EMPLOYMENT TRIBUNALS

Claimant: Ms SR Idu

Respondent: The Ipswich Hospitals NHS Trust

HEARD AT: BURY ST EDMUNDS ET

ON: 15th – 26th May 2017
5th – 6th June 2017 (Discussion days)

BEFORE: Employment Judge G P Sigsworth

MEMBERS: Ms L Daniels and Ms M Lee

REPRESENTATION

For the Claimant: In Person

For the Respondent: Mr S Cheetham, Counsel.

RESERVED JUDGMENT

The unanimous Judgment of the Tribunal is that:

1. The Claimant was not unfairly dismissed by the Respondent, either for making protected disclosures or at all.

2. The Respondent did not unlawfully discriminate against the Claimant because of her sex.

3. The Respondent did not unlawfully indirectly discriminate against the Claimant related to her nationality.

4. The Respondent did not unlawfully subject the Claimant to any detriment on the ground that she had made protected disclosures.

5. The Respondent did not wrongfully dismiss the Claimant.

6. The Respondent did not make unlawful deductions from the Claimant's wages.

RESERVED REASONS

1. The claims brought to this Tribunal by the Claimant are as follows:-

   (1) Ordinary unfair dismissal.
   (2) Automatic unfair dismissal for making protected disclosures.
   (3) Detriment for making protected disclosures.
   (4) Direct sex discrimination.
   (5) Indirect race discrimination.
   (6) Wrongful dismissal/breach of contract (notice pay).
   (7) Unlawful deductions from wages.

2. The Respondent does not pursue time points, in effect conceding that the Claimant is entitled to rely on the concept of a continuing act. The Claimant's unfair dismissal claim is in any event brought in time. There is an agreed list of issues, annexed to this decision, which gives the detail of the claims.

3. The Claimant relies on no less than 32 protected disclosures, and these are set out in the list of issues. The Respondent concedes that 13 of the pleaded disclosures are capable in law of being protected. We have found that a further 6 disclosures are made out as protected (see below). So, the issue for us is whether those 19 protected disclosures – individually or cumulatively – were causally related in the way set out in the legislation to the detriments the Claimant says she suffered and/or to her dismissal. Her dismissal is admitted by the Respondent and the reason given for it is conduct – a potentially fair reason. In the alternative, the Respondent gives the reason for dismissal as some other substantial reason – in this case a substantial breakdown in the relationship between the Claimant and the Respondent, that breakdown being irredeemable such that the Claimant's ongoing employment was untenable (on the Respondent's case). The Claimant was summarily dismissed without notice or pay in lieu of notice, and claims wrongful dismissal and notice pay. The Claimant also claims direct sex discrimination, and has six specific allegations here, identified in the list of issues. The Claimant also has a claim for indirect race discrimination, which is based on the tone of her communications, and is set out in some detail in the list of issues. Finally, in respect of her wages claim, there are two complaints. First, that she was not paid salary commensurate with her nine years seniority and was in effect on the

wrong point of the scale. Second, that she was not paid the appropriate on call availability supplement, which should have been 5% or perhaps 8%, but not 3%. This second wages claim overlaps with one of her sex discrimination complaints.

4. We heard the liability case only over some 8 days of evidence and submissions. We heard oral evidence from the Claimant alone on her own behalf. There were nine witnesses called for the Respondent. These were Dr Barbara Buckley, at the material time medical director of the Trust; Mr Mark Bowditch, consultant orthopedic surgeon and divisional clinical director for division 2; Ms Clare Adams, head of medical staffing; Dr Mark Garfield, consultant anaesthetist and clinical lead for theatres, anaesthetics and critical care; Mr Robert Power, at the material time deputy head of operations for the surgical division; Mr Paul Fenton, director of estates and facilities who heard the Claimant's grievance; Ms Hanne Ness, senior divisional HR business partner; Dr Simon Smith, consultant radiologist and associate medical director who chaired the panel hearing the Claimant's disciplinary hearing; and Mrs Lisa Nobes, director of nursing, who heard the Claimant's appeal against her grievance outcome and against her dismissal, being chair of that panel. There was a sizable bundle of documents, largely agreed but with some complaint from the Claimant that not all documents that she wished to be in the bundle were in the bundle. The bundle ran to some 2860 pages. Other documents were handed to us by the parties as the hearing progressed. At the end of the evidence, Respondent's Counsel provided written submissions and referred to some authorities. Both he and the Claimant made oral submissions. The Tribunal's decision was reserved.

Findings of Fact

5. The Tribunal made the following relevant findings of fact:-

   (1) The Claimant is a Dutch national and English is not her first language. However, her English, both written and spoken, is extremely good and she is fluent in the language. She began her employment with the Respondent Trust as a full time locum consultant in upper gastro-intestinal surgery on 7th January 2014, at the Ipswich Hospital. From 1st September 2014, the Claimant was employed as a permanent full time consultant in emergency surgery, and remained such until the termination of her employment (summary dismissal for alleged gross misconduct) on 10th May 2016. The role of emergency consultant was a new one for the Ipswich Hospital. There were two emergency consultants, the Claimant and Mr Farhed Youssef, the Claimant being appointed second in time. There is substantial dispute between the parties over whether the Claimant was appointed as 'Clinical Lead'. We find that there was lack of clarity in the evidence on this point. The Claimant says she was the Clinical Lead, but the Respondent says it was Mr Youssef. There is no letter of appointment or similar of either of them as Clinical Lead. The Claimant's contract of

employment does not refer to her being appointed as Clinical Lead. Mr Bowditch told us that there was a formal process for the appointment of the more senior grade of 'Clinical Delivery Lead', such as for Mr Isam Osman, the Claimant's line manager. However, for a sub group lead such as that of leading the emergency surgeons' service, the appointment is often made by nomination rather than after interview, etc. As the only emergency surgeon when he was appointed, Mr Youssef was asked by Mr Bowditch if he would be that lead. Although a locum consultant, there was no reason why he should not be appointed as Clinical Lead, and there were other locum consultants who were Clinical Leads. The more formal process for Clinical Delivery Leads is partly because additional payments are associated with that role. We find that Mr Youssef was in fact a substantive consultant, but he was not listed on the hospital website as an emergency surgeon, rather as a vascular and laparoscopic surgeon. We heard evidence, which we accept, that the hospital website had on it other hospital publications such as the internal medical list and press releases of various sorts which were not necessarily accurate, and were influenced by input from the surgeons or other doctors who were being referred to. It was certainly the case with the Claimant, who herself fed the information to the administration for the internal directory and for the press report, saying to them that she was the Clinical Lead. The Claimant and Mr Youssef held themselves out at different times as being the Clinical Lead. Until February 2015, Mr Omar was Clinical Lead in colo-rectal surgery and Mr Osman, Clinical Lead in vascular, took over as the Claimant's line manager. The advertisement for emergency consultant surgeon, to which the Claimant responded, went through various iterations, but nowhere did it say that the post holder would be Clinical Lead of the emergency surgical service. The most that was said was that the successful post holder would 'lead' (with a small 'l') in the delivery of the emergency surgical service. The Respondent told us, and we accept, that all consultants are expected to take a lead in the delivery of the service. That does not mean that they are the 'Clinical Lead'. So far as the 'Medical Director's Newsletter' is concerned, in which the Claimant is described as 'Emergency Surgery Clinical Lead', Dr Buckley told us that she did not proof read it fully and missed that particular reference.

(2) The Claimant began to use the title 'Emergency Surgery Clinical Lead' in all her emails, and there are many of these. She was asked not to do so informally on a number of occasions. On 30th December 2014, Ms Vicky Decroo, head of operations, emailed the Claimant saying that Mr Bowditch had spoken to Dr Buckley and Nick Hulme (CEO) who were both on the panel that confirmed the Claimant's post and neither had confirmed that the offer included the role of Clinical Lead for the Emergency Unit. Mr Bowditch had explained to Ms Decroo that this role was currently being undertaken by Mr Youssef and, although in future

this would revolve between the two surgeons in post, at present it still sat with Mr Youssef. Despite this instruction, the Claimant continued to use the title. On 13th July 2015, Dr Buckley wrote to the Claimant explicitly saying that the Respondent had not appointed the Claimant to the role of Clinical Lead and she had not been subsequently appointed to the role either. Dr Buckley told the Claimant to refrain from using the title and that Mr Youssef was appointed as the Clinical Lead and continued to undertake that role. It was pointed out that the advertisement and job description of the post referred to 'leading the service' which is not the same, as all consultants have a leadership role in their capacity as senior clinicians. Despite this clear instruction from Dr Buckley, the Claimant continued to refer to herself as Emergency Surgery Clinical Lead on her emails, right until the end of her employment.

(3) By the end of March 2015, Mr Osman and Mr Power had reached a complete impasse with the Claimant when it came to job planning. The Claimant was of the view that her job plan should be as set out in her original job description, apparently agreed with Mr Omar, despite the fact that the Respondent believed that this did not meet the needs of the service and that it was a requirement that she agree her job plan with Mr Osman three months into her post. The Claimant did not appear to understand that, as an emergency surgeon, she was not assigned fixed lists. Albeit reluctantly, Mr Osman agreed that the Claimant would not have to work on a Monday (other consultants had one day week set aside for private practice). However, even consultants undertaking private practice needed to be available if required by the Trust in the event of an emergency. Further, the whole point of the emergency surgeons was that they would pick up the drop lists of other consultants, so that if the Claimant was out of the Trust on a Monday this limited her ability to pick up those lists. To try and make progress and reach a conclusion of the issue, the Respondent agreed that the Claimant could have a fixed clinic on Thursday and SPA time on a Friday afternoon in her cold week. Mr Bowditch told us that, because Mr Youssef was also not picking up dropped clinics and lists, the combined effect of him and the Claimant not doing so was having a detrimental impact on the function of the department and the delivery of the service. Mr Bowditch addressed his concerns with Mr Youssef face to face and he agreed to rectify the position going forward. However, the Claimant was not prepared to discuss that matter with Mr Bowditch. She refused his requests to meet, and Mr Bowditch found her somewhat confrontational and dismissive. When Mr Smith and his panel at the disciplinary hearing looked at this matter, on the basis of the evidence obtained in the Mack investigation (see below), he found that documentation bore out the evidence of Mr Osman and Mr Power that they had made numerous attempts to work with the Claimant to agree a job plan. We note a letter from Mr Osman to the Claimant dated 16th October 2015, referring to a meeting on 19th May 2015. A plan

had been discussed at which the Claimant was not required to work on a Monday during a cold week, that she would be given 6 weeks' notice of dates of clinics and theatre lists during her cold week, that she would be allocated sessions when they became vacant, and that the role of the emergency surgeon in their cold week was to have 4-5 SPA sessions allocated on a flexible basis. Despite being asked to review the job plan and confirm it was acceptable, the Claimant did not make contact with Mr Osman. The administration informed Mr Osman that the Claimant had declined to undertake clinics or theatre lists during her fixed SPA sessions every Tuesday morning and fixed ward round on Thursday morning, and that on three recent occasions when, despite providing her with 6 weeks notice, she had declined to undertake sessions, which lead to reduced clinical activity in line with the job plan that she was currently being remunerated against. Mr Osman spoke of an urgent job planning review, and the need to recommence the job planning process, in the light of the Claimant's failure towards working with what was thought to be the existing plan. Thus, the Claimant appeared not to be undertaking theatre slots that she should have been undertaking in order to fulfill her contracted hours, and felt justified in refusing to do so because of alleged poor resourcing of theatre support. Mr Smith's panel found that there was no evidence of under-resourcing, and in any event it was their view that this did not justify the Claimant declining slots. It is clear that the Claimant never agreed with the Respondent a job plan and there continued to be disagreement about it up until the date of her first exclusion on 27th November 2015. It would seem that the Claimant was still adhering to her original job description or job plan, and was reminded by Mr Power that those timetables were indicative of the work required but not rigid and could be flexible depending on service needs. Mr Power noted in an email of 24th November to the Claimant that she refused to undertake various sessions in the week commencing 9th November which resulted in her only having one outpatient clinic for the whole week. Dr Smith and his panel heard that there was evidence that the Claimant had failed to come onto site when requested to deliver care during her SPA time. This is time which a doctor devotes to professional development, research or other non-clinical activities, but there is a contractual requirement for the doctor to attend at the hospital when needed. On one occasion, Mr Power and Mr Osman called the Claimant on a Tuesday morning, time ordinarily designated in the Claimant's timetable for SPA, and got an international dialing tone. According to Dr Smith, the Claimant had apparently replied to say that she was available for doctors but not Mr Power.

