



EMPLOYMENT TRIBUNALS

Claimant: Dr C Connolly

Respondent: Health Education England

Heard at: London Central
(by Cloud Video Platform)

On: 31 January 2022, 1, 2, 3, 4 and 7
February 2022 and 22, 25 and 26
April 2022 and 27 and 28 April
2022 (in chambers)

Before: Employment Judge Joffe
Ms C Ihnatowicz
Ms L Morton

Appearances

For the claimant:

On the agency issue: Ms S Keogh, counsel
Otherwise: Mr A Effiong, lay representative and then Mr A
Otchie, counsel (for April dates)

For the respondent: Ms N Newbegin, counsel

JUDGMENT

1. The claimant's claims of detriment because of a public interest disclosure are not upheld and are dismissed.

REASONS

Claims and issues

1. The claimant brought claims of public interest disclosure detriment against the respondent, which was not her employer, but was, putting it very broadly, responsible for her medical training at the relevant times. There was a list of issues which had been agreed at a case management hearing. There were some aspects of the list which were unclear or required refinement and these were clarified in a document the claimant produced early in the hearing and also in the course of her oral evidence. That list as clarified is as follows:

Issues

Did C make a protected disclosure for the purposes of s 43A?

1. Did C disclose information which, in the reasonable belief of C, was disclosed in the public interest and tended to show one of the matters set out in s 438 ERA 1996?

2. C relies on the information she contends was set out in the 3rd to 5th paragraphs of an email of 19.07.17.

3. Did C reasonably believe that the disclosure of information was in the public interest because it related to the alleged endangering of the health and safety of children in an NHS hospital?

4. Did C reasonably believe that the information disclosed tended to show that the health or safety of any individual has been, is being or is likely to be endangered: s433(1)(d) ERA 1996.

NB: These issues were conceded by the respondent and not the subject of evidence or argument before us.

5. The email was sent to Leanne Goh and Christina Petropoulos who were Educational Supervisors, C contends the disclosure was within section 430 ERA.

6. It is accepted by R that only for the purposes of section 43K(1) ERA the Claimant was a worker.

Was C subjected to a detriment done on the ground that C had made a protected disclosure?

7. Was C subject to the following treatment?

- 7.1. C was removed from night shifts in October 2017. The HEE failed to object to the Claimant being removed from nights without proper justification particularly in light of the effect the removal from nights would have on the completion of her training

- 7.2. C alleged she was undermined;

7.2.1. In October 2017 by Dr Petropoulos and Dr Kingdon making negative comments to C about her abilities when they informed her that she was to be taken off nights

7.2.2 In January 2018 Dr Goh told C that there were emails with criticisms of her when no emails were sent or produced

7.2.3 .In March 2018 in a meeting Dr Kingdon repeating unfair criticism from 2017 and giving C an adverse outcome of a “2”,

It was clarified that the unfair criticism was reflected in the final paragraph of a letter of 4 October 2017 from Dr Petropoulos to the claimant

7.2.4.In November 2018 in a meeting with Dr Petropoulos who unfairly criticised C for seeing A&E as being busier than it was in reality

7.2.5.In January 2019 Dr Petropoulos unfairly criticised C’s capability

This was clarified as being comments in a meeting that *“some people have concerns, not so much about your clinical knowledge and whatever, but about resilience and how because we all know what we hold and what we deal with as consultants how are you going to cope with the juggling and whatever”*

7.2.6.In February 2019 Dr Round (relying on information provided by Dr Petropoulos and Dr Kingdon) at the meeting for annual review unfairly criticising C’s capability relying on the same unfair criticisms that had been made of C’s non-clinical capabilities since Cs disclosure in 2017.

This was the same criticism as identified in issue 7.2.3

7.3. The Respondent (HEE) did not investigate C’s concerns set out in a record of a meeting held on 19 September 2017 (the report was dated 4 October 2017).

7.4 C was released from her training program on 19 February 2019, given an outcome 4 ARCP (annual review competency progression) C alleges that Dr Kingdon relayed incorrect information to the panel, including about the time C had spent on training.

The incorrect information here and in 7.5 was identified as being the information that the claimant had been granted 24 months of additional training time

7.5. The outcome of the appeal, C was informed of the outcome on the 12 July 2019. C alleges that Dr Kingdon relayed incorrect information to the appeal panel including about the time the C had spent on training.

8. Was the treatment detrimental?

9. If C was subjected to detriment, was R liable for the acts of the person carrying out the alleged detriment pursuant to s47B(1 A) ERA 1996?

