EMPLOYMENT TRIBUNALS

Claimant:	**Dr M Benaris**
Respondent:	**Leicestershire Partnership NHS Trust**
Heard at:	Leicester Hearing Centre, 5a New Walk, Leicester, LE1 6TE
On:	9 April 2025 (Tribunal reading in – parties did not attend) 16, 17 April 2025 22, 23, 24, 25 April 2025 28, 29, 30 April 2025, 1, 2 May 2025 6 May 2025 (by video link) 2, 3, 4, 5 June 2025 (Tribunal deliberations – parties did not attend) 20 and 21 August 2025 (Tribunal deliberations – parties did not attend)
Before:	Employment Judge Adkinson Ms F French Mr C Tansley
Appearances	
For the claimant:	Mr O Isaacs, Counsel
For the respondent:	Mr M Sutton KC, Counsel

JUDGMENT

UPON HEARING from Counsel for the Claimant and Counsel for the Respondent

UPON considering the evidence

AND for the reasons set out below

IT IS THE TRIBUNAL'S JUDGMENT THAT

1. The following claims that respondent subjected the claimant to the detriments as identified below because she made one or more protected disclosures are presented out of time. Because it is accepted it was reasonably practicable to present them in time, the Tribunal has no jurisdiction to consider them and they are dismissed.

1.1. Subjected the claimant to intense pressure to move from the ward because she made one or more protected disclosures;

1.2. Subjected the claimant to increased hostility by staff and/or patients, and in particular from Dr Naik and others who had been instigated to do so by Dr Naik for making protected disclosures;

1.3. Subjected the claimant to malicious and unfounded allegations namely

1.3.1. a comment that she had said that "nurses lowered their standards";

1.3.2. an allegation the claimant had "shouted" at bed management;

1.3.3. an allegation that the claimant had used clinical notes to criticise other professionals; and

1.3.4. an allegation that the S1 entries for Patient 3 had been used to criticise other professionals.

because she made protected disclosures;

1.4. The instigation of a disciplinary process because she made protected disclosures;

1.5. Being relocated from the Bradgate Unit because she made protected disclosures;

1.6. The claimant's ongoing suspension from on-call work, including once the investigation processes had concluded because she made protected disclosures;

1.7. A delay in the resolution of the whistleblowing complaints;

1.8. Inadequate resolution of the whistleblowing complaints including the failure to consult with the claimant during this process and to provide an unredacted whistleblowing report;

1.9. Reaching irrational conclusions in the disciplinary process; and

1.10. The claimant's grievance and complaint regarding bullying were not taken seriously and witnesses who could corroborate her complaint were not questioned.

2. The following claims that the respondent subjected the claimant to the detriments as identified below because she made one or more protected disclosures are dismissed.

2.1. Removal of the claimant's teaching responsibilities;

2.2. Failure to respond to Dr Benaris's communications seeking a sustainable return to on-call work and to implement a plan for a return to the on-call rota.

3. The claimant's claim that she was constructively unfairly dismissed for making a protected disclosure fails and is dismissed; and

4. The claimant claims that she was constructively unfairly dismissed fails and is dismissed.

REASONS

Introduction

What this case is about?

1. The claimant (**Dr Benaris**) brings several claims. They are set out in the list of issues below in more detail, but can be summarised as follows:

    1.1. Being subjected to a number of detriments for making a number of protected disclosures;

    1.2. Being constructively unfairly dismissed for making protected disclosures; and

    1.3. Being constructively unfairly dismissed in any case.

2. The respondent (**the Trust**) denies the claims. It also argues that some of the claims are out of time and so the Tribunal has no jurisdiction to decide them in any event.

What this case is not about?

3. It is important to say what we are not deciding. As we made clear at the start, these proceedings

    3.1. are not a general public enquiry into the unit at the relevant times;

    3.2. are not an enquiry into the care, quality or merits of certain clinical decisions taken from time to time by various people;

4. are not an assessment of the clinical or other merits of various policy decisions taken from time to time (unless that policy impinges on an employment law issue);

    4.1. are not an enquiry into or findings about patient safety at the relevant times; and

    4.2. are not enquiries into the deaths of any patient. Specifically, they are not answers to those questions which the law requires HM Coroner to answer, that might arise for answer in other proceedings in the civil courts or in an investigation by a relevant regulator. While it may be necessary for us to make findings of fact about some aspects of the circumstances, we do so only insofar as it relates to employment issues. Sometimes the documents or evidence describe a death as suicide. We use that word where we need to maintain fidelity to the language used by others. We make it clear that we are not making any finding about how a person died or expressing a probable verdict where we use that word.

    Thus, we make findings necessary for us to answer the employment aspects of this case only. To read our judgment deciding issues about matters outside the employment issues would be wrong.

The hearing

5. The hearing proceeded as follows.

5.1. Oliver Isaacs, Counsel, instructed by Capital Law, Solicitors, represented Dr Benaris, and Mark Sutton KC, Counsel, instructed by Browne Jacobson, Solicitors, represented the Trust.

We would like to thank and commend both advocates. Throughout their advocacy was measured, focused on the issues and they co-operated with each other and the Tribunal to ensure the hearing could proceed efficiently and focus on the real issues. They have said everything that could be said for their respective clients, while maintaining a calm, dispassionate tone. We also commend their thorough, yet focused written and oral closing submissions.

5.2. We heard the following oral evidence:

5.2.1. On the claimant's behalf from:

5.2.1.1. Dr Marian Benaris, the claimant and consultant psychiatrist;

5.2.1.2. Dr Adrian Vann, in-patient consultant psychiatrist at the Bradgate Unit;

5.2.2. On the respondent's behalf from:

5.2.2.1. Ms Michelle Churchard-Smith, head of nursing for the Respondent's Mental Health Directorate until September 2022, and Interim Deputy Director of Nursing and Quality from July 2021 to September 2023 when her appointment became substantive;

5.2.2.2. Mr Mark Powell, Deputy Chief Executive Officer and Managing Director of the Respondent from April 2021 to March 2023;

5.2.2.3. Ms Saskya Falope, a registered Mental Health Nurse, and from October 2019 to end July 2021, team manager for bed management at the Place of Safety Assessment Unit (**PSAU**) Mental Health Liaison and Mental Health Urgent Care Hub;

5.2.2.4. Dr Srinivas Naik, consultant psychiatrist, and acute pathway Clinical Director for in-patient and acute care pathways at the Trust from March/April 2020 to April/May 2022;

5.2.2.5. Dr Fabida Aria, consultant psychiatrist, and from May 2018 Associate Medical Director of adult mental health and mental health services for older people. She was Dr Naik's line manager;

5.2.2.6. Dr Avinash Hiremath, Medical Director, interim from May 2020 and substantively from July 2020 to December 2022 when he stepped down. He was Dr Aria's line manager;

5.2.2.7. Mr Gordon King, a registered Mental Health Nurse. He was the Trust's interim Director of Mental Health from September 2019. His appointment became permanent in January 2021 and he remained in post until retirement in September 2021; and

5.2.2.8. Ms Sarah Willis, Director of the Trust's Human Resources and Organisational Development (**HR**).

We have taken their oral evidence into account.

5.3. The bundle consisted of a "main" bundle, a "pleadings" bundle and a "policies and procedures" bundle, though sometimes the distinction appeared arbitrary. By agreement the parties added some documents during the hearing. In total the bundles consisted of 4,131 pages. We were taken to most of the documents (though not necessarily pages) in evidence. As we indicated would be our approach at the start of the hearing, we have considered all those pages to which the parties referred us when we made our decision.

5.4. We are grateful to the respondent's solicitor for preparing an electronic PDF version of the bundles that complied with the **ET Presidential Guidance on remote and in-person hearings dated 14 September 2020 paragraph 24 ("Electronic documents")**. This made it far easier to progress the hearing and enabled the Tribunal to use the e-bundles comfortably.

5.5. Each party made closing submissions both orally and in writing. We have given them careful consideration when making our decision.

5.6. The hearing took place on the dates set out in the heading to this judgment. By agreement the parties made their submissions by video link.

5.7. During the hearings, we took appropriate breaks. No other, specific reasonable adjustments were required. There was nothing during the hearing that alerted us to the need for any, either.

5.8. No party has complained this was an unfair hearing. We are satisfied the hearing was fair.

6. The following procedural issues of note arose during the hearing.

6.1. **Re-examination about the alleged protected disclosure to the Care Quality Commission (CQC) (PD4)**: In her re-examination the claimant was asked what exact words she used when she made her alleged protected disclosure to the CQC. The Trust objected to this question.

6.2. After considering the matter, we upheld the respondent's objection and refused permission to ask the questions for the following reasons:

6.2.1. It was not a matter of re-examination because it did not arise from questions asked in cross-examination.

6.2.2. In fact, it was a matter for evidence-in-chief because it was the fundamental part of the claimant's case. She was alleging she made a disclosure to the CQC. She would have been aware that proving what she said to them was a key factual matter. It was an obvious matter to deal with in evidence-in-chief.

6.2.3. The claimant had had a fair opportunity to set it out in her witness statement and present it as her evidence-in-chief. There was no good reason why she had not done so. Her statement was significant in length and content, and so its omission was even more inexplicable.

6.2.4. The overriding objective does not assist. While we could be flexible, this is tempered by the need to ensure fairness. The Trust is entitled to know in advance the claimant's proposed evidence on this issue. The claimant had not disclosed it. It would also require a departure from the usual trial process that the parties would expect i.e. evidence-in-chief and cross-examination based on what they had just told the Tribunal and the case, with optional clarification in re-examination.

6.2.5. Even to allow re-opening of evidence-in-chief and further cross-examination would be unfair. The Trust would for the first time be finding out about a crucial piece of evidence key to the claimant's case, with minimal opportunity to respond to it.

6.2.6. In essence the parties would not be on an equal footing because the respondent would be ambushed in effect.

6.2.7. The fact that the strict rules of evidence do not apply does not assist because the inherent unfairness remains.

6.3. **Late disclosure of documents:** During the hearing, the respondent also disclosed some extra documents, late. There was no objection to the documents being admitted, albeit the claimant raised concerns about the disclosure exercise, and the respondent sought to justify the late disclosure. These related significantly to disclosure of a bed management policy and distribution of a gatekeeping policy. We are not convinced there is any good reason these were disclosed late because they seem from the pleaded cases and agreed list of issues to be plainly relevant. However, because the parties agreed we could see the documents and add them to the bundle, we admitted them and invited the parties to defer arguments about credibility arising from late disclosure to submissions in closing. The only order we made was that there be supplemental statements formally introducing them. We also allowed the claimant time to consider them before continuing with the hearing.

7. We reserved our decision. This is that decision. It is unanimous. We cannot deal with every single argument, dispute or issue. It would be disproportionate and unwieldy to do so. We also consider many of them to be irrelevant in that they are not the subject of specific allegations and shed no light on the allegations we must decide. We therefore set out our key findings, but it is based on what we have above said we have taken into account.

8. Co-ordinating the diaries of the Judge and non-legal members, and the Tribunal's lists meant there was a delay issuing this judgment. We apologise to the parties for that and appreciate their patience.

Issues and agreement

9. The issues were agreed between the parties. At the end of the case, they stood as follows:

Whistleblowing detriment- s47B Employment Rights Act 1996 (ERA)

10. The Trust accepts the following are protected disclosures insofar as they relate to health and safety:

10.1. **Protected Disclosure (PD) 1:** Dr Benaris emailing Dr Hiremath on 9 September 2020;

10.2. **PD 2:** Dr Benaris emailing the Trust's senior management team, copying in Dr Hiremath, on 25 September 2020;

10.3. **PD 3:** Dr Benaris emailing Dr Hiremath on 12 March 2021;

10.4. **PD 5:** Dr Benaris emailing Angela Hillery, Chief Executive Officer, copying in the Trust's Freedom to Speak Up Guardian, on 14 April 2021;

11. **PD 6:** Dr Benaris's emails to Dr Hiremath and Dr Muhammad on 11 July 2021.

There is no suggestion that any of the alleged detriments were motivated by e.g. whether the disclosure was also relating to alleged criminal offences. Therefore, while the Trust does not concede the point, after

deliberating on the case and noting the claimant did not in closing appear to pursue other bases for which the disclosure was protected, we do not consider the issue of whether any of the above disclosures qualifies under any other heading to be one worth resolving.

12. Did Dr Benaris make one or more qualifying disclosures as defined in the **Employment Rights Act 1996 section 43B**?

12.1. **PD 4:** Dr Benaris calling the CQC on 13 April 2021;

12.1.1. What did Dr Benaris say or write? When? To whom?

12.1.2. Did they disclose information?

12.1.3. Did they believe the disclosure of information was made in the public interest?

12.1.4. Was that belief reasonable?

12.1.5. Did they believe it tended to show that the health or safety of any individual had been, was being or was likely to be endangered?

12.1.6. Was that belief reasonable?

12.1.7. Did they believe that the information disclosed, and any allegation contained in it, was substantially true?

12.1.8. Was that belief reasonable?

12.2. There is no dispute that the CQC is a relevant person prescribed by the Secretary of State for this claim for the purposes of ERA section 43F.

12.3. **PD 7:** The procurement of Patient 3's admission.

12.3.1. What is the case we must determine? The Trust says it is the procurement itself on which the Tribunal must focus. Dr Benaris says it encompasses the computerised medical notes she made (called "SystmOne" (S1)).

12.3.2. What did Dr Benaris say or write? When? To whom?

12.3.3. Did they disclose information?

12.3.4. Did they believe the disclosure of information was made in the public interest?

12.3.5. Was that belief reasonable?

12.3.6. Did they believe it tended to show that the health or safety of any individual had been, was being or was likely to be endangered?

12.3.7. Was that belief reasonable?

There is no dispute that if either or both of the above are qualifying disclosures, then they would be protected disclosures under **section 43A**.

13. Did the Trust do the following things to Dr Benaris? The numbering reflects the detriment numbers used throughout the case, and we have retained it

for continuity. We have also added in the protected disclosures alleged to have caused the detriment and have added in some clarification that the claimant provided after hearing the evidence):

13.1. (withdrawn during the hearing)

13.2. **Detriment 2:** Subjected her to intense pressure to move from the ward (resulting from **PD 1-5 inclusive**);

13.3. **Detriment 3:** Increased hostility by staff and/or patients, and in particular Srinivas Naik and others who had been instigated by Srinivas Naik; (**PD 1-7 inclusive**);

13.4. **Detriment 4:** Subjected to malicious and unfounded allegations (**PD4-7 inclusive**). At the end of the hearing the claimant confirmed those "malicious and unfounded allegations" were:

13.4.1. a comment that she had said that "nurses lowered their standards";

13.4.2. an allegation the claimant had "shouted" at bed management;

13.4.3. an allegation that the claimant had used clinical notes to criticise other professionals; and

13.4.4. an allegation that the S1 entries for Patient 3 had been used to criticise other professionals.

13.5. **Detriment 5:** The instigation of a disciplinary process (**PD1-7 but particularly 6-7 inclusive**);

13.6. **Detriment 6:** Relocation from the Bradgate Unit (**PD1-7 but particularly 6-7 inclusive**);

13.7. **Detriment 7:** Ongoing suspension from on-call work, including once the investigation processes had concluded (**PD1-7 but particularly 6-7 inclusive**);

13.8. **Detriment 8:** Teaching responsibilities were removed, and she was removed as a Clinical Supervisor and Educational Supervisor (**PD1-7 but particularly 6-7 inclusive**);

13.9. **Detriment 9:** Delay in the resolution of the whistleblowing complaints (**PD 6-7 inclusive**);

13.10. **Detriment 10:** Inadequate resolution of the whistleblowing complaints including the failure to consult with Dr Benaris during this process and to provide an unredacted whistleblowing report (**PD1-7 but particularly 6-7 inclusive**);

13.11. **Detriment 11:** Reaching irrational conclusions in the disciplinary process (**PD1-7 but particularly 6-7 inclusive**);

13.12. **Detriment 12:** Failure to respond to Dr Benaris's communications seeking a sustainable return to on-call work and to implement a plan for a return to the on-call rota (**PD1-7 but particularly 6-7 inclusive**);

13.13. **Detriment 13:** Dr Benaris's grievance and complaint regarding bullying were not taken seriously and witnesses who could corroborate her complaint were not questioned (**PD1-7 but particularly 6-7 inclusive**);

13.14. (withdrawn before the hearing);

13.15. **Detriment 15:** Dr Naik and Ms Falope raising allegations against Dr Benaris which Dr Benaris asserts was in retaliation to her having raised protected disclosures (**PD4, 6-7**) – this allegation originally included Mr King but Dr Benaris withdrew that allegation in the hearing;

13.16. (withdrawn at the hearing – it is in effect the claim for constructive unfair dismissal which is pursued separately and was not withdrawn)

14. By doing so, did it subject Dr Benaris to detriment?

15. If so, was it done on the ground that they made a protected disclosure?

Constructive unfair dismissal

16. Did the Trust do the following things:

16.1. See paragraph 0 above?

17. Did that breach the implied term of trust and confidence? The Tribunal will need to decide:

17.1. whether the Trust behaved in a way that was calculated or likely to destroy or seriously damage the trust and confidence between Dr Benaris and the Trust; and

17.2. whether it had reasonable and proper cause for doing so.

18. Did Dr Benaris resign in response to the breach? The Tribunal will decide whether the breach of contract was a reason for Dr Benaris's resignation.

19. Did Dr Benaris affirm the contract before resigning? The Tribunal will need to decide whether Dr Benaris's words or actions showed that they chose to keep the contract alive even after the breach.

20. If Dr Benaris was dismissed, was the reason or principal reason for dismissal (i.e. for the breach of contract) that Dr Benaris made a protected disclosure? If so, Dr Benaris will be regarded as unfairly dismissed.

21. The Trust has not pleaded a potentially fair reason for dismissal (i.e. for breach of contract). Therefore, even if a dismissal was not for making a protected disclosure, it would be unfair in any event (albeit under **ERA section 98** not **section 103A** – and so the statutory cap would apply)

Time limits

22. Were the detriment claims made within the time limit in **ERA section 48**? The Tribunal will decide:

22.1. Was the claim made to the Tribunal within three months (plus early conciliation extension) of the act complained of?

22.2. If not, was there a series of similar acts or failures and was the claim made to the Tribunal within three months (plus early conciliation extension) of the last one?

Dr Benaris does not suggest that, if a claim be out of time, it was not reasonably practicable for her to have presented the claim in time.

Remedy

23. We have adjourned the question of remedy, including any issues of contributory fault or arising under the rule in **Polkey v AE Dayton Services Ltd [1988] AC 334** to be considered separately.

Findings of fact

About the witnesses

24. We begin by setting out our views on the witnesses. We form these views based on observations of the totality of their evidence including their demeanour, how they gave evidence and answered questions put to them by both the parties and us.

25. We make allowance for the fact that no person's memory is a perfect record (and indeed moods can affect what someone recalls and how they recall it), that events took place a long time ago, that giving evidence is not like a natural conversation and that people answer questions in different ways (e.g. perhaps giving an explanation before saying whether they answer yes or no, as may be). We have borne this in mind in making our observations below.

26. We are unhesitatingly satisfied that each witness has told us what that witness believes to be the truth.

27. We comment further on only some of the witnesses where we believe further comment is needed.

27.1. **Dr Benaris**. It is accepted she is a good clinician who has her patients' interests at heart. That said, we cannot accept Dr Benaris is a reliable witness. There are a number of concerns we allude to throughout our findings of fact.

27.2. However, the following is relevant at this stage. Generally, she did not answer questions but instead gave a speech, often that bore little relation to the question asked. For example, she took to making clear in many answers that she had reported matters to the CQC and that in her opinion this was a turning point when things became worse for her at the Trust's hands. This was particularly noticeable later in her cross-examination. Often though this had no relation to the question asked.

27.3. It does not help her credibility she relied heavily on her report to the CQC as a protected disclosure and being the catalyst for the treatment of her but chose in examination in chief to give no evidence about what she actually said to them.

27.4. In addition, we are concerned because not once in any investigation does she tell the investigator the Trust is subjecting

her to detriment for whistleblowing, despite the fact that she had the benefit of advice and active representation from both her trade union, the British Medical Association (**BMA**) and the Medical Protection Society (**MPS** – her liability insurers), who were plainly alive to the question of whistleblowing and who appeared to provide from what we have seen competent and careful advice and representation on what she told them, and despite knowing everything she knew when she commenced this claim. She does however suggest to the investigators on more than one occasion it is because of her sex, though such an allegation was never before us. If she believed she were being subjected to detriments because of whistleblowing, given her willingness to raise issues and given the professional support she had, we would expect to see it mentioned – especially if PD4 were truly a catalyst as she alleged.

27.5. We were left with the overwhelming impression that she was not here to assist us to discover the truth as such, but to use the opportunity as a way of setting out to the public generally her complaints and criticisms of the Trust and what was occurring and to justify her actions and opinions. In simple terms we saw a performance, speech and self-justification. We are left with the impression that the claim has been picked as a vehicle to enable her to achieve that aim and it is only over time that she has convinced herself that everything is down to protected disclosures.

27.6. Finally, we note that the effect of how she answered questions in cross-examination left us with a strong impression that she is unwilling or unable – we cannot say which – to reflect on her own conduct or how her approach affects others.

27.7. **Dr Hiremath**. We agree with Dr Benaris's observations in closing. At times he was open, making concessions and admitting to the limit of his knowledge without trying to fill the gaps. At others he appeared unwilling to accept matters that were otherwise clear. For example, he did not speak to Dr Hamer about PD6. However, in his evidence-in-chief and in cross-examination he maintained he did, until it was shown he was wrong. We also feel the tenor of his evidence came across as placatory, indecisive and being non-committal – in short, he is vague. A significant number of his answers were couched with qualifications and reservations. Not every question permits a yes or no answer, provided the answer given is actually an answer to the question. Often, regrettably, he did not answer the question. We were left with the impression that, as a manager, he was placatory, prevaricated and sought to avoid confrontation and, ultimately, he lacked at the time the skills needed to manage the unit. However, the workplace culture, impact of Covid-19 and his recent appointment with little chance to prepare meant most people would have struggled in the same circumstances. It is no wonder he did.

27.8. **Mr Powell**. He could remember very little outside of his statement. We make no criticism because events were so long ago but the effect is that we find his evidence of limited value.

27.9. **Dr Vann** and **Mr King**. Called by different parties and considered by us individually, but observations are the same. Each gave clear answers, made concessions when appropriate and we were readily persuaded each was here to help the Tribunal rather than to pursue a particular agenda.

27.10. **Ms Falope**: Ms Falope's recollection was not, as she fairly conceded, perfect. However, we formed the impression that overall, she was a reliable witness. She answered questions clearly and firmly, conceding matters where appropriate. She did not give speeches and did not attempt to fill any gaps with supposition or opinion.

27.11. **Dr Naik**. Initially he was confrontational and defensive in the witness box, reluctant to concede anything. However, at one point he asked the Tribunal Judge about the questions, saying he had already had his clinical practice investigated because of these events and had his then-decisions approved, and he felt this was another attack on his clinical abilities. The Judge explained the Tribunal was interested only in the employment issues and that the questions relate to employment issues. The Tribunal further confirmed to him that it would not be judging the clinical decision-making of any doctor. After that we believe he became more amenable, making concessions where appropriate, and being clear about his evidence overall. Despite our initial concerns, his demeanour and answers after the Judge dealt with his concern lead us to conclude he is a reliable witness.

Note about the patients in this case

28. This case involves 3 patients. Before us they were identified as Patients 1, 2 and 3. We have not been told their identities. We use the same labels as the parties, and for grammatical simplicity refer to each as *he, him* etc. because we are unaware of their gender or sex.

About the respondent

29. The respondent is an NHS Trust charged with the provision of mental health care in Leicester and Leicestershire. It provides treatment in the community and to in-patients. The Bradgate Unit is an in-patient unit. It is divided into a number of wards. During the time of this case, the admissions ward was the Beaumont Ward.

30. The Trust has access to advice from an overarching service called NHS Resolution or Practitioner Performance Advice. They are akin to a human resources (**HR**) advisory service. It is important to note they do not run the Trust's HR services or make decisions about HR issues that arise in the trust. A manager contacts them for advice, relays to them the fact and, based on those facts, they provide a response. We note that at various points people in the Trust, particularly Dr Hiremath, contacted them for

advice and accepted their advice. We have not detailed when that happened in general because we do not believe it assists us to decide the claim.

Terms of the claimant's employment

31. The Trust employed the claimant as a psychiatrist from 1 August 2011, though she joined the trust in August 2008. Her earlier career is not material. She worked with adult patients. At the start of the period relevant to this claim she was based at the Bradgate Unit. She has a long career and significant experience. We do not need to go into it in any more detail. There is no dispute she is a competent, able psychiatrist.

32. Her contract of employment contained the following terms.

3. General Mutual Obligations

Whilst it is necessary to set out formal employment arrangements in this contract, we also recognise that you are a senior and professional employee who will usually work unsupervised and frequently have the responsibility for making important judgements and decisions. It is essential therefore that you and we work in a spirit of mutual trust and confidence. You and we agree to the following mutual obligations in order to achieve the best for patients and to ensure the efficient running of the service:

♦ *to co-operate with each other;*

♦ *to maintain goodwill;*

♦ *to carry out our respective obligations in agreeing and operating a Job Plan;*

♦ *to carry out our respective obligations in accordance with appraisal arrangements;*

♦ *to carry out our respective obligations in devising, reviewing, revising and following the organisation's policies, objectives, rules, working practices and protocols.*

33. The said job plan is referred to in clause 6. It comprises "programmed activities" which are units of time for activities such as direct clinical care (**DCC**), additional responsibilities and "supporting professional activities" such as teaching, administration and job planning. This job plan is reviewed and agreed between the doctor and their manager each year.

34. Dr Benaris's was required to abide by the *Good Medical Practice* requirements of the General Medical Council (**GMC** – the regulator of doctors). It is divided into *Domains*. These domains set out what one would expect of good medical practice in certain contexts. It is agreed that

34.1. Domain 1, *Knowledge Skills and Developments*, requires a doctor to consult colleagues or seek advice from superiors if in doubt and to be collaborative with colleagues and all other members of the clinical team e.g. nurses, resident doctors, health care assistants etc.

35. Domain 3, *Colleagues, culture and safety*, requires doctors to treat colleagues with kindness, courtesy and respect. It promotes collaborative working and teamwork.

