claimant; and

11.1.4.4. The decision to dismiss was not within the range of reasonable responses.

11.2. ***Direct sex and/or sexual orientation discrimination (s13 Equality Act 2010) –***

11.2.1. The claimant relies on his sex (male) and his perceived sexual orientation (heterosexual).

11.2.2. Was the respondent's dismissal of the claimant less favourable treatment?

11.2.3. If so, was it because of sex or sexual orientation? The claimant relies on the following hypothetical comparators:-

11.2.3.1. A female doctor faced with a similar accusation by a male patient; or

11.2.3.2. A gay male doctor faced with a similar accusation by a female patient.

11.3. ***Part-time workers (Prevention of Less Favourable Treatment) Regulations 2000 –***

11.3.1. Did the respondent refuse to provide the claimant with assistance to comply with the conditions the respondent had placed on his practice?

11.3.2. Was that less favourable treatment?

11.3.3. Was that less favourable treatment on the grounds the claimant was part-time?

11.3.4. The claimant says the comparator (which is required) is Dr Nigel Harrison, who was employed to undertake the same role in the same location and who was also not a qualified GP.

11.3.5. Was the less favourable treatment justified on objective grounds?

11.3.6. Is the claim in time? If not, can time be considered to have been extended?

Relevant Facts

12. The relevant facts as we find them on the balance of probabilities are set out below. Where we have had to resolve any conflict in the evidence, we say how we do so at the material point. These factual findings are unanimous.

The claimant's employment and protected characteristics

13. The claimant was employed as a Senior Clinical Fellow in Emergency Medicine from 29 July 2019 to 2 December 2022, when he was summarily dismissed by the respondent for what was said to be gross misconduct. The claimant worked 20 hours per week. The claimant also joined the staff bank, having been approved to do so on 11 March 2019 (Supplementary page 108 to 109).

14. On shift, the claimant operated as a registrar. We accept the claimant's account that this involved being involved with the day to day running of the department, requiring him to work with other staff to ensure provision of a safe and effective emergency service to the local population through clinical work, teaching, audit and management. Alongside this core 20 hours role, the claimant took additional work in the department through the bank, in the role of 'General Practitioner'. This attracted a higher rate of pay.

15. When the claimant worked as General Practitioner in the Urgent Care Centre ("UCC"), the claimant was required to address patients with minor illnesses who were referred, often by 111, to the UCC because their own GP practices were closed or could not see them. This involved a close consultation with the patient in a way similar to that which a GP would carry out in a doctor's surgery.

16. We consider the claimant performed his roles well. The respondent does not dispute this (subject of course to its views on the matters leading to dismissal). We accept the claimant's evidence that he received positive feedback from those around him, through formal appraisal processes.

17. The claimant is male and this was known by the respondent. The claimant says, and we accept, that his sexuality was never disclosed. He considers that the respondent assumed he is heterosexual and meted out less favourable treatment on the basis of that understanding. It is relevant to this claim that the respondent was aware in March 2021 that the claimant had a 'girlfriend' (page 216). It is accepted that the claimant was a 'part time worker'.

18. The claimant names Dr Nigel Harrison, who he says undertook the same role in the same location, who was not a General Practitioner. The respondent says he is not an appropriate comparator because he is a consultant and a senior clinician with supervision responsibilities. He would have overall responsibilities to the department which the claimant did not have. Dr Harrison, it says, works at a different level in his employment, even if the role he does is occasionally similar. We accept the respondent's evidence about those differences.

The A&E Department

19. The respondent's A&E department at Lewisham Hospital was separated into three areas: (1) resuscitation, (2) major's, and (3) the UCC. The UCC is slightly separate. The claimant provided a sketch of the layout of the UCC in December 2021 at Supplementary page 268. It was broadly accepted as accurate by the witnesses who were shown it, and so we accept what it shows as accurate for the purposes of orientating what the parties say happened with the geographical layout.

20. We accept the claimant's evidence that the A&E department generally can be a volatile atmosphere. We accept his evidence that unusual interactions with patients are typical, because patients who visit A&E are more likely to have an altered state of presentation compared to those not attending the hospital for some acute reason. We accept that instances of verbal or physical abuse reported by staff at the department increased from 31 incidents in 2018 to 277 in 2022 (Supplementary page 258 to 259).

21. To mitigate the risk to staff and patients, the respondent employs security staff. We consider that security staff are a constant presence in A&E, as the claimant contends. The respondent witnesses did not contradict this suggestion. There was also CCTV in the department, and the introduction of body worn cameras for security staff was being introduced at the time to which the claims relate.

22. On 25 July 2021, the claimant was attacked by a patient who threw a printer at him. The patient was convicted of criminal damage on the strength of CCTV evidence alone. On 23 November 2021, a health care assistant at the respondent was stabbed in the emergency department. In response, the department's security arrangements were reviewed.

23. On 25 November 2021, Dr Harding caused an e-mail to be sent to staff (page 213 to 214) which sets out the decisions made the previous day in light of the incident on 23 November 2021. These are said to be required because of the attack *"and the overall increase of abuse and hostility shown towards staff and the increase in MH* [mental health] *patients attending"*. These decisions include the increasing of security officers present in the emergency department from one to two, and the expedited increase in the use of body worn cameras, with training to be deployed the following day.

The Chaperone Policy

24. The respondent operates a chaperoning policy, shown to us at pages 107 to 120. The policy is expressed to be for the protection of patients and staff from abuse or allegations of abuse. The key definitions are on pages 110 and 111:-

    24.1. *"Intimate examination": an examination, investigation, procedure or photography involving for example, breasts, genitalia or rectum, but could also include any examination where it is necessary to touch or even be close to the patient.*

    24.2. ***"****Informal chaperon": a person who is familiar to the patient…*

    24.3. *"Formal chaperone": a Trust employee with a designated specific role.*

25. The operative policy instruction is on page 111:-

> *"Individuals have the right to a formal chaperone when undergoing any intimate procedure or examination. If a chaperone cannot be provided, the person must be informed and asked whether they wish to continue with the procedure or examination."*

26. The requirement to offer a chaperone is triggered only when there is an intimate examination to be done. In her evidence, Dr Aitken notes that it is not a requirement to have a chaperone where the patient consents to the doctor performing the procedure or examination. She considers it is best practice to have a chaperone in any case, but it is not mandatory.