(4) The Claimant had a big issue with those she called 'fake consultants'. By this she meant locum consultants who were not on the specialist register but who continued to work for the hospital after their original six or twelve months fixed term contract had expired. Dr Buckley told us that there is a regulated process for the

appointment of consultants. Locums cover a post when the process of the substantive appointments is being made. They have appropriate training and experience and are appointed on a 6 or 12 months contract. Dr Buckley said that it can be very difficult to appoint to substantive posts, and so it was not unusual for locum consultants to stay on beyond a year, not always being re-interviewed. However, Dr Buckley stressed that the important point was that these consultants had the appropriate training and experience and that they were not 'fake' consultants. The GMC have a register, but a surgeon did not have to be on this specialist register if they were a locum consultant. A surgeon has to be on the specialist register if they were a substantive consultant or within 6 months of such appointment. It is often the case that locum consultants are trained in a country where they do not have the certificate of specialist training, but they have the equivalent expertise and training. Trusts check internally, to see if their overseas doctors have an equivalent level of training, through their CV, log book, appraisals and so on. Another issue that the Claimant had was that clinics were organised under consultant names and patients allocated to specific consultants, even if the consultant was not there and somebody else took the clinic. Dr Buckley felt that this was administrative issue and that the registrar or whoever was seeing the patient always introduced themselves to the patient. Dr Buckley told us that Mr Dikki was a good example of a locum consultant not on a specialist register. He was an experienced doctor and had worked for the Trust for a considerable period of time. Dr Buckley had absolute confidence in him. He could not be appointed as a substantive consultant because he was not on the specialist register. In an ideal world this would not happen, but it was not illegal to employ locum consultants in this way. Dr Buckley told us that she felt that there was no risk to patient safety because such consultants would not have been appointed to the role in the first place if they had not had the necessary training and experience. Mr Dikki was supported by references for work at other hospitals, and he was subjected to the same training and review as other, substantive, consultants. Dr Buckley told us that she accepted that the Respondent had not gone through the AAC process every time to the letter, and that HR processes had therefore been changed. We were taken to NHS Practice Guidance on the Implementation of the Appointment of Consultants Regulations. The Royal College of Surgeons are aware that not all locum consultant surgeons appointed are on the specialist register or are within six months of obtaining their certificate of completion of training. The College will expect this practice to be phased out and that for the surgeons concerned they would seek to obtain a CCT or certificate of eligibility to the specialist register, and for their colleagues to support them in this. The College also said in their guidance that locum surgeons should be appointed for no more than six months initially, with a possibility of a six month extension leading to a maximum appointment of

twelve months. A locum consultant who is not on the specialist register should be supervised by a named consultant. Locum surgeons are expected to practice to the same standards as all other surgeons.

(5) The Claimant's revalidation was deferred on a number of occasions. Revalidation is an external process, set out and managed by the GMC, through which all licenced doctors are required to demonstrate that they are up to date and fit to practice in their chosen field and able to provide a good level of care. Licenced doctors have to re-validate, usually every 5 years, and demonstrate that they have had an annual appraisal carried out by their employer which has demonstrated that they have met the standards and expectations set by the GMC. The Trust has a responsible officer (RO) who is usually the medical director who is required to make a recommendation to the GMC about the re-validation of each and every doctor employed by the Trust. The appraisals must be completed within six months of the revalidation date, and be quality checked by one of the Trust's associate medical directors. Shortly after the Claimant came into her locum post in April 2014 she was due to re-validate with the GMC. However, she had not had an appraisal at her previous post at Kings College Hospital and had only been working in the UK for two years. Dr Buckley was simply not in a position at that time to make a recommendation about the fitness to practice of a doctor of whom the Trust had so little first hand experience and for whom they had no evidence of assessment against the GMC standards. In April 2014, the GMC re-validation team advised that a deferral for about a year would be advisable in order for the Claimant and the Respondent to gather sufficient information to make a positive recommendation. While the re-validation is deferred, the doctor in question retains their licence and is able to practice freely. The act of deferral is simply that the deadline for re-validation is put back. Following the recommendation for the Claimant's deferral her new re-validation date was for April 2015. On 18th July 2014, the Claimant had an appraisal with Miss Marx (AMD). On 6th February 2015, the Claimant wrote to Dr Buckley asking her to lodge a recommendation for her re-validation with the GMC. She said that she had completed her appraisal and added all her recent activities. However, Dr Buckley did not want to put in the recommendation for re-validation at that point because if she did it too early in advance of the deadline it would only serve to bring the doctor's next re-validation date forward in 5 years time, creating further work before it was due. Dr Buckley informed the Claimant of this. The process of the Claimant's re-validation began in early March 2015. However, it came to the notice of the Trust that the July 2014 appraisal was out of date, in that it was when the Claimant was a locum consultant. The Trust now needed an appraisal, or at least an update to her existing one, to reflect her new role as a substantive consultant. This needed to be done

before Dr Buckley could recommend the Claimant for re-validation. However, the July 2014 appraisal was outside the 6 month window period before the re-validation. Dr Buckley asked the Claimant to meet with Miss Marx on 16th March 2015 for an appraisal so that they could still meet the deadline. The Claimant declined to do so, and Dr Buckley felt that she had no choice but to further defer the re-validation for 6 months. There was no suitable appraisal on which the recommendation to the GMC could be based. Ultimately, the Claimant had a second appraisal with Dr Martin Mansfield on 2nd June 2015. However, by this time a GP had made a complaint about the Claimant. It is a requirement that a doctor undergoing appraisal must take on board such a complaint and show that they have reflected on it and learnt from it, and they must make a reference to this in the appraisal itself. There was still plenty of time before the re-validation for the Claimant to do this. However, the Claimant refused to re-open the appraisal in order to reflect on the GP complaint. By this time, also, there had been a bullying and harassment complaint from a junior doctor against the Claimant. The Claimant asked for a new RO as she said that she had lost confidence in Dr Buckley. Mr Hulme, the CEO, agreed it, but NHS England said that there could be no such replacement. Because of these outstanding complaints the re-validation date of 25th October 2015 was missed and the re-validation deferred again.

(6) On 9th March 2015, the Trust received a complaint dated 24th February 2015 from a GP, Dr Bianca Hawkins, of Deben Road Surgery in Ipswich. Dr Hawkins complained about the manner in which the Claimant had handled a call she had made asking for advice for a patient she had seen in the surgery who was suffering from a breast abscess. Dr Hawkins was told by the surgical registrar that the Claimant refused to see any breast patients. Dr Hawkins asked the switchboard to bleep the Claimant and after several minutes was informed that the Claimant declined to take Dr Hawkins' call as she was performing life saving surgery and she would not accept breast patients anyway. Dr Hawkins was surprised that the Claimant had not agreed to call her back when she had finished so that they could agree a management plan, rather than flatly refusing to speak to her or agree for the patient to be sent in. The matter was escalated to Mr Osman and he made arrangements for the patient to be reviewed as soon as possible by the breast surgeons' service. Dr Hawkins complained that the Claimant's behaviour was not professional and not in line with the GMC Good Medical Practice Guidelines. In particular, said Dr Hawkins, the Claimant had not made the care of this patient her first concern and she had not work collaboratively with colleagues such as Dr Hawkins or other team members to improve patient care. The uncooperative behaviour of the Claimant exacerbated the pressure the NHS was under, said Dr Hawkins. It was also an inefficient use of Dr Hawkins' time to make multiple phone calls to the hospital. Rather than co-operate with the investigation that was

then set up to look into this complaint and provide a statement to the investigator, the Claimant took it upon herself to write direct to Dr Hawkins. In that letter, the Claimant purported to give a lengthy explanation of the incident and concluded her letter by saying: "taking into consideration her workload for the day in question she did not get involved in inappropriate breast surgery referrals during clinic working hours." Dr Buckley was shocked when she read this letter and felt that the Claimant's response was rude, unprofessional and lacking in sympathy or tact about the issues that the GP had raised. The Claimant had pointed to alleged failings in the Trust's breast surgery team and in the GP's referral. Dr Buckley would ordinarily have considered this sort of reply as amounting to a serious concern that would require immediate and further investigation and formal management action. However, as the Claimant was new to the Trust, Dr Buckley decided to give her the benefit of the doubt and advised that they would let the issue go, provided the Claimant reflected on the complaint and how it was responded to. Dr Buckley called the GP herself and apologised for the Claimant's response. The complaint was then considered closed.

(7) The second complaint against the Claimant that was received by the Trust was from a registrar, Mr Tuffaha. On 17th June 2015, the Claimant sent an email to Mr Osman, Mr Power, Mr Tuffaha and some 10 other surgeons, in which she stated that Mr Tuffaha was not on time for emergency surgery and a Mr Greensmith had to step in for continuity of care. Mr Tuffaha responded by email to the Claimant, saying that he was 10 minutes late and that he had no control over traffic on his commute to work. The Claimant replied and said that if he was late he needed to sort things out better in the future, and he had not informed the on call team. She said that patient care was at risk as he was not available for the theatre huddle. This exchange of e-mails gave rise to a complaint by Mr Tuffaha about the Claimant, and this was referred by Mr Bowditch for investigation under the Trust's bullying and harassment procedure to Dr Craig Parkinson, clinical lead for medicine and a consultant physician. There was concern by the Respondent about the Claimant's own health, and she was referred to occupational health and seen by an occupational health physician on 31st July 2015. It is recorded by Dr Sanchez, the consultant occupational physician, in his report that the Claimant believed that she had done nothing wrong so far as the investigation of the complaint was concerned. Dr Sanchez could find no evidence that the Claimant was suffering from any physical or mental health condition and he considered her fit for work. Dr Parkinson reported the outcome of his investigation on 5th October 2015. Dr Parkinson found that the allegations of bullying were substantiated, as there was clear evidence that section 3.5 of the bullying and harassment policy had been breached. There was evidence of Mr Tuffaha being insulted (with regard to his

appearance) in email format, memos that were critical of Mr Tuffaha being copied to others who did not need to know, and evidence of Mr Tuffaha being reprimanded in the handover meeting and subsequently in email format that was widely circulated. It seemed to Dr Parkinson that other surgical registrars were also late for duty and so there was a suggestion that Mr Tuffaha was being victimised and receiving unfair treatment. Additionally, he was excluded from training opportunities by the Claimant on 17th June 2015. There was evidence that the Claimant had sought information about Mr Tuffaha's performance in an unacceptable manner from a junior doctor. There was evidence of the circulation of emails that were critical of Mr Tuffaha's performance which had not been substantiated by other members of the surgical consultant team and the CDG Lead. Dr Parkinson acknowledged that Mr Tuffaha had been late for work on two occasions. Dr Parkinson noted an authoritarian approach to communication which stretched to the Claimant's approach to education of juniors. He also noted her unwillingness to engage with the investigation process and an inflexibility to accept the explanation, despite this being repeated both verbally and in writing, and no evidence of reflection on the events that had taken place.

(8) In November 2015, before Mr Bowditch had an opportunity to take Dr Parkinson's findings further, two further specific concerns arose about the Claimant. The first of these was that she refused to provide cover for Lavenham Ward on the day of the junior doctors' strike on 1st December 2015 and then refused to provide a reason for this to Mr Osman. Mr Osman had written to all general surgeons and asked them to provide cover, converting any SPA time into direct clinical care time, but the Claimant had refused on the basis that she had prior commitments, even though Mr Osman was not aware of any such commitments in her timetable. Mr Osman had asked the Claimant to provide further detail of these prior commitments but she had declined to do so. Second, Mr Osman told Mr Bowditch about a concern that the Claimant was listing patients for surgery who had been waiting less than 18 weeks rather than those who had breached or were about to breach the 18 weeks target, without any good medical reason for doing so. The patient tracking list (PTL) is a record kept to ensure that all patients are treated within 18 weeks from their referral to the Trust. The Trust's performance is measured by national bodies, in part by its adherence to the 18 week PTL. Therefore, it was utterly essential, said Mr Bowditch, both for the patients' well being and care as well as the Trust's reputation and standards, that staff ensured that they prioritise those patients who have breached or are about to breach the 18 week PTL. There would have to be a good medical reason why one patient should be taken out of turn and prioritised for treatment without delay. When challenged, the Claimant presented a number of reasons why she considered that her patient should be taken out of turn, but neither Mr Osman nor

Mr Power were satisfied by those explanations. Mr Bowditch detected a pattern of the Claimant refusing to comply with management instructions and communicating wholly inappropriately with managers, juniors, colleagues and peers. His concern was that there was a strong possibility that the Claimant had become unmanageable. He took advice from Mr Hulme, the CEO, and Ms Clare Edmondson, director of HR, and decided that it was necessary to immediately exclude the Claimant under section 4.7 of the MHPS policy. Section 4.7 allows for an immediate time limited exclusion where there has been a breakdown in relationships between a colleague and the rest of the team. Dr Mark Garfield was appointed as case manager through the MHPS procedure for the Claimant's case. Dr Buckley, the medical director, who would normally have been the case manager was not suitable because she was involved in events with the Claimant, such as the re-validation, and might be a subsequent witness. The Claimant's exclusion was reviewed as appropriate every two weeks. Dr Garfield decided to appoint an external investigator to conduct an investigation into the issues with the Claimant that had come to light. To appoint an internal investigator would have meant difficulty getting the investigation completed in a timely manner. At a case conference on 8th December 2015, it was decided that the Claimant could be allowed to return to work but on restricted duties and in particular she should be kept out of the clinical environment in order to minimise any personal interactions. There was valuable work that she could do in terms of clinical audit and she could also continue with her professional development, guideline and policy work. This would only mean limited contact with others. The national clinical assessment service (NCAS), which advises NHS trusts in such situations, agreed with the approach. Mr Bowditch wrote to the Claimant on 11th December 2015, setting out the requirements of the return to work on restricted duties.