35.1. The document also promotes continuity of care and the requirement to share information across the team.

Policies

36. Dr Benaris's employment was subject to various policies. We set out those which are relevant. They have various dates but no-one has suggested the terms were irrelevant to the material times of this case.

Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy

37. The policy provided a flowchart on how to raise concerns.

38. In clause 7.0, it said staff are responsible for reporting any concern which may affect patient safety or care.

39. Appendix 2 sets out a 5-step approach for managers, headed: *Welcome, Listen, Reflect, Action, Feedback*. The latter specifically provided that a manager:

• *[give feedback] [to] the individual informing them of lessons learned*

• *Acknowledge and give explicit credit if impact on patient care*

• *Openly thank them for having courage to speak up.*

40. Appendix 7 described how to conduct an investigation.

If the Manager feels they are unable to conduct the investigation, they should contact their Head of Service / Director. …

All allegations concerning harm to children, young people or vulnerable adults must be reported to the Trust Safeguarding Lead / or safeguarding named nurse for the service.

The Manager should investigate the issue of concern in a timely, sensitive, confidential and thorough manner and then report back to the employee who raised the concern, advising either the findings, or what further action, if any, will be taken. …

If an 'Investigating Officer' is required, they will be appointed by the Head of Service, Director or Chief Executive. This person will not have been previously involved in the situation and will be independent (usually from a different part of the organisation). In certain circumstances this person may need to be someone external to the Trust.

Anti-Bullying, Harassment and Victimisation (Dignity at Work) Policy

41. It defined bullying as:

Workplace bullying is defined under 'Agenda for Change' as "the unwanted behaviour, one to another, which is based upon the Unwarranted use of authority or power."

Acas characterises bullying as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient.

42. It said the Trust Board oversaw the policy and managers needed to take all reasonable steps to make sure bullying and harassment does not occur on their watch.

43. It also provided in paragraph 10.2 that the Trust was committed to achieving informal resolution of complaints wherever possible, and mediation must be offered when concerns are raised with a line manager. Dr Hiremath agreed a manager should follow this to promote workplace harmony.

Managing Concerns about Medical Staff

44. The policy is intended to outline the *Maintaining High Professional Standards in the NHS* (**MHPS**) scheme and how it works in the Trust. Like the parties, we will refer to this simply as MHPS.

45. The Trust has access to *NHS Resolution*, formally called the *National Clinical Assessment Service* (**NCAS**), and certain provisions of MHPS require liaison with NCAS. NCAS is described in the MHPS as

> *an advisory body that works to resolve concerns about the practice of doctors by providing case management services to healthcare organisations and individual practitioners.*
>
> While case managers can contact it for advice but it does not conduct investigations or make decisions itself – that responsibility remains with the Trust. Doctors themselves can also contact NCAS for advice.

46. Paragraph 1.2 sets out the policy's aims:

> *This policy aims to provide a clear set of procedures which can be referred to when concerns arise about medical staff. The purpose is to support the delivery of a transparent and fair approach to the management of concerns of medical employees, how to approach remediation and to ensure that patient safety is the paramount consideration.*

47. The policy defines Concerns about practice as follows.

> *Any aspects of a practitioner's practice, performance, conduct or behaviour which may:*
>
> *• pose a threat to patient safety or public protection*
>
> *• expose services to financial or other substantial risk*
>
> *• undermine the reputation or efficiency of services in some significant way*
>
> *• be outside acceptable professional or working practice guidelines and standards.*
>
> and makes clear that patient safety is the paramount consideration. It also makes it clear in paragraph 3.3 that the scheme is to address those concerns that are not so minor that they can await normal continuing professional development (**CPD**) training.

48. The scheme is divided into 5 parts. In summary they are as follows.

    48.1. Part I sets out the action required when a concern arises. In short, a case manager (a person who oversees the investigation) meets with the doctor concerned. The meeting is an opportunity

to set out the concern. The policy says specifically at paragraph 6.2

The objective is to determine whether an investigation would be likely to produce information which is not already available, not to begin the investigation process itself. There will normally need to be input from the practitioner.

48.2. Paragraph 6.6 provides for a formal investigation.

Investigation will usually be appropriate where case information gathered in the screening process suggests that the practitioner may:

• Pose a threat or potential threat to patient safety;

• Expose services to financial or other substantial risk;

• Undermine the reputation or efficiency of services in some significant way;

• Work outside acceptable practice guideline and standards.

It is for the Medical Director either to be the case manager (in cases concerning consultants) or to appoint someone else as case manager. The case manager appoints an investigator and sets out the terms of reference.

48.3. The case manager has to write to the doctor under investigation setting out among other things the specific allegations or concerns and whom they will interview.

48.4. Paragraph 6.15 provides that the investigation should conclude within 4 weeks with a report 5 days thereafter.

48.5. The case manager must then decide whether there is e.g. a case of misconduct (which will result in the Trust's disciplinary policy being invoked), or concerns about health (which would invoke the ill-health policy) or performance which would invoke a referral to NHS Resolution for advice. It also raises possibilities of imposing restrictions on work or referral to the GMC.

48.6. Part II deals with restriction of practice and exclusions. It says as follows.

10.3 Exclusion of practitioners from the workplace is a temporary expedient. It is a precautionary measure and not a disciplinary sanction, reserved for specific circumstances. Alternatives to exclusion must always be considered in the first instance….

10.5 Where exclusion is required, the process outlined in Part II of MHPS must be adhered to. Part II gives guidance on the following

• Immediate exclusion – maximum of 2 weeks

• Formal exclusion

• Keeping exclusions under review

• *Returning to work following exclusion*

48.7. Part III provides any issues of misconduct be dealt with under the Trust's Disciplinary and Policy Procedure.

48.8. Part IV provides a detailed scheme for dealing with capability issues.

48.9. Part V provides a scheme for dealing with concerns about health of a doctor and expressly sits alongside the Trust's ill-health policy.

49. The policy also provides a framework for gauging levels of concern for green (complaints etc.), amber (potential for serious harm) and red (harm caused and likely to warrant referral to GMC).

50. The parties do not agree whether an investigation under this policy is disciplinary or to be considered as part of the disciplinary policy. The claimant says it is and the respondent says otherwise.

51. We prefer the Trust's position and find as a fact that investigation under MHPS is not itself part of a disciplinary policy, for the following reasons. The aim of the scheme and the focus is to establish facts and only the facts about what has happened or is happening and to resolve any difficulty as quickly and informally as possible. This is supported by its stated aim, its reference to informal and (we believe we can infer) quick resolution of concerns if possible, and that after the investigation is completed, only then does the case manager have to consider if there be a disciplinary, capability or ill-health issue that arises for consideration. We accept it could lead to a disciplinary process but that does not make the policy inherently disciplinary, any more than the fact it could lead to a capability process makes it inherently about capability or an ill-health process makes it about ill-health. The MHPS policy as a whole conveys to the reasonable reader that it is about, and only about, finding out what has happened so the case manager can make an informed decision about whether there be a concern and what to do about it.

GMC raising concerns policy

52. This policy reassures the doctors it regulates that they have a duty to raise concerns, put patient's interests first and that they do not need to wait for proof to justify those concerns before raising them, provided the doctor acts honestly, based on reasonable belief and acts through appropriate channels. It says a doctor who acts accordingly need not be concerned about being mistaken.

Admission of patients, the on-call rota and the patient's status

53. In-patients can be informally (i.e. voluntarily) admitted or instead formally admitted (i.e. detained) for treatment under the **Mental Health Act 1983 (MHA) sections 2** or **3**. This is often referred to as being "sectioned" but we will use the more neutral phrase of "formally admitted" or similar. Most patients are admitted informally. Emergency admission under **section 4** MHA is not relevant to this claim.

54. The process for formal admission works in practice as follows (so far as relevant):

54.1. 2 doctors assess and recommend formal admission of the patient. One doctor must be approved by the Secretary of State under **section 12** of the MHA. We refer to such doctors as "section-12 approved". Dr Benaris was a section-12 approved doctor.

54.2. Ideally one doctor should know the patient, but that is not a legal requirement.

54.3. If the doctors agree the patient be formally admitted, the matter is referred to an Approved Mental Health Professional (**AMHP**). They are a social worker from the local authority. If they agree, then they are the ones who legally apply for admission under **section 11**. We need not concern ourselves with what happens if they disagree.

54.4. The professionals complete a document or series of documents colloquially called a pink form (based on their original colour).

54.5. The AMHP does not have to complete the form at the same time as the doctors but **section 11** provides they have 14 days to request admission starting from the date of the second doctor's assessment.

55. If the MHPS needs a consultant, they can consult an app to see who is on-call and contact them. The consultants operate a rota for being on-call. We discuss this rota and the app later.

56. There is a dispute about when the admission process begins. We do not consider it beneficial to resolve that issue.

57. Finally, it is relevant to explain the effect of a patient's status. A voluntarily admitted patient may discharge themselves at any time. An involuntarily admitted patient may not – they are in effect detained. However, a number of involuntarily detained patients would be allowed to return to the community while still involuntarily detained.

58. The Unit also has a bed management team. It consists of non-medically qualified personnel and nurses. Their role is to allocate a bed to a patient. They are comparable to a booking service at e.g. a hotel but more sophisticated in that they ensure a bed is available in the relevant ward, keep track of where patients are and moving to, and search for beds when a patient is to be admitted.

Covid-19

59. In the background to this case was the Covid-19 pandemic of 2020-2022. It was particularly acute in Leicester. We do not need to delve into the history. For present purposes we can summarise it as follows. In late 2019-2020 there appeared a (in human) novel severe acute respiratory coronavirus – Covid 19. It spread around the world and caused a pandemic. It was easily transmissible between humans. Some who caught it were asymptomatic. However, it caused 'flu-like symptoms in many, was deadly

in a notable minority of cases (particularly in the early phases) and required many to be admitted to hospital because of breathing difficulties. In the early period the government issued guidance to e.g. hospitals which was updated regularly to try to contain its spread. We had heard about the general guidance in this case but have not been taken to it and do not feel we need to go into it in any detail than that which we do below.

60. In the UK, the government introduced lockdown on spring 2020. We can conveniently take that as a nominal point that the pandemic was definitely present in the UK.

March 2020 - the Beaumont admissions ward and gatekeeping policy

61. The Unit consists of a number of wards. Before Covid-19, a patient would be admitted to a ward depending on availability and whether the ward was appropriate for that patient (e.g. gender, illness etc.).

62. In response to the Covid-19 pandemic, the Trust decided to restructure the wards. All patients were admitted to the Beaumont Ward. They would be tested for Covid-19. If they were positive, then they would remain in that ward until they had recovered. If they were negative, then they would remain there for a few days, being tested regularly. They would then move to another ward as a patient.

63. On 16 March 2020 Dr Aria announced the inception of the change to Beaumont ward by email. It was via a Ms Raynor forwarded to Dr Benaris. The email also provided that admissions should be only in extreme circumstances and that

Informal admissions need to go through a strict protocol via bed management to include discussions with consultants- community/crt and inpatient as needed. Dr Naik and Dr Khokhar are supporting gatekeeping via mental health triage team as well.

64. On 20 March 2020 Dr Aria emailed doctors below consultants with a flowchart and about the gatekeeping scheme. She had Ms Raynor forward it to the consultants. The email said as follows.

We are making a strict gatekeeping process for admissions during this period, because we want to be sure that is the only option we have and to minimise risks to patients. …

Please do not see this process of a gatekeeping by one of the 3 consultants as something to override an opinion from a colleague- it is sincerely to help the patient with other options. If it is not felt to be safe it will not be done. We had a few admissions in the last few days who came in at night and were discharged the next morning. Consultants were not involved in admission.

65. It contained a flowchart. In short, informal admissions led to either consulting the community team to consider diversion from admission, waiting to the next day or if that were not possible calling the on-call consultant. Assessments under the MHA followed a different process. If an involuntary admission, then the patient was to be admitted. If not, then the doctor was to call the on-call consultant. In a separate box, that does not follow from any of the paths outlined above are the numbers of Dr Naik, Dr

Khokhar and Dr Aria under the label *For all information admissions, including after MHAs*. They are distinguished from the role of on-call consultant. While not expressly identified as such, it is agreed that they are gatekeepers.

66. There are numerous disputes about it. There is a dispute about its status as a policy, guidance, standard operating procedure or otherwise, though no-one at the time seemed bothered by this to any great degree. There is a dispute about whether it was binding on consultants or aimed at doctors below consultant grade.

67. The policy is not as well drafted as it could be. For example, the flowchart does not demonstrate when gatekeepers were to be involved or what their role was, really. We must note however that this was a testing time because of Covid-19: The luxury of time for finer drafting was not available to the writers, as they may have wished.

68. We conclude that it was aimed at doctors below consultant-grade. That tallied with the evidence we heard and also with the fact it was sent to the consultants after it had been sent to the doctors on lower grades, and the accompanying email referred to *consultants were not involved in admission* which would be a curious point to make if it were aimed at consultants.

69. We do not accept that Drs Naik, Khokhar or Aria were being given a veto on admissions. There is no evidence we have seen to show they did ever veto or try to veto admissions. It is common ground a right of veto would be contrary to patient best-practice. In addition, the flowchart did not identify them as having a veto. Dr Aria makes it clear that that the scheme was not to override a colleague, but to promote consideration of alternative options. Dr Naik's own evidence confirmed that it was a collaborative approach. He explained that in the last 15 years he had never experienced a situation where colleagues could not reach an agreement on the proposed treatment of a patient.

70. The impression we were left with from Dr Vann was this is how he understood it. We note that he did contact the gatekeepers during his practice to sense-check with them. He did not suggest they had a power of veto over his decision to admit.

71. We are satisfied that Dr Benaris knew all of this, and that speaking to a gatekeeper was not about vetting her decision, but sense-checking with a colleague, as condoned by the GMC's guidance on good practice. She had access to the same information as other consultants.

72. Therefore, issues about whether it were a policy, guidance etc. are irrelevant because the consultants knew what the practical expectations were and how it worked on the ground. Taking into account everything in this case, we conclude that the only real objections were not to its status, but to the idea of consulting with another colleague.

May 2020 - Dr Hiremath goes in post

73. As noted earlier, it is May that Dr Hiremath steps into post. Therefore, he is taking over at a time when the Unit is under severe stress because of Covid-

19. It is also worth noting the gatekeeping policy was introduced before he was in post.

9 September 2020 - review of the Beaumont Ward

74. There was a dispute between the doctors in the Unit about this set-up. Some believed it was problematic because if a patient did not have Covid-19, they would still be in a ward with patients who did have Covid-19. Patients intermingled, and its easy transmission meant it would spread. In addition, there was a risk someone had the virus but would be moved because they did not yet test positive. Others said that simply admitting patients to any ward would mean there was a real risk that Covid-19 would spread quickly through the hospital. The use of Beaumont gave the best chance of keeping Covid-19 in one place. The Tribunal is not qualified or required to decide which was the better opinion. However as non-medically qualified people, we can see force to both positions. We also accept that the concerns were genuine, honestly held and appeared to us to be reasonable.

75. The ward was also a high-pressured environment that was taking its toll on doctors of all grades. There was limited bedspace, time, resources, physical as well as mental illness and patients were not co-operative with the requirement to isolate to minimise the risk of Covid-19 spreading. Staff were stretched trying to control the ward so it was safe.

76. The Trust acknowledged the risk. On 9 September 2020, Ms Churchard-Smith reviewed the admissions ward. She added it to the register of risks and identified a number of concerns. Because of the pressure of the ward, she noted a risk of staff stress and burnout, risk of harm to patients and staff and risk of staff leaving. She used a scoring matrix which rated the risk as $^{20}/_{25}$ – the highest risk rating is $^{25}/_{25}$, and suggested that maybe it should be that highest rating.

Management and senior clinician meeting and complaint 9 September 2021

77. On 8 September 2020, there was a meeting between senior clinicians and management about the Unit. Dr Benaris attended as consultant attached to the Beaumont Ward. Professor Al-Uzri, a consultant on the Watermead Ward and Dr Abbas, a consultant on the Ashby Ward, attended too.

78. It appears the meeting was fractious. We do not have notes of the meeting. However, the next day, Prof Al-Uzri emailed Dr Hiremath with allegations about Dr Benaris's behaviour. He alleged that Dr Benaris had made untrue statements accusing staff at Ashby ward and Watermead ward of delaying and preventing transfers from Beaumont ward leading to prolonged stay of patients on Beaumont ward. He said many had complained about her tone at that meeting.

9 September 2020 – PD1

79. On 9 September 2020 10:28 Dr Benaris sent an email to Dr Hiremath. This is PD1. The email raised concerns about:

    79.1. patient and staff safety, citing that there was no clear management plan resulting in abuse and threats of violence to staff,

79.2. the community teams were not handing over patients to in-ward staff.

79.3. morale and workload, and

79.4. a lack of therapeutic activities for patients in the day.

80. The email is from Dr Benaris's account and signed off by Dr Benaris, Dr Randall and Dr Acharya. It is accepted the latter 2 doctors endorsed its terms.

81. This is one of the matters that in our view undermines Dr Benaris's evidence and suggests she is unreliable. In both her evidence-in-chief and grounds of complaint she did not mention Dr Randall and Dr Acharya being co-signatories. Rather, she gave the impression it was she alone who made a protected disclosure (and as a result the Trust subjected her to detriments). She sought to maintain this position in cross-examination and defended this representation when asked about it. In our view Dr Benaris's evidence misrepresented matters. It is not a disclosure from her alone. It takes on a different significance when one recognises other doctors signed it too because it widens the enquiry: how might they have been treated? Their treatment is relevant to deciding whether it is credible the disclosure resulted in the Trust subjecting Dr Benaris to particular treatment. There is no evidence that either of the other co-signatories were subjected to any detriment for whistleblowing. We therefore find as a fact that they were not.

82. Dr Hiremath did not act on the email. He believed that any concerns had been addressed in a meeting of the consultants that day. There are no notes however of the meeting. On balance we accept that this is what Dr Hiremath thought. There is no evidence of this disclosure playing any role later in relation to anyone's thinking. The lack of action against the co-signatories tends to suggest the protected disclosure did not cause the Trust to subject the signatories to detriments. Dr Benaris was not reliable as a witness and has misrepresented at least some of the facts surrounding this specific disclosure. On the other hand, doing nothing formally about it accords with Dr Hiremath's general approach to management in this case. It is not because they made a protected disclosure, it is because he lacked the management skills to process it. We also concluded from the evidence that he would seek to avoid confrontation. There is no reason to believe he ignored it because it was a protected disclosure. There is nothing to show he reacted adversely to this disclosure. We note that Dr Benaris did not even seem to chase it up at the time, which lends weight to the suggestion it had been dealt with or was not important. Taking that and our view of his approach as a manager, it seems more likely to us there was no formal response to it because he did not occur to him one was needed. We find that as a fact accordingly.

17 September 2020 – Dr Hiremath orders preliminary fact finding in relation to allegations against Dr Benaris

83. He did however order a preliminary fact-find into the allegations in Prof Al-Uzri's email. We are satisfied for reasons above this was not motived by PD1 being a protected disclosure. Reflecting on the above, we consider it more likely than not the fact there was a protected disclosure was not in his

mind when decided to order this fact finding. We also believe it is important that the allegations arose from Prof Al-Uzri. There is no allegation he acted as he did because Dr Benaris made a protected disclosure. We also note that, if true, the allegations against Dr Benaris are arguably a breach of the domains in the GMC's *Good Medical Practice*. The seriousness therefore of the allegations from someone who is not motivated by a protected disclosure also points away from the disclosure being a relevant factor.

About 25 September 2020 – Patient 1 – PD2

84. Each ward had a garden. Patients could access their ward's garden. The perimeter of the garden was fenced to try to prevent irregular egress. Irregular egress could pose a risk to a patient because they might be without medical treatment and so be a risk to themselves, and maybe to one or more members of the public. For involuntary patients it would also be in conflict with their admission under the **Mental Health Act 1983**.

85. A risk assessment on 6 June 2020 noted this risk and provided the garden should therefore be supervised constantly. The later S*erious Incident Review* (**SI review**) into the death of Patient 1 noted that none of the nursing staff were aware of this requirement at that time. Therefore the garden was not supervised but only checked every 15 minutes. Dr Benaris says she did not realise the garden was unsupervised. We do not consider it matters if this were her belief or not. The defensiveness that we refer to below is just as consistent with her holding this belief as it is with not holding it. Whether she believed it or not sheds no light on the employment issues in our view. We put it to one side.

86. The said review shows that there had been an MHA assessment of Patient 1 but he was not suitable for involuntary admission. He agreed to be admitted on 24 September 2020 informally. There was an agreement that he should be reassessed or the assessment resumed if he were to seek to leave. Dr Benaris was his treating consultant at the Unit. There were no identified concerns about the admissions process at all.

87. Patient 1 entered the garden on 25 September 2020. The review shows that between 11:30 and 11:45 he had fled from the garden. He was found that evening, deceased.

88. On 25 September 2020 12:53 (so after Patient 1 fled but before he was found), Dr Benaris emailed Ms Churchard-Smith, copying in Dr Hiremath and others about it, saying that the garden needed a member of staff present at all times. We agree with the respondent the tone of this email is unnecessarily accusatorial in tenor. It does not appear to show that Dr Benaris reflected on her own role in the process.

89. One part of that role is that in the email Dr Benaris herself said she had directed that Patient 1 only needed looking in on every 10 minutes (called *level 2* supervision). We do not make any finding of fact on whether that was medically correct. We can see that it could be possible for a patient to require 10- minute supervision but the garden generally to require permanent supervision (which would align with the Trust's own risk assessment, of which nurses were unaware). We can also see that a

consultant in Dr Benaris's position might after the event at least stop to reflect on whether in hindsight that was appropriate. She does not do that.

90. The other part is that Dr Benaris herself escorted the patient to the ward without notifying bed management in advance, despite Patient 1's *high risk of aggression to others* (see the *S*I review). She also gave an oral handover briefing. This is contrary to the bed management processes – where instead the bed management team allocate a bed and arrange for patient transfer to the bed in the allocated ward when a bed is available. We consider again that a consultant in Dr Benaris's position would reflect on that aspect – particularly as it was a breach of procedures which Dr Benaris would have known about as a consultant.

We agree with the Trust. This is a defensive email in the circumstances. We also consider it is reasonable that Dr Hiremath would put it to one side because he was merely carbon-copied in, and the 6 main recipients were nursing staff.

91. Jane Capes, Senior Manager and Matron, replied within 5 minutes of the email. She asked if Patient 1 were known to be at risk of absconding before admission, whether he were an involuntary patient or whether he should have gone to the psychiatric intensive care unit (**PICU**). She pointed out that nurses could not pull back a patient who was scaling the fence. Dr Benaris's response was sent 5 minutes later and was curt:

The information is all in the notes. First presentation. MHA assessment but agreed to come in informally. Walked with me from PSAU to the ward. PICU - no indication for this at time of admission.

It did not answer all of Ms Cape's questions. We accept the respondent's characterisation that it was defensive rather than collaborative or helpful. That is shown by the cursory reference to the notes but elaboration on reasons for her own actions.

92. Later that day Dr Hiremath emailed all involved as follows.

Folks, I appreciate we are trying to make a point about safety. But lets not continue with a chain of emails with patients details in it. I propose the conversation stays within the Bradgate ecosystem and it will be obviously brought to the attention of the right people. It is helpful for me to know, but I suggest we stop the email chain.

We consider this was a sensible and reasonable step.

93. Dr Benaris says this led her to be increasingly concerned about the safety of patients generally. We do not accept this. Firstly, she was hardly co-operative when providing the information Ms Capes sought. Secondly, she does not appear ever to reflect on her own practices, as the incident in relation to Patient 3 confirms.

94. The incident was investigated as part of the Serious Incident report, which we address later.

November 2020 – Dr Hiremath tells Dr Benaris about the complaint from Prof Al-Uzri.

95. On 12 November 2020 Dr Hiremath emailed Dr Benaris to set up a meeting the next day. He said it was nothing for her to worry about. Dr Benaris called Dr Hiremath. In that call he told her about Prof. Al-Uzri's complaint. We cannot see any good reason for the delay. We cannot however see any link to any protected disclosures. On balance we conclude the delay is a manifestation of Dr Hiremath's management style.

96. Dr Benaris alleged that that Dr Hiremath suggested that she should apologise to Prof. Al-Uzri. This is disputed. If we assume Dr Benaris is correct, we do not consider it assists to determine whether the Trust's management staff were unfairly targeting Dr Benaris. The general tenor of the case is that the doctors are divided and the ward is not working well. Even if Dr Hiremath did say this, there are plenty of accusations being made the other way. We do not accept this would show some particular trend of adverse treatment towards Dr Benaris. If it were said, we would be satisfied it is a clumsy attempt to try to restore peace and co-operative practices, rather than of some hostile animus towards Dr Benaris. That reflects Dr Hiremath's approach, Dr Benaris's tendency not to simply relay facts in a neutral manner and the general dysfunction in the Unit.

26 January 2021 – Draft SI review

97. On 26 January 2021, a draft of the SI review was sent to Dr Benaris and others. The review recorded that (so far as relevant):

    97.1. Admission of Patient 1 was correct,

    97.2. Confirmed that Dr Benaris walked Patient 1 over rather than using the bed management process

    97.3. That staff on Beaumont Ward had endeavoured to maximise the chance of Patient 1's admission being a success.

    Each was given an opportunity to make observations on it.

29 January 2021 – Options for the admissions ward

98. On 29 January 2021, Dr Aria raised the issue of who should work on which wards. She noted the use of the Beaumont Ward was likely to remain long-term while Covid-19 remained a significant risk. She wrote

    Whilst until now we were planning for a time limited approach we need to plan longer term now. It is unfair for any consultant to be on an admission ward long term.

    So we are now considering the best option is to share the beds on the admission ward to the consultants who can work on an amber ward….

    That only leaves the following consultants who can share the beds- [Dr] Adrian [Vann], [Dr] Beena [Kumari], [Dr] Steve Dyer, [Dr] Mariam [Benaris] and [Dr] Sudha [Acharya]….

    If we were to divide 22 beds, at a calculation of 2 beds per pa we can plan this together . Beena, Adrian and Mariam are part time at 4 days a week …

Can we please discuss how we divide this, or do we go for the other option of rotating for few months at a time? I am ok with this to give Sudha and Mariam a break….