27. Page 113 and 114 outlines situations where a patient may have a particular vulnerability. In those situations, a chaperone must be present when there is a patient *"who requires intimate examination, treatment or care"*.

The historic allegation

28. Overnight on 27 March 2021, the claimant was working overnight through an agency at the Royal Hampshire County Hospital at Winchester. There, a patient alleged she was sexually assaulted and the claimant was named in a complaint to the General Medical Council. The claimant spoke to the Police. He then informed his line manager at the respondent, Dr Harding.

29. On 29 March 2021, Dr Harding e-mailed Dr Aitken, the Responsible Person at the respondent, to inform her of the allegation (page 216). Dr Harding advised Dr Harding that –

> *"Neil is happy to continue working and I have advised him that he will need to have a chaperone to see any female patients, he is working a GP shift for us on Wednesday, which is obviously slightly more tricky for him, this room however has a camera which is always on (closed loop) so all his interactions would be recorded. I have said that I think this should be ok, are in agreement?"*

30. On the same day, Dr Aitken said that a formal chaperone should be utilised and documented in the notes (page 224). Dr Aitken explained that this is in line with the chaperone policy. The claimant says that he had already volunteered to restrict his practice in this way to Dr Harding. He says she knew that he offered to only see female patients with a chaperone present. The respondent says there is no record of this and the only record is what is written in the e-mail from Dr Harding. On the balance of probabilities, we accept the claimant's evidence and find that he did offer to restrict his practice in this way. This is what he says he did, as a professional faced with a serious allegation which left him vulnerable. Dr Harding was not present to give evidence to us, but the indication is that she 'cannot recall' any such comments. That is not a denial, and so we find for the claimant on this factual dispute.

31. On 9 April 2021, Hampshire Hospitals NHS Trust wrote to Dr Aitken to give more detail about the allegation (page 238):-

> *"… on Saturday 27th March 2021 a patient in ED alleged contacted the Police to allege that they had been sexually assaulted by Dr Garrard in Royal Hampshire County Hospital (part of Hampshire Hospitals NHS FT) Emergency Department in the early hours of the morning, whilst he was working as a locum middle grade ED Doctor in the department".*

32. The restriction requiring the claimant to have a chaperone was in place until 13 May 2021, when Dr Aitken removed the restriction on the understanding that the Police investigation had closed without any further action, and that Hampshire Hospital were closing their internal case (pages 232-235) and were happy for the claimant to start working there again.

33. Dr Aitken knew on 12 May 2021 that the respondent's safeguarding team had closed the enquiry about the claimant with no further action (page 237). On 16 May 2021, Ms Thomson in the respondent's HR department confirmed to the respondent's Head of Employee Relations that the respondent would take the issue no further because *"there is no evidence to pursue"*.

34. In December 2021, the GMC informed the claimant that it was investigating the complaint lodged in respect of this incident. The claimant informed the Clinical Director at the Winchester Hospital. On 7 December 2021, an internal e-mail chain at that hospital shows that the claimant had made the disclosure (page 239). The hospital decided that, because the complaint had been investigated by the police and internally, it was content for the claimant to continue to work at the hospital as normal.

35. The claimant also informed Dr Harding of the GMC investigation on 15 December 2021. Dr Harding informed Dr Aitken, at the latest, on 17 January 2022 (page 262).

36. On 13 December 2021, the GMC wrote to Dr Alloway at Winchester Hospital, who confirmed by return that she had no fitness to practice concerns in respect of the claimant (page 267).

Patient B's complaint

37. We use the term 'Patient B' as was used during the hearing. This is the second complaint, from someone who encountered the claimant at the respondent's Lewisham Hospital on 27 December 2021. The complaint was made by e-mail to the respondent on the evening of 28 December 2021 (page 255). The claimant explained that she attended hospital after being advised to do so by 111. She had been experiencing anxiety, shaking, bad balance and fast heart rate, as well as memory loss/sleep walking and disorientation after going to sleep at night and waking up a few hours later. She said, in the complaint e-mail –

> *"This was all linked with some anti-depressants I had recently been prescribed".*

38. Patient B then explained that –

> *"After taking my blood, he [the claimant] told me to get him a coffee from outside the hospital (at the Shell garage) and pick up some water for*

myself whilst we waited for blood test results. I had said I'd preferred a drip, which had been given as an option, but he said I had to leave the hospital and go to the garage to get the water.

Later on, he said my boyfriend was causing my sleepwalking and anxiety, my parents didn't understand my anxiety and none of them could be trusted – only he could be. He said that I should follow all his instructions and to avoid my boyfriend.

He insisted on me waiting at the bus stop, no matter how long it took, and he would take me home from there after I was signed off to go home. I said no, I'd walk. He insisted again. (I did walk home).

He made me take off my bra for a subsequent blood pressure test which wasn't necessary the first time.

He also made me drop my trousers and pants, but didn't explain why…"

39. The complaint was brought to the attention of Dr Harding, who exchanged Whatsapp messages with the claimant on 29 December 2021. The claimant told Dr Harding that he was in the eye room with the claimant. Dr Harding says that there is no camera in that room, which causes the claimant frustration. The claimant asked for the CCTV footage of the waiting room to be saved because it could show relevant comings and goings.

40. The claimant provided a statement about the incident to Dr Harding on 11 January 2022 (pages 259 to 261). The claimant considered his notes when constructing the statement. He sets out the work he did with the claimant on that evening. He said that he put a cannula in the claimant's arm, but she preferred to take oral fluids. He said he explained that there was a garage opposite the hospital. He said that Patient B brought him a coffee. He explicitly denied (1) asking Patient B to purchase coffee, (2) discussing the causes of anxiety, (3) her partner apart from if it was safe to discharge her somewhere, (4) offering to take the claimant home, (5) asking the claimant to remove any item of clothing save for her outer jacket.

41. Dr Harding forwarded the statement to Dr Aitken on 17 January 2022, who as Responsible Officer is responsible for safeguarding and compliance. Her e-mail (page 262) forwards the complaint and also says –

"I wanted to let you know of a recent complaint with the ED registrar who had been reported by a patient from another trust (Winchester) to have behaved inappropriately when examined by him and who has since been referred by said patient to the GMC.