10. If C was subjected to a detriment, was it on the ground that C had made a protected disclosure?

11. Are any of the complaints out of time?

Findings of fact

The hearing

2. The situation in relation to the claimant's representation was complicated. Ms Keogh appeared throughout the hearing but was only instructed in relation to the issue of whether the respondent was liable for the actions of Drs Petropoulos and Goh whilst acting as educational supervisors in relation to the claimant. Mr Effiong appeared to represent the claimant in respect of other issues but the claimant in due course decided to cross examine witnesses herself. She had some difficulty at times putting her case to the respondent's witnesses, which we understood was connected with anxiety and the Tribunal put the essential elements of the claims to some of the respondent's witnesses.
3. The case went part heard on 7 February 2022 in consequence of my family emergency and when we reconvened in April 2022, Mr Otchie had been instructed on a direct access basis to represent the claimant for the remainder of the hearing.
4. All parties and witnesses impressed us with the courtesy and civility with which they dealt with what were inevitably at times emotive issues.
5. We had a primary bundle of 2323 pages and a supplementary bundle of a further 237 pages. We had skeleton arguments from Ms Keogh and Ms Newbegin and further written submissions from Ms Newbegin. We also had a short skeleton argument from the claimant.
6. We had witness statements and heard oral evidence from the following witnesses:

The claimant on her own behalf

For the respondent:

Ms F Fletcher: Head of Postgraduate Medical and Dental Education for London (HEE);

Dr L Goh: consultant paediatrician employed by University College London Hospitals NHS Foundation Trust ('UCLH'), claimant's educational supervisor March 2017 – March 2018;

Dr C Petropoulos: consultant paediatrician employed by UCLH, college tutor, claimant's educational supervisor from March 2018. The claimant says Dr Petropoulos acted as the claimant's educational supervisor from an earlier date;

Dr R Shephard: consultant neonatologist at Epsom and St Helier University Trust and Deputy Head of School of the School of Paediatrics and Child Health for London;

Dr S Ahluwalia: GP: Postgraduate Dean at HEE for North Central and East London;

Dr J Round: Director of Medical Education at St George's, from April 2019 Head of School of Paediatrics and Child Health for London;

Dr C Kingdon: consultant neonatologist, Head of School of Paediatrics and Child Health for London. Substantively employed by Guy's and seconded to work at HEE

Facts in the claims

The role of HEE

7. The respondent was established on 28 June 2012 as a Special Health Authority with functions set out in the relevant statutory instruments. Its role is the planning and delivery of training for those employed in the provision of health services in England. In April 2015 the respondent converted to a non departmental public body but retained its statutory functions.
8. We were referred in particular to A Reference Guide for Postgraduate Specialty Training in the UK – the 'Gold Guide'. This spells out the responsibilities of the respondent:

HEE:

Health Education England (HEE) supports the delivery of excellent healthcare and health improvement to the patients and public of England, by ensuring that the workforce has the right numbers, skills, values and behaviours, at the right time and in the right place. It has five national functions:

- i. providing national leadership on planning and developing the healthcare and public health workforce*
- ii. promoting high quality education and training that is responsive to the changing needs of patients and local communities, including responsibility for ensuring the effective delivery of important national functions such as medical trainee recruitment*
- iii. ensuring security of supply of the healthcare and public health workforce*

iv. appointing and supporting the development of Local Education and Training Boards

v. allocating and accounting for NHS education and training resources, and accounting for the outcomes achieved

2.3 HEE will support healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through the development of Local Education and Training Boards, which are statutory committees of HEE. While HEE is accountable for English issues only, it works with stakeholders as appropriate in areas where there may be implications for the rest of the UK.

9. Various other bodies play a role in the training of doctors.

Role of General Medical Council

10. The GMC also has roles and responsibilities set out in statute. It is the independent regulator for doctors, sets the standards for practice and maintains the register and specialist register of medical practitioners. It plays a quality assurance role, approving curricula and training programmes.

Role of Royal Colleges / Faculties

11. These bodies develop the specialty curricula and assessment systems.

How post graduate medical training works

12. Trainee doctors generally are employed by the NHS trusts where they are undertaking placements. Much of the work they do in these placements is for the purposes of their employing trust delivering services. Once a training programme is successfully completed, an ARCP panel (described further below) recommends a trainee for completion to the relevant Royal College. The College makes a recommendation to the GMC, which is responsible for awarding a certificate of completion of training ('CCT') and granting entry to the register.
13. NHS Trusts which offer training placements enter into agreements with the respondent which set out each party's obligations in relation to training: these are known as Learning and Development Agreements ('LDAs').