99. We find that the motivation for this was a genuine concern for the welfare of Dr Benaris and Dr Acharya. Dr Aria identifies both as needing a break, which tends to suggest this is not about Dr Benaris alone. The Beaumont Ward was also highly demanding. Patients were refusing or failing to co-operate with the requirement to isolate. Some had Covid-19, some would be at particular risk if they caught it. Most if not all patients went through the ward. In addition, the manifestation of the symptoms of poor mental health is challenging. It is inherently plausible that one might think it would be mentally exhausting for a doctor permanently allocated to the ward, even if that doctor could not acknowledge the effect on them.

5 February 2021 Dr Benaris comments on Draft SI review

100. Dr Benaris commented on the draft report. There are only two comments worth noting, as follows.

Concerning patient access to the garden. When Beaumont Ward was re-purposed as an acute (psych) admissions ward suitable for Covid, patient access to the garden was initially strictly limited — only available intermittently with direct staff supervision. At some point this changed to unrestricted access and although I do not recall a particular communication about this in terms of timing, I recall the absconsion risk report I mentioned during the StEIS meeting [sic.] *(risk #827 version 17 dated 4.6.20) gave assurances about the need for continuous staffing to offset garden access risks. As such, it was my understanding at the time of Mr B's admission that, given patients were permitted unrestricted garden access, there were corresponding arrangements in place to ensure continuous staff presence/supervision.*

Continuing in this thread but on the matter of ward acuity; you may find it useful to know that the use of Beaumont Ward as an acute high acuity admissions ward during Covid was subject to extensive staff discussion such that it was placed on the Risk Register on 8th September 2020. Should you wish to review this document, the report number (on the Ulysses system) is 4600.

101. We pick these out because we consider they show Dr Benaris adopting a defensive approach to the review. They are attempts to justify her actions and point blame to others, even though the draft review is rather neutral in its tone – and certainly does not cast blame on Dr Benaris. The writers nonetheless looked into these points before producing their finalised SI review.

12 March 2021 – Dr Benaris emails Dr Hiremath – PD3

102. After Patient 1 absconded, the garden was constantly supervised. At some point before 12 March 2021, a decision was taken after discussion between various people from the nursing teams and health and safety teams to reduce supervision to every 15 minutes. Dr Benaris and the other consultants were not involved in making this decision.

103. On 12 March 2021, Dr Benaris discovered that the garden was again not being supervised. She emailed Dr Hiremath on 12 March 2021. She wrote:

…I was then told the ward garden is now open to patients unsupervised at all times. Prior to this it was always supervised following the suicide [sic.] *of Patient 1.*

I am incredibly distressed that this decision was made without any discussion with me. I was not even informed until I checked again today. I have already raised numerous concerns about the risks on the ward and my concerns are always dismissed or ignored. On top of that, I feel like I have been misrepresented as a "difficult consultant" when patient safety and care is my main concern.

I have also raised concerns about the shortage of junior drs and despite taking a proactive role in managing this last July, I was told to stop micro-managing. This remains a problem on a weekly basis and I am frustrated that all my concerns are dismissed.

104. The Trust (rightly) accepts that Dr Benaris was correct to complain about this development. The Trust also picks up on the word *following* as suggesting she always knew the garden was not supervised before Patient 1's death. We accept it is a possibility but the use could equally refer to a change in policy on supervision after Patient 1's death. Her belief is in our view not relevant as we said above, so we say no more about it. Ms Capes emailed Dr Benaris the same day, apologising for not telling her of the change. We are satisfied it was a genuine oversight given the apology and the lack of any reason to keep the change from her.

105. On 14 March 2021, Dr Hiremath replied to Dr Benaris. He offered a discussion either by phone or in person. She did not reply to that email. Those discussions did not happen. We find as a fact that this was effectively her choice because she did not respond and take up his offer. The facts demonstrate she had no difficulty otherwise raising issues with him. There is no basis to believe she was unable to respond for some (unidentified) reason.

16 March 2021 – Dr Benaris comments further on the draft SI review

106. Dr Benaris sought to make further comments on the draft review on 16 March 2021. Two matters stand out

106.1. She again emphasised the garden was supervised, and introduced the change on 12 March 2021 in supervision levels,

106.2. She also sought again to address her non-use of the bed management team and the bed management system, describing them merely as to *communicate information from the assessing team to the ward.* She explained she could give a first-hand account and asked *What could the bed management team add further?* Given her role and how long she had worked in the Unit, we are satisfied she knew the bed management team were more than just a conduit of relaying information. We accept the Trust's submission this is demonstrating of a wilful playing down of the bed management's role to deflect criticism of her own conduct.

This is another continuation of the lack of self-reflection and the tactical nature of her communications to deflect criticism.

18 March 2021 – Ms Puckey complains about Dr Benaris

107. Ms Marie Puckey was the ward manager for Beaumont Ward and so worked alongside Dr Benaris. On 18 March 2021 she complained to Dr Naik and Dr Aria about Dr Benaris. She wrote as follows.

On Friday 12th march whilst I was talking to staff in the main nursing office, Dr Benaris came into the office and stated very rudely and abruptly that she wanted the garden closing now. She asked who had made the decision to open the garden. I explained to her that the trust had made the decision in January and after meeting with Jane Capes that same day we had made the decision to open the garden.

She stated I had no right to make this decision as yet again she hadn't been consulted or included in the trust decision. I offered to show her the email from Michelle Churchard explaining the trusts [sic.] *decision but she said I don't want to see it. I also tried to explain what steps we had put in place to observe the garden but she did not want to listen to these. Dr Benaris stated that all her patients are extremely suicidal and are going to go and abscond and kill themselves. She then walked out of the office.*

I don't feel the way Dr Benaris approached me was professional or acceptable. She was rude and abrupt and did this in front of 2 qualified nurses and a HCSW. These staff were left shocked and appalled by the way she had spoken to me and approached me.

108. In her interview with Ms Diane Pugh she described how she was *shocked* and *degraded* because of the imbalance between a consultant and nurse – the former carrying more perceived seniority than the latter.

109. There are various discussions behind the scenes about how to deal with this but we note as follows:

109.1. If true, it would show a serious, unprofessional approach to colleagues by Dr Benaris that could damage working relationships and undermine trust and confidence between colleagues,

109.2. In turn that would be damaging to the work of the ward and Unit,

109.3. Dr Hiremath thinks it concerns professional behaviour and requires a preliminary investigation.

109.4. Ms Angela West advised that the complaint engaged the MHPS process because of its contents,

109.5. Dr Acovski was appointed to investigate the matter, and

109.6. Dr Aria told Dr Benaris of Dr Acovski's appointment on 24 March 2021.

Absence

110. The claimant was absent from work between 27 March and 13 April 2021.

Death of Patient 2

111. On 5 April 2021, Patient 2 died on Beaumont Ward. It is described in the documents before us as being because of suicide.

13 April 2021 – complaint to the CQC – PD4

112. On 13 April 2021, Dr Benaris contacted the CQC. She did so anonymously. There is no note of what Dr Benaris reported to the CQC, either of the exact words used or the gist of her alleged disclosures. In her pleaded case she said merely

12. On 13 April 2021, the Claimant called the CQC to report her concerns regarding patient safety.

She has chosen not to plead the words used or gist of information she averred she disclosed.

113. In her evidence-in-chief she told the Tribunal

So great were my concerns about the second in-patient death and the number of near misses in my absence, that I felt compelled to contact the Care Quality Commission ("CQC") anonymously on the 13 April 2021 ("PD4"). I described all the concerns relating to patient safety on Beaumont ward and was reassured that this would be explored directly with the Trust.

Likewise she chose in her evidence-in-chief not to set out the information she avers she disclosed or even to provide the gist of it. As noted, we forbade an attempt in re-examination to provide evidence on the matter for the first time.

Later, Dr Benaris described this disclosure as the *catalyst* for an adverse change in how people treated her.

114. Ms Helen Abel, a CQC inspector, emailed the Trust on 14 April 2021 setting out the issues raised in bullet point. She did not name either Dr Dyer or Dr Benaris and did not say who had raised what issue. The list is lengthy, but in cross-examination Dr Benaris identified the following bullet point as capturing her concern

• Mid December in death young man. Action not followed through. Seen by a senior. No faith in the SI process. Draft fails acidity of the ward. RA .Pt absconded — level 1 SI human factor error. 2020/18421. Garden is no longer supervised. Garden is too long, area of fence, no overhang

captured her concern.

115. We consider the evidence wholly unsatisfactory. We can appreciate why there may not be a contemporaneous note. The disclosure was made by telephone and it is natural for people not to consider making a note afterwards.

116. That said, this disclosure is supposed to be a catalyst for a change in treatment. Dr Benaris has made clear it is significant. The Tribunal therefore would expect to see the information allegedly disclosed set out in the pleaded case or, at the very least, in her witness statement, particularly as the latter ran to 40 pages over 218 paragraphs. No explanation has been put before us about why what is said to be a key part of the claim is reduced

in the claimant's case to almost the status of a passing comment that tells us nothing about what information was said to have been disclosed. We do not accept that the bullet point which Dr Benaris pointed to is enough to show she made a protected disclosure to the CQC. It does not tell us what she actually said to the CQC, yet alone what information she conveyed. We cannot discern to what extent that bullet point was influenced by any concern Dr Dyer may have raised. We also reflect on the fact that she did not identify that bullet point, or at least the gist of its contents, as being the information disclosed in her pleading or evidence-in-chief. The need for caution is more acute in our view when she has chosen not to set it out at all in her evidence-in-chief despite its apparent significance.

117. We infer that the reason the contents of the alleged disclosure to the CQC is not set out in her pleading or evidence-in-chief is because she did not disclose information to them – or at least nothing capable of being a protected disclosure. If it were so important as she says we are satisfied she would have included it or, at the least, explained why she could not. Alternatively, we simply say in the absence of evidence she has not proven that she made this protected disclosure. Either way the effect is that this part of her case is not proven and there was therefore no **PD4**.

14 April 2021 – Finding of fact meeting between Dr Acovski and Dr Benaris re Ms Puckey's complaint and report back to Dr Acovski.

118. Dr Vesna Acovski and Dr Benaris met for a fact-finding meeting on 14 April 2021. The notes record the following exchanges.

[Dr Benaris] reflected on the incident and acknowledged that she may have been abrupt but explained this was as a direct cause of her not being aware of the sudden change about the garden and the lack of communication. MB didn't feel she should apologise to Marie as she feels she has not done anything wrong; MB added that she finds working with Marie difficult but is happy to continue to have professional contact, although she feels that this should not be 1 to 1 basis

119. Dr Benaris's stance is part of that theme where she suggests she has done nothing wrong and the fault lies with others. It demonstrates the lack of self-reflection that is a hallmark and came strongly across to us in cross-examination. By suggesting no 1:1 basis for contact with Ms Puckey, Dr Benaris placed an obstacle in there being an effective work environment. It leads us to conclude she was not willing to compromise to provide a supportive work environment.

120. The *demanding emails* refers to emails from about 9 March 2021 where Ms Puckey emails Drs Benaris, Dyer, Kumari and Vann. She explains she is trying to compile a table so staff know when the consultant will be on the ward. She addresses questions to certain doctors in the email. Vis-à-vis Dr Benaris, she wrote

Dr Benaris I need you to commit to one full day either on a Tuesday or a Wednesday as having 2 afternoons is not enough time to review 12 patients. As I said above committing to times and sticking to them will help the nurses hugely.

121. In context, we conclude that it is not reasonable to read Ms Puckey's email as demanding. Dr Benaris replied without any sign of irritation at Ms Puckey's email which suggests she did not at the time see it that way, and it is only much later after the event she saw it as a demanding email.

122. Dr Acovski and Dr Benaris also discussed the complaint from Prof Al-Uzri. Dr Benaris said she had nothing to apologise for. Specifically, she alleged that Prof Al-Uzri called her a liar and said during the meeting that

at least I do not hold my patients.

123. We do not consider resolving the dispute of what happened at that meeting would help to decide this case.

However, the comment about *holding patients* is an example of an impression that came across in the evidence. It refers to the 2 schools of thought about treatment. It appeared common ground that some psychiatrists hold the view that a patient should be discharged from the Unit as soon as possible, because it better promotes their recovery. Others hold that a patient should remain in the Unit until recovered. We appreciate the position is more nuanced, but paraphrasing is suitable for these purposes. It is common ground that Dr Benaris is in the latter category, and Prof Al-Uzri is in the former. It seems common ground both views are medically reasonable. We express no view on that. However, the fact this appears to be such an issue now is illustrative of the dysfunction with the Unit. This disagreement and dysfunction, and intolerance towards each other came across very much in the evidence.

124. The notes also record that Dr Benaris

recognised [that some staff see her as] *rude and abrupt*,

as Ms Puckey alleged. She also recognised that she could get stressed. Later she admitted to Dr Acovski that she was abrupt. We must stress that Dr Benaris was not rude or abrupt to the Tribunal when she gave evidence. However, we can easily see based on her manner and demeanour how her behaviour could, in the more familiar setting of her workplace, be seen by others as rude and abrupt.

14 April 2021 – PD5

125. On 14 April 2021 Dr Benaris emailed Ms Angela Hillery, the Trust's Chief Executive Officer (**CEO**) and Ms Pauline Lewitt, the Trusts *Freedom to Speak Up Guardian* (a person nominated to receive protected disclosures). In the email she wrote (so far as we consider relevant):

You will be aware that there has been another suicide on the ward (05.04.21) a day after admission. I have been raising concerns about the number of patients on the ward, the acuity, lack of medical and nursing reviews, staffing issues etc since last year. Lessons have not been learnt from the suicide of the young man in September last year. The SI report, which has still not been finalised has not identified the crux of the matter. In-patient Consultants have sent numerous emails raising our concerns and suggesting solutions, only for them to be dismissed or ignored.

Sadly, we have been portrayed as a difficult consultant group and the complaints process used to intimidate some of us into silence.

We need to address the issues on Beaumont urgently to prevent another death. I understand there is work planned to reduce dormitories, however, until we are able to accept admissions directly onto all wards, patient safety takes precedence. …

126. We note two matters. The first is that this disclosure is as much about attacking the conclusions of the earlier SI report we detail above. The email is as much about disagreeing with that as anything. The second is to note that at about this time Dr Benaris and others began to promote their proposal to move the Beaumont Ward from 2 consultants to 3 consultants. In context, this email is also about pushing their viewpoint.

14 April 2021 – Dr Dyer contacts the CQC

127. On 14 April 2021 Dr Dyer also contacted the CQC. He did not maintain his anonymity. There is no evidence that Dr Dyer was treated adversely as a result of making a disclosure.

14 April 2021 – CQC contacts the Trust

128. Ms Abel of the CQC contacted the trust on 14 April 2021. We refer to the communication above. We add that there were about 35 or so bullet points and that she specifically referred to staff expressing dissatisfaction about the SI investigation, environment, staff morale, and leadership. She requested feedback on the issues she identified. She said the complaints had come from 2 employees to whom she had spoken separately.

129. The Trust acknowledged this 2 days later.

16 April 2021 – Dr Acovski's conclusions

130. Dr Acovski set out her conclusions in a relatively brief email to Dr Hiremath and Angela West on 16 April 2021.

130.1. She set out the detail of the interaction with Ms Puckey. She noted Dr Benaris was *very affected* by Patient 1's death. She concluded by saying Dr Benaris found it difficult to work with Ms Puckey.

130.2. Dr Benaris had denied she had any need to apologise to Prof Al-Uzri. She noted that Dr Benaris said there were witnesses but declined to name them.

131. One point of note is that there is no note of Dr Benaris telling Dr Acovski that Prof Al-Uzri shouted at her. However, she told us that in her evidence-in-chief. We appreciate the note is not verbatim and Dr Acovski may have not recorded it for whatever reason. However, she captures the remainder of Dr Benaris's case about this interaction with Prof Al-Uzri, it is the sort of thing one might expect Dr Acovski to think significant if it were said, this conversation took place closer to the time when matters were fresher in everyone's memory and Dr Benaris's evidence was not credible generally. We conclude that the reason the shouting is not mentioned is because she never said it and infer that this is because it did not happen. It tends to cast more doubt in our mind on Dr Benaris's credibility.

20 April 2021 – First Quality Summit and outcome

132. In reply to the CQC's enquiry, Dr Hiremath and Ms Scott arranged a series of so-called quality summits. Their purpose was to review the safety and care of patients in the Unit. Each was chaired by the Chief Nurse of Northampton Healthcare NHS Foundation Trust. The first was on 20 April 2021.

133. In the first summit they reviewed all the recent safety data, serious incidents, staffing data and infection prevention and control (**IPC**) data. They also held *listening events* with consultants, team managers and senior nursing staff. Both Dr Benaris and Dr Dyer attended. No-one knew Dr Benaris was the other whistleblower.

134. The summit disclosed the following.

134.1. Consultants favoured a change of model to revert to the original admitting model to all wards. Evidence from others did not support this view.

134.2. A breakdown in communication and positive working relationships between the different professional groups on the Beaumont ward. This needed to be addressed quickly.

134.3. There was concern about the acuity on the ward when all 22 beds were occupied. This needed a review.

135. The outcome was relayed to the CQC on 21 April 2021. Ms Scott also wrote to both Dr Benaris and Dr Dyer to thank them for their involvement.

Concerns about Beaumont ward and Dr Benaris's stress

136. There were also a series of other meetings.

137. Dr Naik and Dr Benaris spoke on 23 April 2021 about the organisation of the Beaumont Ward. Dr Naik sent an e-mail to Dr Benaris setting out a summary of their discussions. We accept the email as an accurate summary. It recorded as follows:

3. You do not feel 2 Consultants on Beaumont is workable and you have felt stretched. You proposed before today, having checked with [Dr Vann] that sharing beds with [Dr Vann] on Beaumont and Thornton [another ward], 6 and 7 respectively on these words, 13 beds in total for you and the same for [Dr Vann] would be your most preferred option. …

5. We talked about other options and your preference in this order, the way I understood

a. Share Beaumont and Thornton with Adrian as above.

b. Swap your current role (12 beds on Beaumont with [Dr Vann's] 14 on Thornton).

c. Remain in your current position.

d. Aston [another ward]— not really to your liking. I explored further and you said you have never worked there and would not want to start something new. You did clarify that there was no other reason but wanted to know why above options, the first one particularly was not possible.

*e. Move to **CMHT** [Community Mental Health Team].*

138. This illustrates ongoing discussion that was taking place about the working arrangements on Beaumont Ward. The accuracy of the contents was not challenged. We draw from the email and conclude that that Dr Benaris herself reported feeling *stretched*. Taken with how she accepts others can see her as abrupt in her manner (which is consistent with someone manifesting stress), and concerns of others that she was appearing stressed, we conclude the focus of the Trust in relation to Beaumont Ward and Dr Benaris was to do what was right both for her welfare in the workplace and for the Trust.

139. These discussions also involved Dr Aria and Dr Hiremath. On 25 April 2021 Dr Aria wrote:

… Mariam is the other person who has worked on the admission for many months. I explored the options with her, for her. (I will share the email I sent her summarising our discussion for your information). She wants to ideally split her current 12 beds with Adrian, 6 each and take half of his patients on Thornton. I have discussed this with Sam and Fabida and we are not keen, nurses definitely are not. This goes against what we agreed 2 months ago to go with 2 Consultant model for the ward. Also, that would mean 3 Consultants on Thornton, again not ideal and not suitable for the team and only suits the Consultants. Also it leaves us with finding cover for the remaining 10 beds on Beaumont working alongside Adrian and Mariam. Also, does it address the concerns expressed by nursing staff ??

Mariam also suggested she swap with Adrian. Again this could work but we need to consider the following. Adrian has not been supportive of the admission ward model, he has concerns about it. I do not know what his views are at this time.

140. 2 days later she wrote:

I have been thinking on this all day. [Dr Kumari] is still off and can't therefore be considered. She has cancelled her meeting with Angela and me tomorrow.

Mariam needs a break.

Adrian can do half though prefers to do quarter with Mariam.

We need two doctors who can provide leadership and are committed to support the team in the best way, until we no longer need the current arrangement. …

141. On 29 April 2021 Dr Benaris and Dr Vann met Dr Naik and Dr Aria. The result of the above was that on 30 April 2021 Dr Naik confirmed to all that Dr Benaris would continue to work on the Beaumont Ward, as she had wished, and Dr Naik would take over as the other consultant.

142. We find as a fact that the concerns held by Dr Naik and others for Dr Benaris's welfare were genuine concerns and the focus was on her wellbeing and nothing more. Beaumont Ward was an intense working environment. We consider that Dr Benaris's own admitted behaviour of being abrupt, and her concession that she could come across like that

would be demonstrative of an adverse reaction to stress. This is consistent with what was a stressful workplace. We think it reasonable and plausible for Dr Aria to conclude she needed a break. We note however they respected her wish to continue to work on the ward, albeit they did not accept the recommendation from Dr Vann and her for the 3-consultant model. We cannot comment on which model would have been better but note the concerns about the 3-consultant model. We do not consider there is anything that shows they were artificial objections to the model. The key takeaway is the Trust accommodated Dr Benaris's wish to keep working on the Beaumont Ward. We also see nothing that suggests any disclosures played a role on this process. None of this suggests there was any pressure on Dr Benaris to move, yet alone *intense* pressure. We find as a fact there was no pressure on Dr Benaris to move.

26 April 2021 – Feedback from quality summit meeting

143. On 26 April 2021 Dr Scott and Dr Hiremath wrote to Dr Dyer and Dr Benaris as follows.

Dear Dr Dyer and Dr Benaris

Thank you for attending the Beaumont Ward Quality Summit last Tuesday and openly and honestly sharing your thoughts on what you feel is going well and what you feel, as a team, we should focus future quality improvements. Your contribution to this event was very much appreciated and valued. We are in the process of thematically analysing the information we gathered at this event and we plan to further meet with you to share our findings in the very near future.

We accept this email reflected Dr Scott and Dr Hiremath's genuine and personal views, and those of the Trust generally.

28 April 2021 – Dr Naik expresses concerns about Dr Benaris

144. On 29 April 2021 Dr Naik wrote to Dr Benaris, as follows.

Fabida and I have been open about our concerns for you and the stress you have shared with us about working in the admission ward for many months now. We were very keen for you to have a break 2 months ago. You were generous in offering to continue in the absence of other offers and also due to your preference at that time. We want to reiterate our concerns for you and our preference is still for you to take a break from Beaumont.

Let's talk tomorrow.

145. The meeting took place at 2pm the next day. Dr Benaris characterised it as Dr Naik took no account of her wishes and he was unable to explain why he maintained a 2-consultant model despite her proposal for a split role. She says she was concerned when Dr Naik said he would take on the role as consultant alongside her because of his "close tie" to Ms Puckey. She cited Dr Vann as a witness.

146. We do not accept her attempt to characterise this as in some way critical of Dr Naik. Dr Benaris is generally unreliable as a witness. We think it more likely her evidence on this is part of her animosity to him rather than a

genuine recollection. Dr Vann made no reference to this meeting in his evidence-in-chief despite apparently being a witness to what is in substance an allegation of Dr Naik's intransigence and Dr Benaris being concerned by his decision he would work with her. Therefore, we reject the claimant's negative characterisation of this meeting. Instead, we accept the email at face value and conclude that Dr Naik was simply concerned for her welfare and doing his best to promote it.

30 April 2021 – Meeting for feedback from quality summit meeting

147. Dr Dyer and Dr Benaris met with Dr Hiremath on 30 April 2021. He provided feedback about the outcome of the first summit. He describes the meeting as professional and polite. We accept that description. We find as a fact this was a genuine attempt to keep both consultants informed.

30 April 2021 – SI review

148. Dr King provided comments and amendments relating to the SI review. He said he was concerned it opened a number of lines of enquiry that *may not ultimately be helpful to understanding the key issues*. He attached the lengthy draft report. We have read the draft report with his comments. Taking into account his evidence and the contents of his comments, we can see nothing that is a cause for concern. We conclude he was simply making observations and offering what he honestly believed to be helpful, constructive criticism. We see nothing that reflects in any case on the claims before us.

3 May 2021 – 12 May 2021 – Beaumont Ward and Patient 3

149. Dr Naik commenced his clinical duties on the Beaumont Ward on 3 May 2021.

150. Dr Benaris raised a concern with Ms Puckey on 4 May 2021 that some patients had not had face to face reviews. She copied in both Dr Aria and Dr Naik. She also raised a concern with Ms Falope on 7 May 2021 that a patient has not had a review for 28 days.

151. On 10 May 2021, the Trust admitted Patient 3. Dr Benaris was his consultant. It appears that Patient 3 had a number of mental health issues. Dr Benaris set out a summary of risks and her plan for Patient 3 in an email to Dr Vann, asking him to watch Patient 3 while she was away for a short time. The email suggests the notes were on S1 for other doctors to see if necessary.

152. Because of later events, it is worth mentioning that the note records as follows: Patient 3 had a risk of self-harm and threatening serious harm to others. He had caused criminal damage on one occasion resulting in a conviction. He had reported he felt safe on the ward. He also had repeatedly expressed a desire to harm his neighbour. He said he wanted to be arrested by the police to expose their corruption. He gave the impression of paranoid schizophrenia. We make clear for our purposes it does not matter whether this is accurate (though no party suggested it was not), but we do accept this represented Dr Benaris's honest opinion and understanding of his relevant history.

13 May 2021 – Second Quality Summit

153. The second quality summit took place on 13 May 2021. This reviewed recent data. Dr Hiremath describes its conclusion as follows, which we accept as being accurate. They noted that there were no areas of risk or any data to suggest Beaumont Ward was unsafe. They also noted that themes from the Freedom to Speak up concerns were mainly around

relationships across the multi-disciplinary team and staff being civil and compassionate to each other, difference in treatment between groups and a lack of confidence in staff to raise issues.

154. These were relayed to the CQC on 21 May 2021.

19 May 2021 – CQC closes investigation

155. On 19 May 2021 the CQC wrote to Dr Dyer. Ms Abel said the CQC had not identified any concerns in relation to safety and care of patients on Beaumont Ward and noted the Trust had been responsive. Dr Dyer replied the next day. He made his continued profound disagreement clear.

c. 21 May 2021 – fall out in the workplace

156. Dr Naik and Ms Puckey raised complaints about Dr Benaris. They alleged that Dr Benaris had made disparaging comments in a ward review. They also alleged Dr Benaris had behaved aggressively. There is no record of this complaint but it is referred to enough in other emails to be satisfied the summary is correct and the complaint was made.

157. Dr Benaris that evening also lodged a complaint that nursing staff had been unprofessional regarding comments she may have made to Crisis Resolution and Home Treatment Team (**CRHTT**). She also alleged that nurses had made disparaging remarks about her to patients. She asked for their identities.