(9) The Claimant returned to work on restricted duties in late January 2016, after a period of sick leave and annual leave. There was then an exchange of correspondence with Ms Ness about secretarial support. The Claimant was seeking the same level of such support as she had had when she was undertaking her clinical duties. However, that secretarial support had gone to her replacement. Ms Ness asked her on 3rd February 2016 to answer certain questions about the work with which she required assistance. However, the Claimant declined to answer those questions. The Claimant was asked for details about the reports that she said she drafted, the meetings that she attended, archiving work etc and the amount of time of administrative support required for this. The Claimant did not come back to Ms Ness with answers.

(10) There was a surgical business meeting to be held on 5th February 2016. On 4th February 2016, Mr Osman wrote to the Claimant by email, stating that as part of her restrictions she was

able to attend the governance meetings but this did not include the business meetings. He concluded his letter with this – "therefore I will update you on the discussion following the business meeting tomorrow". In contravention of that instruction, and indeed a written instruction from Dr Garfield which the Claimant did not receive until after the meeting, the Claimant attended the surgical business meeting. She had a different view of what was allowed in terms of her restricted duties. The Claimant said that she was the surgical lead for NELA (an audit process) and business meetings were a part of her non clinical duty. Whatever the position, a decision was taken by Ms Edmondson and Dr Mansfield that the Claimant should be asked to leave the meeting. The Claimant refused to do so, however, and so Ms Adams asked other attendees to go next door leaving the Claimant alone in the room. Some colleagues wondered if this was necessary but nevertheless left the room. There was some concern among the doctors/surgeons present at the meeting about what occurred and who said that they had lost confidence in Mr Osman (we assume they meant to control effectively the Claimant). Following this incident, Dr Garfield took the decision again to exclude immediately the Claimant from the workplace. He met with Dr Mansfield on 12th February 2016 to inform him of this decision, which was followed up in writing. Dr Garfield could not meet the Claimant personally, as he was immobile at home with a broken leg. There was a second reason for the Claimant's immediate exclusion, and that was that, in contravention of the clear instruction from Mr Osman in his email of 4th February 2016 that any patient safety concerns should be raised directly with him, the Claimant had sent an email on 9th February 2016 to three of her consultant colleagues raising issues about the way in which her colleague, Mr Dikki, had handled a surgical case on 2nd February 2016. Dr Garfield felt that the Claimant had made unnecessarily derogatory comments about Mr Dikki and Mr El Khiddir. Dr Garfield was very concerned that the Claimant's behaviour was continuing to have a detrimental effect on the wellbeing of the team and further contributed to the breakdown in working relationships between her, the team and management. He was also generally concerned that she was willfully ignoring management instructions. He had no confidence that she would comply with the terms of her restricted duties.

(11) Dr Garfield decided to appoint a Mr Alan Mack to undertake the investigation. Mr Mack is an experienced HR professional and had undertaken complex investigations for the Trust previously. He was given a number of issues to be investigated, some 11 in total. These included the Claimant's refusal to accept that she was not Clinical Lead for Emergency Surgery, failure to engage with management over the agreement of a job plan, the refusal to provide cover for the Lavenham Ward on the day of the junior doctors' strike, listing patients on the waiting list who had been waiting less than 18 weeks, the tone and style of her written and

verbal communications with colleagues and managers, whether as a result of her behaviour she had become unmanageable, whether relationships between the Claimant and her colleagues and managers had broken down, and the impact of any such breakdown on colleagues and managers and on the service. Mr Mack met with the Claimant on 19th February 2016. The Claimant was not accompanied. The Claimant told Mr Mack that she had emails from Mr Omar confirming that she was appointed Clinical Lead, but she said that they were private and she would refuse to divulge them to Mr Mack. The Claimant admitted that her contract did not state that she would be Clinical Lead. So far as failing to agree the job plan was concerned, she said that she had been discriminated against as she has not been given fixed clinics, and had been underpaid on-call availability supplement. The Claimant said that others were better suited to cover Lavenham Ward on the day of the junior doctors' strike, and it was not mandatory for her to do so. She had 72 patients to manage. She said she was correct in listing patients who were not breaching 18 weeks. The Trust had made mistakes and she had urgent patients. She said that her secretaries could not work together. She said that the criticism over the tone of her emails was because English was not her first language, but when asked why she had sent the email concerning Mr Tuffaha widely, she said it was to the emergency surgery group and that it should be an open culture of safety and it was not name and shame. She was less than complimentary about the skills of Mr Osman, questioning whether he had enough experience in general/emergency surgery. When asked by Mr Mack if she thought there had been any relationship breakdown between her and her colleagues she replied; "No. Some colleagues could be better but they are working on it." Mr Mack interviewed a number of other people. These were Mr Bowditch, Mr Osman, Mr Youssef, Dr Buckley, Mr Power, Ms Brill, Ms Tyler, Ms Adams, Ms Edmondson and Mr Crabtree. He did not interview consultant colleagues of the Claimant, locum consultants or junior doctors who worked with the Claimant. Mr Mack also read all relevant documentation, including Trust policies etc. In his findings and conclusions at the end of his report, he essentially found that the matters he was asked to investigate had been made out against the Claimant. It was his view that the Claimant had become unmanageable as a result of her behaviour and her refusal to address it, and that it was unlikely that the situation could be remedied, given the Claimant's refusal to address her behaviour. He was concerned that the breakdown had impacted on the division's operational effectiveness and prolonged management processes to effectively manage patient lists and the 18 week standard. Mr Mack's view was that this situation was unsustainable.

(12) On 23rd February 2016, the Claimant made a written complaint to the CQC relating to two deaths at the hospital which she said could be put down to the fact that the two surgeons involved were not on

the specialist register. This complaint is accepted by the Respondent to be a protected disclosure. Dr Mansfield and Mr Bowditch immediately reviewed and investigated the allegations, and their report or reply was sent by the director of governance, Ms Denver Greenhalgh, to the CQC on 1st March 2016. In that reply, Ms Greenhalgh said that the Claimant (unidentified in the report) had appropriately raised concerns about safety issues over the past year. Eight concerns were raised by the Claimant with the GMC. The first two concerned Mr Abdullah, a locum consultant, and two patients who had died from volvulus (twisting and obstruction of the bowel), allegedly as a result of his actions. These patient deaths had already been the subject of an internal review, and no evidence had been found to suggest that the Claimant's allegations against Mr Abdullah were well founded. Learning points relating to the cases were, however, identified, which would benefit from a review. The third allegation was that the switchboard had not been informed of the Claimant's exclusion and that she was therefore identified as the 'on call' consultant. However, the problem was quickly rectified (Mr Abdullah in future notified to callers as the consultant on call), and no patient safety issues arose. The fourth complaint was that two surgeons – Mr El Khiddir and Mr Dikki – had failed to provide adequate care to vulnerable patients. In fact, their care had already been scheduled to be discussed at forthcoming morbidity and mortality meetings. Having reviewed the patients' notes, Mr Osman was satisfied that appropriate standards had been followed. He was unable to identify any adult safeguarding concerns in the three cases cited by the Claimant. The fifth and sixth complaints concerned a locum registrar – Mr Abusin – covering the Claimant's clinic and then writing to the GPs signing himself off as a locum consultant. Although the Claimant was technically correct, Mr Osman's position was that it was not unreasonable for Mr Abusin to refer to himself as a locum consultant in the context, when he was covering the Claimant's consultant clinic and was shortly to take up a locum consultant post. The seventh complaint was that the Trust had failed to ensure that all consultant surgeons had undertaken damage control training. This issue had already been brought to the Trust's attention by NHS England in January 2015 after a visit by them to the major trauma unit. Such training was not mandatory and was expensive - £1550 - £2000 for each consultant. However, a plan was in place for at least one consultant per annum to attend the training course. Efforts were made thereafter to make the course more cost-effective. The eighth complaint was about high complication rates in gallbladder surgery, dating back to Autumn 2015. The cases were reviewed at a senior level and the results presented to the whole team, including the Claimant. One of the cases was further investigated as a serious incident. The duty of candour was completed (open and honest communication with the patient). Ipswich Hospital is a key member of the NSQIP where surgical complication rates for the department and individual surgeons are monitored and compared to other institutions. This is

a good tool to monitor quality and highlight trends in morbidity and mortality. Mr Bowditch told us that it did not make sense that anyone would subject the Claimant to unfair treatment for raising such concerns, as they were all matters that were out in the open already and had been discussed with clinical staff positively to ensure that every one was able to learn lessons from them. Ms Greenhalgh stated that she trusted that the information was sufficient to assure the CQC that they were aware of the Claimant's concerns and were already 'sighted' on the many issues.

(13) On 25th February 2016, the Claimant made a formal grievance to Mr Hulme, the Chief Executive, raising many of the issues that have been raised before us at this Tribunal. This is relied on as a protected disclosure and agreed by the Respondent to be such. Apart from references to patient safety issues, the Claimant also raised matters personal to herself, such as gender discrimination in relation to pay, discrimination on grounds of her nationality and the protracted re-validation process. Mr Paul Fenton, director of estates and facilities, and a chartered engineer by training, was appointed to investigate the grievance. The Claimant had objected to Ms Edmondson, who would have been the appropriate investigator as director of human resources and a board member. Mr Fenton had a step 2 investigation meeting with the Claimant on 7th April 2016. He felt able to deal with the matter, although not a clinician, because the Claimant's allegations/complaints were about discrimination, unfair treatment and breaches of policy and process. If Mr Fenton had needed clinical input, he would have sought and obtained it. Mr Fenton had meetings with Mr Bowditch and Dr Garfield and he looked at all relevant documentation. The grievance outcome, set out in the letter of 13th May 2016, post dates the Claimant's dismissal, and Mr Fenton did not uphold the Claimant's grievance. However, the outcome of the grievance itself is not a separate and specific complaint that we have to determine. Further, the appeal against Mr Fenton's outcome which was determined by Ms Nobes and her panel, also post dates the Claimant's termination of employment. We believe that therefore we do not need to deal with the grievance outcome or the grievance appeal. Anyway, there can be no detriment (in the legal sense) after the Claimant's dismissal because she was no longer an employee.

(14) On 28th March 2016, Dr Garfield received a copy of Mr Mack's report. As case manager, he had to consider whether on the basis of that report there was a case to answer and, if so, what action to take, including whether the allegations should be considered further at a formal hearing. On 4th April 2016, he convened an ad hoc decision making panel, with himself, an HR representative and the director of emergency medicine. The other two people had not been involved in any aspect of the case to that date. All three reviewed the content of the report together with the extensive supporting appendices and, having discussed the matter with these

colleagues, Dr Garfield had no hesitation in concluding that there was a case to answer. It was clear to Dr Garfield that the concerns raised were ones of conduct and that they were very serious. He decided therefore that they should be considered at a disciplinary hearing. He also decided that there was a suggestion of a breakdown in normal working relationships between the Claimant and her colleagues which was potentially irredeemable and was having a dysfunctional effect on the service. Dr Garfield therefore also decided that the panel should be asked to consider whether the Claimant's employment should be terminated on the basis of that breakdown. Dr Garfield then informed the Claimant of his decision (on 8th April 2016), and he updated NCAS on 19th April 2016. There was then a further case conference at which, as there had not been any material change to the circumstances which lead to the Claimant's exclusion, Dr Garfield extended her exclusion by a further four weeks.