14. We saw the relevant LDA between the respondent and UCLH under which the respondent provided funding to UCLH and UCLH provided training services.

People involved in training

15. An educational supervisor is a consultant who is usually employed by the trust which employs the trainee in question. Each trainee has an educational supervisor who is responsible for overall supervision and management of their educational progress during the placement.

16. The role is described in the Gold Guide:

2.49 An educational supervisor is a named trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's educational progress during a training placement or series of placements.

(Some training schemes appoint an educational supervisor for each placement.) The educational supervisor is jointly responsible with the trainee for the trainee's educational agreement.

2.50 The educational supervisor is responsible for collating evidence of the performance of a trainee in a training placement, providing feedback to the trainee and agreeing action plans to ameliorate any concerns or issues identified

17. The educational supervisor is responsible for producing an educational supervisor's report and declaration in collaboration with the trainee; this is uploaded to the trainee's eportfolio prior to an ARCP.
18. Responsibility for selection, assessment and accreditation of educational supervisors under the LDA which we saw was the responsibility of UCLH. Time is allocated by the Trust within educational supervisors' job plans to carry out the educational supervisor role. They undertake training and maintain a portfolio which is appraised every three years by the director of medical education.
19. A clinical supervisor is a consultant employed by the trust which employs the trainee. The clinical supervisor supervises a trainee's clinical work and provides feedback during the placement.
20. A College / Speciality Tutor is a consultant employed by the trust who acts as the relevant Royal College's representative in the Trust.

21. Postgraduate deans are employed by the respondent to commission and manage the delivery of postgraduate education for the doctors and dentists within a particular Local Education Training Board ('LETB'). Postgraduate deans have overall responsibility for the quality of postgraduate medical and dental education in their LETB. They are senior medical practitioners who have a background in medical education.
22. A Head of School is a consultant employed by the respondent to lead on training for a particular specialty for a region.
23. A training programme director is a consultant employed by the respondent who has overall responsibility for trainees on a particular training programme and oversees the ARCP process.
24. A director of medical education is a consultant employed by a placement provider trust who is responsible for the relevant LDA.

Process of specialty training

25. We were told that for paediatrics, this is an eight year process after the completion of medical school and two years of foundation training as follows:
Level 1 ST1 – ST3, expected to take 24 – 36 months
Level 2 ST4 – ST5, expected to take 12 – 24 months
Level 3 ST 6 – ST8, expected to take 24 – 36 months
26. A trainee has to achieve competencies from the Royal College of Paediatrics and Child Health ('RCPCH') curriculum to pass to the next stage of training. The trainee rotates through placements at provider trusts.
27. Trainees record their progress on their eportfolio using a range of tools: including case based discussions ('CBDs') and multi source feedbacks ('MSFs'). The eportfolio is owned and controlled by RCPCH.
28. Educational supervisors produce the educational supervisor's report after review of the trainee's eportfolio and discussion with the trainee, to summarise the trainee's progress during the training period.
29. Dr Kingdon told the Tribunal that paediatrics speciality training differed from adult medicine specialties because trainees started at level 1 without any prior experience of treating children. They were therefore heavily supervised in

their early years of training to ensure they were clinically safe. Dr Kingdon said that this could mean that issues with non-clinical elements of practice such as leadership, time management or prioritisation, might only become apparent at level 2 or level 3 of the training when trainees were expected to practice with more autonomy.

Annual Review of Competency Progression ('ARCP')

30. This is a process of assessment which takes place at least yearly for each trainee. ARCPs are arranged by the respondent and the ARCP panel consists of speciality consultants from the local education network. The panel considers documentation collated by the trainee on the trainee's eportfolio.
31. The possible outcomes of an ARCP relevant for the purposes of these proceedings are:
 - Outcome 1: satisfactory progress
 - Outcome 2: insufficient progress without additional training time
 - Outcome 3: insufficient progress requiring additional training time
 - Outcome 4: release from training.
32. An outcome 4 can be awarded even if the trainee's training time / additional training time has not been exhausted.
33. Additional training time may be awarded in accordance with the Gold Guide. For higher speciality trainees a maximum of one additional year may be awarded by an ARCP panel. Exceptionally a further additional year may be approved by the relevant postgraduate dean.
34. As part of her role as Head of School, Dr Kingdon instituted trainee support meetings; these were monthly meetings with trainees experiencing difficulties to provide support. Dr Kingdon and/or her deputies – Dr Opute and Dr Shephard - would attend these support meetings.