158. In a more detailed, separate email she alleged that:

158.1. A patient had said to her he had hoped to see the male doctor because *he lets people go*. *The nursing staff have told me that you are the one that doesn't let people leave.* When pressed he said he had learned this from *a few nurses*. He later said that nurses had said Dr Benaris's approach was because she did not *want to get bitten on the backside*. She commented that she believed Ms Puckey was driving this.

158.2. She also complained that Dr Naik had told her how offensive she had been to nursing staff (which she denied), and that Dr Naik had reported that she was aggressive when she relayed what the patient had said.

158.3. She alleged that Ms Puckey's earlier complaint was *malicious*.

158.4. She also said that:

Going forward:

1. I refuse to recognise Dr Naik as my line manager from today. He has engaged in bullying, unprofessional behaviour towards

me spanning over the past year (I will provide this evidence in writing next week).

She added that the attitude to her on ward had changed adversely since Dr Naik and Ms Puckey had started to work on the ward.

159. On 22 May 2021 Dr Naik emailed Dr Benaris, Dr Hiremath and Dr Aria. He expressed concern about the current relationship between the professionals on the ward. He also expressed concerns about the quality of email exchanges and some being copied verbatim onto S1, because the latter are accessible to professionals, patients and their representatives.

160. In our opinion none of this shows any link to protected disclosures. No-one knew for example that Dr Benaris had contacted the CQC.

161. Rather it is our view this illustrates that in simple terms the working environment was toxic and people were not able to work together, and that Dr Benaris was neither willing to compromise her position or work collaboratively. We note that she for example continued to question the SI review. We note her unreliability as a witness and demeanour. We consider the tenor of the allegations against Dr Benaris and her insistence that she would not recognise Dr Naik as her line manager as being of a similar tenor to earlier complaints where she had admitted she had been abrupt, admitted people may see her that way and being consistent with how she described her approach to Ms Diane Pugh in the later investigation (to which we will come):

If [she] ask[s] people to do it in a nice way, they don't do it.

162. As an aside, we use the word *toxic* repeatedly to describe the workplace. It may be considered a shorthand or informal way of describing life in the Unit. However, we consider that no less a word will do. A lot of the evidence that shows how toxic a place it was to work. This idea of toxicity includes the power imbalance that Ms Falope told us of in her evidence (which we accept): Namely, there was a hierarchy between consultants on the one part and nurses and support staff on the other, with some consultants being particularly dismissive of the opinions of those who were not consultants.

23 May 2021 – claimant's email suggests welfare issue

163. There had been some correspondence between Dr Benaris and Dr Saquib Muhammad (associate medical director). We need not address the majority of the correspondence but we note this passage.

I am sorry that I have dragged you into all of this. I think maybe I need to accept I cannot carry on working here as doubt anything will change. I cried in front of Steve on fri (tears of frustration), I have cried in front of Adrian (when Abbas threatened me with GMC for being nice to patients and daring to question him), I have cried in front of Dan and Hayley. And in front of you. All makes me feel quite pathetic as that is not the person I am, my friend reminded me today that if I am crying about work at work, then it is time to leave.

I always loved my job, but when I cannot even do that because patients think I am not acting in their best interest, then where do I go from here. I

do worry about patient care and all the near misses and deaths but no-one wants to listen anymore. CQC response shocked me and I am glad Steve is pursuing that.

Anyway, below was going to be my response but then I thought what is the point. For your reference really.

164. We think this email is telling about Dr Benaris's state of mind. We conclude her own words show that she was stressed, struggling and not coping well at work. We infer that this written reflection of how she felt is more likely than not to have shown itself in some perceptible way to others, because stress and feelings like this tend to be manifested in a person's comportment and be visible to others. We also note the clear fact that working on the Beaumont Ward was inherently stressful, and the workplace was one where people did not work well together. All this in our view supports the fact that leadership's views about Dr Benaris needing a break and being stressed were views that were genuinely held and focused only on her welfare.

Follow up from the second quality summit

165. Thanking both Dr Dyer and Dr Benaris for their contributions, Mr Powell wrote to them on 25 May 2021. He described their input as very valuable and as the Trust being grateful for their openness and honesty. He suggested a meeting to discuss matters.

166. That meeting took place on 28 May 2021. Dr Dyer summarised Dr Benaris and his views in an email the next day. He said he personally would work constructively to improve working relationships, though his relationships seemed to be *ok* when going about his clinical duties. He said only that he *wondered* if his whistleblowing had had an adverse effect on relationships – he cited no examples of deterioration.

167. In our view this lends support to the proposition that protected disclosures played no part in what happened. He was never anonymous. He sees his working relationships as being acceptable. He does not allege any adverse reaction to his making a disclosure. Dr Benaris was anonymous. There is no evidence at this point anyone knew she was a whistleblower. Evidence shows she can be abrupt. She is having difficulties in professional relationships. This leads us to conclude that the problems she experienced do not extend from any disclosures, but from the dynamic of her professional interactions with others.

168. Mr Powell had suggested a further meeting. Dr Dyer acknowledged that Mr Powell had been personable and attentive, but they declined because they did not see a separate meeting as worthwhile. The email made it very clear they did not agree that Beaumont ward was safe, and that they had not spoken to the right people at the *coalface*.

169. On 29 May 2021 Dr Dyer wrote an email that Dr Benaris and he did not accept the view that the Beaumont ward was "not unsafe". Dr Benaris was copied in. They had clearly discussed matters. It was clearly an expression of Dr Benaris's own position (it accords with her own evidence to us). It shows her refusal to accept the conclusion that the CQC was happy with.

Claimant's waiver of anonymity

170. On 28 May 2021, Dr Benaris emailed the CQC following on from Dr Dyer's email of 20 May 2021 (above). She made clear she too profoundly disagreed and sought copies of the data the Trust provided to the CQC in 2021 about safety and the like. She also said she now waived her right to anonymity.

171. Ms Abel reiterated the CQC considered the matter closed. She directed Dr Benaris to Dr Hiremath and Ms Scott if she had further enquiries. She forwarded Dr Benaris's email and her reply to Dr Hiremath and Ms Scott on 1 June 2021, identifying to the Trust for the first time Dr Benaris as the other whistleblower. We are satisfied that the evidence shows this is the first time the Trust would have known she was had contacted the CQC. Dr Benaris suggested in evidence they knew before this that she had contacted the CQC – or at least suspected it. There is no evidence to support either proposition. Rather the evidence suggests the focus was on genuinely addressing the concerns.

4 June 2021 – Claimant's grievance

172. The claimant lodged a grievance (dated 31 May 2021) against Ms Puckey and Dr Naik on 4 June 2021. The grievance is 7 pages in length. It opens

I am writing to raise a formal complaint against the in-patient Clinical Director (also my line manager), Dr Srinivas Naik and Beaumont ward matron, Marie Puckey, for engaging in bullying behaviour towards me and for fostering a hostile workplace by creating a culture of unprofessional behaviour on the ward which has impacted on me directly and affects the quality and safety of patient care. This has been a problem since the beginning of March 2021 when Marie Puckey took over as ward manager. I have attempted to resolve this matter informally through various means but I am now left with no choice but to submit a complaint and request a formal investigation as per trust policy into the issues outlined below.

173. We have read through the grievance. Dr Benaris complains about Dr Naik and Ms Puckey, a complaint that Ms Puckey's complaint was malicious, repetition of concerns about Beaumont Ward which appear to cover those the CQC were concerned about but did not pursue further after the second quality summit. She also wrote:

Dr Naik has done this before when he disagrees with a decision I have made. Rather than have a direct conversation with me, he will insinuate that the reasons for my decisions are ones based on emotion — I find this behaviour to be discriminatory on the ground of my gender.

And

*Dr Naik has a history of unprofessional and undermining behaviour towards me since he was appointed as in-patient [clinical director (**CD**)] (he has undermined my clinical opinion and made inappropriate remarks such). He has a tendency to approach people individually rather than as a group when discussing unit and job issues hence preventing any unity. He will often interrupt me in meetings but then allow other Consultants to talk at length about the same points, which I feel is discriminatory towards me. I have not*

previously raised this formally as this is not in my nature. My priority has always been patient safety and I feel as though I am now reaping the consequences of vocalising these.

174. A most striking thing in our view is that though Dr Benaris mentions sex discrimination, she does not even suggest that any of the alleged misconduct happened because of any of the prior disclosures she now cites. We find this telling and leads us to infer that she does not really consider that she had been subjected to any detriments for whistleblowing. Firstly, it seems implausible that, much later when it comes to presenting her claim, she would suddenly decide that there was no sex discrimination at all in fact, but it was all because of disclosures – which in summary is what appears to have happened. Secondly this was over 1½ months after she contacted the CQC and they had contacted the Trust – the event that she says was the catalyst for the worse for behaviour towards her. If that were so, then it is implausible that by this stage she was not asserting the link. Thirdly as we will see while she was represented by both the British Medical Association (**BMA**) and Medical Defence Union (**MDU**), she never advanced any suggestion that she was being subjected to detriments for whistleblowing.

Further developments

175. On 9 June 2021, Ms Falope complained by email to Dr Hiremath about Dr Benaris. She alleged that at a meeting the previous day that Dr Benaris said that nursing staff had lowered their standards and implied Ms Falope did not understand fluctuating nature of acute care. She also alleged Dr Benaris said that one good day on the ward does not demonstrate all is well. In her evidence, Ms Falope told us that during the times material to this claim, Dr Benaris did not always respect nurses' opinions or her role in bed management. Dr Benaris denies this.

176. The same day, Dr Aria wrote to Dr Benaris as follows.

I wanted to bring to your attention something you said at yesterday's meeting whilst discussing Beaumont ward. You mentioned a comment — `nurses have lowered their standards' . I know you were conveying your concerns about how you feel the admission ward is, and also mentioned other things.

However this particular comment has impacted on several staff who were in the meeting and they have raised this . I am sure you will understand how this would have impacted on others.

177. Dr Benaris alleges this is a malicious and unfounded allegation. We accept that Ms Falope's description is accurate. We do so because of the relative credibility of the witnesses and because it tallies with Dr Benaris accepting she can be abrupt and her belief that if she is polite, nothing is done. It also tallies with her approach that she is right and cannot accept other opinions. Her refusal to accept the conclusion that Beaumont Ward was safe, the CQC's decision to close its investigation and, later as we will see, Dr Naik's decisions over Patient 3. Her failure or refusal to accept others' opinions is consistent with these other examples. It also is reflected in the contemporaneous email from Dr Aria. There is no specific allegation that Dr

Aria is unreliable or biased. We have been given no reason to explain why Dr Aria would write this email if the allegation were untrue.

178. On 11 June 2021, Louise Short, service manager, emailed Dr Naik with allegations about Dr Benaris's conduct. She alleged

I was contacted by Marie Puckey the ward sister on Beaumont last night, tearful and upset. Marie had received a message from her Deputy who had been contacted by a ***RMN*** *[Registered Mental Health Nurse] on Beaumont upset and concerned about Mariam's behaviour. She had asked the RMN whether Marie had discussed anything Mariam may have said in the Tuesday meeting, and whether Marie was talking about her behind her back to which the nurse replied no, Mariam went on to say "well it doesn't matter anyway as the doctors (not sure who) are documenting evidence against Marie, Dr Naik and staff", then told her to be careful.*

… This is becoming a dangerous situation and one that needs to be dealt with formally following procedure. Marie is at the point where she can no longer come to work confident and happy, and I am not willing to lose an exemplary ward sister who has done wonders for the Beaumont Team because of a consultant who wants her own way all of the time and fails to comply with procedures and process. The staff give nothing but praise regarding Marie's management and [Dr Naik], you have seen for yourself how safe the ward is and how engaging the staff are.

She also alleged that Dr Benaris did not attend daily reviews, did not let Ms Puckey, the nurse in charge or Dr Naik know if she is about. She averred that she was colluding with junior doctors to prove Beaumont Ward was unsafe.

We are satisfied that some parts of this allegation are factually accurate. There is a clear tension between Dr Benaris and Ms Puckey. It is inherently plausible the tension would exist with her team. That is also consistent with her inability to accept different viewpoints. It is supported by her comments that nursing staff had lowered their standards and is consistent in our view with the fact she can be abrupt, and that she believes being nice hinders her getting things done. In addition, everything so far, and her tensions with Dr Naik lead us to find it is more likely than not that she said, *"well it doesn't matter anyway as the doctors (not sure who) are documenting evidence against Marie, Dr Naik and staff", then told her to be careful.* We do not however accept that she was orchestrating any such actions. There is no real evidence in our view that she did. In addition, we have seen no evidence that that is what was happening. It does not matter in our view if she believed it, because it is what was said that matters.

179. What we do draw from them though is further evidence of difficulties in the workplace, the division into 2 or more camps, and that the environment was *toxic*.

180. On 24 June 2021 Ms Puckey raised with Dr Aria, Dr Benaris's continued non-attendance at morning reviews. This is further evidence of the fractious relationship between Dr Benaris and Ms Puckey. She wrote

I have monitored over the last week her attendance please see below.

17/6/21 she attend part way through and interrupted asking who her new admissions were and then left.

18/6/21 did not attend

22/6/21 arrived 10 minutes late then sat talking to junior doctor whilst nurse was handing over

23/6/21 15 minutes late

24/6/21 did not attend

I do understand that on the odd occasion doctors have other things to attend but it would be helpful if this was communicated to myself so that I can inform staff.

28 June 2021 – Third quality summit

181. The third and final quality summit took place on 28 June 2021. Its key themes were that data suggested Beaumont Ward had no specific risk, overall, there had been a positive improvement in team dynamics, that staff felt comfortable contacting the CQC but they should feel confident to use the internal whistleblowing processes too and there were considerations about changes to the admissions model.

Our conclusions about the quality summits

182. We have considered them in detail. We note the thoroughness of the summits. We note the involvement of an outside person to run them. We note that they fed back to the CQC (for example

183. on 21 May 2021) until the CQC were content to close their investigation, and that initially they were under the scrutiny of the CQC. We also note the appreciation expressed to Dr Dyer and Dr Benaris and feedback. We note also that Dr Dyer did not aver he had been subjected to any detriment for contacting the CQC, even though he had not been anonymous. We conclude that the process demonstrates that the Trust took seriously complaints and concerns about care and risks. We conclude it demonstrates the Trust and people within it did not seek to pick on those who raised issues, but rather focused on considering the concerns raised. We believe it shows the Trust did not ignore those who had raised concerns but sought to keep them informed. In short, the process demonstrates that disclosures were taken seriously by the Trust, rather than seen as an inconvenience or worse.

184. While we cannot comment on the validity of its conclusion that the Beaumont Ward was, generally, safe we cannot see anything to suggest this conclusion was an obviously unreasonable one. We consider this too demonstrates the seriousness that the Trust approached complaints like the one that triggered the summits

10 July 2021 – readmission of Patient 3 – PD7

185. We take details surrounding Patient 3 from the Rathore-Crossley review. We address that later. But for present purposes we accept it is accurate and thorough.

186. The detail of his treatment does not matter except as follows. By the end of June Dr Vann and the ward manager agreed he was ready to be discharged. The only issues related to accommodation on discharge. By 1 July 2021 he was on the rehabilitation ward.

187. Patient 3 asked to be discharged on 2 July 2021, but agreed to remain. On 5 July 2021 he requested a clinical review. Dr Vann was his consultant but absent on leave. Therefore, he was reviewed by another doctor. They concluded he could be discharged. On 6 July 2021 Dr Naik reviewed matters and met the patient. He agreed with the decision, undertook a risk assessment and created a discharge plan. Dr Naik agreed with the other assessments that Patient 3 had capacity to make decisions about his treatment. He also noted that Patient 3 was a voluntary patient. He concluded there was no basis to make him an involuntary patient. Therefore, in reality he could not legally prevent Patient 3 from discharging himself. Therefore, he was discharged on 6 July 2021.

188. Patient 3 was readmitted as a voluntary patient on 8 July 2021. He was expressing suicidal thoughts but Dr Naik concluded that these arose from social circumstances not acute mental health issues. He considered the CRHTT were best placed to treat Patient 3.

189. We note that the Rathore-Crossley review does not suggest Dr Naik's decision was clinically unjustified in any way. It is not necessary for us to evaluate if that is correct.

190. The CRHTT saw Patient 3 on 9 July 2021. They saw no sign of mental illness. They discussed matters with Dr Naik. They again determined that Patient 3 was not mentally unwell – he just did not want to return to his flat. As a result, Patient 3 was discharged. Again there is no evidence before us to suggest that decision was clinically unsound.

191. On 9 July 2021 Dr Benaris was the on-call consultant who reviewed Patient 3's notes. She was concerned about the circumstances around discharge and felt that Patient 3 should be admitted. Dr Benaris attended Patient 3's home with Dr Kumari (who was not rostered to work). They assessed Patient 3 under the MHA. The AMHP was not present but, as noted earlier, need not be. Patient 3 agreed to return to hospital voluntarily. They arranged he be taken to the Unit by taxi.

192. She created a detailed note on Patient 3's S1 medical notes. Her note was lengthy. It goes well beyond simply detailing Dr Benaris's interactions of 9 July 2021 and Patient 3's readmission. The Rathore-Crossley report criticised the use of the notes to record what was not strictly medical information but which implied criticism of the decisions of other doctors. We also note that on 22 May 2021 Dr Naik had reminded colleagues not to use the S1 notes this way because they are accessible to patients, representatives, and other medical staff. We have read the S1 notes. They come across to us as defensive of her actions, rather than a simple record of the near-contemporaneous events.

193. The entry ended as follows (sic.):

IF, HOWEVER his risks increase on the ward, compliance with medication become impaired or a request is made to leave THEN DUTY DR TO BE

CONTACTED FOR ASSESSMENT OF MENTAL STATE AND DISCUSSION WITH DR VANN (/ ON CALL CONSULTANT). A MHAA will need to be arranged at this point.

TO BE TRANSFERRED TO THORNTON WARD AFTER SWABS AS KNOWN TO DR VANN. I will review on my return.

We note that it is very clear that Dr Benaris was steering Patient 3 away from being referred to Dr Naik.

11 July 2021 – email re care of Patient 3 – PD6

194. On 11 July 2021 Dr Benaris emailed Dr Hiremath and Dr Muhammad. She began

I am formally requesting that the care provided by Dr Naik in relation to the patient below is investigated. I apologise in advance for any typos — It is near) 2.30am, but I need to highlight the serious concerns that I have about the management of [Patient 3].

195. It included the S1 notes. The complaint is detailed and sets out a lot of information. However the subheadings are sufficient to give the gist for our purposes. Even if it were not a protected disclosure, it raised a number of serious allegations that required serious consideration:

Overdose taken with suicidal intent whilst on leave discharged from hospital prior to review despite known risks…

Quality of mental health assessments at the [CRHTT] and assumptions made re reason for impatient admission

Clear evidence of deteriorating mental state... Yet impression is no evidence of mental illness or need for admission/[face to face] medical review

Unsafe discharge

Hubris of assessors

Bed management team and role of gatekeepers

11 July 2021 to 13 July 2021– enquiries about Patient 3's admission

196. Ms Falope was concerned about how Patient 3 came to be admitted. She emailed Dr Benaris for an explanation asking which external agencies raised concerns about Patient 3. She also asked if it was in her capacity as on-call consultant. She said it was for auditing purposes. Dr Benaris said only

Concerns were raised by Turning Point. I acted on them in my capacity as the On Call Consultant.

197. Ms Falope enquired further such as whether the call was by switchboard and why it went to her rather than through the clinical decision-making team (**CDM**). Dr Benaris said only that it was the drug and alcohol services and referred Ms Falope to the medical notes.

198. Ms Falope asked further if the call came via switchboard from drug and alcohol services. Dr Benaris replied but did not answer the question saying

the end result is he is safe and well

and that she had discussed it with Dr Vann.

199. Ms Falope chased again pointing out it was important to follow processes and suggesting that the matter of Patient 3's admission had caused issues with bed allocation and availability. Dr Benaris replied on 13 July 2021 as follows.

I am concerned about the tone of this e-mail. As on call Consultant, it is my responsibility to act on patient safety concerns. Policies and procedures are there to assist clinical decision making and not to drive it. I will not be responding to any more e-mails about this matter. I will escalate this for further investigation and action.

Conclusions about Patient 3's admission

200. While we note Dr Benaris's belief about Patient 3's condition (see paragraph 152 above), we conclude that Dr Benaris orchestrated a situation to admit Patient 3 because she strongly disagreed with Dr Naik's previous clinical opinion and approach to treatment of Patient 3, felt unable to work with him and wanted to exclude him from Patient 3's readmission and disagreed with the bed management process generally. Our reasons are as follows.

201. Dr Benaris's evidence surrounding these events was evasive and incoherent.

202. She told us that CRHTT's drug and alcohol team had contacted her. They were supposed to contact the switchboard. There is no explanation why they appear not to have done that.

202.1. She gave us no professionally convincing reason why she would need review another consultant's decision of her own volition.

202.2. She gave us no good explanation about why she involved Dr Kumari specifically when she was not on the rota to work and other doctors were available.

203. Her answers to Ms Falope's appropriate enquiries are evasive, do not answer the simple question about whether the call came through the switchboard and the last one is threatening and in our view an attempt to stop further enquiry. In particular we do not understand why all the information was not volunteered initially or why she chose never to answer the question about the switchboard. We conclude it is because she knew she had deliberately not followed the correct procedures like she knew she ought to do and was seeking to stall scrutiny.

203.1. We have no good explanation why she used the S1 notes like she did. The details are clearly excessive. It reads and has hallmarks as an attempt to discredit another doctor.

203.2. We note it was Dr Naik to whom she had a hostile animus (see e.g. her refusal to recognise him as her line manager) and Dr Naik who made the decision to discharge. We note the note makes it very clear to steer enquiries to Dr Vann, whom she considered a sympathetic colleague.

203.3. Dr Benaris also was unable credibly to explain why Patient 3 was admitted by taxi if his condition were so serious.

203.4. Dr Benaris was unable to explain credibly why she admitted Patient 3 to the Unit without going through the bed management team to allow them to find and arrange a bed.

204. We can assume that it was clinically appropriate to readmit Patient 3. However, everything surrounding his readmission above and directing enquiries to Dr Vann lead us to conclude this was also motivated by her hostile animus towards to Dr Naik and her desire to discredit him and his clinical approach.

205. We also make a finding about the status of the S1 notes. We find as a fact that S1 notes are in simple terms medical notes and records that follow the patient. They are not read by e.g. the Trust's management team unless circumstances call for it. Likewise, they are not read by other medical professionals unless circumstances call for that note to be read. We can easily envisage a situation where a doctor makes an entry about a consultation, but it is never read again by anyone else because no situation arises that requires anyone to read it. We can also envisage a situation where the whole of the note is not read (perhaps because one looks only for what was prescribed) or is only read many months or years later.

206. The relevance of this is that is feeds into the narrative and impression in our view that the Unit – and Beaumont Ward particularly – was a toxic environment to work with various teams pitted against each other, different medical views about treatment but a lack of respect for others. More importantly rather than showing Dr Benaris as the mere victim she seeks to portray; it shows that she was also willing to connive to promote her view at the expense of others.

13 July 2021 – incident report

207. Ms Falope felt that the circumstances were such she needed to submit an incident report. Among others, she sent it to Dr King. He wrote to Mr Powell on 15 July 2021.

Fyi

I have asked Avinash to discuss

If true this is not just a gross misconduct investigation++ but possible GMC

Primae [sic.] facie very worrying indeed on a number of levels

Goes beyond "cultural" issues

Rest of medics stepping back as they see lines crossed

208. We can see nothing objectionable in this email. It is blunt and to the point but also seems a reasonable statement of fact. We think it reasonable to believe that Dr Benaris's conduct may have been a breach of the domains of the GMC code of practice, and it is reasonable to say it would be worrying. However, it is clear he is not accepting it as fact, because he says *if true*. Based on how he was a witness, we are satisfied he means what he

says, and so he genuinely was making no prejudgment. He was responding reasonably.

15 July 2021 – Dr Kinnair and Dr Vann ask for action

209. On 15 July 2021 Dr Daniel Kinnair and Dr Vann wrote to Dr Hiremath. The email demonstrates the nature of the workplace and we believe is worth quoting in full.

Adrian and I have been discussing concerns that are circulating about what happened at the weekend with Beena and Mariam.

Although they are friends of ours, we too share some of these concerns. We realise we don't know all of the facts but we think it is important that action is taken in relation to this in a fair and proportionate way, and if their practice has fallen short of expected standards then these needs addressing. We are concerned without appropriate and prompt action being taken then problems at the Bradgate will continue to worsen.

As senior clinicians would it be helpful to share some of our thoughts about what should happen next?

Happy to meet tomorrow if we can help — preferably morning or early afternoon.

It is relevant because it shows the conduct of Dr Benaris at least was having a far wider impact than simply calling into question Dr Naik's clinical judgment.

15 July 2021 – Ms West raises concerns

210. Ms West and Dr Hiremath also spoke about the Unit. She gave him advice on managing people's anxieties and feelings of vulnerability and managing breaches of in-patient assessment protocols. They did not discuss any of the alleged disclosures.

15 July 2021 – Majahal Sibanda raises concerns

211. Ms Sibanda (known as Endy in the documents) also set out how Dr Benaris admitted Patient 3. He said on 10 July 2021, when he was on duty, she had told him that she was unhappy at the suggestion that Dr Naik or Khokhar gatekept informal admissions and insisted to him she did not need to go through Dr Naik. When asked, she said that if Patient 3 required an MHA assessment, it could be done later. There was a lot of debate about whether an MHA assessment had started or not. For what it is worth, we think it had but see no issue with it having started and are not convinced resolution is necessary anyway to the issues we must decide. He explained that she organised the admission of Patient 3 to Beaumont Ward directly. He did not mention being shouted at, but we are satisfied it shows she was abrupt and rude with him. This is supported by what he reported, her attitude generally, her admission people do not do things if she is nice, and her general comportment surrounding the admission of Patient 3 when challenged by Ms Falope.

16 July 2021 – Dr Naik ceases to be line manager

212. On 16 July 2021 Dr Aria wrote to Dr Naik. She said both Dr Benaris and a Dr Kumari had complained to her about him. We know nothing about Dr Kumari's complaints, can say no more about it and put it to one side. We do know that Dr Kumari and the claimant liaised together, as will be seen later with Patient 3. She instructed him to cease to be their line manager. Instead, she became their line manager. Dr Naik replied that in those circumstances he would wish to also cease to be a clinical director.