(15) Dr Simon Smith, consultant radiologist and associate medical director, was invited by the Trust to be the chair of the disciplinary panel which heard the case against the Claimant. He had investigated various serious incidents in his career, but had not chaired a disciplinary hearing before. Thus, in advance of the hearing, he was given some specialist internal training on hearing disciplinary cases. He also familiarised himself with all the relevant Trust policies. He had received training on equality and diversity issues and was up to date with that. He had not been involved with the Claimant previously. On 25th April 2016, he wrote to the Claimant asking her to attend a disciplinary hearing on 6th May 2016 (later changed to 10th May 2016 at the Claimant's request), and set out the purpose of that hearing, which was to consider formally the matters set out in the letter and for a decision to be taken on what disciplinary action, if any, should follow if the matters were substantiated. He then listed the allegations of misconduct to be considered, and they were essentially the same ones that Mr Mack had looked at and had made recommendations on. The Claimant was told that in addition to the allegations of misconduct, the panel would consider whether there had been a breakdown in trust and confidence between the Trust and the Claimant. This was not an allegation of misconduct. However, as with the allegations of misconduct if they were serious enough this could include sanction up to and including summary dismissal, and if the panel concluded that there was an irretrievable breakdown then there could be termination of the Claimant's employment with the Trust. The Claimant was told that she could be accompanied by a representative of her choice (although not a legal representative). Dr Smith told the Claimant that he would be chairing the hearing and that Ms Karen Lough, head of operations, division 2 – surgery, and Ms Caroline Wiltshire, HR business partner, would be the other members of the panel. The Trust would be calling five witnesses; Mr Mack, Dr Parkinson, Mr Crabtree,

Dr Buckley and Ms Brill. Mr Power was unable to attend the hearing due to being on leave, but the Claimant was advised to send any written questions for him to Dr Smith and Mr Power's written responses would be available in advance of the hearing. There would be a note taker present at the hearing. The Claimant was sent all the relevant documents and policies. She was told that she could submit a written statement and supporting documents of her own, and she could call any witness that she wished to call. She was reminded of the confidential staff support scheme and other support facilities. The meeting took place on 10th May 2016. The Claimant attended the hearing in person but alone, and she was told at the start of the hearing that she had the right to be accompanied, but said that she was happy to proceed without a representative or colleague. The Claimant confirmed that she did not intend to call any witnesses. Dr Garfield presented the management case and called witnesses, who were questioned by the Claimant. Dr Smith noted that when the Claimant was presenting her case it was difficult to keep her on track as she tended to go off on tangents, and it became difficult to follow her or to understand the points she was trying to make. Dr Smith repeatedly had to remind her to focus on the issues before the panel. Although she referred to an email confirming that she had been appointed as Clinical Lead, she did not disclose it to the panel. The hearing lasted from 10am in the morning to 3.30pm, after which the panel deliberated. They were unable to reach a conclusion that day, and returned the following Monday morning to deliberate further. They then reduced their findings and conclusions into a 12 page letter.

(16) Dr Smith and his panel found the allegations of misconduct made out. As far as the Clinical Lead issue was concerned, they found that the Claimant had continued to hold herself out as such, even after being told not to do so. They noted the exchange between Mr Youssef and the Claimant, where Mr Youssef asked the Claimant to stop using the title of Clinical Lead of Emergency Surgery in her emails, clinic letters and so on, as he was appointed as Clinical Lead in September 2013 and that was still the case until he heard otherwise from Mr Bowditch or Mr Osman. In response, on 8th May 2015, the Claimant had written to Mr Youssef to say that she had been officially appointed as the Clinical Lead Emergency Surgery, and that what she had termed Mr Youssef's false representation was now an illegal act and would not be tolerated. It was also noted that Mr Osman's letter to the Claimant of 15th July 2015 stated that on the Clinical Lead issue he had spoken to Dr Buckley and she had confirmed that the Claimant had not been appointed Clinical Lead, and the advert and the job description referred merely to leading the service which was an expectation of all consultants. Mr Osman noted that, as part of Mr Youssef's job planning discussions, the role of Clinical Lead was included with his job plan. Mr Osman noted that the confirmation in

writing from Mr Omar that the Claimant was Clinical Lead was not a document that was shared with the Respondent. Despite Dr Buckley writing to the Claimant following this and telling her that she was not the Clinical Lead, the Claimant was still resolute at the disciplinary hearing that she was the Clinical Lead. Dr Smith and the panel made a finding that the Claimant had deliberately and consciously ignored reasonable instructions from senior managers on the issue. The next matter that was considered was the job plan. The Claimant's position was that she would only adhere to the job plan contained in her job description on the basis that it was legally binding. She also considered that the Trust's attempts to engage in job planning were not transparent. However, Dr Smith noted that the Claimant's job description included a statement that "the proposed timetable is indicative of the work required but is not rigid and will be flexible depending on service needs and the interests of the applicant". It also stated that "a formal job plan will be agreed between the appointee and clinical lead on behalf of the medical director three months after the commencement date of the appointment". Dr Smith also noted that it was a requirement of the national terms and conditions of NHS consultants that the job plan be reviewed and agreed with the consultant on an annual basis. Numerous attempts had been made to work with the Claimant to agree a job plan. The Claimant had declined meetings on the basis that she was busy or had other commitments, although her timetable did not suggest that this was the case. Dr Smith and his panel found it contradictory that whilst the Claimant raised concerns about the transparency of the job planning process, she would then simultaneously refuse to meet with Mr Osman or Mr Power to discuss the issues and agree a job plan with them. It was noted that the Claimant refused to undertake theatre duties to fulfill her contractual hours and had failed to come on site when requested to deliver care during her SPA time. The panel found that the Claimant had refused to cooperate or engage with the Respondent in it's attempts to create a job plan with her, and had done so without justification. It also found that the Claimant had failed to fulfill the commitments of her job plan on occasion. The panel went on to consider the issue over whether the Claimant had unreasonably failed to cover the junior doctors' strike or explain her position on it. When questioned by the panel, the Claimant remained resolute in her position about her right not to undertake cover for strike periods and to refuse to explain her position to Mr Osman. She told the panel that she chose not to provide cover because she had been on call the previous weekend with 96 patients. However, from reviewing the records, it was clear from enquiries made with Ms Lough that in fact the Claimant had not been on call the previous weekend as she had swapped with another consultant, Mr Abdallah. However, even if she had been, the panel noted that the strike fell on a Tuesday when the Claimant was contracted for SPA time in the morning. In that context, they considered it a reasonable request for her to cover the ward. From

his own experience as a consultant, Dr Smith's view was that all other consultants had worked flexibly at that time to ensure cover for wards and essential services during the strike period. The consultants had prioritised the care and safety of patients at that particularly difficult time and there was therefore a significant contrast with the Claimant who had flatly refused to do so.

(17) The 18 week target issue. Mr Osman had written to the Claimant via Ms Brill on 24th November 2015, expressing surprise that, having gone through the Claimant's list of patients, he had noted that they were not being taken in turn. Mr Osman said that he had been unable to identify mitigation to justify them being taken out of turn, especially when the Claimant had seven patients who had already waited longer than 18 weeks without an operation date and another 10 patients who had been waiting for between 10-17 weeks. In response, the Claimant said that the patients on her list on medical grounds were higher prioritised and urgent, and said that she objected to Mr Osman looking at patient medical details as it was a breach of confidentiality, and that his interference was incorrect and she had asked him to focus on arranging theatre assistance for her. At the disciplinary hearing, Ms Brill explained that the Claimant had not been singled out and that she had personally reviewed all the consultants' waiting times. In her interview with Mr Mack, Ms Brill had said that she had used the same review process for all consultants but had never experienced the level of difficulty with any other consultant as she had with the Claimant. Dr Smith said that he was particularly struck by the Claimant's refusal to accept that there were any issues around her conduct in respect of this matter. She continually appeared to attribute the issues surrounding her failure to adhere to the PTL to the alleged poor performance of her colleagues, allegations which the panel found unsubstantiated.

(18) The panel considered the tone and the style of the Claimant's written and verbal communications with managers and colleagues. The dismissal letter set out a number of examples. There was evidence about it given to us, as Dr Smith gave us a few examples. The Claimant saying to her manager Mr Osman "again; excellent example; today booking cascade of mistakes". Asking Liz Brill and Jo Rayner, "why is part of your management task so amateuristic"; telling Dr Buckley, "I do not accept you sending a deferral request – I will take appropriate legal actions and you will be held responsible for legal costs and liable for any loss in salary"; and to Joss Johnson, "clearly leave out your subjective opinion of being disappointed". We were referred to other examples of the Claimant's written communications. There was also an example of her verbal communications, given in Mr Power's interview with Mr Mack, where he told Mr Mack that the Claimant had come into his office and made reference to a job plan issue and called him a liar. Mr Power said that he had asked the Claimant not to call him

this again but she had repeated the comment. When asked, the Claimant did not deny that she had said it. Her position on this was that she had not put the comment in writing. The panel agreed that this did not make the comment any less offensive or improper. Dr Smith referred to the Claimant's interview with Mr Mack where she referred to Dr Buckley, saying that "she is not to be trusted and she is unreliable". In relation to the on call supplement and Mr Power's handling of this, the Claimant said "they have committed fraud", the "guy is not an amateur, well he is in some ways …". In relation to Mr Power and Ms Brill's management of the waiting list, she said "they kept making mistakes". The panel agreed with Mr Mack that such comments were inappropriate and derogatory. We have seen the contemporaneous email from Mr Power to Mr Bowditch dated 1st April 2015, setting out this particular incident. As far as Mr Tuffaha was concerned, then the panel found that the widely distributed email was not necessary, and also that the Claimant had ridiculed Mr Tuffaha in a handover meeting on 17th June 2015. We have seen emails in the bundle from Mr Tuffaha to Dr Parkinson, saying that he was being singled out, when all registrars came in a little bit late on occasion, and the Claimant's reference to Mr Tuffaha as 'a repeat offender who does not seem to learn from his mistakes and puts emergency surgery patients at risk' (that email also went to four different people). As far a the 5th February 2016 surgical business meeting was concerned, then the panel found that the Claimant's refusal to leave the meeting was unreasonable and her behaviour in response was wholly inappropriate.

(19) The panel went on to consider the allegation that the Claimant was unmanageable. They were referred to the GP complaint, and were shocked by the content of the written response to the GP from the Claimant. They did not consider it to be satisfactory or professional. They found it to be arrogant and expressly inappropriately critical of the GP and also of another Trust service. They found that it could potentially have brought the Trust into disrepute. The panel also believed that the Claimant should have referred to the complaints policy to ensure that she operated within it, and even if she did not do this she should have followed Mr Hudson's express request only to provide a statement. During the disciplinary hearing, the Claimant continued to argue that her response was appropriate and professional and that she indicated that she would not change her practice in the future. The panel considered this to be an example of the Claimant being completely unmanageable, amounting to a refusal to adapt her behaviour to meet the Trust's expectations and processes. Another example that demonstrated the Claimant's refusal to cooperate in or engage with management instructions or requests with which she did not agree was provided by the validation issue, the panel believed. The Claimant had failed to reflect upon the need to refer to the GP complaint within her appraisal document, despite repeated clear requests by Dr Buckley

and Dr Mansfield for her to do so. The Royal College of Surgeons' job planning and appraisal framework highlights the need to reflect upon complaints and complements, in order to modify practice and identify any areas of further learning. The panel agreed that referral was a mutual act and a routine practice, and this had been clearly explained to the Claimant by Dr Buckley. It was clear to the panel that the Claimant had refused repeatedly to adhere to Trust policies, processes and expectations, including the Trust's access policy in relation to the PTL and the complaints procedure in relation to her reply to the GP. Further, the Claimant had also unilaterally attempted to change the practice around utilisation of secretarial resource, and had declined to constructively review theatre disposals as per routine practice.

(20) In conclusion, the panel found that the deliberate tone and style of the Claimant's communication, her clear challenges to any attempt to exert authority, her refusal to accept any alternative innocent explanation for events, and her refusal to adjust her behaviour even when she was provided with a clear explanation as to why it was unacceptable and how it impacted on those around her, had rendered her completely unmanageable. The panel concluded that the inordinate amount of time that management had spent in dealing with the various issues that the Claimant had caused was significant and disproportionate. In circumstances where the Claimant so clearly refused to comply with management instructions, the Trust could not properly meet its obligations of accountability to patients or to other staff. The panel found that it was plainly not a functional working environment. They considered that it was not acceptable for some members of staff to feel they had to take advice before they are able to have any sort of conversation with a colleague, and not have to fear that they will be subjected to degrading and aggressive communication. The Claimant had caused disruption to the service and to management processes, and it was likely that this impact would have a serious effect on patients' services. The situation was not sustainable. The panel believed that it was irremediable, because the Claimant had failed to acknowledge the impact this situation was having on others or the part she played in the breakdown. Mr Mack interviewed Mr Crabtree, who had replaced Mr Osman as the Claimant's line manager. Mr Crabtree felt that the working relationships were irretrievable because the problems were not confined to a single person on a one to one basis in which case mediation could be offered. Mr Crabtree's view was that if the Claimant did not agree with anyone in authority she would "castigate, challenge and undermine them". There was no middle ground with the Claimant. The panel's own experience of the Claimant at the hearing demonstrated to them that she lacked any insight into the impact of her behaviour or how inappropriate it was. They found that the Claimant had become unmanageable and they did not consider that there were any steps that could be taken by the Trust to remedy the

situation. The Claimant had not demonstrated any ability to reflect on the issues raised or to adjust her behaviour. Although other complaints the Claimant made about discrimination and whistle blowing matters were not being dealt with by Dr Smith and his panel, nevertheless the panel looked at them to see if they were genuine examples of unfairness that might in some way have justified or explained the Claimant's behaviour or whether these complaints might have been the reason the allegations against her were being pursued. In short; the panel found that there was no evidence of any deliberate attempt to remunerate the Claimant at a lower level than her male colleagues, the panel was wholly satisfied that the Claimant's seniority had been calculated correctly, there was no evidence that the Claimant had been given less secretarial support on grounds of gender, and the allocation of professional leave had been on a first come first served basis and was not to do with gender. The Claimant's nationality was irrelevant to the inappropriate nature and tone of her verbal and written communications. The panel was also satisfied that the basis for the Claimant's exclusion was the serious concern about her behaviours and attitudes, and the impact on the team and potentially on service delivery. The panel found that the Claimant had not been excluded because she had raised concerns about patient safety etc.