Claimant's background:

35. The claimant has an impressive academic background . She has a PhD in pharmacology as well as her medical qualifications. She did her ST1 – ST3 in paediatrics in Ireland before moving to London for further training in 2010. She commenced speciality training in September 2010 at Broomfield Hospital in Essex at ST4/5 level.

36. In March 2011, the claimant moved to Queen Charlotte's & Chelsea Hospital, London. We were referred to some documents from this placement which made reference to issues which we considered had some relevance to the issues we ultimately had to decide.
37. On 23 March 2011, Dr J Ziprin, the claimant's educational supervisor, wrote to the claimant:
- We have discussed the circumstances in which you came to be working at Queen Charlotte's Hospital, those being that there were concerns at your previous post that you had not achieved the required ST5 competencies, had been taken off the night rota and needed more support in gaining Neonatal experience.*
38. On 10 May 2011, the claimant emailed Dr Ziprin in relation to some feedback:
- I have looked through some of the reports. What I find most upsetting is inaccuracies in recounting events that show me as having failed to prioritise and manage time eg Baby Ali did go up on iv fluids by 1pm.*
- There have been several other instances such as my first attempt at intubation and the report that you obtained that I was shaking so much that I could not intubate and you later clarified that this was incorrect, I don't know how the deanery will respond to all of this. I feel unable to comment on your appraisal as I just feel so awful. I do appreciate the time and effort that you have put into things. I'd much rather be investing my time and effort into WPBA as means of gauging how I am doing, this has ended up getting side-tracked.*
39. On 22 Jun 2011, there was an email from Dr Ziprin to others:
- We plan to let her work low dependency weekends. We do not though yet have enough confidence in her to do night shifts.*
40. On 1 August 2011, Dr Ziprin set out some concerns in an email:
- We raised these concerns to Claire today - avoiding all the details that she fixates on. As is always the case it is everyone else's fault and not hers. She reports that we haven't given her the training that we should have, haven't supported her and she criticises everyone else including the consultants as having the problem and not her. She is completely unable to see that the problem may lie within her.*
41. On 4 August 2011, Dr Ziprin forwarded a report from another doctor:
- I'm not sure who will be conducting Claire Marie Connolly's face to face ARCP tomorrow but I wondered whether they would be able to take the time to read the email below and attached letter beforehand.*

This is one report from one SHO but provides a very accurate account of the concerns many of the staff are reporting back to me. We have further reports but I don't want to swamp you. I am documenting everything as Claire has told me that she is considering pursuing a bullying charge against me. This is a little disappointing following the amount of time and support the whole team have put into her, but I suppose reflects her lack of insight

Claire's behaviour is deteriorating to the point that not only are there issues with patient safety but it is having a very negative impact on our staff. I'm seeking advice from the head of HR at present on how to manage her bullying and aggressive behaviour.

...

I have informed Claire that I had been asked to write this as I did not want to do anything behind her back and everything I have written I have said to her in person. However this discussion in itself was cause for concern. She became very aggressive and accused me of lying about incidents above and then also became very upset and told myself and Dr Pickard (who was also asked to write a report and we went together to explain to Claire that we were writing these reports in an effort to be upfront and honest) that she is being bullied, that the consultants are 'twisting everything' and making things up to push her out of her job and 'end her career'.

42. On 5 August 2011, the claimant was awarded an ARCP Outcome 3 and given twelve months additional training time to demonstrate level 2 competencies. Comments at the time included:

Colleagues (ST 4-6) have raised concern about her generic competencies of time management, prioritising, delegating, not having an overview of the unit and babies. When Claire is only given limited number of babies or responsibilities she manages OK.

However on ward rounds there still feels to be more a reiteration of what is written on the charts rather than an overview appreciation of the baby and how it is progressing.

Consultants have expressed concerns about her lack of neonatal knowledge and skills and feel that she cannot work independently at a registrar level.

43. In March 2012, the claimant rotated to the Homerton Hospital. An outcome 2 was changed to an outcome 5 on review in July 2012. An outcome 5 is an outcome reflecting incomplete evidence. For an outcome 5, the panel agrees what evidence should be provided and in what timescale. The claimant then achieved an outcome 1 in September 2012 and a further outcome 1 in February 2013.
44. In July 2013, the claimant achieved a further outcome 1 at a placement at Northwick Park.

45. In September 2013 the claimant rotated to the Royal Free Hospital for sub-specialty training in Paediatric Gastroenterology . On 9 January 2014, Dr S Gabbie from the Royal Free wrote to Dr Long at the respondent:

I was hoping to catch you at the STI interviews to ask your advice about a gastro STS we have at the Royal Free but missed you, so I hope its OK to email instead.