16 July 2021 – Dr Hiremath launches a formal investigation

213. On 16 July 2021 Dr Hiremath wrote to Dr Benaris to advise there would be a formal investigation into the admission of Patient 3. He would be case manager. He set out the concerns as follows. Professor Supid Ghosh was appointed as the investigator.

• You initiated the request for a MHA Assessment, did not discuss with the team whom the patient was receiving care and treatment from and did not arrange assessment through the Urgent Care Hub

• The process for selecting the second medic for MHA Assessment breached the Trust protocol and was undertaken by a doctor not on call or involved in the care of the patient.

• AMHPs were not involved in the MHA Assessment and therefore the assessment did not meet the legal criteria.

• Entries made by you within SystmOne were inaccurate and discredit the work of other healthcare professionals.

19 July 2021 – desktop review on Patient 3

214. Dr Aria had emailed Dr Samantha Hamer and Mr Zayad Saumtally, Lead Nurse of the Family, Young People and Children's Service, to ask them to check if the right processes were followed in relation to Patient 3. They reported back on 19 July. They noted 4 deficits. The only relevant one for our purposes is:

The full reasoning and risk assessment for discharge from CRT rather than admission to hospital at 08.50am on 09/07/2021 has not been fully documented to explain why admission was still not appropriate after the patient showed reluctance to engage with CRT.

They commented.

Although we have only been asked to comment on the processes, as clinicians, we do feel that what is documented, is a patient who is escalating risks at each point when admission is declined with no evidence of the psychosis seen at the point of admission on 10th May 2021. From 08/07/2021, he first reported suicidal thoughts, then phoned to report homicidal thoughts, then after previously agreeing to engage with CRT, he declines this, and the suggestion is of manipulative behaviour in an attempt to get readmitted to the ward each time the request is denied and so we also agree that clinically, attempting to keep him out of hospital was the correct course of action.

19 July 2021- more concerns about staff working together

215. Dr Aria raised more concerns with Dr Hiremath about the situation on the ward. She said staff were concerned about making clinical decisions because they felt Dr Benaris and Dr Kumari had been scrutinising decisions. Some had reported they may leave the Trust's employment.

216. It resulted in Dr Hiremath emailing staff on 21 July 2021. He acknowledged the high stress, and the significant spike in tension. He noted that disagreement is fine, but deep conflict was destructive. He wrote in particular

The above values will continue to drive the approach of clinical leadership; but where necessary and appropriate, the recourse to more formal routes of engagement will have to be taken. Over the next few weeks, we are

1. Organising to investigate a number of complaints that have been made over the last few weeks; and due to the peculiar nature of this situation; we have had to look at it from a non-standard approach.

2. Organising an Organisational Development approach to work with colleagues on Bradgate to develop the kind of culture that you would want to work in. The civility saves lives conversation that most of you attended was one of those first steps.

Apart from the above, let me state very clearly that

1. Where an incident requires attention, it will be done as per process with diligence and compassion; but without prejudice.

This will be an action focussed approach.

2. I will (and my clinical leadership colleagues share my view, and I am sure you will all share this view too) have a fair threshold for firm action to directly address behaviours that threaten the harmony and climate in the unit; because none of you deserve to feel threatened or vulnerable. Therefore, such behaviours will not be overlooked.

3. I have heard rumours that there are behaviours to undermine other professionals care; I have had representations from various sources about this; again, this is unacceptable and if it is indeed happening, I will refer to the guidance on professionalism and employ the right approach to tackle these behaviours without hesitation.

4. I will seek opinions about a behavioural charter that I will bring to you and expect you all to respect it; with the expectation that we as a collective will follow it and have a dim view of outlying behaviours as and when they occur; and will act on it.

19 July 2021 – removal from on-call rota

217. There operated a rota for on-call consultants. Being on the rota is voluntary. The rota was an app for mobile devices. In summary

217.1. It was for section-12 approved consultants.

217.2. A consultant was registered on the app by their Trust.

217.3. Once registered, a consultant would indicate if they were on-call or not.

217.4. If a AMHP needed a consultant to attend an MHA assessment, the AMHP could open the app and see who on-call at that time was.

217.5. The AMHP could then contact the consultant and arrange for them to attend to provide their assessment of a patient.

217.6. Attendance was beneficial for a consultant for 2 reasons

217.6.1. The consultant would receive a call-out fee. There was some discussion about whether the fee should have been set off against salary, but the issue is irrelevant and the parties rightly let the issue drop.

217.6.2. As agreed, a consultant gained valuable professional experience attending an on-call event. Patients presented in diverse states and with diverse issues. The differing nature of each call out assisted a consultant to maintain their skills and broaden their practical experience, which benefitted their practice and thereby indirectly their patients.

218. On 19 July 2021 Dr Hiremath suspended Dr Benaris from the rota. Dr Benaris received full payment for her on-call duties while suspended from the rota. He did so he said as a supportive measure. Dr Benaris does not allege that being removed from the rota was a detriment. We have seen no evidence that showed at the time she was removed she protested. While she was removed, she continued nonetheless to receive a payment equal to what she would have earned if she were on the rota.

219. After he removed her, he had no further involvement in whether she should return to the rota or not.

21 July 2021 – Dr Hiremath's email

220. Dr Hiremath sent an email to everyone to try to manage the workplace. We quote it because we conclude that it evidences the nature of the workplace, and shows how toxic it had become, and how stressful it was. We need only quote certain parts. We consider it remarkable that such a letter was required in the first place. He wrote as follows.

Hope you are well ? I write to you today informally to acknowledge we are witnessing a period of time where there is a significant spike in tension at the Bradgate Unit. Whilst in acknowledging that state of tension and that this email does not provide succour in these circumstances, I hope you will receive this in the same open way you did when we met face to face a few weeks ago.

I recognise that:

1. Inpatient units are high stress areas due to the complexity of patients and the dynamics between professionals.

2. Everyone is trying to their jobs to the best of their ability, and the passion that comes with that drive and focus sometimes

ends up seeming abrasive to other colleagues.

3. While it is normal and actually healthy to have disagreements, deep conflict can be seriously destructive.

As an aside the claimant accepted the above characterisation was correct. Conflict is not an issue; its how we handle it and how we manage it that's important….

Some of it is about being re-introduced to what that looks like, and some of it is a process of reflection whether we display those behaviours or whether we fall short. …

The above values will continue to drive the approach of clinical leadership; but where necessary and appropriate, the recourse to more formal routes of engagement will have to be taken. Over the next few weeks, we are

1. Organising to investigate a number of complaints that have been made over the last few weeks; and due to the peculiar nature of this situation; we have had to look at it from a non-standard approach.

2. Organising an Organisational Development approach to work with colleagues on Bradgate to develop the kind of culture

that you would want to work in. The civility saves lives conversation that most of you attended was one of those first steps….

Apart from the above, let me state very clearly that

1. Where an incident requires attention, it will be done as per process with diligence and compassion; but without prejudice. This will be an action focussed approach.

2. I will (and my clinical leadership colleagues share my view, and I am sure you will all share this view too) have a fair

threshold for firm action to directly address behaviours that threaten the harmony and climate in the unit; because none of you deserve to feel threatened or vulnerable. Therefore, such behaviours will not be overlooked.

3. I have heard rumours that there are behaviours to undermine other professionals care; I have had representations from various sources about this; again, this is unacceptable and if it is indeed happening, I will refer to the guidance on professionalism and employ the right approach to tackle these behaviours without hesitation.

4. I will seek opinions about a behavioural charter that I will bring to you and expect you all to respect it; with the expectation that we as a collective will follow it and have a dim view of outlying behaviours as and when they occur; and will act on it. …

Taking sides and losing objectivity will only worsen the situation and I and my clinical leadership colleagues will employ a fair, compassionate but unwaveringly firm approach in tackling issues that compromise the integrity of professionals and the unit.

221. We also consider this is clear evidence that Dr Hiremath was doing his best to maintain an effective and pleasant workplace and take leadership of a difficult situation. We are quite satisfied he wrote this out of general concern and was not motivated by any one particular issue.

22 July 2021 – Prof Ghosh meets the claimant

222. Prof Ghosh and the claimant met on 22 July 2021. Dr Hiremath had provided Prof Ghosh with a briefing note. We have seen it and are satisfied it sets out fairly the concerns in a neutral way.

223. Prof Ghosh explored a number of issues. He produced a minute of the discussion. The following particular exchanges are noted.

2. Process for assessment was not followed putting self at increased risk.

I do not understand which process they are referring to? I ensured that I had a Consultant colleague with me and we had arranged to meet the AMHP (social worker). The questions here relate to the legal criteria for arranging an assessment. This was met and I do not see how it is relevant to placing myself at risk.

224. In her own note, Dr Benaris said that Prof Ghosh was not aware of the wider issues on the Unit. We conclude this can only be a reference to her views about Beaumont Ward and disagreement with the findings it was safe. She also said there was no gatekeeping policy. We cannot accept she honestly believed this because as we found above, she was aware of such a policy being in place, and the admission of Patient 3 by-passed it. She also wrote she did not speak to Dr Naik because she *did not want to engage in discussions about differences in clinical opinion*.

225. There has been suggestion that Prof Ghosh was prejudiced and judgmental in the fact-finding interview because he did not investigate the whistleblowing concerns. We do not accept that. Prof Ghosh received a brief on what he was to investigate. We consider he cannot be criticised for sticking to his brief. There is nothing else in the notes or evidence that persuades us there was any other prejudice or being judgmental.

Commencement of the Pugh Investigation

226. On about 22 July 2021, the Trust retained Diane Pugh, a case investigator from Impartial HR Ltd to investigate Dr Benaris's grievance. We will turn to this later but mark this is the day the process was instigated, Dr Benaris was told of it a few days later and Ms Pugh began the investigation in earnest about 2 or so weeks later. By that time her remit had been extended by Mr Powell to include the grievance from Ms Puckey and the grievance from Dr Naik against Dr Benaris and Dr Kumari. Ms Pugh interviewed a number of people. She did this while what follows was occurring. We see no need to set out the timetable of when she interviewed people, but to note it included the claimant. We have referred to an interview date in the evidence where necessary.

26 July 2021 – Relocating the claimant away from the Beaumont Ward

227. On 26 July 2021 Dr Aria emailed Dr Muhammad. She explains there is a formal investigation, that both Dr Benaris and Ms Puckey work on the ward

and that Dr Benaris has complained about Ms Puckey but forbade anyone to share the details with Dr Aria.

Is it possible for you to check with Mariam if she wants to consider any alternate option during the investigation (I believe it starts on August 9th for a period of 8 weeks) . When we had discussion in the past at the time Marie put in a complaint she has previously said her preference was to continue at Beaumont and she will be professional with Marie and also does not meet or talk to her daily as they both have busy jobs. Helen Perfect has spoken to Marie and her preference is to continue on Beaumont and not move and she has said she will be professional at all times too. We will also need to monitor this as we go on for the next few weeks and let Mariam know she can contact us if needed at any point.

228. We see nothing sinister in this email or any surrounding circumstances to suggest there were an ulterior motive for the suggestion (e.g. protected disclosures).

26 July 2021 – Ghosh report

229. On the 26th of July 2021 or thereabouts – the report is undated – Prof Ghosh provided the outcome of his investigation into Dr Benaris regarding Patient 3.

230. He concluded there were no issues with probity and established that it was Dr Kumari who contacted Dr Benaris to forewarn her and then got someone in the team to call Dr Benaris. He did not consider this was an issue of probity. He did note however:

2. Information Governance Issues — Breach of Confidentiality — this is difficult case in that Dr B opened the notes on Sat 10/7 after the forewarning from Dr K. According to LPT policy — mental health notes should not be opened of patients where there this no direct care involvement — i.e. Referral directly from step up care or through CAP. From the conversation with Dr B it is clear that this practice of safely opening notes is not followed by Consultants as a whole generally and there appears to be a clear breach of policy. Her justification for opening the notes was entirely attributed to clinical care and patient safety and she did not have the insight to explain her lack of following LPT policy on information governance or patient confidentiality. Dr B made no attempt to call the Consultant RC (Dr Naik) to discuss any involvement with the case prior to opening the notes which would have been a mitigating factor in this. The LPT policy on Data protection is attached (Appendix B).

3. Communication with Senior Staff and working with Colleagues Following her conversation with me — it has become clear that there are issues within the In-patient Consultant that does not lead to cohesive working within this Unit. Clearly there was no communication between herself and Dr Naik (the RC responsible for patient [3] last inpatient stay and subsequent care) and no attempt to do so. In this light, Dr B actions are not in line with Good Medical Practice as set out by the GMC. Her overwhelming excuse for her actions appear to be driven solely by her understanding of what is 'good and safe care' as she sees it. There appeared to be no reflection that a fellow Consultant care may be different but still acceptable and must be

respected. If this respect is to be undermined then a clinical conversation needs to occur between the parties. Secondly, there are examples within her documentation that makes attempts at trying to malign colleagues without explicitly doing so — these were highlighted in my conversation with her. Her understanding of the processes involved in warranting a MHA is present but she does take a circuitous route to get a result and in this case did not fully follow the process laid by LPT policy. I gather this is not unusual within the Consultant body according to Dr B. This in itself is not concerning but what is her lack of contrition around this and her justification that any action is merited if the 'mean justifies the ends'. In this case there was a lot of solo working and using the processes already in place to safeguard both patient and clinician (e.g. Using AMHP, asking Registrars to play 'gatekeeper role' and lack of utilising 'gatekeeper' senior Clinicians to acquire an in-patient bed).

26 July 2021 – Further concerns

231. Dr Mohammed Abbas, consultant psychiatrist, emailed Dr King on 26 July 2021. He set out the summary of their earlier conversation. This was about the toxic environment in the Bradgate Unit and behaviour of some, unnamed colleagues. He described the working environment as *very difficult*

232. Dr Kinnair raised concerns with Dr King about the workplace on 27 July 2021. He referred to his previous complaint about Dr Benaris and Dr Kumari and said they

are both contributing to the toxic environment here which is now affecting multiple stuff and I believe patient care.

He added that he believed some of the motivation for their actions lay in splits between staff, and that

they both seem to be on a crusade to prove that other individuals are not safe practitioners, or do not care about patients, (particularly Dr Naik in the crisis team, but also other inpatient colleagues, and entire ward teams) . Both seem unable at the moment to see that different clinicians have different points of view, that there isn't always a clear right or wrong way of doing things, and will continue to clash with colleagues, which inevitably puts patients at risk.

233. We note that his email lends further support to our findings of fact surrounding the admission of Patient 3.

29 July 2021 – Dr Naik raises a grievance about bullying and harassment against Dr Benaris and Dr Kumari

234. On 28 July 2021, Mr Powell told Dr Naik about Dr Benaris's grievance against him. On 29 July 2021 or thereabouts he raised a bullying and harassment grievance against her and Dr Kumari. He made it clear he relied for the most part on information from Dr Kinnear. His complaint is detailed and lengthy but is adequately summarised in his second paragraph.

2. The latest incident is around the way in which a patient was admitted to hospital bypassing several protocols which appear to be with a malicious

intent to unduly criticise my clinical competency and create a malevolent case of clinical negligence against me.

235. He set out concerns about how Patient 3 came to be admitted, noting the lack of documentation about the "external agency" that referred Patient 3 to the Unit. He also reported that Dr Benaris was said to have shouted at Bed Management when they tried to clarify how Patient 3 came to be admitted.

236. Taking into account his evidence and Dr Benaris's attitude towards him (including particularly no longer recognising him as her line manager), we find as a fact that Dr Naik honestly believed the contents of his grievance to be true, and the grievance was not motivated by a desire for revenge against anyone else.

30 July 2021 – Feedback from Dr Ghosh

237. On 30 July 2021 Prof Ghosh provided preliminary feedback to Dr Benaris. The tenor was similar to that which we quoted earlier.

Start of August 2021 – Suggestion Dr Benaris moves

238. Dr Benaris also met with both Dr Aria and Dr Muhammad on 30 July 2021. The purpose was to discuss a temporary move. There is no note of that meeting but Dr Hiremath summarised the Trust's understanding in his letter of 4 August 2021.

239. On 2 August 2021 Ms Willis, Mr Powell and Ms Kirsty Whatmore, Senior HR Business Partner at the Trust, met to discuss Dr Benaris's situation. Ms Whatmore drafted a letter afterwards. We are satisfied it became the letter of 4 August 2021 which Dr Hiremath was content to put his name to. She also wrote an email to Dr Aria and Dr Muhammad as follows.

I've drafted a suggested letter to go to MB following the meeting with her on Friday. It was agreed at the meeting this morning with Mark/Sarah that this letter would inform her of the counter-complaints, emphasise the requirement to move to support her health and wellbeing, but also make clear that she ***must*** *[emphasis in original] move. I hope I've been able to capture those three aims!*

240. The letter was actually sent on 4 August from Dr Hiremath. It explains (so far as relevant)

They arranged to meet with you to discuss how we can best support you in consideration of both the formal investigation into your grievance, which will commence on 9th August 2021, and the preliminary MHPS investigation into the incident which occurred on 10th July 2021.

Although you assured Saquib and Fabida that you did not require any additional support, we remain very concerned about your health and wellbeing.

I am also now aware that Marie Puckey and Dr Srinivas Naik have submitted counter-complaints which name you and the terms of reference for the investigation commissioned by Mark Powell, Deputy CEO has been extended to include the information submitted by them.

Additionally, Dr Naik has raised his concerns about the incident on 10th July 2021 which will form part of the separate investigation into that issue.

As Saquib and Fabida explained at the meeting, we do not believe it is in your best interest to remain working on the Bradgate Unit at this time and hope that we can come to a mutual agreement about a suitable temporary placement whilst the investigations are ongoing. The specific options were not discussed; however, Fabida has clarified that the placements available for you to consider are as follows:

• Any of the CMHTs

• ADHD

• ASD

All the options above could be undertaken principally from home, or we could identify a suitable base for you to work out of, if that was your preference.

We also note the letter signed off with pointers to support including her trade union, the Freedom to Speak Up guardian and various other sources of support.

11 August 2021 – commencement of formal MHPS investigation

241. On 11 August 2021, Dr Hiremath told Dr Benaris he was commencing a formal investigation in line with MHPS Part I because of the conclusions of Prof Ghosh and because of Dr Naik's grievance.

August 2021 – further consideration of moving

242. Dr Benaris contacted both the BMA and MPS. Though they are separate organisations, they worked together, with one relying on the other to provide advice and representation at various times. So far as we can see, the Trust liaised with both simultaneously, and they kept each other informed of developments, often copying each other into emails. In effect for the purposes of this case, they were one unit.

243. On 10 August 2021, Dr Claire Harriman, BMA, wrote to Drs Aria, Hiremath, Muhammad and Ms West. She quite properly raised several queries about the various investigations and complaints against Dr Benaris. We need not quote them. However, she also asked specifically about the proposed move:

Concerning moving Dr Benaris from the Bradgate Unit, this is something that she is considering but would appreciate a response to the following questions before making a decision:

• In terms of the decision making process, what was the information used to arrive at the decision to move Dr Benaris? Who was involved in this decision?

• Who has raised concerns about Dr Benaris's health and welfare and what is the nature of these concerns?

• Has there been any concerns re Dr Benaris's clinical care?

• You have suggested a temporary move out of the unit, can you clarify in writing what the date of return will be and whether this will be on the same ward?

244. The same day Dr Harriman wrote to the claimant a detailed email about the issues that Dr Benaris faced. She copied in Dr Johnathan Bernstein of the MPS. The email is lengthy and detailed, but is also objective, clear, well-reasoned advice and guidance. On moving she wrote as follows.

Dr Benaris, concerning the request for you to move placements, now that I have received the majority of the correspondence relating to this query I can advise further. Often when employees have raised concerns about others behaviour towards them it can be uncomfortable continuing to work with these same people whilst there is an intense and prolonged investigation. Separating employees under these circumstances is done to support individuals and to protected them. How this is done and who is moved depends on practicalities and circumstances. When deciding who should be moved management will consider things such as how many people are needed to be moved, given that you have complained about two people and you are just one person from this situation management may deem it that you as an individual would be easier to move. Management will look at whose job is easier to move. It would not be based on who is the most guilty or about apportioning blame. Given this situation I would recommend that you do accept to move, as if you don't it could be questioned as to whether your complaint is warranted if you are able to continue working with these people in such difficult circumstances.

Dr Bernstein replied saying he agreed with the above advice.

245. Dr Hiremath replied to all the queries from Dr Harriman. In relation to the move, he wrote as follows [sic.].

The conversation with Dr.Benaris about considering working in an environment outside of the Bradgate Unit.

1. There are no specific concerns about Dr.Benaris' clinical decision making or the care she offers her patients. However, there are concerns about her adherence and approach to policies and pathways particularly around admission. These concerns relate to whether Dr.Benaris is able to work with other clinicians and teams mediating the admission process.

2. Investigations can be stressful for all parties and have an adverse impact on an individual's health and wellbeing. Any concern therefore comes from a position of compassion and concern about Dr.Benaris's overall wellbeing in the current circumstances.

3. The temporary move out of the Unit would be for the period of the investigation. In this regard, there are two investigations

a. The broader investigation in the Bradgate unit to investigate complaints and counter-complaints by various clinicians; which we expect to last 8 to 12 weeks [This is the investigation by Ms Pugh].

b. The investigation into Dr.Benaris' approach and conduct to the admission of the patient on the 10th July, which we will know shortly following the outcome of the preliminary investigation.

4. The temporary move would therefore be aligned to the completion of both investigations which we expect to be completed in 8 to 12 weeks time. We will keep Dr.Benaris informed about specific timelines and any extension to these.

17 August 2021 – meeting about moving

246. There was a meeting on 17 August 2021 between Dr Hiremath, Dr Aria, Dr Benaris and Dr Bernstein (who summarised it in an email to Dr Harriman). Dr Hiremath agrees it is an accurate record. Dr Bernstein wrote as follows as far as relevant.

… In regard to support for Mariam's welfare, Mariam has been offered the opportunity to move to one of the community teams rather than remain in the Bradgate Unit so that she is removed from the toxic environment there, has less stress and can be supported while the investigations progress. A placement alongside Dr Saquib Mohammad has been promoted as Dr Mohammad is apparently keen to support Mariam. Mariam has been assured that the placement is only for as long as the investigation takes. When she asked if she could decline the suggestion, Avinash said she could but that his planned discussion with NHSR (PPA) planned for this Thursday may alter that flexibility. Any placement will include consideration in the job plan of the effects on Mariam's childcare needs, will include some orientation and shadowing at the start. Mariam may say otherwise, but I think she is inclined in principle to accept a placement outside the Bradgate unit during the investigation.

247. On 18 August 2021, Dr Benaris emailed Dr Aria saying

I would prefer City East. Can we arrange a meeting on Friday to discuss the post in more detail?

248. On 19 August 2021 Dr Benaris opted to work in the Community Mental Health Team (CHMT) at City East.

Finding of fact about the move

249. Dr Benaris invites us to conclude she was relocated from the Bradgate Unit because she made protected disclosures. We find as a fact that there was no connection. It was a decision she freely made and was in short only about her welfare while the various investigations went on. Our reasons are as follows.

250. On its own, Ms Whatmore's email is clear that Dr Benaris faced a fait accompli: *Move!* However, context is everything. We conclude that the instruction ***must*** *move* is driven by concern for Dr Benaris's welfare and to reflect the surrounding circumstances and that she ought to move for her own sake. We consider it is infelicitous language but does not in fact reflect the reality. It is not motivated by any belief she has made protected disclosures.

251. Dr Hiremath's letter reflects the discussions at the meeting. He accepted in evidence that, contrary to what he said in his written statement, he did attend that meeting. We have been given no reason to doubt they accurately capture the gist, and both Dr Aria and Dr Muhammad read the draft before it was sent. They did not flag any inaccuracy.

251.1. The words must be seen in the context of the surrounding circumstances. Dr Benaris has complained about Dr Naik, she is being investigated because of potential misconduct for bypassing the gatekeeping and bed management process, there are concerns about the admission of Patient 3, Dr Naik and Ms Puckey have complained about her and other consultants have raised concerns about her and about the workplace more generally. In addition, it is a stressful workplace. It is obvious she would be under a lot of pressure and a move could well be sensible.

251.2. The letter is written in a far more conciliatory way than one might expect if she were to be given no choice. It is not written as an ultimatum. There is no evidence that this is mere "window-dressing" to cover up the real message.

252. The letter signposts sources of advice (e.g. her trade union) and other support (e.g. counselling services etc.). If it were an ultimatum then it is unlikely the letter would signpost sources of support who might push back on the suggestion.

253. The email of 18 August 2021 is, in our view, indicative of her agreement and willingness to move.

253.1. The above letter from Dr Hiremath alone also confirms the reasons for the proposed move does not relate to any protected disclosures, but rather to everything else that was going on. It seems inherently more plausible the toxic environment, investigations and complaints and cross-complaints are behind the decision to move than the fact there may have been a protected disclosure.

253.2. Her own advisors suggested the move would be appropriate. They are not alleged to be in cahoots with the Trust, applying pressure on the Trust's behalf. Their reasoning is in essence similar to that of the Trust – it is about promoting her welfare. Their advice is well-reasoned and there is no suggestion it was unreasonable. She was clearly accepting and following their advice.

253.3. The nearest there comes to compulsion is a comment Dr Hiremath made in the meeting *When she asked if she could decline the suggestion, Avinash said she could but that his planned discussion with NHSR (PPA) planned for this Thursday may alter that flexibility.* We do not think this can be described as improper pressure. It is an obvious statement of fact. If Dr Benaris declined to move, the Trust would have to do something else because it is plain the current situation was intolerable and could not await the outcome of diverse investigations. It is clear a potential step might be her suspension pending investigation, depending on advice. His reply is a reasonable statement of fact to a reasonable question. It cannot in our view be read as an

ultimatum, as undue pressure. Moreover, there is no basis to link it to the fact there were protected disclosures.

253.4. Overall, there is no positive evidence that points to an ulterior motive, e.g. protected disclosures.

Lack of investigation into the claimant's whistleblowing

254. While all of the above was taking place, nothing had happened in relation to her protected disclosure PD6. On 26 August 2021 Dr Harriman emailed to Dr Hiremath to ask what the outcome was. She noted that Dr Hiremath had not followed the Trust's own policy on whistleblowing because the Trust was well outside the timescale for actions it had to take. She also reminded Dr Hiremath that on 17 August 2021 he said that the investigations had concluded and the outcome would soon be shared with Dr Benaris.