The complaint has similar undertones to the previous one – but has occurred at UHL.

I have talked the case over with Neil who is adamant that the allegations are not true, his notes do back up his statement with respect to timings and the patients refusal to receive IV fluids.

> *My current plan would be to respond to the complainant using the statement above. I have checked and unfortunately there are no cameras in this particular triage room.."*

The respondent's investigation

42. On 18 January 2022, Dr Aitken informed Dr Harding that the complaint will need further investigation. She also instructed that the claimant will need a *"chaperone with him at all times to protect both himself and his patients"*. She said an investigation will be instigated *"ASAP"* (page 264). Dr Aitken saw the response from Winchester to the GMC, where Dr Alloway said that she had no concerns about the claimant. On 20 January 2022, Dr Aitken forwarded the document to HR with the e-mail (page 266) –

> *"Hi both*
>
> *Very similar incident…."*

43. We find as a fact that Patient B's complaint was instantly linked to the previous complaint from March 2021, which had not been taken further by the Police or the other Trust because of a lack of evidence. The respondent had no information other than what that initial complainant had said to Winchester Hospital, and that nothing was being taken forward.

44. Also on 20 January 2022, Dr Aitken spoke to NHS Resolution's Practitioner Performance Advice Service and it was agreed that a formal investigation should be done following the Maintaining High Professional Standards in the Modern NHS policy ("MHPS"). That policy was shown to us at pages 121 to 154. Dr Aitken explained, and we accept, that this is a national framework. On 27 January 2022, NHS Resolution wrote a letter to Dr Aitken summarising the position as it understood it (page 276 to 277). An error in the letter was corrected by Dr Aitken. Dr Aitken also confirmed for herself that this was a serious allegation which required formal investigation and, as Responsible Officer, it was part of her role to launch such an investigation.

45. Dr Aitken appointed Dr Patel (Consultant Physician in General, Geriatric & Stroke Medicine and Deputy Medical Director for Workforce and Engagement) to act as case manager, and Sophie Gayle (Associate Director of Corporate Affairs) to act as case investigator. Dr Aitken's view was that each was sufficiently trained and experienced.

46. Dr Aitken drafted an MHPS investigation letter to Dr Garrard, in Dr Patel's name (page 271 to 272). On 1 February 2022, Dr Patel issued a letter to Ms Gayle (pages 283 to 284) and to the claimant (pages 286 to 287). It is clear that Ms Gayle was given autonomous control over the investigation and was given instructions about the standard and type of investigation requested. Ms Gayle was to gather evidence and find 'unbiased' facts, and compile a report for further consideration. The four allegations (drafted by Dr Aitken) which were to be investigated, were:-

46.1. Whether on 27 December 2021, the claimant inappropriately examined Patient B.

46.2. Whether following the examination, the claimant inappropriately asked Patient B to obtain a coffee.

46.3. Whether the claimant wilfully disregarded the respondent's Chaperone Policy when already under investigation by the GMC for a similar incident.

46.4. Whether there is a pattern of behaviour.

47. There is some ambiguity over the wording of the fourth allegation, but we find all parties understood it to be whether there is a pattern of behaviour of sexually inappropriate behaviour through the linking of the initial complaint with Patient B. There was also some indication that the terms of reference, and allegations, were to be expanded during the investigation to include considerations about probity. Indeed, the claimant was even written to (when on sick leave) with a suite of additional allegations. These never became part of the dismissal process and so we do not take account of them here as they should not have been relevant to the respondent's decision.

48. In evidence, Ms Gayle confirmed that she had carried out four Trust investigations previously, but none of those had been MHPS cases. She had never done this type of investigation before. She also confirmed that she is not medically trained and had never worked in an A&E department or interacted with vulnerable patients who may be disorientated. She confirmed that she did not have any specific training about interacting with vulnerable people or investigating the evidence of potentially vulnerable witnesses.

49. On 25 January 2022, Ms Gayle was provided with an account of a conversation that Ms Peck (Deputy Chief Nurse) had had with Patient B (page 289 to 290). The relevant parts of that e-mail, seen by Ms Gayle, were:-

49.1. Patient B was happy to be named if there were other complaints.

49.2. Since the interaction, Patient B's heart rate had remained high and so her GP had decided to take her off Sertraline.

50. The rest of the account is consistent with the original complaint, with the added detail that Patient B only thought it was all strange when discussing it with a friend the next day. There is no transcript of that conversation and no primary notes. There is no statement from Patient B.

51. On 8 February 2022, Ms Gayle met with the claimant. Notes of that meeting were at pages 334 to 337. They are accepted by the claimant as an accurate non-verbatim record. The saliant facts are –

51.1. The claimant told Ms Gayle that he did not recall the patient at all and his statement was compiled based on his medical notes.

51.2. The claimant said that he would not ask a patient to remove their bra for a blood pressure check.

51.3. When asked whether he asked Patient B to remove her trousers and pants, he said that he did not ask her to remove any item of clothing.

51.4. The claimant reviewed his notes during the meeting and reiterated that there was no need to ask Patient B to remove clothing.

51.5. The claimant said he could not remember Patient B at all but he did remember her bringing him a coffee.

51.6. The claimant explained that he placed a cannula into Patient B's arm, but that she did not want to have a drip, so he sent her to the shop across the road on the understanding that the hospital shop would be closed.

51.7. He did not know why he did not direct the claimant to get a drink in the emergency department.

51.8. The shift was busy and he did not think about whether it was particularly unusual for Patient B to have brought him a drink.

51.9. The claimant thought it was possible that his examination with Patient B was interrupted or observed somehow because there were many comings and goings, but he could not be certain.

51.10. The claimant confirmed he was not under any specific chaperoning instruction at the time but that there was no intimate examination carried out that would trigger the policy.

51.11. The claimant denied there were similar complaints and said they were malicious, the first one having been not proven and not taken forward.

52. The claimant was asked if any specific witnesses should be spoken to and he did not name anyone but suggested it is worth checking CCTV to see who entered and left the consultation room. Ms Gayle agreed to consider the CCTV footage.