We have a gastro trainee called Clare Connelly [sic] who is an ST6 I think you have met, as she has struggled rather along the way, I am supporting Mark Furman, her supervisor, on this in the capacity as college tutor.

Fundamentally she is considerably below the standard we would expect and I am not sure how best to take this forward. There are doubts as to whether she can be safely signed off, or whether it is right to do so.

In the meantime we are collecting data and WBPAs as best we can to try to provide evidence, but her exposure is quite limited so even this is not easy!

46. In March 2014, the claimant rotated to King's College Hospital. She was awarded an ARCP outcome 3 on 13 August 2014. The claimant was awarded an additional twelve months training time and told this would be the final extension. It was expressly said that the twelve months would not be pro rated to reflect that fact that the claimant was working 60% of full time hours. The panel noted:

You have said that you feel your Trainer's Report doesn't cover everything that you have been doing, for example teaching, and are unhappy with the panels decision to give you extra time. The panel said that you need to document everything in your ePortfolio as there is currently not any evidence in your ePortfolio to contradict your Trainer's Report.

12 months additional training time has been given. This results in 24 months total additional time having been given during training. This will therefore bring you to the end of the total maximum additional time allowed by the Gold Guide, by September 2015. If the recommended actions below are not met by September 2015, your training number will have to be removed.

47. The claimant appealed that outcome unsuccessfully, stating as part of her appeal:

I feel that previous (unfairly) negative reports (which I did not question) have contributed to periods of adversity which I have experienced in my training.

48. In September 2014, the claimant rotated to Chelsea & Westminster Hospital for ST7.

49. In August 2015 the claimant achieved an ARCP outcome 1.

50. The claimant had time out of training for personal reasons between September 2015 and March 2016, at which point she was employed by Homerton University Hospital NHS Foundation Trust on a subspeciality in Neonatology.
51. Her MSF feedback included:
Has a tendency to be indecisive and perhaps overcautious at times.
Sometimes reticent to volunteer, should aim to increase her support of colleagues.
Because of a lack of confidence and decisiveness Claire may not inspire confidence in her juniors / nursing staff
52. We note at this point that we are not in a position to make detailed findings about the events of this earlier period save insofar as they are not in dispute or are a matter of record. We note that the material we have summarised was evident from the claimant's eportfolio and fed into some later decisions.
53. In March 2017 the claimant commenced work at UCLH. She was working 60% of full time hours and was at ST8 level. Ordinarily ST8 would be the final year of training for a trainee working full time
54. Her appointed educational supervisor was Dr Goh. On 4 March 2017 the claimant had an induction meeting with Dr Goh. Dr Goh recorded:
Claire is currently an ST 8 trainee, returning to General Paediatrics after Neonates. She is up-to-date with all exams and assessments required and has completed 1 audit/ WTE year during her training.
As she approaches her final year in training, she is confident that she will have covered the curriculum by the time she finishes and has the necessary skills to make the next step to a consultant job. Over and above General Paediatrics, Claire is close to completing equivalent SPIN training in gastroenterology.
55. Dr Goh told the Tribunal that usually trainees meet with their educational supervisors at three points: at the outset, midway point and end of a placement. She said that she met more frequently with the claimant because concerns became apparent from the early days and she wanted to support the claimant as much as possible.
56. Dr Kingdon described UCLH as 'an exceptionally supportive training environment'.
57. On 16 March 2017, the claimant achieved an ARCP outcome 1, reflecting performance in her previous placement.

58. In early May 2017, emails from another consultant, Dr Cohen, who raised concerns about the claimant's clinical letters being incomplete, unsigned and or not on the correct template, were copied to Dr Goh. Dr Goh's evidence was that this this feedback was unusual for an ST8 trainee and was concerning.
59. On 23 May 2017, another consultant, Dr Eisen, raised concerns with Drs Petropoulos and Goh about a weekend shift she had worked with the claimant. She said that the claimant:
- Was unable to prescribe
 - Had 'difficulty managing time: prolonged periods spent in ED when department not busy and therefore unable to assist on ward round/ward work. We do often need an SpR to be in ED rather than the ward, but there were times when it was not busy and patients could have been seen on the ward round.'
60. She also expressed concerns about:
- leadership;
 - lack of overview of the service;
 - poor communications about cases seen;
 - over investigating and over referring;
 - safeguarding;
 - lack of confidence.
61. Dr Eisen emailed the claimant offering to discuss the weekend. The claimant's initial response suggested that she accepted there had been some issues:
- Thank you for your email. I am really sorry about the weekend. I had been sick on Friday and also I have been on some medication which has not been agreeing with me.*
62. Dr Baki, a further consultant, also wrote to Dr Goh raising concerns about an email the claimant had sent to Dr Baki:
- More evidence of poor management and an inability to be organised and coordinate patient care by Claire*
- I am finding it difficult to figure out her management plan from this RRC and plans re: follow up as this patient has been re-referred to RRC*
- I find it shocking that an ST8 cannot get letters sent out and on the correct letterhead 3 months into a post.*
- RRC 21/4 letter only just sent after prompting due to re-referral*
63. Dr Petropoulos wrote to Dr Kingdon: *I know that you are probably inundated but when you have a sec can we discuss Claire Connolly? – all falling apart a bit this end and I know that this is nothing new but she is now ST8!*