255. Dr Hiremath was away to 1 September 2021. He replied on 6 September 2021. He said [sic.]

I have written to Dr.Benaris today about the outcome of the investigation into her whistleblowing concerns. I have apologised to her about the delay. I must reiterate what i said in the meeting in August in that

1. theToR's [terms of reference] of the investigation relating to Dr.Benaris practice and approach leading to the admission on the 10th July is not related to her whistleblowing conerns [sic].

2. the ToR's do not include the subsequent complaint made by Dr.Naik about Dr.Benaris.

3. the investigation into the whistleblowing concerns was requested soon after the concern was raised, and concluded on the 20th July.

I do not agree with the suggestion that the MHPS investigation into Dr.Benaris is related to either her whistleblowing concern or the complaint from Dr.Naik. I am sure you will note that while the whistleblowing concern was attended to promptly; the decision to commission an investigation into Dr.Benaris was taken after due consideration.

256. The same day he emailed Dr Benaris as follows [sic.]

Following your concerns about the care of the patient who was admitted on 10th July; i had asked for an investigation to be conducted immediately. The investigation was conducted by Dr.Hamer, , CD of MHSOP and Zayad Saumtally, Lead Nurse, FYPC. Both the investigators made some observations about clinical record keeping, SCA and a missed blood test at the Hub. Both clinicians also reviewed clinical decision making, particularly the decision about hospital admission or community management, and agreed with the rationale behind the clinical decision making by Dr.Naik. They did not find any serious concerns that warranted a further investigation. …

This investigation was requested following your concern, and i received the conclusion on the 20th July. so there was no serious delay in getting this done. I must emphasise, as i did in the meeting; that the whistle-blowing or the grievance by Dr.Naik do not inform the ToR's of your MHPS investigation.

In our view this does not actually engage with PD6.

257. Understandably, we think, the BMA did not accept this reply. On 8 September 2021, Mr Ali Karim from the BMA observed the process did not follow the Trust's own whistleblowing policy. He also queried why there was such a delay.

258. Dr Hiremath replied on 10 September 2021 that he would reply the next week. He wrote that he would need more time on 17 September 2021.

1 October 2021 - Concerns about the investigation

259. Behind the scenes, there had been efforts to find an investigator for the formal MHPS investigation that Dr Hiremath had decided to investigate. We need not recite the emails except to note that HR had made it clear they were not going to conduct the investigation, and exchange about 1 October 2021. Ms West wrote to Ms Whatmore

Reservation though is that I was involved in the preliminary investigation and ideally it should be someone not previously involved. Secondly I would find it ethically challenging as I don't agree with it.

The statements collected in the preliminary investigation, which I heard first hand, have been twisted to fit an allegation. I am struggling with some of the statements that Avinash has subsequently made when there was no evidence to support his views. I am meeting him face to face next week to try and discuss with him as I have concerns about the way the whole thing has been handled.

The findings of concern from the preliminary investigation don't really relate to the specific events of 10th July. The findings that raised concern were that MB stated she would put clinical decision over policies and that she would retain responsibility for patients that transfer from her ward. For me this requires more of a coaching and mentoring input to shape and move that view point.

260. Ms Kathryn Burt, Deputy Director of HR concluded that *something needs to be done to break the cycle. I think [Ms West]'s far too close to all the medical issues – and personally invested* with Ms Whatmore adding S*erious implications if she was ever asked to attend a tribunal as a witness*.

Discussion about lack of action over PD6

261. Mr Karim decided to raise the issue over the lack of progress investigating PD6 with various senior people. One of those was Mr Powell. The email is lengthy but makes plain the lack of progress yet alone outcome from PD6, the lack of apparent action from Dr Hiremath and urged a prompt response.

262. Various enquiries were made internally. On 11 October 2021, Dr Hiremath replied to those enquiries of him. He denied a breach of policy. He cited that the Samutally/Hamer desktop review as his investigation, that he had relayed the outcome on 20 July 2021 and that was sufficient enquiry into the issues raised in PD6. However, he conceded there should be a fresh review of the concerns raised. He also agreed that it would be sensible to pause the MHPS investigation to allow Dr Benaris to attend the review without the investigation hanging over her.

263. On 22 October 2021, Mr Powell acted on this and instructed Ms Pugh not to investigate the incident on 10/11 July 2021 concerning Patient 3.

264. On 27 October 2021, and chasing 11 November 2021, Dr Bernstein requested the MHPS process to be ended.

265. The Trust agreed. It appointed Dr Abhay Rathore, consultant psychiatrist, and Ms Claire Armitage, Deputy Head of Nursing to investigate as well to investigate the concerns Dr Benaris raised in PD6 and others had raised about events on 10/11 July 2021 concerning Patient 3. We set out more detail below. It told Dr Benaris of their appointment on 16 November 2021

266. On 17 November 2021, Mr Powell confirmed the MHPS process was closed.

Our views about the delay dealing with PD6 and starting the MHPS process.

267. We conclude that the complaint or concern about the way the Trust and Dr Hiremath dealt with PD6 is merited. In particular we note

267.1. Dr Hamer and Mr Samutally were never tasked with investigating PD6. They were merely asked to do a desktop review. Dr Hiremath was wrong when he said they had investigated it.

267.2. There is no explanation why, if he believed the investigation into PD6 had concluded, he did not say so much earlier. The chronology above shows large gaps where, despite the numerous witnesses and significant amount of documentation, nothing appears to have happened in relation to PD6. There is no credible explanation for example for why he asked for more time to respond if he believed he had already completed the investigation.

267.3. It is unexplained, simply put, why this all took so long.

267.4. We are also concerned that the allegation for the MHPS investigation does not, as Ms West suggests, appear to match Prof Ghosh's conclusions.

268. However, the context in which this takes place is important. We repeat what we say about Dr Hiremath above when we discussed what we made of the witnesses: As a manager, he was placatory, prevaricated and sought to avoid confrontation and, ultimately, he lacked at the time the skills needed to manage the unit. As the non-legal members pointed out, this would be a challenge to even the most experienced manager or director: there were complaints and cross-complaints and factions between the nurses and various doctors. We make no apology for repeating this was a toxic workplace. In addition, we cannot lose sight of the pressures Covid-19 was placing on the Unit. Finally, to be fair to Dr Hiremath, he took up post in the early days of the Covid-19 pandemic and as these issues started to manifest. He had no time to settle into post – no honeymoon period. It is no wonder he lacked the skills – he was out of his depth as most people would have been.

269. We also note that it appears reasonable that Prof Ghosh's conclusions taken at face value *could* suggest a breach of clause 3 of Dr Benaris's

contract of employment and of Domains 1 and 3 of the GMC's *Good Medical Practice* requirements. We cannot say whether the employer should have started an MHPS investigation. However, we can say that Prof Ghosh's report is not an exoneration and so it is not inherently concerning that a manager thought some action was appropriate. He also had clear allegations from Dr Naik that, if true, could arguably amount to breaches of those provisions.

We note the terms of reference for the MHPS were *twisted* – to use Ms West's words. However, we conclude on balance this is because of the pressure Dr Hiremath was under, taking into account his abilities to perform his role in the trying circumstances. We consider it more likely than not he was not thinking clearly, rather than trying to manipulate a situation to subject the claimant to the process. That reflects better the circumstances and ability in role in those circumstances.

270. We also reflect on how the Trust, and Dr Hiremath, had engaged with the Quality Summits, even after the CQC closed its investigation, that the participants had taken them seriously and that no-one was subjected to any adversity for whistleblowing. We also note the lack of positive evidence that shows any protected disclosures provided a motive for the delay dealing with PD6 or instigation of the MHPS process.

271. Taking everything into account we find as a fact that the delays dealing with PD6 and the instigation of the MHPS process were not linked to the fact that Dr Benaris had made any protected disclosures. In addition, we see no positive evidence that any other protected disclosures played any part in the process, particularly when we reflect on how the Trust responded to the CQC's complaint and continued to do so after the CQC closed the case. We find as a fact therefore that protected disclosures played no part in either issue.

Commencement of the Rathore-Crossley review of PD6

272. Mr Powell provided Dr Rathore and Ms Armitage with a detailed brief that set out Dr Benaris's concerns in PD6, Ms Falope's concerns and Dr Naiks concerns about the events of 10 and 11 July 2021. It instructed them to focus on matters so far as they related to Patient 3. They were instructed to establish the full chronology, and whether procedures had been followed regarding readmission and if so, why not. They were to set out any improvements to be made or lessons learned. The brief was copied to the claimant, BMA and MPS. None came back to suggest it was inappropriate.

273. Dr Rathore and Ms Armitage however did raise various queries to clarify the brief. On 1 December 2021, Ms Armitage had to withdraw for unforeseen reasons, and Dr Jon Crossley, lead for psychology and specialist psychological therapies, took her place. The claimant was informed of this change. She took no objection.

274. Dr Crossley identified a further potential conflict of interest. On 8 December 2021, he noted both he and Dr Naik were members of the director management team, and he had had intermittent meetings with Ms Falope. His view was that there was almost always going to be a situation where someone knew someone else, and it was manageable. He raised it with Mr

Powell. He notified colleagues but no-one raised objections. The significance is the openness both Dr Rathore and Dr Crossley took to this issue. Rather than ignore it, they flagged it. In our view this taken with the numerous queries they raised to clarify matters tends to support the seriousness and independence of mind with which they approached the task.

275. During the time that followed Drs Rathore and Crossley interviewed many people including the claimant.

Outcome of investigations

The SI review

276. The SI review into Patient 1's death concluded formally on 20 December 2021. The report is lengthy and detailed. It concluded that that Patient 1 was admitted when there was high acuity (and just after 3 other, new, separate admissions). It also concluded that there were no staffing or environmental issues affecting functioning. It noted the contradiction in the controls over supervising the garden: one saying always supervise and one saying to the contrary.

277. It also concluded

277.1. Dr Benaris escorted Patient 1 to the bed before the other doctor had notified bed management.

277.2. Bypassing the admissions procedure meant there had not been the opportunity to have the fullest understanding of risk, history or purpose of admission. However, this was not necessarily a causative of his death.

277.3. It recommended following the bed management procedure by medical staff.

The Pugh Report

278. Ms Pugh finished her report and Mr Powell received it on 10 March 2022. He sought a number of detailed clarifications. These included questioning if mediation would be a benefit and noting allegations of sex discrimination in the interviews and asking for Ms Pugh to comment on it. The questions are all open and we are satisfied show Mr Powell had fully considered the draft report and was genuinely seeking clarification. Ms Pugh replied on 12 April 2022. We need not go into this further.

279. The report excluding appendices is 104 pages. To prepare the report, Ms Pugh interviewed the following 25 people (with date of interviews).

Dr Adrian Vann (AV), Consultant Psychiatrist, 28 October 2021

Dr Avinash Hiremath (AH), Medical Director, 04 November 2021

Dr Beena Kumari (BK), Consultant Psychiatrist, 08 September 2021, 19 October 2021, 03 December 2021

Ms Charlotte Hings (CH), Crisis Team Nurse, 22 December 2021

Ms Deanna Rylance (DR), Matron, 05 November 2021

Dr Fabida Aria (FA) – (also referred to as Dr Noushad in part), Associate Medical Director, 09 November 2021

Ms Helen Perfect (HP), Head of Service, 04 November 2021

Ms Jane Capes (JC), Clinical Matron, 26 October 2021

Ms Elizabeth Compton (EC), Clinical Matron, 27 October 2021

Ms Louise Short (LS), Service Manager, 27 October 2021

Dr Mariam Benaris (MB), Consultant Psychiatrist, 09 September 2021,

15 October 2021, 16 November 2021

Ms Marie Puckey (MP), Ward Matron, 14 September 2021

Dr Mark McConnochie (MM), Consultant Psychiatrist, 14 September 2021

Dr Mohammed Abbas (MA), Consultant Psychiatrist, 02 September 2021

Professor Mohammed Al-Uzri (MA), Consultant Psychiatrist, 29 October 2021

Dr Samantha Hamer (SH), Clinical Director, 21 October 2021

Dr Saquib Muhammad (SM), Associate Medical Director, 27 October 2021

Ms Saskya Falope (SF), Bed Manager, 26 October 2021

Dr Srinivas Naik (SN), Clinical Director/Consultant, 09 September 2021,

10 November 2021

Dr Steve Dyer (SD), Consultant Psychiatrist, 15 December 2021

Dr Vesna Acovski (VA), Clinical Director, 28 October 2021

Dr Waqqas Khokhar (WK), Consultant Psychiatrist, 02 September 2021

Ms Zahra Makhany (ZM), Ward Matron, 06 September 2021

We have read the interviews. They are thorough, detailed and focused on the real issues she had to grapple with. They are often lengthy, and as we can see, a number of people were interviewed repeatedly.

She also noted

2.9 It should be noted that a number of witnesses were put forward by each of the complainants but as investigator, I have applied a degree of proportionality in the extension of the investigation, only interviewing witnesses where I felt additional context or detail could be added that wasn't already available to draw a conclusion from.

Dr Benaris also makes this complaint.

280. Her investigation covered the following.

Section 1

1.1 Underlying Culture on the BMHU

1.2 Anonymous Complaint regarding the BMHU Culture on the BMHU

Section 2

2.1 Formal complaint by MA dated 26 March 2021 regarding BK and Grievance by BK dated 18 May regarding MA

2.2 Formal complaint by WK dated 08 April 2021 regarding BK and Grievance by BK dated 18 May regarding WK

2.3 Formal grievance by BK dated 18 May 2021 regarding SN and Complaint by SN dated 29 July 2021

2.4 Formal complaint from ZM dated 10 June 2021 regarding BK

2.5 Formal complaint dated 31 May 2021 by MB regarding MP and SN, complaint from MP dated 28 July 2021 regarding MB and complaint from SN dated 29 July 2021 against MB

2.6 Alleged Harassment and Victimisation from BK – 19 May 2021

Not all of these are relevant to the case before us. They however are yet further evidence of the state of the Unit and toxicity of the workplace.

281. Ms Pugh set out the background as follows

3.1 The Trust has received a number of concerns and complaints either directly or via the CQC from staff in respect of a range of behaviours, conduct, sex discrimination, bullying and harassment and lack of respect on the Bradgate Mental Health Unit (MBHU). This has included two complaints to CQC, one anonymously which alleges that there are wider systemic issues which are impacting on patient care and creating an uncaring culture and a toxic working environment. The Trust has taken immediate steps in terms of an action plan in respect of the raised concerns to CQC in April 2021.

She, rightly, notes that no-one, including Dr Benaris, alleged detriments from making protected disclosures. This tends to suggest that nobody including Dr Benaris believed that they had been subjected to detriments for whistleblowing.

282. She also noted there had been a perceived use of the Bradgate Unit for scapegoating and for blame by the Trust. Dr Vann for example told her

So, if there's an issue around for example, we don't have enough beds, well its consultant's fault for not discharging people or admitting too many. Or if an audit's missed it's the Matrons fault.

283. There was a general theme of a split between the consultants, as Dr Hiremath said to her. There is also a recognition that Covid-19 added its issues. Some also cited Dr Naik's appointment as being divisive.

284. Ms Pugh reached a number of conclusions based on and cross-referenced to the evidence. We can summarise and quote selectively to give a fair flavour of the outcome.

285. She did not accept Dr Benaris's grievances were made out. She found no evidence of discrimination.

286. She also said

Recognising the limitations that the pandemic response brought with it, the evidence demonstrates the lack of a cohesive team and lack of buy-in/engagement on the BMHU [the Unit] key objectives.

The evidence shared on culture point to:

• Lack of clarity on the overarching BMHU objectives and timeframes for delivery leading to uncertainty of personal impact

• Lack of cohesive engagement by the BMHU Leadership team in terms of key objectives i.e., seeking input of views

• Gaps in constructive two-way communication

• Some people feeling not listened to when raising their concerns

• Some staff feeling lack of early intervention in addressing alleged issues of poor behaviours

• No forward-looking workforce plan amongst the Inpatient team including changes anticipated through dormitory project, ward changes etc.

• Lack of forward-looking short-term workforce planning to cover maternity, paternity, and rota gaps.

• Over-reliance in email communication inhibiting two-way constructive conversation to resolve differing views or concerns as they occur

• Unprofessional comments between some staff groups [h]ad towards some feeling personal to individuals

• No medical forum to discuss cases when professional clinical views can be explored and discussed

• Lack of full integration of the Trust Leadership Behaviours

287. On bullying she said

The overriding and more substantial evidence points to breakdown of relationships, splits between inpatient consultants, splits between the medical, nursing, and operational teams, splits between medical management and inpatient consultants, poor communication with a thread of perceived poor behaviours. This has inevitably led to poor staff experience on a number of levels.

We conclude this is yet further evidence of the toxic workplace.

288. Dr Benaris has complained about the report. In particular she avers that Ms Pugh did not speak to enough people or the right people. We are not clear who, specifically, it is said she should have spoken to or what smoking gun would have been uncovered.

289. We reject any criticism of the report. In essence it reduces to the fact that one does not like the outcome. The option was available for Dr Benaris to appeal, but she did not do so. We can see no good reason why she did not. She had the support of the BMA and the MDU so she had access to advice and support if she wanted it. The fact the complaints are reserved to the trial when she was well-placed to appeal lend support to the fact she knew that there was no proper objection to the report. We cannot think of any person who it is clear should have been interviewed but was not.

290. From what we have seen of the evidence available to Ms Pugh and that additional evidence before us, we conclude that Ms Pugh's report and conclusions cannot be impugned. The non-legal members in particular drew on their experience in the workplace to observe that it is an impressive, thorough document based on a reasonable investigation and on the evidence and does not come close to falling short of what they would expect to see in the workplace with the Trust's resources and size. The Judge agrees. Moreover, we see no grounds to believe that the report was influenced in any way by the fact there were protected disclosures.

The Rathore-Crossley report

291. Like with the Pugh report, Mr Powell thoroughly considered the report and asked for clarification. The final report is dated April 2022.

292. Their report is similarly thorough, evidenced and cross-referenced to the evidence available.

293. The report expressed concern about Dr Benaris's commencement of a MHA assessment, because she had not been involved in his care previously, and Patient 3 was willing to be admitted voluntarily.

294. In their letter to Mr Powell, they said as follows.

4 d It wasn't acceptable for [Patient 3] to be transported via a taxi. This was justified by the risks being specific to [Patient 3] being in his flat. However given that the risks were perceived by MB and BK to be high enough to warrant admission, [Patient 3] should have been transported by an ambulance or with the police.

4 e MB accepted that suggestion and explained her thinking was based on her willingness to put patient safety first and challenge a policy that she believed to be contentious.

…

5 a Yes, she was aware that she was deviating from the policy.

5 b We do not believe that her explanation of her actions were justified. She was aware of the flow chart, and the standard practice that had developed by this point regarding admission.

5 c … MB nevertheless accepted that she was angry and did use her position as on-call consultant to justify her decision to the Bed management team. This conversation was reportedly heated and we believe that the high level of professionalism expected of our colleagues was not maintained on this occasion. Copy of the flowchart is included with the letter.

We note that in interview she told Dr Rathore and Dr Crossley

The reason I deviated from it on that occasion was because I felt the primary priority was to get the patient back into hospital and I don't want to get involved in any conversations or actions that would cause an obstruction to that.

295. They continued as follows.

6 a There were several shortfalls in this part of the care provided to [Patient 3]. As an absolute minimum, the established gatekeeping bed management

processes should have been followed. But more broadly considering the re-admission of [Patient 3] as a whole, while understandable given the risks that were apparent, it is our view that it was inappropriate and should not have happened. It undermined a collaborative and shared process that had been established to manage a very complex set of circumstances, and resulted from an interpretation of the presenting risks based on a specific perspective and formulation of the patient. Although it ensured safety in the short term, regarding longer term outcomes this intervention would have reduced [Patient 3]'s commitment to work with the healthcare system to increase his ability to tolerate stress, and confirmed his views of his inability to cope in his home environment and the willingness of the system to react to his escalation of risk.

b We have made recommendations in other parts of this report (sections 2-7 and 3-5).

We would recommend that MB should similarly undergo an appropriate training and/or mentoring with a trusted senior colleague over an extended period of time, to provide opportunities for self-reflexivity and to enhance her professional development with regard to working collaboratively, providing constructive challenge and leadership, and managing unconscious bias within a wider organisational system.

Finally they said

7 … Dr Benaris' and Dr Kumari's actions were in stark contrast to the direction of care that had been established. Whilst challenge to existing practice can undoubtably be required and helpful at times, in this instance it is our view that it placed unnecessary stress on an already overwhelmed system. It is our opinion that Dr Benaris' and Dr Kumari's commitment to their philosophy of care regarding admissions and safety, were higher level motivational factors than working with the wider system.

296. As for contextual factors, they noted (among other factors not relevant to the issues) in their report.

ii) Unfortunately, the Bradgate Mental Health Unit as a whole was not readily receptive to change, due to fractious relationships, a difficult working

environment including two deaths of patients in 2020, and the pressure of sudden changes in approach due to Covid. Some of the new gate-keeping procedures impacted previous roles, for example the on-call Consultant now had to justify informal admissions which previously they would have been solely responsible for, which caused some to feel aggrieved and led to questions about legal responsibility. Several of the interviewees described two distinct attitudes regarding discharge amongst the Consultants: one of longer treatment and slower discharge, and the other of more immediate discharge and support in the community. The impression of the investigation team was that these views became increasingly polarised as the pandemic went on. The contrasting nature of these two philosophies of care contributed to the events in this case and were played out in a stark and heightened fashion.

297. It concluded:

i) It was clear to the investigation team that all staff were seeking to act in the best interest of the patient and no harm came to the patient. However, the team also became acutely aware of the challenging working environment, due to bed pressures and relationship difficulties between clinicians, that had a significant impact on decision making. This is a worrying situation for any organisation. Some of the clinicians are very senior and need to reflect on their decision-making process, to ensure they work more closely with colleagues to provide the most consistent service possible in the best interests of service users. They need to minimise biases introduced through anxiety to manage risk, or to justify their own clinical judgement and approach to care.

It also noted poor communication and severe pressures such as from Covid-19.

298. Again, this report was written after detailed interviews with 10 people all involved in the 9/10 July 2021 incident. We again cannot see anyone who was not interviewed who ought to have been. While the report is not as verbose as Ms Pugh's report (being more of a bullet point style than discursive style), it is thorough, lengthy, detailed, well-reasoned and cross-referenced to the evidence. While we cannot comment on its medical content, we can see nothing that suggests it is influenced in any way by the making of protected disclosures, or that it does not represent the honestly held opinions of the authors. We are satisfied in the circumstances it was completed within a reasonable amount of time.

Subsequent developments

299. There were various meetings with the people involved to discuss the outcomes of the reports. Mr Powell formally notified Dr Benaris

299.1. her grievance had been dismissed on 19 May 2022, following a meeting between them and Ms Pugh the previous day, and

299.2. of the conclusions of the Rathore-Crossley report on 25 May 2022 at a meeting where Mr Karim attended to support Dr Benaris.

300. The letter relating the grievance is 3 pages long and set out clearly that no evidence supported her allegations. He proposed informal resolution of the complaints against her by mediation. He advised her of the right to appeal.

301. Despite a request to do so, Mr Powell declined to provide the reports to Dr Benaris, in order to preserve confidentiality. We consider this was reasonable. Each report had caused there to be a meeting to discuss the findings and permit questions. Much of it did not relate to Dr Benaris. Maintaining confidentiality was important. The decision accorded with the policy. The non-legal members particularly felt in their experience the refusal to release the report was justified because it might deter people from participating in future if they thought that their details would be revealed to a person they had e.g. complained about or they could not complain confidentiality and so speak freely. The key was that she knew the outcome and the gist of the reasons for it. They also felt it significant there was a meeting at which she could ask questions. The Judge agrees. Therefore, we see nothing untoward with Mr Powell's stance.

302. Dr Naik left the Trust in June 2022. Dr Aria quit in August 2022.

303. Dr Benaris took sick leave for the whole of June 2022.

304. On 13 July 2022, Dr Benaris agreed she would mediate but said she would not return the Bradgate Unit.

305. On 15 July 2022, Dr Benaris raised further questions about the Rathore-Crossley report. She said she needed to do so, to *engage in more meaningful reflection.* However, we have read the questions. They run to 2 pages in an email. They are not strictly questions but attempts to reargue the matter and justify her actions.

Teaching responsibilities

306. Like many consultants, Dr Benaris taught those doctors training in psychiatry and students reading medicine. This was on-the-job training (such as conducting medical examinations of patients and tutoring) to enable those learning to become familiar with psychiatry. It involved educational- and clinical supervision It is for the trainees and students an essential part of their training. For consultants it is a rewarding experience to be able to assist them in their learning and to pass on their own learning. Trainees were allocated to either the Unit or the CMHT, and then to a consultant.

307. Dr Benaris alleges that when she transferred to the CMHT, the Trust stopped her from taking on trainees. We find as a fact that this is wrong. She was not stopped from having trainees. The reason she did not have any trainees was because there was a lack of trainees seeking to work in the CMHT. Our reasons are as follows.

307.1. Dr Benaris is not a reliable witness.

307.2. We have seen no documentary evidence that shows the Trust took the decision to stop Dr Benaris from taking on students and trainees, either temporarily or otherwise.

307.3. On her appraisal dated November 2022, Dr Benaris wrote on 5 November 2022 that

I provide teaching to the trainee doctors during supervision who review patients in clinic. In December I will resume my role as [Educational Supervisor] and [Clinical Supervisor] which will allow me to provide teaching during supervision sessions. Medical students have not been allocated to the community clinics as of yet.

We consider this is inconsistent with Dr Benaris's allegation.

307.4. We accept Dr Hiremath's evidence that the Trust did not stop her continuing with her teaching responsibilities. Rather, there are fewer students and trainees in CMHT. We also accept that the Trust continually puts out requests to consultants to volunteer to assist in medical training.

Return to the on-call rota

308. The Trust had not returned Dr Benaris to the on-call rota when the MHPS process ended. On 7 October 2022, Dr Bernstein emailed Mr Powell to ask why she had not been returned to the rota. So far as we can tell, this is the first time she complains to the Trust about not being returned to the on-call rota.

309. Mr Powell replied 10 days later. He wrote as follows (so far as relevant).

The outcome of the investigation for Dr Benaris was to engage in a facilitated reflection/supervision with a senior consultant colleague. I understand that this is due to take place in November as part of Dr Benaris' appraisal with Dr Jinghan. Dr Muhammad, Acting Medical Director and RO, and I are in agreement that once Dr Benaris has undertaken the reflective supervision the matter will be closed and she will be able to undertake on-call duties once again.