(21) As far as sanction was concerned, Dr Smith told us that the panel had agreed that the Claimant's conduct was so serious that it amounted to gross misconduct. The allegations taken together demonstrated a clear and sustained pattern of refusal to accept the authority of management, and a refusal to communicate with managers, peers and junior members of staff in a manner that was acceptable. They felt that the Claimant's behaviour towards others frequently amounted to bullying. The Claimant consistently refused to accept any criticism of her behaviour, and reflect on the impact of her behaviour on colleagues and the service, demonstrating a significant lack of insight and a wilful refusal to comply with the standards and expectations reasonably set by the Trust. In the circumstances, the panel did not feel that a written warning or a final written warning was an appropriate sanction. It was considered that the Claimant could not be allowed to continue in her role as a senior clinician in the Trust. The panel considered whether downgrading as an alternative to dismissal was appropriate. However, they had no confidence that even with further support and opportunity the Claimant's behaviour would not continue. They felt that the situation might in fact deteriorate further. Therefore, they concluded that the appropriate sanction was summary dismissal. They further concluded that, even if they had not applied that sanction for acts of gross misconduct, they would have dismissed the Claimant in any event by reason of the breakdown in her relationship with the Trust which, for the reasons they had given, they had concluded was incapable of remedy and meant that her continued employment by the Trust was untenable.

In his evidence to us at this hearing, Dr Smith said he found it a very difficult decision to make. He said he was a doctor first and had a bias towards colleagues. However, he believed it was impossible for the Claimant to return, even with mediation or re-training. Ms Brill had stressed to the panel that it would be a real challenge to work again with the Claimant. Someone who had such a bad lack of insight presented a real danger to the service. The Claimant had an inability to take advice and an inability to recognise an error of judgment. Dr Smith emphasised that they all learn in an open environment and do not make accusations. However, if the Claimant was challenged she would throw as much mud in the hope that some of it would stick. The culture should be to learn and grow and not be judgmental, and not constantly looking for someone who was guilty. Dr Smith said that he recognised the Claimant's concerns about patient safety as having potential relevance and he decided to escalate them to the director of governance as the lead for patient safety. Dr Smith recognised that there were issues with locums who were long term. However, they were subject to the Trust's appraisal and re-validation process and they worked as part of the team where any deficiencies would be noticed. Dr Smith told us that he gave the Claimant every opportunity to say that she would have acted differently, but when asked about this she laughed and said: "you must be joking".

(22) The Claimant appealed the decision to dismiss her. Her appeal was heard on the same day as the grievance appeal, the dismissal appeal following the grievance appeal. The appeals were heard by Mrs Nobes, the director of nursing, who is a board member and senior to Dr Smith in the management structure. Mrs Nobes chaired a four person panel, including an external person who was an experienced HR director to give a professional and independent view. All the panelists pre-read the full set of relevant documents, but the process was to deal with the matter as a full re-hearing. As before, the management case was presented with witnesses called, and the Claimant could call witnesses if she wished to although in the event she did not. The panel was not concerned to investigate the patient safety issues raised by the Claimant, but referred these to the director of governance and told the Claimant that they were doing so. The panel did not uphold the grievance appeal. They then turned their minds to the disciplinary appeal. They found that Mr Mack was an appropriate investigator, and did not need clinical experience to determine the issues raised against the Claimant, which were of a personal nature rather than of a professional clinical nature. Mr Mack had carried out a full and thorough investigation, in the appeal panel's view. The Claimant complained that the disciplinary panel dismissed her before her grievance outcome, but the appeal panel did not think that there was any error in that. Even if the grievance outcome should have been delivered before the disciplinary hearing, the appeal panel rectified that, believed Mrs Nobes. They heard and determined the Claimant's

grievance appeal first, before turning their focus to the issues surrounding her dismissal with a full re-hearing. Although acknowledging that there were some minor errors, such as the letter inviting the Claimant to meeting having an incorrect date, and Mr Bowditch's statement originally missing from the Claimant's pack, nevertheless these errors were not deliberate and when they came to the Trust's attention they were rectified without delay. As a panel, the appeal hearing felt that the Claimant's verbal communication with witnesses at that hearing was of considerable concern. She was rude and abrupt, and the manner in which she addressed the witnesses lacked any professional respect. Many of the witnesses seemed to be intimidated by the Claimant's questioning and the manner in which she interacted with them. As chair of the panel, Mrs Nobes tried hard to keep the tone of the hearing courteous but she struggled to do so. When challenged by Mrs Nobes as always being on the attack, the Claimant accused Mrs Nobes of discriminating against her. Mrs Nobes found her lack of insight in this respect quite extraordinary, as though she was intent on finding anything to reinforce her position that she was a victim, rather than reflecting on the effect of her actions on others. Mrs Nobes told us that in her entire professional career she had never encountered anyone so combative, so dismissive and ultimately so rude as the Claimant was towards her colleagues. The appeal panel did not uphold the appeal and also found that the employment relationship had totally broken down. There was no evidence to persuade them to overturn the sanction of summary dismissal. The panel also agreed with Mr Mack and Dr Smith that there had been a complete breakdown in the Claimant's relationships with the Trust and her colleagues. Although the Claimant said that the Trust should consider mediation, Mrs Nobes and the panel believed this would not work as the Claimant was not willing to compromise and reach a middle ground. Continuing the relationship was simply untenable. If she was reinstated as she wished, the Trust would simply have no confidence at all that she would follow any instructions. If colleagues cannot work together cooperatively then the multi disciplinary approach would simply fail and patient care would be put at risk. That was a view shared by all of the panel, including the external member. Any patient safety concerns that the Claimant raised were passed on to the director of governance.

(23) The Claimant relies on 32 alleged protected disclosures. 13 of them are agreed or conceded by the Respondent to be protected disclosures. They are identified in the attached schedule of protected disclosures. They are disclosures 3, 11, 13, 14(17), 19, 22, 23, 25, 27, 28, 29, 31 and 32. Numbers 29, 31 and 32 post date the Claimant's dismissal. They are the dismissal appeal, grievance appeal and the online complaint to GMC. The other conceded protected disclosures took place on 20th January 2015 then 1st July 2015, 10th and 27th November 2015,

28th December 2015, and a clutch of disclosures in February 2016. They were made to Mr Osman, Dr Buckley, Mr Bowditch and Mr Groot-Wassink, and concerned matters related to patient safety, such as staffing levels, alleged fake consultants, concerns about the death of patients because of alleged mis-management of their care etc. The February 2016 protected disclosures are particularly noted because they preceded by a few days key events that happened on 5th February, 12th February and 25th February as identified above in our findings of fact.

(24) We also find the following six protected disclosures made out:-

Number 1 – is information given, among other things, that Mr Osman cannot do a laparoscopic hernia operation and that the Claimant's patient for this had been taken from her list and given to him. It was raised as a patient safety issue.

Number 4 – a complaint by the Claimant of sub-optimal middle grade support for the ward round and afterwards, in other words – no upper GI registrar to supervise juniors. In the context of the looking after of a patient that needed and had life saving surgery. The Claimant might have been wrong to have concerns (for example, because the Respondent was aware of the problem and was dealing with it), but it was a reasonably held belief by her, we find.

Number 6 – is contained within a lengthy letter to Dr Buckley, where the Claimant makes the same complaint as in Number 4 – i.e. no upper GI registrar for the ward round that week after the Claimant's busy weekend on call. She said that junior doctors would not know which registrar to contact, which put patients at risk if the team was below the minimum staff levels.

Number 8 – comprises two emails from the Claimant to Mr Power asking for fixed theatre sessions, as she does more work with bariatric patients and needs to discuss in advance cases with the anaesthetist. Again, a patient safety issue.

Number 9 – was a complaint to the administration about bookings, but the Claimant is stressing here that medical issues are key, urgent and high priority patients bypassing the PTL process for that reason. It is disclosure of information about a potential health and safety risk to patients.

Number 10 – is a disclosure to Mr Rory Martin of 16th June 2015 and is a concern from the Claimant that increased patient risk occurs with locums arriving to work in emergency situations for surgery without experience, without access to patient records, without any training, without an induction and without being able to

generate the necessary GP notification discharge summary. Again a disclosure about health and safety.

(25) However, there are 13 alleged protected disclosures which we found not made out as such:-

Number 2 – is an email from the Claimant to Mr Osman and Mr Power of 26th November 2014, which is a request for information (the job plans for the whole team) and which makes complaints but does not disclose information.

Number 5 is an email from the Claimant to Mr Osman of 11th February 2015, containing an allegation that he is putting patients at risk, which is a statement of position or opinion, but does not disclose information.

Number 7 was an alleged verbal disclosure between the Claimant and Dr Buckley at a meeting on 13th February 2015. Contrary to the Claimant's pleaded case, Dr Buckley's evidence (unchallenged by the Claimant) was that the Claimant wanted Dr Buckley to recommend her for re-validation immediately which Dr Buckley explained that she could not do. Other matters touched on included the Claimant not being paid the right on-call supplement, again not a protected disclosure, as not made in the public interest.

Number 12 – is an email from the Claimant to Mr Power, Mr Osman and Ms Brill in which the Claimant complains about administrative deficiencies. It is not a protected disclosure as no information was conveyed in the public interest. It contains an allegation of discrimination against the Claimant.

Number 15 – is an email from the Claimant to Mr Osman, dated 25th November 2015. It is a complaint that there was no communication about a new locum joining the team. It is not a disclosure.

Number 16 – comprises two emails from the Claimant to Dr Buckley and others, in which she raises concerns about patient safety, complaints about communication, and an allegation about a colleague (on 26th November 2015). We find that this was not a protected disclosure as it lacked the necessary communication of information in the public interest.

Number 18 – the emails to Mr Collins and Mr Hulme of 9th and 15th December 2015 complain about the Claimant being suspended (excluded) and Mr Bowditch being appointed case manager. The Claimant simply makes a statement of her position and the emails do not amount to a protected disclosure.

Numbers 20 and 21 – are emails of 2nd and 10th February 2016 about alleged inadequate resources, and again are not protected disclosures.

Number 24 – the email from the Claimant to Mr Osman and others of 4th February 2016 simply sets out what was discussed at a meeting. It does not amount to a protected disclosure.

Number 26 – the meeting with Mr Mack of 19th February 2016 in which the Claimant raised a number of issues about her own position, but again not containing protected disclosures.

Number 30 – is the schedule of loss and the only information it conveys is the amount and the calculation of the compensation being sought by the Claimant.

Number 33 – contains emails or letters from others to the Claimant, and cannot be protected disclosures because they are made to her and not by her.

(26) The first allegation of direct sex discrimination is that the Claimant received less on-call supplement than her male comparators. She compares herself with a number of surgeons. However, according to the national terms and conditions for consultants, the level of on-call supplement will be determined by the frequency of rota commitment. The Claimant and Mr Youssef (who the Respondent says was the only true comparator) were on a low frequency rota – 1 in 9 or less frequent. Thus, they were paid an on-call supplement of 3%. The Claimant's other comparators were on a different, medium frequency rota of between 1 in 5 and 1 in 8. Therefore, they were paid an on-call supplement of 5%. On-call supplements relate to out of hours work, evenings and weekends. In fact, when Mr Power undertook his review, it was clear that the Claimant had been paid a 5% supplement during the period when she was working as a locum consultant, because at that time she was working on the higher frequency upper GI rota. The Claimant was notified of this error on 13th May 2015, and back pay was awarded to her. She was not the only surgeon who received the incorrect rate.

(27) The second allegation of direct sex discrimination is whether the Claimant received less direct secretarial support than her male comparators, and these are identified as Mr Youssef, Mr Crabtree, Mr Pitt, Mr Morgan, Mr Malick, Mr Groot-Wassink, Mr Sinclair, Mr Dikki, Mr Snyders, Mr Osman, Mr Assar and Mr Abu-Own. Again, the Respondent's position is that only Mr Youssef is a relevant comparator on the basis that he is the only one who worked in the same department as the Claimant (emergency surgeons). The Claimant's other alleged comparators were in different departments with differing workloads, complexity of

patients and therefore had different requirements for secretarial support. Mr Power undertook a comprehensive review of the secretarial structure in 2014. He and Ms Brill assigned 25 hours of secretarial support to a consultant for the colo-rectal team – Mr Crabtree, Mr Malik, Mr Snyders, Mr Morgan and Mr Pitt. They allocated 26 hours each for the upper GI team of Mr Groot-Wassink, Mr Sinclair and Mr Dikki. Finally, 25 hours was allocated to the emergency surgeons, the Claimant and Mr Youssef. The position of the vascular surgeons was more complicated, because they worked both in Colchester and Ipswich. Compared with Mr Youssef, the Claimant received 17 hours from one secretary and 8 hours from another. Mr Youssef got all his support (25 hours) from one secretary (Ms Tyler). Ms Tyler worked a 33 hour week, so the other 8 hours were for the Claimant. On that basis, the Claimant received exactly the same amount of secretarial support as Mr Youssef, albeit from two secretaries rather than one. She regarded that as being inefficient. Mr Power did not agree. In an email to the Claimant of 28th April 2015, he said that there were some opportunities for the two secretaries to work better as a team and Ms Brill would be looking at how Ms Tyler could provide an increased level of support to the Claimant on the days that her colleague did not work.