64. On 7 June 2017, the claimant attended a feedback meeting about the concerns raised by Dr Eisen with Dr Petropoulos, Dr Goh, and Dr Eisen.
65. Dr Goh said that the purpose of the meeting was to support the claimant and ensure her training needs could be met. Apart from the concerns raised by Drs Baki and Eisen, there had been feedback from medical and nursing staff about the claimant – her situational awareness, overview of the emergency department and communication with colleagues.
66. Dr Petropoulos' note of the meeting said: *The meeting was convened to give support and think how Claire's training needs may be met in order to successfully complete the ST8 year and gain CCT. There has been feedback from both medical and nursing staff that needed to be addressed. Claire shared some background with us about her personal situation and we explored how this may be influencing her performance at work. Claire told us that she feels able to do her work to a satisfactory standard.*
67. A further passage from the note recorded:
The clinical post is split into several areas:
- a. Out-patient clinics: Claire has run her own general paediatric list under the supervision of Prof Sutcliffe. She has discussed those patients with him and he has reported being pleased overall with her letters although a month ago it became apparent that there was a month's delay in dictating letters and this was addressed through protected time to catch up. Claire is now aware of the expectation that she completes the dictation at the end of every general paediatric clinic and that she is responsible for subsequent communication with parents and any admin associated with them including delegating this responsibility to a colleague if needed.*
- Rapid Referral Clinics are different in that they are urgent clinics and letters are typed by the doctor at the end of the clinic. The letters should be given to admin staff to post and messaged to GPs where relevant. Here there have been significant problems both with the letters themselves and closing the loop with administrative actions. Letters were created with no template or name at the end and the letters had to be re-written by Dr Penny Salt who also changed many of the action plans. Penny expects to meet with Claire soon in order to review the cases and plans and provide feedback.*
- b. ED: Claire had a rocky start to the post with a busy first on call weekend and there has been ongoing poor feedback from nursing staff in ED. We discussed the need to take a step back and keep an overview of the area so as to maintain situational awareness. We also discussed teamwork and communication with the Nurse in Charge and other team members. She will need to gain the confidence of the team again and we discussed strategies of how to do this.*

c. The wards: Claire has not attended many if any ward rounds and was not confident to rise to the challenge of leading a ward round as she reported not to know key departmental processes. We discussed that not knowing processes yet was not an obstacle to a successful ward round as there are lots of people in the team who do and that we would support her with this.

We suggested that she runs her own ward round as soon as possible and suggested that she leads the round starting this week. Claire appeared very apprehensive and refused to lead a ward round this week. We therefore agreed that she should shadow the consultant ward round for the rest of the week and lead the ward round soon.

Claire reported that the differences in the UK and Irish systems were overwhelming at times and disagreed with Sarah Eisen on some points.

68. An action plan was set out to address the issue with letters and the fact that the claimant had not accessed the electronic prescribing system.
69. There was a discussion about night shifts. At this point the claimant had done few night shifts and those she had done had been quiet and well supported. The claimant was unsure whether to undertake an upcoming set of night shifts and agreed to consider the following week with consultant support
70. Dr Petropoulos' evidence about the issues discussed in this meeting was that it was unusual that the claimant was refusing to lead ward rounds at this stage. ST8 trainees were expected to proactively seek opportunities to develop consultant competencies. The claimant did not do that and actively seemed to avoid opportunities to be observed and supported. Dr Petropoulos said that it was the first time she had had encountered an ST8 who could not prescribe. Even ST1 doctors can prescribe. Dr Petropoulos said that the claimant's lack of insight was concerning, particularly because the claimant was hoping to CCT in March 2018 rather than September 2018, which latter date would have been the expected date. The issue of whether the claimant should do upcoming night shifts was going to be discussed with other consultants.
71. The document recording this meeting for the claimant's eportfolio was only created on 14 July 2017. The claimant added a document to the eportfolio taking issue with much of what had been said:

I have been working really hard to improve my performance in ED and confidence of staff in me.