310. She completed her appraisal/self-reflection on or about 30 November 2022. The appraisal documents show it is completed in stages. In the document on 17 November 2022, she wrote

I recently made the decision to remain as a Consultant in City East CMHT and will spend the next year focusing on my clinical caseload, resuming training and teaching responsibilities and returning to the on-call rota.

311. On 7 December 2022 Dr Muhammad was asked to add Dr Benaris back to the on-call rota. He passed the request on to those who had administrative access.

312. Dr Bernstein later chased up her non-return to the rota because the Trust had not added her back even though she had completed her reflective supervision.

313. The key next development in our view was on 7 December 2022.

313.1. Mr Powell wrote to Dr Bernstein as follows.

Dear Dr Bernstein

Thank you for your email. My sincere apologies for not replying sooner.

I can confirm that I have liaised with Dr Muhammed regarding Dr Benaris being added back onto the on-call rota and have asked him to speak directly with Dr Benaris about this.

He neglected to send it directly to Dr Benaris. He forwarded it to her on 22 December 2022.

313.2. At the same time, Dr Sanjay Rao (a colleague consultant based at the CMHT City East) wrote to Dr Benaris as follows:

Re- Oncall rota: can you plan to return to the Rota in the new year please.

This can be a gradual transition plan if you like.

Please let me/Vesna know- how this can be facilitated.

Dr Benaris replied that she would await Mr Powell's reply to the MPS.

314. On 22 December 2022, Dr Bernstein asked Dr Benaris if she were now back on the on-call rota.

Claimant reopens issues

315. We find as a fact that everything was back in place for Dr Benaris to return to the rota and it was up to her to indicate when she was ready and willing to rejoin the rota and be available. She was not working at the Bradgate Unit (to which she did not want to return). The MHPS process had ceased. The only action required as a result of the reports was self-reflection, which she had done in her appraisal. So far as we can tell she appeared to enjoy working in the City East CMHT centre.

316. On 29 December 2022, Dr Bernstein confirmed to the claimant she would be returned to the on-call rota. He noted the email (below) and said the Trust should treat it as a grievance. He hoped she would obtain closure, but he could advise no further.

317. The email referred to was dated 29 December 2022, from Dr Benaris to Ms Willis about her return to the rota. She wrote

Phased return to the on call rota had been mentioned (for my benefit) given the 18 month gap. From a HR perspective, I would be interested to know what your recommendations may be. This is important given the assertions made by yourself and the MD at the time that my presence at the Bradgate unit was compromising the safety of staff and patients, and indeed "putting the unit as a whole at significant risk" (PPA Correspondence: 26 July 2021). I would like to know how Dr Hiremath and HR reached this conclusion as it is both unsubstantiated and defamatory. I assume that these were based on the unfounded opinions of other clinicians and therefore HR had already prejudged the situation without ensuring that facts had been checked and my side of the story was heard. Medical management have stated on several occasions that there has never been any concerns about my clinical care and in actual fact commended my "very high standards" in the unit investigation.

Following the several investigations conducted over the past 18 months, there has been no concerns about my fitness to practise and categorically no evidence to support the statements made to the PPA by yourself and Avinash. I have not at any point been offered an apology for the actions taken in regards to removing me from both the on call rota and the Bradgate unit or been provided with any cogent reasons for these actions or how this opinion has now changed.

If there is evidence to support your claims, then please email me with these as I should be given the courtesy to challenge comments which I have grounds to believe were unfounded and malicious. If I have had no response in the next fortnight, then I will assume that there is no such evidence and that this is also no longer your opinion. I am aware that feedback is usually requested from those who raise concerns via the WB policy. I have not been approached and therefore will proactively feedback my views. I am disappointed that the whistleblowing safeguards were not

extended to me. I am concerned about the complete lack of transparency and failure to share the final reports (which could have been redacted if confidentiality was an issue) and most of all the egregious failure to follow the spirit of the law itself.

In the next paragraph she quoted directly from **Crawford v Suffolk Mental Health Partnership NHS Trust [2012] EWCA Civ 138** and Elias LJ's opinion that suspension is not neutral (that employees would question a suggestion that suspension was really in their best interests).

318. Ms Willis replied on 12 January 2023

In response to your email,

I am pleased to hear that you are returning to the on-call rota in a supportive manner.

The discussion and decisions made at the time we believe were reasonable and proportionate and in response to concerns raised leading to significant unrest for all working in the unit. The decision to move only yourself was to ensure the least disruption to the service and I understand this was explained to you at the time.

This decision was supported by the PPA and we deemed was a neutral protective measure to support both you and colleagues and thus keeping the unit safe from further workforce disruption whilst the investigation took place.

You have been provided with feedback as follows and these investigations are considered closed:

** Letter dated 19 May 2022 which summarised the feedback provided to you following the conclusion of the investigation by Diane Pugh into complaints you raised under the Anti-Bullying and Harassment Policy and Procedure*

** Letter dated 25 May 2022 which summarised the feedback provided to you in respect of concerns raised in relation to the re-admission of patient [Patient 3] on 10 July 2021.*

319. Dr Benaris replied on 19 January 2023 with a lengthy email with 8 questions seeking a reply by the end of that week. We think the email is worth quoting in full.

Thanks for your e-mail Sarah. I note that you have failed to answer my questions. in my last e-mail I asked for your advice in relation to a phased supported return to the on-call rota. I did not say that the return had already been planned in a supportive way. [All references I have made in this e-mail refer to the PPA correspondence for meetings held on the 19 and 26 July and 19 August 2021 between Avinash Hiremath, yourself and Jacqueline Gilbey - PPA case advisor].

The PPA encouraged both you and Avinash, to be transparent in your decision-making with me. They advised you to clearly "document your rationale ... in coming to any decision on restricting (my) practice". Aside from whistleblowing about patient safety issues, I remain unclear about why you thought that I was a "risk to the unit". This allegation has not been

addressed in either of the investigations into this matter. I have requested the investigation reports on several occasions, and this has been refused without an adequate reason. It is for the Trust to demonstrate that this decision to move me was "reasonable and proportionate"; and you have not been able to do so.

Could you please answer the following questions:-

Q1. Why is there a refusal to share the details of both whistleblowing reports and the wider unit investigation (in relation to my grievance) with me? A summary has been provided but with no explanation as to how these conclusions were made.

Q2. What Trust policy was followed in relation to the decision to remove me from the unit and the on-call rota?

Q3. The investigations were all completed in early 2022 and feedback provided in May 2022. Why were there continued restrictions on my practise until December 2022? (The MPS was of the opinion that the restrictions were discriminatory and indeed illegal (E-mails to Mark Powell on the 31 October 2022 and 07 December 2022).

As per your communication with PPA dated the 26 July 2021.

Q4. What did I do to pose a risk to patients? Where did you get this information from and please provide me details. If this were the case, how do you justify moving me into a CMHT job without any supervision of my practice?

Q5. What did I do to pose a risk to staff? Please provide me the information / evidence.

Q6. What has changed from the Trust perspective that means I am no longer deemed to be a "risk to the unit" or to patients?

I am keen to return to the on-call rota yet remain very concerned that further allegations will be made against me if I raise patient safety concerns or make a decision in the best interests of the patient which may not align with those of bed management or the service requirements. Understandably this is very anxiety provoking, and I am disappointed that there has been no acknowledgement from HR or indeed the Trust that I have been unfairly victimised for following good medical practise and whistleblowing about patient safety concerns.

You also stated that the move was a "neutral protective factor". I disagree with this. I suffered significant reputational damage and this whole process has had an impact on my health and wellbeing. My last 2 periods of sick leave in May 2021 and June 2022 were as a result of work-based anxiety. I was not offered a return-to-work meeting on either occasion and hence I was not given the opportunity to discuss the reasons for my absence. The Trusts Sickness policy was not adhered to on either of these occasions.

In relation to your comment "the decision to move only yourself was to ensure the least disruption to the service". I was informed in an e-mail on the 17 October 2022 from Mark Powell that the decision to remove me from the on-call rota was a "mutual agreement with Dr Hiremath" — it was not. I

strongly disagreed with the decision. You have now acknowledged that the restrictions were decided unilaterally by the Trust based on your advice. I am pleased that you have been clear and transparent about this and hope my remaining questions will be answered in a similar vein so this matter can finally be resolved.

PPA advice and WB

You have stated that your decisions "were supported by the PPA". I note that you had informed them about Dr Naiks' formal grievance relating to the on-call incident, a grievance which you were "keen to ensure (was) properly investigated" (PPA 19th Aug 2021). My question is: -

Q7 - Did you as HR director also ensure that the PPA were aware that my whistleblowing was related to the same incident and that the WB investigation did not follow the Trust policy?

I have copied HR into previous emails where I have raised concerns about the version of events conveyed to the PPA.

Unfortunately, this was never acknowledged or addressed by you. I therefore raised my concerns directly with the PPA, specifically that the information provided to them was misleading and untrue. The case adviser, Jacqueline Gilbey informed me that the advice they had provided was based on the information given to them and therefore they were reliant on the medical director and yourself to give them a true and factual account. Jacqueline was unaware that I had raised a grievance against Dr Naik for bullying and she was also unaware of the details in relation to my WB concerns.

The LPT whistleblowing policy states "Only where unfounded allegations are made maliciously; will it be considered appropriate to act against the employee who raised the concern. This will normally be under the Trust's Disciplinary policy". The MHPS investigation was looking at both the process and the intention of the admission. My intention was to protect the patient, whereas Dr Naik, Dr Hiremath and you concluded that my intention was to malign him. This is evident in PPA correspondence, the initial fact-finding meeting with Dr Ghosh and the subsequent decision to refer me for an MHPS investigation.

Q8 — What were your reasons to believe there was any malice in my whistleblowing actions? Please provide me with the evidence of this.

My clinical entry in the patients' notes was misinterpreted by individuals included Saskya Falope, Gordon King and Avinash Hiremath and the question of intent based upon this. Gordon King stated this explicitly in his e-mail dated the 15 July 2021 to Mark Powell and Avinash Hiremath — "an attempt to discredit the work of other professionals including Dr Naik and those at the hub". I can only assume that the other clinicians who raised concerns to Avinash included Dr Abbas (whom I had complained about re bullying and discrimination at length in the Diane Pugh investigation). I note that Saskya Falope had forwarded an email communication with myself (13 July 2021) relating to the whistleblowing incident directly to Dr Abbas with patient identifiable details, itself a breach of IG given he had no clinical involvement with the patient. I am aware that he had told individuals in the

unit that I was going to be investigated before even I was made aware of this. The above events occurred immediately after I whistleblew.

320. On 13 February 2023, Ms Willis replied with a detailed letter. She wrote

Between July and September 2021 Dr Hiremath was in regular discussions with the Practitioner Performance Advice (PPA) service. It is clear from that correspondence that the decision to reach agreement on the offer to you of a placement outside of Bradgate Unit was a compassionate measure due to the variety of difficulties which were arising on the unit at the time, including the patient safety investigation relating to the incident with patient [3] on 10 July 2021 conducted by Dr Abhay Rathore and Dr John Crossley and the Diane Pugh investigation. This was not a formal measure to restrict your practice but a neutral and compassionate measure on behalf of the Trust. I note that you accepted the offer of redeployment, evidence of which is your email dated 18 August 2021 to Fabida Aria in which you stated your preference for redeployment in the community was in the City East area. …

It is clear that both by your actions in attending for work in the community setting without raising any formal objection or grievance about the redeployment decision at the time the decision was made and communicated to you in 2021 and that you agreed with this decision. You did not object to or disagree with the decision to temporarily redeploy you at the time this was proposed, discussed and communicated to you….

I would also draw to your attention the contents of the Trust's Grievance Policy which states that an employee wishing to raise a grievance should do so within three months of the incident or action giving rise to the grievance. Any complaint arising from the redeployment decision would need to have been raised within 3 months of the decision (i.e. by 30 October 2021). You are therefore considerably out of time in raising these matters now some 15 months later. However, I have attempted to provide you above with a response regarding the decision prior to closing this issue down….

Concerns raised about investigation reports

You have also raised concerns about the two investigation reports that were obtained. Mark Powell sent to you details of the outcome and recommendations of the Diane Pugh report on 19 May 2022 and advised you of your right to submit an appeal by 1 June 2022. This period was subsequently extended to 13 July 2022 due to your sick leave. On 13 July you responded to Mark to say that you would not be returning to the Bradgate Unit. You did not raise any appeal against the Di Pugh report or any of the associated issues.

On 26 May 2022 Mr Powell also sent you the outcome of the whistleblowing report into the 10 July 2021 incident regarding patient [3]. You also had feedback meetings with Mr Powell and were advised in clear terms that under the Raising Concerns policy that there was no right of appeal but that you could raise matters with Trust Chief Executive or other bodies identified within the policy if you remained dissatisfied with the outcome.

This is also made very clear in the Trust's Dignity at Work Policy which states that any appeal should be made within 10 working days of the

employee being informed of the outcome of the investigation. Your appeal period was extended to take account of your sickness absence and you did not appeal within the timescales required. You did not do so and therefore this matter is also at a close.

321. We find as a fact that Dr Benaris was attempting to re-open the matter. We conclude that somehow she had been directed towards the possibility of a whistleblowing complaint and was seeking to set it up. We do not know what or who was guiding her. However, it is notable that issues that were well-settled and stale are suddenly and (on the evidence before us) inexplicably re-opened by her. We note also she was quoting case law. We note she focused later on the whistleblowing and made for the first time the implication that action was taken against her for whistleblowing (that is the only reasonable way to read e.g. the final sentence), despite the fact she alleged to us that the respondent subjected her to detriments for whistleblowing from the start of the time relevant to this claim, and earlier sought to suggest it was discrimination.

322. We note later that she resigned (she cites Ms Willis's reply as the final straw). However, the email leads us to conclude that she had already decided she was going to resign by the time she wrote her email of 29 December 2022 and was at the very least contemplating this claim as well We realise that is a strong inference to make. However, we consider it the only credible explanation of how matters progress from everything ending and her being returned to the rota as she wished to email seeking to reopen matters, referring to case law and whistleblowing. There is no other obvious driver. There is no other explanation for their tenor or contents.

The final days

323. On 3 February 2023, Dr Rao asked to meet with Dr Benaris to complete a job plan in time for March. There was no meeting.

324. On 12 February 2023, Dr Muhammad emailed Dr Benaris to ask to meet to discuss her concerns about returning to on-call duties. There was no discussion.

325. Dr Benaris took annual leave from 14 to 24 February 2023. She was on sick leave for anxiety from 22 February 2023 to 14 March 2023. Though on sick leave, she was interviewed for her new job 13 March 2023. They offered her employment on 21 March 2023, which she accepted. She resigned on notice on 29 March 2023.

326. Early conciliation day A is 30 March 2023. Her employment ended 5 May 2023. Day B is 11 May 2023. She presented her claim on 11 May 2023.

327. We end with a comment about the fact she resigned on notice. We note she had a number of patients. All patients are vulnerable, but it is easy to accept those with such mental health issues that they are under a consultant are particularly vulnerable. We readily accept her evidence she could not just cease work. It was important to arrange for their handover to new doctors, to enable the doctor to be familiar with the patient and the patient with the idea that their doctor was changing. To the extent that it is suggested her resigning on notice is evidence against her claim having merit, we reject that. It is a fact that it was sensible and compassionate to

prioritise patient care, and whatever else we have said, shows her to be a doctor with her patient's best interests at heart.

Law (so far as relevant)

328. We understand the law to be as follows (so far as relevant).

Whether something is a qualifying disclosure

329. The **ERA section 43B** provides (so far as relevant):

> "(1) In this Part a "qualifying disclosure" means 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— … (d) that the health or safety of any individual has been, is being or is likely to be endangered,…"
>
> …

330. **Section 43F** also provides:

> "(1) A qualifying disclosure is made in accordance with this section if the worker— … (b) reasonably believes— … (ii) that the information disclosed, and any allegation contained in it, are substantially true."

331. A disclosure must convey factual information, with sufficient factual content and specificity that tends to show one or more of the relevant categories, rather than a mere allegation without that factual content.: **Kilraine v Wandsworth London Borough Council [2018] ICR 1850 CA**.

332. "Tends to show" is a lower hurdle than "shows": **Twist DX Limited v Armes UKEAT/0030/20/JOJ**

333. When deciding if a disclosure is in the public interest, the Court of Appeal has suggested the following factors may be helpful to consider: the numbers in the group whose interests the disclosure served, the nature of the interests affected and the extent to which they are affected by the wrongdoing disclosed, the nature of the wrongdoing disclosed, and the identity of the alleged wrongdoer: **Chesterton Global Ltd v Nurmohamed [2018] ICR 731 CA.**

334. When deciding the question of reasonable belief, we ascertain the claimant's subjective belief, and then whether a reasonable person in the claimant's position with the claimant's knowledge at the time would have the same belief: **Babula v Waltham Forest College [2007] ICR 1026 CA; Ibrahim v HCA International Ltd [2020] IRLR 224 CA; Darnton v University of Surrey [2003 ICR 615 EAT; Twist**.

Whether the Trust subjected Dr Benaris to a detriment for making a protected disclosure

335. **Section 47B** provides:

> "(1) A worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure…."

336. "Detriment" has the same meaning as in discrimination law: It exists if a reasonable worker might take the view that the employer's action was

putting them at a disadvantage: **Shamoon v Chief Constable of Royal Ulster Constabulary [2003] ICR 337 HL**; **Tiplady v City of Bradford MDC [2020] ICR 965 CA**; **Warburton v Chief Constable of Northamptonshire Police [2022] ICR 925 EAT**.

337. **Section 48(1A)** provides for the right to complain to the Tribunal about detriments for whistleblowing. **Section 48(2)** provides:

"(2) On a complaint under subsection … (1A)… it is for the employer to show the ground on which any act, or deliberate failure to act, was done."

338. "…on the grounds that…" means that the protected disclosure must materially influence the imposition of a detriment: **Fecitt v NHS Manchester [2012] ICR 372 CA**. Whether there is a motive to do harm is irrelevant: **Croydon Health Services NHS Trust v Bett [2017] ICR 1240 EAT**. The protected disclosure need not influence the decision-maker themselves. It is enough if the employer subjects the claimant to a detriment because the protected disclosure materially influences the imposition of a detriment. Suggested examples might be the decision maker being manipulated by someone else motivated by the making of a protected disclosure or an anti-whistleblowing culture or chain of command: **Moussa v Great Western Railway [2024] EAT 82 EAT**.

339. There is an issue between the parties about the burden of proof as set out in **subsection (2)**.

339.1. The Trust contends the correct approach is in **Chatterjee v Newcastle-upon-Tyne Hospitals NHS Trust UKEAT/0047/19/BA** at **[33]-[34].**

339.1.1. the claimant must establish a prima-facie case so the conduct calls for an explanation,

339.1.2. if so, the respondent has to explain it, but

339.1.3. even if the Tribunal is not satisfied by the explanation, it does not follow the claimant must win. It may draw that inference but may also conclude it was a different, innocent, reason based on all the evidence.

339.2. The claimant posits in essence that contends the section should be read naturally – that if the respondent does not explain the treatment, then the claimant should win – essentially a binary outcome akin to that in discrimination law. She cites **Fecitt** at **[37],[48]** and **[51]** as supporting that proposition**.**

340. In our view we should follow the approach in **Chatterjee**. Our reasons are as follows:

340.1. It is a trite observation but worth making, we are bound to follow the ratio of decision of the Employment Appeal Tribunal. If there is a concern the decision is wrong, that is for the higher courts to consider and resolve.

340.2. While guidelines themselves in cases are not binding (**Anandarajah v Lord Chancellor's Department [1984] IRLR 131 EAT**), we consider the Appeal Tribunal in **Chatterjee** at **[33]-**

[34] is interpreting the relevant statute to make it clear it does not provide the Tribunal must choose between the two parties, with the burden on the respondent. That ratio is binding on us and we follow it accordingly. Insofar as the rest might strictly be guidance and not binding, it is relevant, useful, and it does not do an injustice to follow it.

340.3. If there be a binding decision from a Court superior to the Employment Appeal Tribunal and in conflict with the Appeal Tribunal's decision, we must follow the more superior of the two. The question there is whether **Fecitt** is contrary to **Chatterjee**. We conclude it is not.

340.3.1. We consider paragraph **[37]** is not on point. Read with **[40]-[43]**, it is merely the Court of Appeal (per Elias LJ, Mummery and Davis LJJ agreeing) accepting the respondent had discharged the burden of proof as set by the Appeal Tribunal.

340.3.2. However, the Court of Appeal considered, obiter, a second submission relating to the burden of proof:

> "38. The second point is that the proper test in this context is not whether the decision was materially (in the sense of more than trivially) influenced by the proscribed reason but, as in unfair dismissal cases, it is whether the proscribed reason was the sole or principal reason for the action taken. Mr Linden submits that the EAT was wrong to draw analogies between the whistle blowing legislation and domestic legislation giving effect to EU law. In the latter context it is incumbent on a court to read the legislation compatibly with EU law and the "no sense whatsoever" test is adopted in EU Directives. But where there is no such requirement, the legislation should be given its domestic meaning even if that means that the same statutory language may be differently interpreted depending upon whether there is an EU context or not: see the observations of Lord Brown of Eaton-under-Heywood in **R (Hurst) v London Northern District Coroner [2007] 2 AC 189** at **[52] HL**. Accordingly, the EAT was wrong to consider that it was obliged to follow the principles set out in **Igen v Wong**.…
>
> "43. Strictly, therefore, Mr Linden's second point, challenging the EAT's analysis of causation, does not arise for determination and I will deal with it briefly. Suffice it to say that I agree with the submissions of Ms Romney, counsel for the claimants, that liability arises if the protected disclosure is a material factor in the employer's decision to subject the claimant to a detrimental act. I agree with Mr Linden that **Igen** is not

strictly applicable since it has an EU context. However, the reasoning which has informed the EU analysis is that unlawful discriminatory considerations should not be tolerated and ought not to have any influence on an employer's decisions. In my judgment, that principle is equally applicable where the objective is to protect whistleblowers, particularly given the public interest in ensuring that they are not discouraged from coming forward to highlight potential wrongdoing."

340.3.3. We read this as Elias LJ making the point that the ethos underlying anti-discrimination legislation and whistleblowing detriment is similar. However, the Court of Appeal did not say it meant that a reverse burden of proof was to be imported into whistleblowing detriment claims and that **section 48** was to be interpreted accordingly. Nothing in **Fecitt** suggests that is what the Court contemplated, even though they clearly had in mind the reverse burden of proof in discrimination law.

340.3.4. At **[48]** onwards, the claimant and intervenor sought to argue for a stricter approach that "justice is done once it is recognised that the dysfunctional situation and the making of the protected disclosures were so inextricably inter-linked that it was not possible for the employer to take action to resolve the former without necessarily engaging the latter."

The Court of Appeal disagreed:

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

340.4. We note the caution at **[51]**. However, at **[52]** onwards the Court of Appeal made clear that such an extreme approach that the claimants campaigned for was not correct because in some cases the objective would become impossible.

340.5. Therefore, we are bound to follow the ratio of **Chatterjee** and we have considered its guidance too, which is not contradicted by **Fecitt**. As an aside we note all of this was explored in **Chatterjee** itself at **[22]** onwards, which had specific regard to **Fecitt**, and

other cases dealing with similarly worded statutes of other non-EU derived rights. None of them support the proposition Dr Benaris puts forward. The Appeal Tribunal also had regard to an earlier whistleblowing detriment case of **Ibekwe v Sussex Partnership NHS Foundation Trust UKEAT/0072/14** which supports the propositions set out in **Chatterjee** specifically in relation to whistleblowing detriments.

341. We remind ourselves that:

341.1. there needs to be a proper connection between the detriment and protected disclosure: **Fecitt**.

341.2. We also bear in mind we can draw inferences from the evidence if we feel it appropriate. Guidance on that can be found in **International Petroleum Ltd v Osipov UKEAT/0058/17/DA** (not affected by the appeal to the Court of Appeal on this issue): if a respondent does not show why detrimental treatment was done, the Tribunal may draw an adverse inference against the respondent, provided the facts justify that inference.

Time limits for such detriment claims (so far as relevant)

342. The **ERA section 48** provides:

"(3) An employment tribunal shall not consider a complaint under this section unless it is presented— (a) before the end of the period of 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, or …

"(4) For the purposes of subsection (3)

" (a) where an act extends over a period, the "date of the act" means the last day of that period, and

" (b) a deliberate failure to act shall be treated as done when it was decided on;

"and, in the absence of evidence establishing the contrary, an employer … shall be taken to decide on a failure to act when he does an act inconsistent with doing the failed act or, if he has done no such inconsistent act, when the period expires within which he might reasonably have been expected to do the failed act if it was to be done."

343. For acts/deliberate omissions to be continuing acts, there needs to be some link between them: **Arthur v London Eastern Railway [2007] IRLR 58 CA**.

344. Therefore, time starts from the date of the detriment, whether or not the employee was aware: **McKinney v Newham LBC [2015] ICR 495 EAT**.

345. We also bear in mind we should precisely identify the act or deliberate omission and its quality when considering if it was a one-off or extended over time, rather than merely whether it had an effect over time: **Flynn v Warrior Square Recoveries Ltd [2014] EWCA Civ 68 CA**. By way of example the parties have cited to us:

345.1. **Ikejiaku v British Institute of Technology Ltd UKEAT/0243/19 EAT** where the imposition of a new contract was a one-off act. The fact the effects continued did not make it a continuing act.

345.2. **Kilraine** where the Appeal Tribunal (not overturned on this point) said a disciplinary suspension is "clearly" a continuing act because while it begins with a decision, the continuing suspension is a continuation of that decision and not a simple consequence.

346. All of this is in practice academic if we can make a positive determination one way or the other without having to resort to the burden of proof: **Kirby v Glasgow Caledonian University UKEAT(S)/0021/18/JW**. Nothing is served by applying the burden slavishly except for the sake of it, when the answer is clear.

Automatic constructive unfair dismissal

347. Dr Benaris relies on the implied term of trust and confidence (which it seems is common ground mirrors clause 3 in her contract of employment).