53. In her evidence, Ms Gayle asserted that she thought some aspects of the claimant's responses in the hearing were strange. She thought it was unusual for a doctor to send a patient off site for water when she understood there was water in the emergency department. It is clear, in the meeting, Ms Gayle was unsure why the claimant could say that an outer jacket was removed and a coffee brought if the claimant could not remember the patient.

54. The claimant's notes, entered on the respondent system, from his appointment with Patient B were available to the claimant and Ms Gayle during their meeting. We were shown redacted notes at pages 246 to 248. The notes record that he saw Patient B around 7:40pm. Patient B had started taking sertraline for anxiety/depression, and had been sleep walking over the past few days. Her Mum had found her walking downstairs and she also had a new tremor. It is clear from the notes that the claimant checked the claimant's heart rate and blood pressure, observed her pallor and listened to her breathing. He took a history of symptoms and a social history in terms of the claimant's living arrangements. He conducted a neurological examination. He

took bloods. The notes indicate, on first examination, the claimant considered Patient B might be experiencing anxiety or hyperthyroid symptoms.

55. The notes record that *"offered IVF* [intra-venous fluids] *but would prefer to take oral fluids and see if her tachycardia improves"*. At 9:10pm, the claimant notes that the claimant's symptoms had improved. At 9:15pm, the claimant notes he offered referrals but that the patient would prefer to seek talking therapy through self-referral. The notes record she *"has boyfriend support at home"*. The notes record that the claimant considered the visit was triggered by anxiety.

56. Ms Gayle met with Patient B on 23 February 2022. Notes from that meeting were at pages 358 to 360. The claimant gave an almost identical account of what she set out in her e-mail complaint, with some differences:-

    56.1. Patient B said she texted her friend about being sent for coffee at the time (we have seen those messages and accept that evidence).

    56.2. Patient B said that the claimant had asked her to take her top and bra off multiple times, continuously.

57. Patient B also told Ms Gayle that she went back to her GP because she did not trust the claimant's advice to keep taking the sertraline medication.

58. When Patient B was asked if there was anything else she wanted to say, Patient B said that it was odd how the claimant did things. She described how he would tell her to close her eyes and then clicked his fingers, and that he would say 'the weird things' when her eyes were closed. Elsewhere in the meeting, Patient B used the phrase 'weird' to describe being asked to go and buy coffee, and about the bus stop.

59. Ms Gayle did not ask Patient B if the instruction to close eyes and the finger clicking occurred as part of the neurological examination (where testing hearing is an essential part of the procedure).

60. Ms Gayle's report was produced at pages 363 to 374. It is dated 8 March 2022. In addition to the interviews, the report shows that Ms Gayle also considered:-

    60.1. The previous complaint;

    60.2. The GMC referral letter; and

    60.3. The Chaperone Policy.

61. Ms Gayle report does not include any of the following lines of enquiry, nor does it explain why these steps were not carried out:-

    61.1. Seeking out and speaking to anybody else on shift at the time;

    61.2. Seeking out and considering CCTV evidence;

    61.3. Seeking out and speaking to the receptionist who must have interacted with Patient B;

61.4. Seeking out and speaking to the security officer likely in the vicinity;

61.5. Seeking out and securing any body worn footage;

61.6. Seeking out and reviewing any primary evidence from Winchester about the initial complaint;

61.7. Consideration about whether Patient B's complaint could have been triggered by anything else, including the reasons for her visit to the respondent that evening.

62. In respect of allegation 1, Ms Gayle considered she could make no findings because there was no CCTV in the room. The report highlights perceived inconsistency in the claimant's account about what he could and could not remember.

63. As well as the coffee incident, Ms Gayle places emphasis on the claimant saying that he did not remember Patient B but that *"he was clear that"* he only asked her to remove her outer jacket. We consider, as a fact, that this is an error in the investigation report. Looking at the notes of the meeting between the claimant and Ms Gayle, the claimant is recorded as saying (page 259) –

> *"I do not recall what the patient was wearing but it would be my normal practice to ask them to remove any outdoor coat or jacket as it is not possible to take a blood pressure reading without removing them".*

64. It is therefore a fact that the claimant did not say that he asked the claimant to remove her outdoor jacket, and so it is flatly wrong for Ms Gayle to have said that he did and then used that as emphasis for why the claimant's account should be questioned.

65. On page 370, Ms Gayle writes about allegation 2. She says that it was usual to offer hydration from the emergency department, and that this had been confirmed with the emergency department matron *"as part of the investigation process"*. The report does not indicate that anybody else was spoken to, and the Matron was not identified in the introduction as providing evidence which contributed to the investigation.

66. In respect of allegation 3, Ms Gayle notes that the claimant was not subject to any practice restrictions and was aware of the respondent's chaperone policy and that he had a complaint being investigated by the GMC.

67. In respect of allegation 4, Ms Gayle sets out the entirety of the previous allegation made against the claimant. Ms Gayle repeated Patient B's words about closing eyes and clicking fingers, linking them to alleged chanting in the previous complaint, and saying that the complaints *"appear to have similarities"*. She does not say that she asked the claimant about that part and she does not consider whether any of the behaviour complained of by Patient B could be explained in any other way.

68. In conclusions, Ms Gayle again emphasised (1) what we consider to be the outer jacket mistake, (2) the Matron's account of hydration on the emergency department despite not identifying her as a witness or providing first hand evidence, (3) an implication that the claimant should have had a chaperone, despite this not being what the policy actually required (as confirmed by Dr Aitken in evidence), and (4) the linking of the two complaints despite the first complaint being unproven (and

considering no primary evidence), and not investigating whether the finger clicking could be part of a normal neurological examination.

The dismissal process

69. Dr Patel decided that a disciplinary panel should be convened to consider the allegations made. Mr Knevett was appointed to chair the hearing. He had not previously chaired a disciplinary hearing but had no involvement with the case previously and was sufficiently senior to make a disciplinary decision.

70. The claimant was sent an invitation to the disciplinary on 25 August 2022 (page 469). Mr Knevett reviewed relevant material ahead of the hearing. On 26 September 2022, the claimant's legal representative sent an expert report from Professor Cowan (page 504 to 514) and the claimant was allowed to rely on it even though it was sent after the deadline for additional evidence. The claimant was permitted to have two representatives accompanying him to the hearing.