(28) The third allegation of direct sex discrimination is that the Claimant was offered significantly fewer fixed clinics and fixed theatre lists by the operational team than her male comparators, from 9th November 2014 to the date of her dismissal. We find that the reason why the Claimant received fewer fixed clinics and fixed theatre lists than Mr Dikki, Mr Pitt and Mr Crabtree and all the others (except for Mr Youssef) was because, like Mr Youssef, she was an emergency surgeon. The position was exactly the same for Mr Youssef. The Claimant considered she should be given fixed theatre lists and clinics on set days of the week. However, Mr Osman tried to explain to the Claimant in a meeting early in her tenure in October 2014 that it had never been envisaged that the emergency surgeon role would have fixed theatre sessions or fixed clinics and there was not any way the physical clinic or operative capacity to allow the Respondent to do this. Rather, the emergency surgeons were expected to pick up the dropped theatre lists and clinics for other consultants during their cold weeks. In fact, the Claimant was favoured over Mr Youssef, because she was offered a fixed clinic once a week on a Thursday to try and obtain agreement on a job plan for her. Although Mr Youssef had a private session on Thursday afternoons he had no fixed clinics. The Claimant had Mondays off, on which she could have carried out private work if she had wished to.

(29) The fourth allegation of direct sex discrimination was that the Claimant was given less access to extra lists plus the opportunity to earn extra pay between 9th November 2014 and the date of her

termination of employment. Mr Power's unchallenged evidence to us was that extra lists are occasionally arranged and offered to consultants to ensure the Trust meets the 18 week PTL and in an effort to reduce waiting times. As such, lists are offered on top of consultants' agreed job plans and programmed activities, and the Trust pays an enhanced overtime rate for this work. An email was circulated asking for volunteers for this work. This was sent to all consultants, including the Claimant. We have seen examples of this from 30th January 2015, 9th February 2015 and 18th July 2015. Alternatively, a post was sometimes put on the departmental whiteboard advertising the extra sessions. If a consultant wanted to do it he/she would email his/her team leader or the operational secretary, Ms Brill. The lists were then assigned according to availability. Mr Power did not recall the Claimant putting herself forward on many occasions at all. If she had done, because of the backlog of her patients, it is likely that she would have been given them if she had asked. The Respondent was concerned that the Claimant was already impacting adversely on the PTL by refusing to take dropped lists even when they formed part of her core contractual duties. The Claimant's pay slips indicate that she did not do the extra lists. However, that is not the point. The question is whether she was offered them after July 2015 and before her exclusion in November 2015. We have no evidence that the Claimant was excluded from any offers of extra lists, and the Respondent's witnesses were not cross examined to the effect that she was.

(30) The fifth allegation of direct sex discrimination is that the Claimant's male colleagues took away many of her straightforward cases and added them to their private lists for which they were paid. Mr Power gave us evidence on this point. The Respondent operates a scheme with a private healthcare organisation, Nuffield Health. The scheme was introduced and funded centrally by the Department of Health as an initiative to lower waiting times. It operated by taking the simple cases and outsourcing those patients over to Nuffield. The Claimant objected to her patients being transferred to Nuffield, and complained about this to Mr Osman who, while he sympathised with her objections, told her that the position remained that the scheme was funded centrally and had to be put in place for the good of patients. Mr Power put together a document showing how many patients were sent to Nuffield during the time when the scheme was in force. The Claimant had 17 patients who were originally listed in her name transferred over to Nuffield. However, this was the same number as Mr Groot-Wassink and only two more than Mr Dikki. The point was that it meant that the Claimant's patients could be seen more quickly.

(31) The sixth and final allegation of direct sex discrimination concerns the Claimant initially being refused professional leave to attend the Cambridge Trauma Conference at Churchill College, Cambridge on

2nd and 3rd March 2016, whereas Mr Youssef was allowed to attend the conference despite the fact that he had used up more of his professional leave than had the Claimant. Ms Ness gave us the evidence on this point. The practice within the CDG at that time was that leave was allocated on a first come, first served basis. At all times it was necessary to ensure that where leave was requested adequate cover would be in place. It was not uncommon for leave requests to be refused on the basis that leave had already been granted to someone else and that cover was not therefore available. By the time the Claimant put in her request, Mr Youssef had already requested and been granted annual leave over the same dates. As Mr Youssef and the Claimant were the only two consultants in emergency surgery, it was not possible to ensure adequate cover in the circumstances as they were both away at the same time. As far as comparison with the upper GI and colo-rectal surgeons was concerned, there were nine consultants there, so if more than one of them was off at the same time there would still be sufficient cover for the service. Those services, anyway, were separate services with differing needs and requirements to the emergency surgery service. In fact, the Claimant was able to go to the Cambridge Trauma Conference because at that date she had been excluded from the Trust, so alternative arrangements had already been made to cover her duties to accommodate her absence.

(32) We have already made findings of fact concerning the Claimant's allegation of indirect race discrimination. See above.

(33) The first claim for unpaid wages relates to the Claimant's seniority payment. The consultant's basic salary on commencement of employment is determined in part by the years of NHS consultant level experience. The Claimant began her employment with the Trust as a locum consultant on 17th January 2014 and remained in that post until 31st August 2014. On 1st September 2014, the Claimant began employment as a substantive consultant with the Trust. In order to work out her seniority and starting pay, Ms Adams used the details provided in the Claimant's CV and in her two application forms. She extracted this information and inserted it into a timeline, which showed that at the time the Claimant commenced her substantive post with the Trust she had 4 years and 5 months of NHS consultant lead experience. As set out at clause 5 of the terms and conditions of employment, where a consultant has a period of absence from his or her consultant post, their seniority will only accrue where that absence is due to an employment break scheme to reflect the gaining of approved non NHS consultant level experience. In the Claimant's case, she had been undertaking ad hoc work under an honorary contract from June 2010 to December 2014. This period was not an employment break scheme and did not therefore count towards her accrued consultant lead experience. Because she had 4 years and

5 months of NHS consultant lead experience, the Claimant's pay therefore fell within threshold 5 of annex B of schedule 14 in the terms and conditions. She was due to move to threshold 6 in 2019. The Claimant did not really challenge Ms Adams' evidence on this point.

(34) The second allegation relating to unpaid wages concerns the on-call supplement, about which we have already made findings of fact under direct sex discrimination (above).

The Law

6. By sections 43A, C and F, "protected disclosure" means a qualifying disclosure (as defined by section 43B) which is made by a worker to his employer or to the GMC or NHS England (in this case).

Section 43B: Disclosures qualifying for protection

(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:-

(a) that a criminal offence has been committed, is being committed or is likely to be committed;

(b) that a person has failed, is failing or is likely to fail to comply with any legal obligations to which he is subject;

(c) that a miscarriage of justice has occurred, is occurring and is likely to occur;

(d) that the health or safety of any individual has been, is being or is likely to been endangered;

(e) that the environment has been, is being or is likely to be damaged; or

(f) that information intending to show any matter falling within any of the preceeding paragraphs has been or is likely to be deliberately concealed.

7. It is understood that the Claimant in this case relies upon section 43B(1)(b) and (d), and possibly (f).

Section 103A: Protected disclosure

An employee who is dismissed shall be regarded for the purposes of this Part as unfairly dismissed if the reason (or, if more than one, the principal

reason) for the dismissal is that the employee made a protected disclosure.

Section 47B(1) provides that a worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure.

Section 48(2) provides that, on a complaint of protected disclosure detriment, it is for the employer to show the ground on which any act, or any deliberate failure to act, was done.

8. We were referred to case law. In *Geduld v Cavendish Munro Professional Risk Management Limited [2010] IRLR 38, EAT*, it was held that in order to fall within the statutory definition of a protected disclosure there must be a disclosure of information. There is a distinction between "information" and an "allegation" for the purposes of the Act. In this case, a position letter from the Claimant's solicitors was written as part of an ongoing, unresolved dispute between the parties. It did not disclose facts and so was not a protected disclosure.

In *Goode v Marks and Spencer Plc [2010] ALLER63, EAT*, it was held that an expression of opinion about a proposal put forward by the employer could not amount to the conveying of information which, even if contextualised by a reference to a document, could form the basis of any reasonable belief in the making of a qualifying disclosure.

Our focus is on what the worker in question believed rather than what anyone else might or might not have believed in the same circumstances. In consequence, the worker's personality and the individual circumstances have to be taken into account when judging whether he or she had a "reasonable belief". However, section 43B(1) requires a reasonable belief on the part of the worker making the disclosure, not a genuine belief. This introduces an objective standard into the test, suggesting that there has to be some substantiated basis for the worker's belief. Those with professional or "insider" knowledge will be held to a different standard than lay persons in respect of what is "reasonable" for them to believe – see *Korashi v Abertawe Bro Morgannwg University Local Health Board [2012] IRLR 4, EAT*.

The fact that a worker must have a "reasonable belief" does not mean that the worker's belief must necessarily be true and accurate. The statutory provisions require only that the information disclosed "tends to show" that the relevant failure has occurred, is occurring or is likely to occur. It follows that there can be a qualifying disclosure of information even if the worker is wrong, but reasonably mistaken, in his or her belief – *Darnton v University of Surrey [2003] ICR 615, EAT*. However, the determination of the factual accuracy of the worker's allegations will, in many cases, be an important tool in helping to determine whether the worker held the reasonable belief that the disclosure in question tended to show relevant failures. As EAT observed, it is extremely difficult to see how a worker can

reasonably believe that an allegation tends to show that there has been a relevant failure if he or she believes that the factual basis of the allegation is false.

In *Fecitt & others v NHS Manchester [2012] ICR 372, CA*, it was held that the employer can discharge the burden of proof under section 48(2) by showing that the making of the disclosure had played no part whatsoever in the relevant acts or omissions.

Under section 103A of the Act, as the Claimant has the necessary length of service to bring a claim for ordinary unfair dismissal, the burden is on the employer to show the reason for dismissal. Generally, the employer seeks to justify this by showing that, where dismissal is admitted, the reason for it is one of the potentially fair reasons for it under section 98(1) & (2) of the Act. It will therefore normally be the employee who argues that the real reason for dismissal was an automatically unfair reason. In these circumstances, the employee acquires an evidential burden to show – without having to prove – that there is an issue that warrants investigation and which is capable of establishing a competing automatically unfair reason, rather than the one advanced. However, once the employee satisfies the Tribunal that there is such an issue, the burden reverts to the employer, which must prove, on the balance of probabilities, which of the competing reasons was the principal reason for dismissal – *Maund v Penwith District Council [1984] ICR 143, CA*.

Under section 47B there is no statutory definition of "detriment". In *Ministry of Defence v Jeremiah [1980] ICR 113*, CA, it was said that "detriment" meant simply "putting under a disadvantage" or a detriment exists if a reasonable worker would or might take the view that the action of the employer was in all the circumstances to his detriment (approved in *Shamoon v Chief Constable of the Royal Ulster Constabulary [2003] ICR 337, CA*).

In the case before us, the Claimant made a protected disclosure and was then excluded, and the Respondent seeks to differentiate between the content of the communication (i.e. the protected disclosure) and the manner in which it was made. The situation was recently considered by the EAT in *Panayiotou v Chief Constable of Hampshire Police [2014] IRLR 500*, where Lewis J stated;

> 49 … There is, in principle, a distinction between the disclosure of information and the manner or way in which the information is disclosed. An example would be the disclosing of information by using racist or otherwise abusive language. Depending on the circumstances, it may be permissible to distinguish between the disclosure of the information and the manner or way in which it is disclosed. An employer may be able to say that the fact that the employee disclosed particular information played no part in the decision to subject the employee to the detriment, but the offensive or abusive way in which the employee conveyed the information

> was considered to be unacceptable. Similarly, it is also possible, depending on the circumstances for a distinction to be drawn between the disclosure of the information and the steps taken by the employee in relation to the information disclosed.
>
> 50 … Secondly, that distinction accords with the existing case law which recognises that a factor which is related to the disclosure may be separate from the actual act of disclosing the information itself. In *Bolton School v Evans [2007] IRLR 140*, the Court of Appeal recognised a distinction between disclosing information – in that case, that the School's computer system was not secure – and the fact that the employee hacked into the computer system in order to demonstrate that the system was not secure. Disciplining the employee on the ground that he had engaged in unauthorised conduct by hacking into the computer system did not involve subjecting the employee to a detriment on the ground that he had made a protected disclosure. The conduct, although related to the disclosure, was separable from it. The Court of Appeal noted, however, that a "Tribunal should look with care at arguments that say the dismissal was because of acts related to the disclosure rather than because of the disclosure itself" … .

We also note the recent authority of *Shinwari v Vue Entertainment Ltd UKEAT/0394/14*.