Recently, I have felt that comments expressed by one of the nurses have been unfair to junior doctor staff and not just to me. Often, there is the situation of no beds for admissions nor observation, and this was the case on the Sunday evening of my long days, at a time when it became very busy in

A&E (I have asked for events on this specific Sunday to be looked at). In A&E as the sole Paediatric Registrar, we do not receive any break (the guardian of working hours in the hospital is now aware of this and hopefully this will help).

72. On 8 June 2017, Dr Petropoulos wrote to Dr Kingdon:

Re Claire-

Met yesterday and will do so monthly from here. Big gap to achieving competencies to CCT. Making a plan.

I told her about possibility to stay till Sept 2018 and she got v upset as absolutely intends to CCT in March. She said that she would go full time if necessary.

We are working on her leading a ward round - "wouldn't know how" and running the flow in ED and getting nurses to trust her again. We might take her off her next set of nights

I offered that we meet together but she prefers to keep separate.

Shall we speak so that plan from September agreed when I next see her in 4 weeks?

73. On 9 June 2017, Dr Petropoulos wrote to the claimant after the claimant had not undertaken a planned shift in in the emergency department, attaching the note of the 7 June 2017 meeting:

We want to be as supportive as possible but recognise that there is a lot to achieve in the coming months.

It will probably be better to move you into days rather than nights next week so that we can work on competencies.

74. Dr Baki forwarded an email to Dr Petropoulos with a negative report about the claimant from another member of staff:

the paedrs registrar Claire, was completely unable to make decisions on very basic patients causing an enormous amount of breaches because she was asking consultants to review patients she was also was unable to allocate resources when she was in resus and there was 7 paedrs patients, 3 of which I was quite concerned about, that all needed seeing. I escalated numerous times to her but there was a big delay before not sure why she needed to be in resus with a very stable patient who had been assessed...

Dr Petropoulos discussed this with the claimant.

75. On 10 June 2017, the claimant emailed Dr Petropoulos about the meeting on 7 June saying she did not wish to continue at UCLH from September 2017. Other emails from this time suggest that she was thinking to change placements or take a career gap.
76. 21 June 2017, there was correspondence with Dr Goh about concerns about the claimant's handling of a case with a safeguarding issue. The claimant had not made a social services referral although one was deemed necessary and the safeguarding issue was only picked up when raised at a department safeguarding meeting several days later. This was later documented as a safeguarding CBD on the claimant's eportfolio. Dr Goh spoke with the claimant and gave her constructive criticism about the failure to make a referral. She said in evidence that this was well below the level expected of an ST8 and was concerning. She asked the claimant how she felt about a run of night shifts coming up in August and recorded the further discussion:
- We also discussed your communication with the nursing team, especially when they expressed concern, could have been better. It is vital that we listen to our nursing colleagues and it is our duty to resolve any conflict by escalating to seniors. I was the attending consultant that week and especially as the plan had changed from when we discussed, I should have been escalated to. It is not ok to tell them they could submit an eCAF if they wanted, but not in your name.*
77. The claimant emailed Dr Goh and said that she would put a reflective note on the case in her eportfolio.
78. On 22 June 2017, Dr Cohen wrote to Dr Goh with a concern about the claimant's handling of a case. Dr Goh said she would raise this case at her next meeting with the claimant.
79. On 23 June 2017, Dr Eisen wrote to Dr Goh:
- Just to let you both know I let Claire know today that I had noticed a significant improvement in how she managed ED this week. No major issues from my perspective although she was only really in ED without much input into the ward or the wider team.*
- I still needed to rv some of her intended admissions and found I still tended towards de escalating plans in terms of investigations and admissions but on the whole things were much better than last time*
80. On 5 July 2017, there was a review meeting attended by the claimant, Dr Petropoulos and Dr Goh. They discussed the claimant's improvement in the emergency department but also that she was still struggling with time management, clinical decision making, over-investigating / over-admitting. The claimant said that she felt able to manage her upcoming nights but was

concerned she might struggle to maintain an overview if the department was busy.

81. Dr Petropoulos emailed Dr Kingdon:

Leanne and I had a meeting with Claire this morning to review progress in the post.