71. The hearing took place on 30 September 2022. Mr Knivett and Dr Hanna were present. Dr Hanna was an independent doctor appointed to the disciplinary panel. Three members of HR were present. Dr Patel and Ms Gayle attended. The claimant attended with a barrister and a solicitor. Patient B also attended. The notes from the meeting are at pages 536 to 553 of the bundle.

72. At the hearing, Dr Patel presented a paper which the respondent witnesses described as being in response to Professor Cowan's evidence. The report from Professor Cowan indicated that Patient B had some symptoms consistent with serotonin syndrome. It did not make any diagnoses and the Professor never met Patient B. Dr Patel's paper was at pages 528 to 535.

73. At the hearing, Dr Patel gave evidence to the effect that his views and the article show that Patient B did not have serotonin syndrome according to the better accepted criteria. The claimant had suggested that serotonin syndrome could have caused Patient B to be delusional. Dr Patel gave his thoughts about the allegations. He considered that the claimant should have been using a chaperone.

74. At the hearing, it transpired that Ms Gayle had reviewed the CCTV of the waiting room *at length* with an emergency department colleague. Ms Gayle considered it showed nothing relevant. The claimant had not previously been told the CCTV had been reviewed and he had not had the opportunity to see it.

75. Patient B gave evidence at the hearing. The claimant's counsel was permitted to ask Patient B questions to clarify evidence and highlight areas that might support the claimant's case. She talked about the issues that led her to attend the hospital. She agreed that it was busy. She could not recall if anyone interrupted her examinations by the claimant. She confirmed the essential parts of the claimant's notes of the examination before she had sight of the notes. Patient B's messages to her friend, where she said it was strange to have been sent to buy the claimant a coffee, were considered. Patient B said that she had not sleep walked prior to attending hospital, and this is where her memory fades. Patient B said that the claimant had asked her to get him a coffee and had explained how the machine worked.

76. The claimant answered questions at the hearing. He explained that he diagnosed anxiety but with more thought and time, he may have diagnosed serotonin syndrome. He said that it was extremely busy. He said he thought the CCTV was present and working. He denied the allegations. He was asked about the previous complaint. He said he did not consider a chaperone because he understood he was under CCTV observation. He said that although water was available in the emergency department, it was not available in UCC. He said that it is not part of his role to find a normal water source and so, once the IV fluid had been refused, he guided Patient B about where to get water from.

77. The claimant explained that there was a lack of staffing to bring hydration and so once the IV fluid was refused, he was not able to get water. He explained that the claimant may feel elements of hypnosis but that these were because of him rubbing his ears to test hearing and conduct the appropriate tests. In questioning, Mr Knevett accepted that there may have been water restrictions as a result of COVID.

78. In respect of the GMC letter, the claimant said he had spoken to Dr Harding and been told that nothing else needed to be done. He was not sure if he had written confirmation.

79. Each party closed their cases. The claimant's counsel outlined the good character of the claimant and the way in which the notes support what he said, and queried Patient's B's reliability in light of what had brought her to the hospital. Some areas of inconsistency were highlighted, including Patient B knowing she may have serotonin syndrome from her messages, and the possibility of other substances interacting to cause an issue. In essence, the panel were urged to believe the claimant – as a known person of long-standing – over Patient B, who was unknown and had attended the hospital with neurological symptoms possibly caused by medication.

80. The Panel considered the evidence and decided that there was more evidence to gather before reaching a decision. These were:-

    80.1. Statements from Dr Harding, Dr Aitkens, the Matron, someone who knew about CCTV; and

    80.2. Communications from the GMC.

81. The claimant's representative objected to this step, saying that it was not in line with policy and that closing submissions on all the evidence had already happened. It seems that Mr Knevett may have reflected on this, because on 4 October 2022 he e-mailed to say that he was unsure (page 558). On 5 October 2022, he wrote to the claimant to say that he did have enough information after all and would work on providing an outcome (page 560). Dr Hanna provided some input into that outcome (page 563).

82. On 17 October 2022, Mr Knevett changed his mind and decided that he needed to understand from Dr Harding whether or not she recalled a conversation with the claimant to the effect that the claimant did not require a chaperone from earlier in December 2021 (page 564). It is not clear what led Mr Knevett to change his mind, and he did not answer that question when asked by the claimant's solicitor.

83. On 21 October 2022, Dr Harding wrote a e-mail (page 573) to say that she could not remember a meeting at the time or any discussion about the chaperone policy. In response, the claimant submitted a statement (pages 580 to 581) which sets out more detail about the conversation he said he had with Dr Harding. He also submitted a rota showing that the pair were on shift at the same time.

84. In evidence, Mr Knevett said he considered the e-mail from Dr Harding and the claimant's statement.

85. A meeting took place on 2 December 2022, and there Mr Knevett read out the contents of the dismissal letter shown to us on pages 594 to 601. Mr Knevett considered that allegations 1 to 3 were so serious that any other sanction considered was inappropriate. In summary –

85.1. **Allegation 1 –**

Patient B's evidence was credible and there was no reason to disbelieve her. In comparison, the claimant said he did not remember seeing the patient but did ask her to remove her outer jacket (thereby Ms Gayle's clear error is used as justification to dismiss). The claimant suggested the patient may have been suffering from serotonin syndrome but this was a suggestion only.

The reasoning for this allegation being upheld does not set out that the allegation was denied and, apart from the jacket error, it does not give any reason why the claimant's account about what actually happened (including the contents of his notes) were not believed.

The letter indicates, on page 598, that Mr Knevett considered that because it was unlikely that the patient was suffering from serotonin syndrome, the allegation was true.

The letter goes into detail about the alleged similarities between the previous complaint and Patient B to lend weight to Patient B's allegations, including the similarities between 'hypnotic chanting' and the clicking of fingers and saying *"weird things"* (ie. the bus stop issue) with eyes closed.

85.2. **Allegation 2 –**

The Whatsapp messages were used to lend weight to the fact that the claimant did ask Patient B to buy coffee for him. There is no reason offered for why the claimant's evidence was considered to be insufficient but the weight of evidence leant by the previous complaint and Patient B was again referred to.