348. There are 3 elements to establishing a constructive dismissal (**Western Excavating (ECC) Ltd v Sharp [1972] ICR 221 CA**):

348.1. The employer actually (or anticipatorily) fundamentally breached the contract (repudiatory breach);

348.2. It was a reason the employee resigned; and

348.3. The employee's conduct did not amount to them affirming the contract before they resigned.

349. Into each contact there is an implied term of trust and confidence (**the implied term**). This is 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] ICR 606 HL; **Courtaulds Northern Textiles Ltd v Andrew [1979] IRLR 84 EAT.**

350. Breach of the implied term is necessarily repudiatory: **Morrow v Safeway Stores [2002] IRLR 9 EAT**.

351. Affirmation is an issue of conduct, not mere delay itself: **Chindove v William Morrison Supermarkets plc UKEAT/0201/12**, though if a delay goes on too long it could be evidence of affirmation: **WE Cox Toner (International) Ltd v Crook [1981] ICR 823 EAT**.

352. The breach must be **a** reason for resignation, but does **not** need to be the sole or principal reason for resignation: **Nottinghamshire County Council v Meikle [2005] ICR 1 CA.**

353. In this case, Dr Benaris relies on a "last straw" i.e. an event that, coupled with other events, amounts to a course of conduct that cumulatively amounts to a fundamental breach of contract: **Kaur v Leeds Teaching Hospitals NHS Trust [2019] ICR 1 CA**. The last straw event must be more

than innocuous and contribute materially to the circumstances that amount to the alleged fundamental breach of contract, however slightly. It does not however need to be an example of unreasonable or blameworthy conduct: **Omilaju v Waltham forest London Borough Council [2005] ICR 481 CA**. It does not itself need to be a breach of contract: **Lewis v Motorworld Garages Ltd [1986] ICR 157 CA**.

354. **Kaur** sets out guidance on the correct approach to the constructive element of a constructive unfair dismissal claim.

354.1. What was most recent act (or omission) that triggered or caused the employee to resign?

354.2. Has the employee affirmed the contract since that act?

354.3. If no, was the act or omission itself a repudiatory breach?

354.4. If no, was it part of a course of conduct which taken together amount to breach of implied term of trust and confidence?

354.5. If yes to either of the preceding questions, did the employee resign in response to that breach?

355. For a claim to succeed, the public interest disclosure must be the sole or principal reason (i.e. the reason that operates on the employer's mind when dismissing: **Fecitt**)

356. In unfair dismissal cases where the employee is entitled to claim ordinary unfair dismissal the employer must prove a potentially fair reason for dismissal. We have taken the guidance in **Kuzel v Roche Products Ltd 2008 ICR 799, CA** as to how we approach the burden's here:

356.1. the employee must produce some evidence to suggest that his or her dismissal was for the principal reason that he or she had made a protected disclosure, rather than the potentially fair reason advanced by the employer. This is not a question of placing the burden of proof on the employee, merely requiring the employee to challenge the evidence produced by the employer and to produce some evidence of a different reason

356.2. having heard the evidence of both sides, it will then be for the employment tribunal to consider the evidence as a whole and to make findings of primary fact on the basis of direct evidence or reasonable inferences, and

356.3. finally, the tribunal must decide what was the reason or principal reason for the dismissal on the basis that it was for the employer to show what the reason was. If the employer does not show to the tribunal's satisfaction that it was its asserted reason, then it is open to the tribunal to find that the reason was as asserted by the employee. However, this is not to say that the tribunal must accept the employee's reason. That may often be the outcome in practice, but it is not necessarily so.

356.4. If the employee is not entitled to claim ordinary unfair dismissal, then it is for the employee to prove they were dismissed for making a protected disclosure. This is because the respondent

bears no burden of showing a potentially fair reason. Considerations of overall reasonableness of the dismissal including procedural fairness are irrelevant: **Wandsworth LBC v CRW UKEAT/0322/15 EAT**.

357. Thus, if the dismissal was because of a protected disclosure, it is automatically unfair and its otherwise reasonableness is irrelevant.

358. In this case the Trust has not sought to argue a potentially fair reason for dismissal (i.e. for any fundamental breach of contract). Therefore, if Dr Benaris were constructively dismissed but not because she made a protected disclosure, then the dismissal would nonetheless be unfair because there would be no potentially fair reason for the Trust breaching her contract.

Conclusions

359. Taking into account the facts found and the law, we have come to the following conclusions.

PD4 – alleged disclosure to the CQC

What did Dr Benaris say or write? When? To whom?

360. It is not disputed that Dr Benaris contacted the CQC. However, we are unable on balance to reach a conclusion that she conveyed to them information.

361. We note that Dr Benaris told the Tribunal in cross-examination that the bullet-point in the CQC's email of 14 April 2021:

> • *Mid December in death young man. Action not followed through. Seen by a senior. No faith in the SI process. Draft fails acidity of the ward. RA .Pt absconded — level 1 SI human factor error. 2020/18421. Garden is no longer supervised. Garden is too long, area of fence, no overhang*

captures her concern.

362. However, it does not tell us what **she** actually said, and we cannot discern to what extend that bullet point was influenced by any concern Dr Dyer raised. We do not know to whom she spoke at the CQC and so do not know if Ms Abel is writing the email based on her own interactions or notes from others.

363. Against it we note Dr Benaris gave a lengthy witness statement, knew this was a key issue because she herself identified **PD4** as being a "catalyst", but chose not to set out expressly what she said to the CQC in her evidence-in-chief. We also note that she did not adopt this bullet point as being in effect evidence of her disclosure in her evidence-in-chief either.

364. We do not consider it safe to fill the significant gap by relying on a note-form singular bullet point written by someone else over 3 years ago and the contents of which may have been influenced by another's disclosure, and which the claimant only adopts in cross-examination as being her protected disclosure. The need for caution is more acute in our view when she is not a credible witness, she has chosen not to set it out at all in her evidence-in-

chief and she attaches such significant weight to it to call it the catalyst for a change in treatment towards her.

Conclusion

365. Therefore, **PD4** was not a protected disclosure. Subsequent issues do not arise. Therefore, to the extent any claim relies on **PD4**, it must fail.

PD 7: The procurement of Patient 3's admission.

What is the case we must determine? The Trust says it is the procurement itself on which the Tribunal must focus. Dr Benaris says it encompasses the S1 notes she made.

366. We have referred back to the pleaded case. In her grounds of complaint, Dr Benaris identified the protected disclosure in these terms:

> *57. The claimant made the following protected disclosures: … g. Protected Disclosure 7: The procurement of Patient 3's admission is in itself a protected disclosure which discloses information which tends to show that the health and safety of patients and members of the public were endangered. The course adopted by the Claimant tended to show that she had no confidence in the clinical assessment process,* [sic.]

367. We consider that the only reasonable reading of this paragraph is that Dr Benaris is specifically relying and only relying on the procurement of the admission. That is the only matter mentioned. She made no reference to anything else being the disclosure, and we note specifically did not identify the S1 notes that she wrote as part of Patient 3's admission being a disclosure. There is no reasonable basis in our view to read her claim as being obviously an implied reference to the S1 notes.

368. We consider the agreed list of issues also supports this interpretation. The agreed list identified **PD7** as

> *The procurement of Patient 3's admission*

and nothing more.

369. We considered the recent case of **Moustache v Chelsea and Westminster Hospitals NHS Trust [2025] EWCA Civ 185** is informative here. These are adversarial proceedings. The case is determined from an objective reading of the claim and response. We are not required to look for what the claim could or ought to be if e.g. we were presenting it. Where there is an agreed list of issues, we are usually entitled to confine our attention to that list. We note there is no application to amend the claim. There was no application to amend the list of issues or suggestion it does not capture the claim.

370. Objectively reading the claim as pleaded, it matches the list of issues. Both leads us to conclude that, objectively, Dr Benaris's case before the Tribunal is that the procurement of the admission alone is the protected disclosure. She has never pleaded that the S1 notes or any other matter associated with the procurement of admission are protected disclosures. It follows that the respondent is right and the claimant is not: We must focus only on the procurement of admission alone and not the other matters such the S1 notes being disclosures.

Does the admission of Patient 3 amount to the disclosure of information?

371. There is no dispute that Dr Benaris procured the admission of Patient 3, so we move straight to the question of whether that is a disclosure of information.

372. Applying **Kilraine** we do not consider that the procurement of Patient 3's admission can in any sensible way be described as disclosing information. Drawing on the definition in the **Oxford English Dictionary (2009 revised edition)**, we do not consider that is capable of being described as information because it is not the imparting of knowledge, news or opinion. We also considered the words of Sheldon J in **Nicol v World Travel and Tourism Council and others [2024] ICR 893 EAT** support this:

For employers to be fixed with liability, therefore, they ought to know at least something about the substance of [the disclosure that] has been made; that is, they ought to have some knowledge of what the employee is complaining or expressing concerns about.

Procuring the admission of Patient 3 is an act that is not a communication of information because it does not impart knowledge, news, opinion. It says nothing about the substance of any information Dr Benaris is wanting to communicate. Even if we ignore that, we consider the only information one can reasonably deduce from Patient 3' admission is that Dr Benaris believed he should be admitted. The admission does not convey why, or any other concerns. Procuring Patient 3's admission says nothing about them because the act of procuring his admission does not have any factual content that is capable of tending to show any relevant failure.

Conclusion

373. **PD7** was not a disclosure of information or, if in fact it were, it was not information that tended to show one of the relevant failures. Therefore, to the extent any claim relies on **PD7**, it must fail.

Detriments

374. We have come to the following conclusions on whether or not the respondent subjected the claimant to the following detriments.

Detriment 2: *Subjected her to intense pressure to move from the ward*

375. We conclude there is no evidence that anyone pressured, yet alone intensely pressured Dr Benaris to move from the Beaumont Ward. We refer to our findings of fact above for the following.

375.1. The emails of 29 January 2021 from Dr Aria were motived by a genuine concern for her welfare (see 98 above ff)

375.2. Dr Benaris was reporting feeling stretched. Her own conduct above is consistent with her welfare being affected by work. Particularly her abrupt manner was consistent with her being stressed (see 136 above). The ward was high pressure. It is inherently plausible it would cause stress. It is inherently plausible to consider moving her as a welfare move.

375.3. Dr Naik's email of 29 April 2021 was purely an attempt to promote her welfare (see 144 above).

375.4. It is not possible to read any of these emails as being pressure, yet alone undue pressure.

375.5. We note that during the investigation she did move from the ward. We cannot see any evidence this could be described as intense pressure. Dr Hiremath was merely making a reasonable statement of fact when he said he implied suspension may happen at the meeting on 17 August 2021 (see 246 above ff). We think the most significant factor that shows this was not intense pressure from the respondent though was that her own advisors suggested she should move from the ward for the investigation in a way that cannot be sensibly described as pressure (see 244 above).

375.6. Drawing it together we see no evidence that shows there was intense pressure on her to move from the ward. Therefore, we find there was no detriment 2.

375.7. For the avoidance of doubt, nothing in the evidence, yet alone the findings of fact, begins to persuade us that there was some sort of manipulation of circumstances to amount to pressure for her to move.

376. Therefore, we conclude that the Trust did not subject Dr Benaris to intense pressure to move from the ward.

Detriment 3: *Increased hostility by staff and/or patients, and in particular Srinivas Naik and others who had been instigated by Srinivas Naik*

377. We conclude is not made out. Our reasons are as follows.

377.1. Nowhere in her claim does she provide any particulars of what she says are increased hostility by staff or patients or by others

instigated by Dr Naik. That lack of early clarity undermines her credibility in our view.

377.2. The facts show this was a toxic workplace with tensions and confrontations drawn across many fronts.

377.3. We note that some staff (particularly Ms Puckey) complained about Dr Benaris. We can detect no evidence that they were doing nothing more than making what they perceived to be legitimate complaints.

378. We can detect nothing to show or even hint that Dr Naik was motivating or driving any of these complaints or interactions. It seems the allegation is based on no more than Dr Benaris's personal, adverse views about him.

379. The only patient who is cited in evidence who might be described as showing hostility is the patient cited in an email about 21 May 2021 by Dr Benaris (see 158 above). We note this is a report via Dr Benaris who has not demonstrated herself to be a reliable witness. We note also the suggestion is that it is Ms Puckey – not Dr Naik – who caused the patient to express this view. We do not consider this shows that there was an increase in hostility from patients.

379.1. The allegation does not reflect Dr Benaris's own attitude and behaviour. The following are in our view the key examples.

379.1.1. She adopted a position of not working one-to-one with Ms Puckey and declined to apologise because she had done nothing wrong even though she acknowledged she could be abrupt (see 118 above).

379.1.2. She was uncooperative in relation the questions asked about Patient 3's admission, did not cooperate with Ms Falope and was motivated by her hostile animus to Dr Naik (see especially 201 above ff). She has not reflected on her own behaviour.

379.1.3. She did not have any reflection on her own behaviour e.g. in the meeting with Dr Acovski.

379.1.4. Evidence of her own conduct is reflected in what she told Ms Pugh: if she did not ask people to do things in a nice way, they did not do it (see 161 above).

379.2. Considering the totality of the facts and evidence put before us, it shows a hostile working place. It shows a divide between her Dr Niak, and her and the nurses (there are many other divides as we have set out). In our view they do not prove any behaviour that can be labelled like this alleged detriment.

380. Therefore, we conclude there was no increased hostility as alleged.

Detriment 4: *Subjected to malicious and unfounded allegations. The "malicious and unfounded allegations" were: a comment that she had said that "nurses lowered their standards"; an allegation the claimant had "shouted" at bed management; an allegation that the claimant had used clinical notes to criticise other professionals; and*

an allegation that the S1 entries for Patient 3 had been used to criticise other professionals.

381. We deal with the first allegation about saying nurses had lowered their standards. As we found above (see 175 above ff), Dr Benaris did say this. It cannot be described as malicious or unfounded.

382. We turn to the second issue. We do not have direct evidence from Mr Sibanda that he was shouted at. Therefore, on the balance of probabilities we conclude Dr Benaris did not shout at him. The question is whether Dr Naik's allegation that she did was "malicious and unfounded". Having considered the evidence, we conclude it was not "malicious and unfounded". On the evidence we can see nothing to support Dr Naik's allegation so it was unfounded. However, we do not consider it was malicious. We need to look at the context in which it was said, which was in a complaint about Dr Benaris undermining him. He was angry and frustrated with her at this point. She had been abrupt with Ms Falope and Mr Sibanda when each had expressed concerns about the admission of Patient 3. He knew about the circumstances surrounding the admission of Patient 3. We conclude that it was infelicitous language but written with an honest belief in its truth. We do not find it to be "malicious and unfounded".

383. Professor Ghosh expressly found that*, there are examples within her documentation that makes attempts at trying to malign colleagues without explicitly doing so — these were highlighted in my conversation with her* (see 229 above). We also note that earlier email exchanges had been copied onto the earlier S1 notes (see 159 above). In the circumstances we cannot see that these allegations can be described as "malicious and unfounded".

384. Therefore detriment 4 is not made out. There were no malicious and unfounded allegations as alleged.

Detriment 5: *The instigation of a disciplinary process (PD1-7 but particularly 6-7 inclusive)*

385. As we found above, the MHPS process is separate and distinct from any disciplinary process (see 48 above). Part I is purely an investigation. It may disclose matters that lead to a disciplinary process and if that happens it makes clear the respondent must follow its own disciplinary process. It also posits that it might trigger a capability process or possibly no action involving the medical professional as such but rather a wider change in procedures. It is separate and distinct. This is the respondent's position. We agree with it. We cannot accept Dr Benaris's attempt to characterise it as a disciplinary process. It runs contrary to the words of the policy and its purpose which is clearly expressed to gather information and then decide what route to follow.

386. While the Trust started the MHPS process, it never invoked a disciplinary process against her. Therefore, the claimant was never subject to a disciplinary process. This allegation must therefore fail.

387. We note under detriment 7, as an aside, the claimant herself calls it the investigation processes and makes no reference to a disciplinary process.

This in our view shows even Dr Benaris did not consider that there had been a disciplinary process.

388. This detriment is not made out. There was no disciplinary process.

Detriment 6: *Relocation from the Bradgate Unit (PD1-7 but particularly 6-7 inclusive)*

389. We do not see any rational basis on the evidence presented to us to conclude that could be a detriment in principle. There is no evidence for example that it is work that provides less opportunity for challenge, promotion or is seen as less prestigious. There is no evidence that it would harm her career to move from the Unit. There is no evidence that her moving from the Unit had some detrimental impact on her personally. We see no evidence from example that it decreased her chance to practise, to deal with challenging cases, or it denied her a change to progress her career or it harmed her reputation in any way.

390. Her various managers were concerned about her welfare. Moreover, as we noted, her own advisors advised her that she should move (see 242 above ff). She accepted this advice. Therefore, we find as a fact she agreed to the move – it was not something forced on her.

391. She was relocated therefore but not against her will. Therefore, there was no detriment because a reasonable employee would not call a move they agreed to on advice from their own representatives a disadvantage in the circumstances of this case.

Detriment 7: *Ongoing suspension from on-call work, including once the investigation processes had concluded*

392. We refer to our findings of facts at 308 above ff. Therefore, there was no detriment. We draw from those the following that led us to conclude there was no detriment.

392.1. She did not object to be being removed from the rota (see 217 above ff).

392.2. She did not raise any complaint about not returning to the rota until 7 October 2022. We infer that her continued removal was not an issue for Dr Benaris until about this time.

392.3. On 17 November 2022, we find as a fact from her own appraisal that she knew that the Trust was happy for her to return to the on-call rota, and she was happy to do so. We come to this conclusion based on what she wrote in her appraisal (see 310 above).

392.4. There was no obstruction to her returning to the on-call rota. She completed her appraisal by 30 November 2022. On 7 December 2022, Mr Powell confirmed he had taken steps to ensure she could return to it (see 310 above ff). We find this was genuine and reasonably prompt action on the Trust's part and we find as a fact that the emails from Dr Rao on 3 February 2023 (see 323 above) and Dr Muhammad of 12 February 2023 (see 324 above) demonstrate a clear willingness to have her back on the on-call

rota. We also consider the emails from Ms Willis do not suggest that there was any desire to frustrate her return (see 315 above).

393. Rather we conclude the obstruction to Dr Benaris returning to the on-call rota was herself. We found as a fact (see 321 above) the emails that she sent to Ms Willis on 29 December 2022 and 19 January 2023 were Dr Benaris's attempt to reopen matters. Considering the totality of the correspondence and chronology, we draw the conclusion that there was no ongoing suspension that could be described as a detriment. The reason she was not back on the on-call rota was her own decision not to add herself back but instead to seek to reopen matters. We concluded it was because she was contemplating this claim at the very least, but it does not matter why she reopened matters. The key point is she was her own obstacle to returning to the rota.

394. In summary she did not object to the initial suspension. This persuades us that she did not see it as a detriment. The reason for a delay in restoration was because of her own actions. This is not a detriment but her own choice. Therefore, there was no detriment as alleged.

Detriment 8: *Teaching responsibilities were removed, and she was removed as a Clinical Supervisor and Educational Supervisor*

395. We found as a fact this did not happen (see 307 above).

Detriment 9: *Delay in the resolution of the whistleblowing complaints*

396. We refer to the totality of the case above. We are in danger of repeating ourselves too often but it shows serious concerns about how Patient 3 came to be admitted, an allegation that the admission was undermining of a fellow consultant, consultants themselves complaining at the time of the admission of Patient 3 about the issues in the workplace, division between nurses and consultants and within consultants and allegations and counter-allegations.

397. We have dealt with the Rathore-Crossley report but we cannot do justice to reflect how detailed and complex a report it was and the work that went into it. They carried out a detailed, thorough investigation. Mr Powell properly asked them for clarification and they, properly, provided answers. We also note that there were other matters (cross-complaints) that are intwined.

398. As we noted above, the report is detailed and we found it was completed in a reasonable amount of time.

399. So far as other protected disclosures are concerned, we conclude that in the circumstances there cannot be said to be a delay to their resolution. We note the claimant's focus was on disclosures 6 and 7 principally and there is no basis to suggest resolution of the others was delayed.

400. But for one matter, below, we conclude that no reasonable employee could consider there to be a disadvantage in the circumstances. To that extent we dismiss this allegation.

401. We however have a different view on one specific matter. Dr Benaris made protected disclosure 6 on 11 July 2021. Nothing appeared to happen until about 11 November 2021 to investigate it (see 261 above ff and 267 above

ff). It required the intervention of the BMA and MPS to get any progress. There is no explanation for the delay. At the same time the Trust did not appear to be struggling to progress other investigations and complaints. We consider a reasonable employee would be aggrieved and consider it a disadvantage. We therefore conclude, to this limited extent only, that the Trust subjected the claimant to detriment 9.

Detriment 10: *Inadequate resolution of the whistleblowing complaints including the failure to consult with Dr Benaris during this process and to provide an unredacted whistleblowing report*

402. We conclude that the did not Trust subjected Dr Benaris to this detriment. We repeat our earlier comments about the Rathore-Crossley report. We repeat our observations about the thoroughness of the Pugh investigation. We conclude the SI review was an adequate resolution.

403. We note that Dr Benaris was interviewed in lengthy interviews for the Rathore-Crossley report and the Pugh Investigation. We note she attended the quality summits and was involved in them. Neither the non-legal members nor the Judge can see why she ought to be involved any more or "consulted". It is not clear still to us what, rationally, she avers she should have been consulted about. We can see no reason that she should have been involved in the investigation more widely than she was.

404. We conclude that there is no detriment from not being provided with an unredacted copy of the reports. Mr Powell fed back to Dr Benaris the outcome of the reports (see 299 above). As we found above, it was not appropriate to provide unredacted copies. The policy does not require it. She did not need them to understand the outcome. They referred to others and confidentiality is important so people feel able to complain and speak freely (see 301 above).

405. There was no inadequate resolution as described. This detriment is not made out.

Detriment 11: *Reaching irrational conclusions in the disciplinary process*

406. As we set out above, there was no disciplinary process (see 385 above). In any event we have not seen any conclusions in the report that could be described as irrational. This is not made out.

Detriment 12: *Failure to respond to Dr Benaris's communications seeking a sustainable return to on-call work and to implement a plan for a return to the on-call rota*

407. We repeat our answer to detriment 7. The facts show there were responses. The claimant did not raise an issue about a sustainable return, but rather sought to re-open everything that had been brought to an end by the investigations. Therefore, we conclude she was not subjected to this detriment.

Detriment 13: *Dr Benaris's grievance and complaint regarding bullying were not taken seriously and witnesses who could corroborate her complaint were not questioned*

408. This detriment is not made out. As we set out above (276 above ff), the investigations were thorough and every relevant person was interviewed.

The reports were well reasoned and cross-referenced to the evidence. The allegation that her complaint and grievance were not taken seriously is divorced from reality and clearly incorrect.

Detriment 15: *Dr Naik and Ms Falope raising allegations against Dr Benaris which Dr Benaris asserts was in retaliation to her having raised protected disclosures*

409. There is no evidence beyond the bare allegation that their grievances and allegations were purely retaliatory and did not reflect genuine concerns. We refer to the findings of fact above for full detail. We conclude that the facts show that any grievance was based on the honest and reasonable belief of the parties. This detriment is not made out.

Conclusions on detriments

410. Except for the delay between 16 July and 11 November in relation to investigating protected disclosure 6, none of the detriments are made out.

Detriments because of protected disclosures

411. We focus first on the detriment that was made out. We found as a fact that Dr Hiremath was not motivated in this delay by the fact she had made a protected disclosure (see 267 above especially 271 above). Therefore, she was not subjected to this detriment for making protected disclosures.

412. Had we to consider the other alleged detriments, we too would have concluded they had no connection to the protected disclosures. There is no evidence beyond assertion that the making of the disclosure was prima facie the cause of anything that might be described as a detriment. The workplace was clearly dysfunctional and toxic. She disregarded procedures and contributed to that toxic workplace. The disclosures are merely part of the background but in no way causative.

Time limit in relation to the detriment claims

413. There are no detriments but for one relating to the delay.

414. Only one actually happened – the delay from 16 July to 11 November 2021 dealing with protected disclosure 6. The rest did not happen. We consider that means, strictly, it cannot be said sensibly that they form part of a series of similar acts or failures. Therefore, each must be considered separately.

    414.1. Claims founded on detriments 2, 3, 4, 5, 6, 7, 9, 10, 11, 13 and 14 were all presented more than 3 months after the alleged detriment, allowing for any extension in time under the early conciliation procedure. Because the claimant concedes they could have been presented in time, we dismiss the claims founded on those detriments for a lack of jurisdiction. If we had to decide them on the merits, they would have failed in any event.

    414.2. Detriment 8 is in time. It fails however on the merits. It is therefore dismissed.

Constructive unfair dismissal

What was most recent act (or omission) that triggered or caused the employee to resign?

415. We found as a fact that Dr Benaris had already decided to resign by the time she wrote the email of 29 December 2022. The final straw therefore is not Ms Willis's email as she alleged. We are unable to say from the evidence when she decided to resign. She has not proven to us what was the final straw. Therefore, we cannot make a conclusion that the respondent did something, however innocuous, that caused her to resign. We conclude this is enough to cause the claim to fail.

Has the employee affirmed the contract since that act?

If no, was the act or omission itself a repudiatory breach?

If no, was it part of a course of conduct which taken together amount to breach of implied term of trust and confidence?

If yes to either of the preceding questions, did the employee resign in response to that breach?

416. We cannot sensibly comment on these issues because we do not know what the act or omission was.

417. However, we have considered what our conclusion would have been if Ms Willis's final email were the final straw. Dr Benaris accepts it is not itself a fundament breach of the implied term. She relies on the detriments. None of them however has been proven with the exception of the delay to dealing with protected disclosure 6.

418. We do not consider that that detriment and Ms Willis's email could be described as together amounting to a fundamental breach of contract. We note the passage of time between the two that is bound to lessen the impact. But even so, the simple fact is that, taken at their highest neither the non-legal members drawing on their experience in the workplace nor the Judge think it passes the high threshold to be capable of being labelled a fundamental breach of contract.

419. As an aside, we do not consider there was any delay resigning that could amount to affirmation. In the circumstances of her job and need to arrange for the handover of vulnerable patients, none of the conduct could be described as affirmation.

Final observations

420. The above is enough to dispose of the claim. We make the following brief comment. If it had been needed, we would have positively found that protected disclosures had nothing to do with the claimant's resignation. We do not consider there is any evidence that shows a connection between the two.

Approved by the Judge

Employment Judge Adkinson

Date: 22 August 2025

JUDGMENT SENT TO THE PARTIES ON

.....29 August 2025.....

.....

FOR THE TRIBUNAL OFFICE

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