9. The law relating to unfair dismissal is well established.

By section 94(1) of Employment Rights Act 1996, an employee has the right not to be unfairly dismissed by his employer.

By section 95(1)(a), for the purposes of the unfair dismissal provisions an employee is dismissed by his employer if the contract under which he is employed is terminated by the employer (whether with or without notice).

By section 98(1) & (2), it is for the employer to show the reason (or if more than one, the principal reason) for the dismissal, and in the context of this case that it related to the conduct of the employee. Conduct is the reason relied upon by the Respondent (although they rely in the alternative on some other substantial reason – see below). In *Abernethy v Mott, Hay and Anderson [1974] IRLR 213, CA*, it was held that the reason for a dismissal is a set of facts known to the employer or beliefs held by him that caused him to dismiss the employee.

By section 98(4), where the employer has shown the reason for dismissal, the determination of the question whether the dismissal is fair or unfair having regard to that reason;

(a) depends on whether in the circumstances (including the size and administrative resources of the employer's undertaking) the

employer acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the employee; and

(b) shall be determined in accordance with equity and the substantial merits of the case.

The law to be applied to the reasonable band of responses test is well known. The Tribunal's task is to assess whether the dismissal falls within the band of reasonable responses of an employer. If the dismissal falls within the band, then the dismissal is fair. If the dismissal falls outside the band, it is unfair. We refer generally to the well known case law in this area; namely, *Iceland Frozen Foods Ltd v Jones [1982] IRLR 439, EAT*; and *Foley v Post Office; HSBC Bank Plc v Madden [2000] IRLR 827, CA*.

The band of reasonable responses test applies equally to the procedural aspects of the dismissal, such as the investigation, as it does to the substantive decision to dismiss – see *Sainsbury's Supermarkets Ltd v Hitt [2003] IRLR 23, CA*. So far as the investigation is concerned, and the formation of the reasonable belief of the employer about the behaviour, conduct or actions of the employee concerned, then we have in mind, of course, the well known case of *British Homes Stores Ltd v Burchell [1978] ICL 303, EAT*. Did the Respondent have a reasonable belief in the Claimant's conduct, formed on reasonable grounds, after such investigation as was reasonable and appropriate in the circumstances?

In *Taylor v OCS Group Ltd [2006] ICR 1602, CA*, it was held that if an early stage of a disciplinary process is defective and unfair in some way, then it does not matter whether or not an internal appeal is technically a re-hearing or a review, only whether the disciplinary process as a whole is fair. After identifying a defect the Tribunal will want to examine any subsequent proceeding with particular care. Their purpose in so doing would be to determine whether, due to the fairness or unfairness of the procedure adopted, the thoroughness or lack of it in the process and the open mindedness (or not) of the decision maker, the overall process was fair, notwithstanding any deficiencies at an earlier stage.

In *Perkin v St Georges Healthcare NHS Trust [2005] IRLR 934, CA*, it was held that an employee's "personality" of itself cannot be a ground for dismissal. However, an employee's personality may manifest itself in such a way as to bring the actions of the employee within section 98. Whether, on the facts of a particular case, the manifestation of an individual's personality results in conduct which can fairly give rise to the employee's dismissal, or whether they give rise to some other substantial reason of a kind such as to justify the dismissal of an employee holding the position which the employee held, the employer has to establish the facts which justify the reason or principal reason for the dismissal. A breakdown in confidence between an employer and a senior executive for which the latter was responsible and which actually or potentially damaged the operation of the employer's organisation, or which rendered it impossible for senior executives to work together as a team, can amount to some

other substantial reason for dismissal. Provided the terms of section 98(4) are satisfied, it must be possible for an employer fairly to dismiss an employee in such circumstances.

In *Ezsias v North Glamorgan NHS Trust [2011] IRLR 550, EAT*, it was held that, where a fundamental and irretrievable breakdown of working relations between an employee and his colleagues has occurred, and the employee is dismissed because of the fact that the breakdown has occurred and not because he was to blame for causing it, the reason for dismissal is "some other substantial reason" rather than conduct, and therefore the employer need not follow the same conduct dismissal procedure.

10. By section 4 of Equality Act 2010, sex and race are protected characteristics.

By section 13(1), a person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others.

By section 19: Indirect discrimination

(1) A person (A) discriminates against another (B) if A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B's.

(2) For the purposes of sub-section (1), a provision, criterion or practice is discriminatory in relation to a relevant protected characteristic of B's if –

(a) A applies, or would apply, it to persons with whom B does not share the characteristic,

(b) It puts, or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it,

(c) it puts, or would put, B at that disadvantage, and

(d) A cannot show it to be a proportionate means of achieving a legitimate aim.

By section 23(1), on a comparison of cases for the purposes of sections 13 or 19, there must be no material difference between the circumstances relating to each case.

By section 39(2), an employer (A) must not discriminate against an employee of A's (B) –

(a) as to B's terms of employment;

(b) in the way A affords B access, or by not affording B access, to opportunities for promotion, transfer or training, or for receiving any other benefit, facility or service;

(c) by dismissing B;

(d) by subjecting B to any other detriment.

Section 136(2) & (3) deals with the burden of proof.

If there are facts from which the Tribunal could decide, in the absence of any other explanation, that a person (A) contravened the provision concerned, the Tribunal must hold that the contravention occurred. But this provision does not apply if A shows that A did not contravene the provision.

11. We note the authorities of *Igen v Wong [2005] IRLR 258, CA*; and *Madarassy v Nomura International Plc [2007] IRLR 246, CA*, on how to apply the burden of proof. If the Claimant establishes a first base or prima facie case of direct discrimination by reference to the facts made out, the burden of proof shifts to the Respondent to prove that they did not commit those unlawful acts. However, the burden of proof does not shift to the employer simply by the Claimant establishing a difference in status (e.g. race or gender) and a difference in treatment. They are not, without more, sufficient material from which the Tribunal "could conclude" on a balance of probabilities that the Respondent has committed an unlawful act of discrimination. A very recent decision of the EAT – *Efobi v Royal Mail Group Ltd*, *10 August 2017, UKEAT/0203/16*– appears to cast doubt on this orthodoxy. It suggests that there is no burden of proof on the Claimant to prove facts from which a Tribunal could conclude that the Respondent has discriminated against him. Section 136(2) requires the Tribunal to consider all the evidence, from all sources, at the end of the hearing, so as to decide whether or not 'there are facts etc'.. It may therefore be misleading to refer to a shifting of the burden of proof as this implies, contrary to the language of section 136(2), that Parliament has required the Claimant to prove something. Other case law suggests, however, that reliance by a Tribunal on the burden of proof provisions will not be necessary where the Tribunal is in a position to make positive findings of fact on the evidence one way or the other – see *Hewage v Grampian Health Board* [2012] IRLR 870, SC.

The basic question in a direct discrimination case it what are the grounds/reasons for the treatment complained of, see *Amnesty International v Ahmed [2009] IRLR 884, EAT*. We have to have regard to the motivation of the alleged discriminator, whether conscious or unconscious, that may have led the alleged discriminator to act in the way that he or she did. We should draw appropriate inferences from the conduct of the alleged discriminator and the surrounding circumstances (with the assistance, where necessary, of the burden of proof provisions) – see *Anya v University of Oxford [2001] IRLR 377, CA*.

12. We note the wages provisions in Part II of Employment Rights Act 1996. By section 13, an employee/worker has the right not to suffer unauthorised deductions from his or her wages.

When considering whether the Claimant has been wrongfully dismissed or dismissed in breach of contract by reason of her summary dismissal, we have to be satisfied on the evidence that, on the balance of probabilities, there was a repudiatory breach of contract by the employee entitling the Respondent to bring the contract of employment to an end with immediate effect.

Conclusions

13. Having regard to our findings of relevant fact, applying the appropriate law, and taking into account the submissions of the parties, we have reached the following conclusions:-

(1) We determine first the Claimant's case with regard to acts/failures to act (detriments) done on the ground of making protected disclosures. The Claimant alleges some 13 detriments (before the dismissal process from 6th May 2016), as can be seen from the list of issues. The first and second detriments concerned the revalidation deferral of 19th March 2015. We have made findings of fact concerning the reasons for the revalidation deferral, and we refer back to paragraph 5(5) of our Findings of Fact. We conclude that this was simply a case of the management applying the rules relating to revalidation. They also applied the rules when the Claimant later failed to reflect on the GP complaint in her appraisal. We find the Respondent's explanations for deferral to be credible and we conclude that they have nothing to do with any disclosure that the Claimant may have made at the relevant dates. If the Claimant had been to Miss Marks for her appraisal, there would have been no ground for a refusal of revalidation and the revalidation would not have been deferred. In any event, deferral is a neutral act, according to GMC and NHS England, and anyway does not prevent the doctor concerned continuing to practice. Therefore, it is arguably not a detriment.

(2) The third detriment alleged is the exclusion by Mr Bowditch of 27th November 2015. This was a time-limited exclusion, and it is important to note the context of it. Mr Osman had complained that the Claimant's behaviour was making it impossible to run the department and that the Claimant's manner of communication which she had been asked to moderate had caused offence. There had been a finding that she had bullied a junior colleague, she would not accept that she had not been appointed as Clinical Lead, she had not explained why she would not cover for the junior doctors' strike and she would not explain why she was not following the Trust's policy on the PTL. We conclude that she had no good

reason for not covering the strike, on the evidence we have read, and that she failed without good reason to explain to her managers why she could not stick to the 18 week waiting list rule. We also take into account the other factors referred to above, and note that a breakdown in relationships with colleagues is a ground for exclusion. We refer back to our Findings of Fact at paragraph 5(8). The exclusion was kept under review, and indeed the Claimant was allowed back within a few weeks on restricted duties. We understand that she continued to be paid her full salary. The Respondent has satisfied the section 48(2) burden on it and established that the reason for the Claimant's exclusion was for the reasons relied on by them and not because of any protected disclosure.

(3) The fourth detriment is really a catchall allegation, that the Claimant was subjected to ongoing disciplinary sanctions, investigations and formal exclusion. We deal with the individual allegations as separate detriments. The fifth detriment alleged is that the Claimant was told that her alleged misconduct would be put before a conduct committee. After two investigations into her conduct, it was the case that the Claimant had a case to answer. It was the start of the disciplinary process. The Respondent has satisfied the burden on it under section 48(2). The sixth allegation is that the Claimant's operations target and thus her expertise and sub-specialty registration were jeopardised by the exclusion, to the detriment of her career as she was not allowed to do any clinical work. Dr Garfield's decision was based on his concerns about her interpersonal relationships and a refusal to follow management instructions regarding clinical work. NCAS approved Dr Garfield's approach. Indeed, the Respondent was so concerned about the Claimant's behaviour and attitude they commissioned an independent consultant to conduct an MHPS investigation. We conclude that the Respondent has satisfied us that the reason for the restrictions on the Claimant's practice were connected to her behaviour and not to her protected disclosures.

(4) Detriment seven is an allegation that the Claimant was given less secretarial support than other substantive consultants. The facts do not support her case. She had the same level of support as her comparator colleague, Mr Youssef. Detriments eight, nine and ten concern the exclusion, or attempted exclusion, from the 5th February 2016 meeting. We conclude that she should not have attended. However, we also conclude that the Respondent's approach to her removal was somewhat heavy handed and embarrassing for her and for them. It would have been better for the HR director, perhaps, to speak to the Claimant privately afterwards and remind her that she should not in future attend such meetings. The exclusion from the meeting and the way that her removal was handled was a consequence of the restrictions placed

on her following her exclusion, and was not, we conclude, anything to do with her protected disclosures.

(5) The Claimant was further excluded on 12th February 2016, and this is her 11th alleged detriment. We have set out Dr Garfield's reasons for it in our Findings of Fact. One reason is directly related to the protected disclosure that was made on 9th February (number 25). However, we are quite satisfied that it is appropriate to sever the content of the disclosure from the manner of its making, in accordance with case law – *Panayiotou, Bolton* and *Shinwari* – see above. The reasons for the Claimant's exclusion at this date was that she had attended a business meeting that she should not have attended and she had raised patient safety issues, not through her line manager as she had been instructed to do, but much more widely, causing unnecessary disruption, particularly if her complaints were not true or correct in the context of the surgeons she was referring to. In any event, the Claimant's concerns were not ignored by the Respondent. Those concerning alleged fake consultants were taken on board by Dr Buckley and changes were made to HR arrangements. Those relating to patient safety were referred to the director of governance (see below). We refer to our Findings of Fact at paragraph 5(12). Further, as Dr Buckley told us, many of the matters raised by the Claimant concerning patient safety were already known to the Trust and were discussed at regular so-called 'morbidity and mortality meetings', so that lessons could be learned and events not repeated. Dr Buckley told us that the Claimant was aware that such matters were discussed and were on the Respondent's radar. We conclude that the Claimant was not excluded on the ground that she had made protected disclosures. As Mr Bowditch said, it would make no sense to 'punish' the Claimant for her disclosures about patient safety issues, as many, if not most, of them were already known to and being dealt with by the Trust, and were openly discussed with clinical staff such as the Claimant.