85.3. **Allegation 3 –**

Mr Knevett writes that there is a *"clear conflict in the evidence"* between the claimant's account of the Dr Harding conversation and her account. He appears to consider Dr Harding saying she cannot remember anything as being positive evidence that the thing did not happen.

The claimant is then found to have breached the chaperone policy on the basis that Mr Knevett considered that Patient B had been asked to remove items of clothing (ie. because allegation 1 had been proven). It is also said that Mr Knevett thought that the chaperone policy would be employed by the claimant given the GMC investigation, although that is not put as a breach of the policy because it is not.

85.4. **Allegation 4 –**

Mr Knevett writes *"the similarities between these allegations and those of an earlier incident are relevant to the credibility of the allegations, as already set out above. However, I do not consider that this is an allegation on which it is appropriate to make findings in its own right."*

The appeal

86. The claimant appealed the decision and was given an extension to do so. The grounds of appeal were shown at pages 616 to 624. There were four grounds of appeal. These related to:-

86.1. Failure to give proper weight to the medical notes or the claimant's statements about CCTV;

86.2. The respondent expected the claimant to prove a reason why Patient B would be inaccurate, and when it considered she did not have serotonin syndrome, so the allegations were belived;

86.3. Giving improper weight to the academic article as opposed to Professor Cowan's opinion;

86.4. Using the previous allegation as justification for believing Patient B's account over the claimant, whilst also saying it would be inappropriate to make a misconduct finding in respect of a prior unproven matter.

87. The appeal took place on 5 September 2023 and was chaired by Dr Purday. It was convened in line with policy. Dr Purday had not been involved previously. All of the grounds were considered and the claimant was represented by Counsel. A management report was considered (pages 634 to 647). There was a disagreement about whether Dr Purday was entitled to ask the claimant questions in clarification. The respondent considered that it was. The policy is silent on the point.

88. On 22 November 2022, an appeal outcome letter was sent to the claimant (pages 720-730). The only ground upheld was in respect of the use of the previous complaint in the process against the claimant. In considering the impact of the error on the part of the Knevett panel, Dr Purday accepted Mr Knevett's claim that the use of the previous allegation to lend weight to allegations 1 and 2 (leading to allegation 3) were not a significant factor in the decision to dismiss. In summary, she wrote –

"I find that it was not appropriate for the panel to take the Hampshire complaint into account in weighing the credibility of the patient's account.

I accept that having made their decision not to address allegation four, they should have put the Hampshire complaint out of their minds as it had not been upheld. However, I also accept that this factor was not determinative of the outcome."

89. This means, then, as a fact, following the appeal, the respondent considered that:-

89.1. Patient B had not had serotonin syndrome;

89.2. There was no other known reason for Patient B to make up the allegation;

89.3. The claimant's account was dismissed because it was [mis]understood that he could not recall the consultation but could recall that only the outer jacket was removed;

89.4. The claimant had sent Patient B to buy him a coffee because Whatsapp messages were to be believed over the claimant because of that misunderstanding;

89.5. The claimant breached the chaperone policy because he had inappropriately examined Patient B, because she was believed as she did not have serotonin syndrome and because of the outer jacket 'inconsistency';

89.6. No other evidence was required or available.

Relevant Law

Unfair dismissal - liability

90. Under *s98(1) of the Employment Rights Act 1996*, it is for the employer to show the reason for the dismissal and that it is either for a reason falling with *section 98(2)* or for some other substantial reason of a kind such as to justify the dismissal of the employee. The respondent asserts that the claimant was dismissed by reason of the claimant's conduct. Dismissal for conduct is a potentially fair reason falling within *section 98(2)*.

91. Where the employer has shown a reason for the dismissal and that it is for a potentially fair reason, *section 98(4) of the Employment Rights Act 1996* states that the determination of the question whether the dismissal was fair or unfair depends on whether, in the circumstances (including the size and administrative resources of the employer's undertaking) the employer acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the employee and must be determined in accordance with the equity and substantial merits of the case.

92. In *Iceland Frozen Foods v Jones [1982] IRLR 439*, it was held that, when considering s98(4), the tribunal should consider the reasonableness of the employer's conduct and not simply whether the dismissal is fair. In doing so, the tribunal should not substitute its view about what the employer should have done. The case also outlined that there is a range of responses open to a reasonable employer; although different employers could come to different decisions in the same circumstances, all might be reasonable. Consequently, the tribunal must consider whether, in the

particular circumstances of the case, the decision to dismiss the employee fell within the reasonable range of responses which a reasonable employer might have adopted. If a dismissal falls outside that band, then it is unfair. The tribunal should consider the whole dismissal process, including any appeal stage, when determining fairness (*Taylor v OCS Group Ltd [2006] ICR 1602*).

93. When considering cases of alleged issues of conduct, it is important to consider the case of *British Home Stores v Burchell [1980] ICR 303*. This case establishes a three stage test for dismissals:

    93.1. the employer must establish that it believed that the misconduct had occurred;

    93.2. he employer had in its mind reasonable grounds upon which to sustain that belief; and

    93.3. when the belief in the misconduct was formed, the employer had carried out as much investigation into the matter as was reasonable in all the circumstances of the case.

94. The band of reasonable responses test applies as much as much to the respondent's investigation as it does to the decision to dismiss (*Sainsbury's Supermarkets v Hitt [2003] IRLR 23*). The tribunal must focus on whether the employer's investigation was reasonable in all the circumstances (*London Ambulance v Small [2009] IRLR 563*). There is helpful case law to assist with determining what sort of investigation might be reasonable in all the circumstances of the case as envisaged in *Burchell*. In *W Weddel & Co Ltd v Tepper [1980] IRLR 96*, Stephenson LJ said that employers

    "must make reasonable inquiries appropriate to the circumstances. If they form their belief hastily and act hastily upon it, without making the appropriate inquiries or giving the employee a fair opportunity to explain himself, their belief is not based on reasonable grounds and they are certainly not acting reasonably".

95. This means that the respondent must seek out and consider any evidence which would show the employee had not committed the conduct alleged (*Miller v William Hill Organisation Ltd [2013] All ER 110*). When the allegations are particularly serious with potentially serious consequences for the employee if the allegations are proven, such as with accusations of a criminal offence, then more will be expected from an employer if it is to be said to be acting reasonably (*Salford Royal NHS Foundation Trust v Roldan [2010] IRLR 721*).

Direct discrimination – sex and sexual orientation

96. *Section 4 Equality Act 2010* lists protected characteristics for the purposes of that Act. Sex and sexual orientation are each listed as a protected characteristic. The protected characteristics that the claimant says are relevant to the claim are within the list at *section 4*, and are therefore protected characteristics which the claimant has.

97. *Section 13(1) Equality Act 2010* provides:-

> *"A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others"*.

98. This means that the claimant would have suffered from direct discrimination if we find that, in relation to each allegation, he was treated less favourably than someone who did not have the characteristic that he either has (being male), or was perceived to have (being heterosexual) (*Chief Constable of Norfolk v Coffey [2019] EWCA Civ 1061*).

99. The claimant must establish that he was objectively treated in a 'less favourable' way. It is not sufficient for the treatment to simply be 'different' *(Chief Constable of West Yorkshire Police v Khan [2001] ICR 1065 HL*). The person(s) with whom the comparison is made must have *"no material difference in circumstances relating to each case"* to the person bringing the claim (*section 23(1) Equality Act 2010*). The comparator should, other than in respect of the protected characteristic, *"be a comparator in the same position in all material respects as the victim" (Shannon v Chief Constable of the Royal Ulster Constabulary [2003] ICR 337 HL)*. If there is no such comparator in reality, then the Tribunal should define and consider how a hypothetical comparator would have been treated if in the same position as the claimant save for the fact that they would not have the protected characteristic relied upon *(Balamoody v United Kingdom Central Council for Nursing, Midwifery and Health Visiting [2002] ICR 646, CA)*.

100. The phrase 'because of' is a key element of a direct discrimination claim. In *Gould v St John's Downshire Hill [2021] ICR 1 EAT*, Mr Justice Linden said, in respect of determining 'because of':-

> *"It has therefore been coined the 'reason why' question and the test is subjective… For the tort of direct discrimination to have been committed, it is sufficient that the protected characteristic had a 'significant influence' on the decision to act in the manner complained of. In need not be the sole ground for the decision… the influence of the protected characteristic may be conscious or subconscious."*

101. It is a defence for a respondent to show that it had no knowledge of the protected characteristic relied upon, on the basis that the protected characteristic it did not know about could not have caused the treatment complained of (*McClintock v Department for Constitutional Affairs [2008] IRLR 29 EAT)*. However, this defence does not apply where the act itself is inherently discriminatory (such as differentiation on the grounds of a protected characteristic), and in such cases whatever is in the mind of the alleged perpetrator of the discrimination will be irrelevant (*Amnesty International v Ahmed [209] ICR 1450 EAT*).

102. Under *section 136(2) Equality Act 2010*, the claimant needs to show facts, found on the balance of probabilities, which could lead the Tribunal to properly conclude that the discrimination has occurred before any other explanation is taken into account. If the claimant succeeds with this, then it is for the respondent to show that the contravention has not occurred (*section 136(3) Equality Act 2010*). The Tribunal must first consider whether the burden does shift to the respondent. The claimant must show more than simply there is a protected characteristic and a difference in treatment (*Madarassy v Nomura International Plc [2007] IRLR 246*).

103. Once the burden has shifted, if it does, the respondent must to show that the treatment was 'in no sense whatsoever' due to the protected characteristic *(Igen Ltd v Wong [2005] IRLR 258)*. In weighing up whether or not there has been discrimination, the Tribunal should consider all of the evidence from all sides to form an overall picture. Causation, or the 'why' the conduct was committed, is a subjective conclusion of law rather than objective conclusion of fact: what is the reason for the conduct and is that reason discriminatory (*Chief Constable of West Yorkshire Police v Kahn [2001] UKHL 48*. It is almost always the case that the Tribunal needs to discover what was in the mind of the alleged discriminator (*The Law Society v Bahl [2003] IRLR 640*).

Part-time workers' discrimination

104. For part-time workers' discrimination to be found, the claimant must establish that he was treated less favourably than someone in the same employed role as him but who works full time. There needs to be an actual comparator who does all the same work but on a full time basis.

Discussion and conclusions

Unfair dismissal

105. We remind ourselves that we are not to substitute our decision for the one reached by the respondent. We are considering whether what the respondent did at each point in the process was inside or outside the reasonable range of responses.

106. Considering the list of issues, we are satisfied that the claimant was dismissed for a conduct reason, which is a potentially fair reason for dismissal. We are similarly satisfied that the respondent had a genuine belief in the misconduct it found. That was not questioned in the hearing, and it is clear to us that all of the individuals involved believed, at the time of dismissal or appeal, that at least the three of four misconduct allegations found were proved.

107. Was that belief formed on reasonable grounds sustained after a reasonable investigation? These are incredibly serious allegations. Following *Roldan*, more is expected where the ramifications for the allegations are particularly serious because they may be criminal in nature and they would, in our view, have huge impact on a doctor's career. In our judgment, the respondent would have to do a great deal in terms of running a fair and thorough investigation if that investigation was to be reasonable.

108. We have highlighted above some of the areas that the investigation failed to explore. In our judgment, the failure to explore speaking to other members of staff who must have or may have had interaction with Patient B was a significant failing. Crucial evidence, the nature of which we cannot know, was not able to be secured if anybody could remember Patient B. In the hearing, Ms Gayle said this would have been an onerous task to identify all staff in the department at that time. Respectfully, the respondent ought to have an easy to hand record of who should have been present. It would not be disproportionate to seek to find those people and ask questions.

109. Similarly, Ms Gayle did not know if anyone on the department was wearing body worn cameras. This is another area which, in our view, an investigation into an allegation of this kind would be required to explore if it is be done reasonably.

110. Ms Gayle did not consider whether any of the allegations could be explained by a normal examination, particularly in respect of the clicking fingers which we consider would be a usual part of the neurological examination.

111. We are satisfied that the failure to follow those lines of enquiry also mean that the respondent failed in its duty to seek out evidence that might clear the claimant of the allegations (*Miller*). In our judgment, these avenues would have done nothing to confirm the conclusion the claimant committed the misconduct and, in circumstances where he was dismissed without the potential evidence, we consider that any such enquiry would only turn up evidence that might have cleared him. Also in line of what is 'reasonable' in these particular circumstances, we consider this to be a significant failing.