(6) The twelfth alleged detriment is that the Claimant was formally excluded on 25th February 2016 after making qualifying and protected disclosures to the CQC. It is correct that these two events were close together in time. However, we are quite satisfied by Dr Garfield's evidence that the reason for the exclusion was that he had no confidence that if the Claimant was retained on restricted duties she would comply with the restrictions imposed. It was not because she had written to the GMC. Dr Garfield decided on a four week formal exclusion to protect the interests of staff, the Claimant and patients pending the outcome of the full investigation. The complaint to the CQC was thoroughly investigated by Dr Mansfield and Mr Bowditch and their report was sent to the director of governance on 1st March 2016. Ms Greenhalgh sent the report to the CQC. We have looked at its contents in some detail in our Findings of Fact. So, the concerns raised by the Claimant were

looked at and a response was given. In some cases learning points were found and review recommended, and in others clinical or safeguarding concerns were identified. The final pre-disciplinary/dismissal detriment was an allegation that the Claimant was not allowed to attend audit meetings or chair surgical Friday morning teaching meetings. We conclude that this was because it was not part of the Claimant's duties under the terms of her exclusion, and not because she had made protected disclosures.

(7) We turn now to the six allegations of direct sex discrimination. We do not need recourse to the statutory provisions on the burden of proof (as interpreted by case-law), as the claims can be determined simply on the evidence and facts. With regard to the first allegation, then the comparator has to be like for like, according to statute (section 23(1)). Apart from Mr Youssef, none of the Claimant's alleged comparators were in materially the same circumstances as her. We refer back to our Findings of Fact at paragraph 5(26). Her only true comparator is Mr Youssef, and he was paid the same on call supplement as the Claimant was, namely 3%. The claim therefore fails. It also fails as a claim for unpaid wages, as the payment was not due to her and therefore was not unlawfully withheld.

(8) The second direct sex discrimination allegation is that the Claimant received less secretarial support than her comparators. However, on the facts, the Claimant did not receive less support here than her colleagues (and see above at sub-paragraph 4). Again, her only true comparator is Mr Youssef and they both received 25 hours per week, albeit that the Claimant was assisted by two secretaries and Mr Youssef by only one. Again, the claim fails.

(9) The third allegation of direct sex discrimination is that the Claimant was offered significantly fewer fixed clinics and fixed theatre lists than her male comparators, from November 2014 until the date of her dismissal. The reason why the Claimant and Mr Youssef had no or few fixed clinics and fixed theatre lists was because they were emergency surgeons. It was not part of their role to have such fixed clinics/theatre lists, but rather they were expected to pick up the work of other consultants in their cold weeks. Again, the Claimant is not comparing like with like. The claim fails.

(10) The fourth allegation of direct sex discrimination is that the Claimant had less access to extra lists from November 2014 to the date of her dismissal. On the evidence, the claim is simply not made out. There was no evidence that the Claimant was excluded from extra lists that she had requested. She may not have done extra lists, but this was because she did not volunteer for them. The claim has not been made out. The fifth direct discrimination allegation is that the Claimant's male colleagues took away many of her straightforward cases and added them to their private lists for which they were paid.

If the Claimant had more patients taken away from her list and given to Nuffield Health than had others, that was simply because she had more patients waiting for surgery than had most of her colleagues, and so they were moved so that they could be dealt with more quickly. It happened also to other surgeons with long lists, such a Mr Groot-Wassink and Mr Dikki. The claim fails.

(11) The final allegation of direct sex discrimination is that the Claimant was initially refused professional leave to attend the Cambridge Trauma Conference at Churchill College, whereas Mr Youssef was allowed to attend despite having used more of his professional leave than had the Claimant. The non discriminatory explanation for this is that Mr Youssef asked first, and at that time attendance at such conferences was on a first come first served basis. We refer to our Findings of Fact at paragraph 5(31). In any event, the Claimant attended the conference and so suffered no detriment. The claim fails.

(12) We turn next to the indirect race discrimination complaint. The provision, criterion or practice alleged is that the Respondent had an expectation of a certain standard of English, especially in terms of style and communication. The Claimant's written and spoken English is and was fluent. She could and can communicate effectively and politely if she wanted/wants to. The problem – as is clear from the evidence as we set it out at paragraph 5(18) of our Findings of Fact – was in the way the Claimant communicated with her colleagues and others on occasions, both orally and in writing. The tone and content of her communications was sometimes aggressive, rude and derogatory, as we have heard and read. There is no evidence that on these occasions her failure to be polite and respectful had anything to do with her Dutch nationality or the fact that English was her second language. In her questions to the Respondent's witnesses, the Claimant did not suggest to them that her "direct" communication style was down to her Dutch nationality. It clearly was not. The claim fails.

(13) The seniority payment issue as part of the wages claim case. We refer to our Findings of Fact at paragraph 5(33), and we accept Ms Adams' essentially unchallenged evidence. The Claimant was on the right part of the pay scale. The claim fails. We have already dealt with the other aspect of the Claimant's wage claim (the on-call availability supplement) in our conclusions on direct sex discrimination. That claim fails also.

(14) The allegations of unfair dismissal (both ordinary and automatic) and our conclusions about these. As far as procedure is concerned, then we note that this was not a case of professional misconduct. Therefore, under the MHPS Guidance, the Respondent did not need a panel with an external doctor on it. The disciplinary case was not about the Claimant's clinical or

professional conduct or competence. There was no issue with this. Clinically, the Claimant was a good, or at least competent, surgeon. The concern was with her personal conduct. Further, the panel was properly constituted under the Trust's disciplinary procedure, with two senior managers and a HR representative. Dr Smith was given specialist internal training on hearing a disciplinary case. The Claimant was given advance notice of the hearing on 25th April 2016 – of the allegations, and all the evidence to be relied on was sent to her. She also received a copy of the Trust's disciplinary policy. Witnesses to be called were identified and the procedure to be followed at the hearing was set out. The Claimant was told that she could submit her own statement and documents and call witnesses. She was told that she had the right to be accompanied. She was also told that one outcome could be her dismissal. The hearing itself took nearly a whole day, and the panel came back the following morning for further deliberations and reached a unanimous decision. The Claimant was advised of the outcome at the re-convened meeting on 10th May and was then sent an outcome letter as well. There was a minor error over the last day of service, but that was put right a few days later. The Claimant was summarily dismissed. The Claimant was advised of her right to appeal and she exercised that right. Although the appeal panel had four people rather than three, it was to the Claimant's advantage to have an HR director or panel member who was from outside the Trust. The Claimant complains that there should be an uneven number of panelists. Having four panelists might have been of concern if there had been an equal split between them over outcome. However, the panel was unanimous in its decision. The appeal was by way of a re-hearing, and lasted a full day. The grievance appeal went first, then the dismissal appeal. Mrs Nobes is a board member at director level, so in the management structure thus more senior to Dr Smith. Witnesses were called and questioned by the Claimant, and the Claimant was able to say everything that she wished to say. Looking at the procedure overall (*Taylor v OCS*), we conclude that it was fair.

(15) We have set out in our Findings of Fact the panel's reasons for dismissal, upheld by the appeal panel. So far as the Clinical Lead issue is concerned, then we conclude that the advertisement for the post was somewhat ambiguous, and the lack of a formal process for the appointment to a sub group clinical lead meant that there was understandable confusion in the Claimant's mind about it. Save by reference to Mr Bowditch's informal nomination, Mr Youssef himself could not be shown to be definitively 'the Clinical Lead of the Emergency Service'. However, Dr Buckley herself told the Claimant not to hold herself out as Clinical Lead and the Claimant had no contract of employment that stated that she was the Clinical Lead. Dr Buckley was one of the managers who appointed her, so we would expect her to know to what post the Claimant was appointed. The Claimant's evidence was

disingenuous, because she was the one who fed to the press office and the internal staff list the information that she was the Clinical Lead, Emergency Service that she now seeks to rely upon. Between December 2014 and July 2015 she was told on a number of occasions not to refer to herself as the Clinical Lead of the Emergency Service, but she continued to do so, even when she could have been in no doubt that the Respondent (Dr Buckley and others) did not regard her as being appointed to that post. With regard to the job plan, the Claimant's position was intractable, and she stuck to the original job plan agreed, apparently, with Mr Omar, but the Claimant failed to produce to the Respondent any evidence of such an agreement. She failed to abide by the requirement in the Trust's procedures to agree further details with her line manager. She refused to meet, discuss and agree with her current managers an up-to-date or contemporary job plan, despite the many attempts by the Respondent to do so. The needs of the Trust and their requirements of the emergency surgeon role were inevitably going to change and modify over time. The Claimant also failed to follow a reasonable management request to assist on the day of junior doctors' strike. There was no record of her weekend working just before it. We conclude that she was not a team player and she later gave inadequate reasons for her non support at that critical time for the Respondent. There was no adequate explanation to her managers of why she could not cover the strike. If she had good reasons to prioritise certain of her patients over and above those on the 18 week waiting list, she did not share this and refused to share it with her line manager. We conclude that there was no breach of patient confidentiality by Mr Osman or Mr Power when they were reviewing the patient notes in the context of managing the 18 week target (PTL). Mr Osman, as the line manager, was the person who would make a proper assessment of the situation and make decisions about it. He was not given the information by the Claimant on which he could do this. Another reason why the Claimant was dismissed was because of her written and verbal communication with her colleagues, managers and admin staff. We have set out in some detail in our Findings of Fact what that was. She should not have attended the business meeting that she attended on 5th February (even if the Respondent handled the situation badly) and she disobeyed an express instruction from her line manager not to attend. We entirely agree with the Respondent's assessment that she had become unmanageable, in terms of refusing to explain or discuss her actions or do what was required. The Respondent tried to compromise with her to try and reach agreement over the job plan by offering her a fixed clinic once a week, but that did not work out. The Claimant refused to follow the 18 week rule without adequate explanation and was uncooperative over the junior doctors' strike. She was uncivil to the point of rudeness to colleagues and admin staff, and bullied Mr Tuffaha. The Respondent was entitled to come to the view that all these matters, founded as they were on a substantial body of

evidence, cumulatively amounted to misconduct on the part of the Claimant.

(16) We conclude that the Claimant was not dismissed because she had made protected disclosures. That was not the reason or the principal reason. The Respondent has established that the Claimant's conduct was the reason or principal reason for her dismissal, in the ways found by the disciplinary panel and upheld on appeal. In so far as part of the reason for the Claimant's exclusion by Dr Garfield was because of a protected disclosure (number 25), as well as her presence at the 5th March meeting then, as we have concluded above, we can separate out the content of the disclosure from the manner in which it was made. The Claimant had been expressly asked not to cause unnecessary disruption by disclosing her concerns to all and sundry, but to make the disclosure to her line manager who would then deal with it appropriately. That was a reasonable request, given the Claimant's tendency to cause upset by her widespread and often inaccurate communication to colleagues. An important fact is that the Respondent was not hostile to her disclosures. On occasion, they thanked her for them. They told her that they had investigated or were doing so, and that her concerns for patient safety was shared by others. She was told that her concerns over patient safety that she raised at the disciplinary hearing and the appeal hearing would be referred to the director of governance. Indeed, her disclosure to the GMC of 25th February 2016 was investigated in some detail by Mr Bowditch and Dr Mansfield, who reported back to the GMC via the director of governance. The Claimant did not have a monopoly on concerns over patient safety. We are satisfied that the Trust had these concerns at the forefront of their thinking. We also conclude that they did not punish the Claimant (or others) for raising these concerns (and see sub-paragraph (5) above). The disciplinary panel also concluded that, even if they would not have dismissed the Claimant for her gross misconduct, they would have dismissed her in any event because of the breakdown in the relationship between her and the Trust, which could not be remedied and which rendered her continued employment by the Trust untenable. See *Perkins* and *Ezsias* (above). We conclude that the panel was entitled, on the evidence before them, to reach that conclusion.

(17) We now consider the sanction of dismissal itself. We conclude that, given the misconduct found, the time that had passed and the impasse that had been reached, and the Claimant's non acceptance of her behaviour and her unwillingness to remedy it, the dismissal was a fair sanction. There was really no other way forward for the Trust at this stage. A warning, re-training or demotion were not viable alternatives, as it was inevitable that the Claimant's behaviour as found by the Respondent would continue, as she failed to recognise it and refused to remedy it. The dismissal was therefore within the band of reasonable responses.

(18) It follows that we also conclude that the claim for breach of contract and notice pay fails. We accept the evidence of Dr Smith and his panel's findings and conclusions on each of the allegations considered by them. We refer back to our Findings of Fact and our other Conclusions. The Claimant's conduct was unacceptable and she was unmanageable. She was guilty of repudiatory breach of the contract of employment by reference to her behaviour. The Respondent was entitled to summarily dismiss the Claimant, and therefore she was not wrongfully dismissed and she is not entitled to pay in lieu of notice.

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Employment Judge G P Sigsworth, Bury St Edmunds.

Date: …18 August 2017……..

Sent to the parties on: .....

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For the Tribunal Office