112. In our judgment, it is clear that Ms Gayle formed a view that the claimant was not a credible witness based on him saying he could not remember Patient B but he did remember being handed coffee and asking her to remove her outer jacket. It does not appear that Ms Gayle asked the claimant how he could remember being handed coffee but not the patient herself. In the hearing, the claimant told us that the coffee was brought separately, and was something he remembered when being asked, but that did not mean that he could remember Patient B itself or an examination that he considered to be unremarkable. In our view, the fact the claimant says he could not remember Patient B actually lends weight to his evidence that the allegation is not true, but the investigation report does not consider that angle.

113. It is apparent that the mistake about the claimant saying it would be his normal practice for an outer jacket to be removed being interpreted as a statement of what actually happened has infected the report, because it is used repeatedly to emphasise why the claimant may be considered unreliable.

114. Overall, in our judgment, the investigation was not reasonable and falls outside of the reasonable range of responses. Any decision based on this investigation is liable to be unfair unless those deficiencies are recognised.

115. In our judgment, those deficiencies were not recognised, and were carried through to the dismissal itself, where the evidence presented (incomplete and with at least one crucial error) was used in preference to the claimant's denials.

116. Additionally, the previous complaint was used to support that tilted evidential carpet against the claimant. The similarities between that unproven complaint, which had been closed by the police and by another Trust (which had a lower burden to pursue), and Patient B's were used to lend weight to Patient B. The respondent had not considered, as outlined above, that the similarity drawn about Patient B's complaint could have been explained elsewhere. The respondent unreasonably failed to consider that Patient B was talking about the things the claimant said when talking about 'weird things' and not the way he said them.

117. It is clear that the panel gave a great deal of weight to the previous complaint when weighing evidence which led to dismissal. In our judgment, alongside the jacket error, it is the only significant reason why Patient B's account could have been believed. In doing so, the panel used unproven complaints, the circumstances around which it had no direct evidence, to dismiss. This would be outside the range of reasonable responses.

118. Alternatively, Patient B was believed as soon as the claimant failed to convince the panel that Patient B had been suffering with serotonin syndrome. If that is so, then the burden of proof applied where the claimant had to actively disprove Patient B's account was not appropriate and would also lead to the decision falling outside the range of reasonable responses.

119. We also consider that there were procedural deficiencies. The claimant was not given the opportunity to view the CCTV directly. CCTV is often interpreted differently with different arguments available for what is shown. The claimant was deprived of this opportunity. Similarly, an article which was given significant weight by the panel in assessing Patient B's possible diagnoses was only given to the claimant on the day of the dismissal hearing. This was almost an ambush which, in our view, is only partially mitigated by the claimant's ability to respond rapidly to new information. This is unfair.

120. Finally, we are not clear how Mr Knevett could say that Dr Harding's complaint was in conflict with the claimant's about whether she told him he needed a chaperone at the time in question. She could not remember. That is not evidence one way or the other. It is, though, a failure to support the claimant's account. His account was already in question for the unreasonable reasons outlined above. In the circumstances, we consider that the reason to hold Dr Harding's response against the claimant indicates that Mr Knevett was only searching for reasons to support dismissal. That, in addition to relying on the neutral response at all, further means the decision to dismiss falls outside the band of reasonable responses.

121. These issues could have been rectified on appeal. In our judgment, they were not. The appeal correctly identified that the previous complaint should have been put out of the mind. Unfortunately, that previous complaint was part of the reason the investigation was launched. It was in the terms of reference. It was used in the investigation to question credibility. It was used in the dismissal to disbelieve the claimant. We do not see how it is within the range of reasonable responses to conclude, on the basis of Mr Knevett's assertion, that it did not affect the decision to dismiss because it is not significant. It was significant.

122. If it was not, then the decision to dismiss could only have been based on the items listed at paragraph 89 above. That evidence, taken together in light of the seriousness of the allegations, with the errors built into the conclusions, plainly would not justify a fair dismissal. Such a dismissal, too, is outside the band of reasonable responses.

123. In our judgment, the claimant was unfairly dismissed.

124. We have considered whether correcting the procedural deficiencies would result in the chance of a fair dismissal. We do not consider that it would. The unreasonableness of the investigation and decision to dismiss, given the

seriousness of the allegations, would not have been cured. We make no reduction for the possibility the claimant could have been dismissed for a fair procedure.

125. In the circumstances, the facts found, and these conclusions, we make no other reduction to any award on a basis formed in legislation. We make no uplift either. The issue of mitigation of losses is to be dealt with at remedy.

Direct sex / sexual orientation discrimination

126. We note that the claimant did not appear to press the respondent witnesses on any of the decisions in respect of the discrimination claims. He did not challenge the respondent witnesses about whether they would have made a different decision had he been assumed not to have sexual preference for women, or if he had been a woman.

127. In any case, we have no evidence to indicate that these individuals would have made any other decision if the claimant did not have the characteristics relied upon. What we have are the characteristics, and the decisions made which the claimant has objected to. In our view, the claimant has not established the 'something more' required to shift the burden of proof to the respondent.

128. In short, the absence of evidence around any contextual issues with gender or sexual orientation, or any indication in evidence that those things could have played a part, means that we have not found facts from which we could conclude that discrimination has occurred.

129. It follows that the discrimination claims are not made out, and they fall to be dismissed.

Part-time workers' discrimination

130. We have accepted that Dr Harrison worked at a level above the claimant with a more senior managerial role and different responsibilities. This means that, although he may work on the same department in the same role seeing patients, he balances other demands at the same time. When not working in the emergency department as a GP, his role is entirely different to that of the claimant. He is not an appropriate comparator, and so there is no comparator for this claim. It must fail.

Overall disposal

131. The claimant was unfairly dismissed. Remedy is to be determined in the remedy hearing already listed. The claimant's other claims for discrimination fail and are dismissed. This means the claimant is entitled only to a basic award and a compensatory award which is subject to the statutory cap.

Employment Judge Fredericks-Bowyer
Date:15 January 2025