I have not been able to upload our previous meeting notes in Kaizen but Claire will upload the notes from our June meeting and her comments / reflections. We will briefly summarise today's meeting and Leanne will also send a summary of a meeting from May. There are objectives from the initial induction meeting but today's focussed on leading ward rounds and showing clear leadership in the clinical areas.

Claire is keen to explore options with you with an aim to CCT by March 2018. This will be a challenge on a part time basis and there may be an option to increase sessions.

I hope that I have helped reassure Claire that we are trying to manage things tightly to ensure progress and achieve competencies which is in Claire's interest.

Your advice would be greatly appreciated.

You are currently meeting mid August which is far away and we recommended that this be brought forward and if Claire wants then Leanne or I could join.

We are obviously keen to support Claire as best we can given the level of training that she is at.

82. After Dr Kingdon thanked her, she sent a further email:

The team are literally tearing their hair out. She is very defensive and tries to keep under the radar.

Nights coming up. Which she feels able to do.

83. On 6 July 2017, Dr Goh sent an email to the claimant summarising the 5 July meeting, which included the following account:

Nights

o Feel able to manage (coming up in 2 weeks)

o Concerns that if busy – may find difficult maintaining an overview

84. Dr Goh sent a further email which included notes from the 12 May 2017 meeting:

- *Concerns highlighted*

o JC7RR 31/3/17: general organisation re: ordering and chasing up of investigations, wrong template, late signing off of urgent letters

o PS4RR 20/04/17: wrong template, ability to write a structured meaningful outpatient letter, delay in signing off

o Time management and overview in ED/ tendency to over investigate– feedback from nurses and consultants

Actions:

o Lead on ward rounds

o Have an overview of the acute paediatric service: ED and ward patients

o Quickly sort out templates

o Expectations especially re administration for rapid referral clinics.

o Develop organisational systems

85. The Claimant replied to Dr Goh on 7 July 2017:

Were these points not documented in the report on the 6th June? Why is this report being written so late? What is the purpose of all these negative reports some of which contain inaccurate information and are unfair, and there is no recognition of difficulties in the system or of the day to day changing registrar rota (eg yesterday yet again I was in A&E covering as the registrar). The one positive feedback (Prof being happy with my letters you omit from this record).

This is all so negative towards me, although I don't think it is intended to undermine me, it is having that effect. There is no recognition of difficulties in the system.

The most recent meeting we had on the 5th July - I do not understand some of the points, again it is very negative. There is a Cdb with a reflection on my eportfolio from the case discussed with Dr Baki, I don't understand why you could not see this. I found this way of discussing issues helpful rather than all these generalisations. Can you bring to my attention cases which I have over investigated and unnecessary admissions? MSF feedback, 6 reports, has never highlighted this issue. It would be more helpful to discuss cases where I am felt to over investigate/admit unnecessarily, perhaps as cbd?

As another issue, I am concerned as (not my cases) specific cases in A&E have been sent home with near disastrous consequences. Also, recurrently, there are issues with no beds been available on the ward, and there have been delayed admissions of patients from A&E, giving rise to situations of

unsafe care. I am really struggling to receive such negative feedback and there is no recognition of these problems.

Today I wanted to meet to emphasise that I really want to work with you to resolve the issues raised about me. I also want to make you aware that this level of feedback and negativity (which may be well-intended), I feel is undermining.

86. Dr Goh then responded to the claimant:

These are the points from our very first meeting with Christina on the ward after your nights. When the pattern of our concerns was becoming apparent. We had asked you to log these meetings in your eportfolio.

Please let's discuss this morning which points you feel are unfair/inaccurate. Do you still want to meet before handover? I will be on the ward from about 8:15am.

Yes I agree it is important that the specific feedback with Prof Sutcliffe (great to show positive improvement in your letters) as well as from the other consultants/nurses who have fed back re: time management/ inappropriate admissions/over investigating. Please do log these as the relevant WBPA.

It is also really important for you to report to us these cases who you have witnessed being sent home with disastrous consequences. Have you spoken to the consultants/completed incident forms? I am happy to go through these with you too.

I am so glad you have got in touch with us - both Christina and I are here to support you - we have always said through out how we really want to help you succeed.

87. The claimant did not at that time ask to discuss the cases of concern she mentioned in her email with Dr Goh or anyone else.

Protected disclosure

88. On 19 July 2017 the claimant wrote to Dr Petropoulos and Dr Goh:

I see the supervision report you completed on my e-portfolio on the 14th July, its saved so I can't add any trainee comments. The report from the meeting on the 7th June is now uploaded twice to my e-portfolio. In the report of the 14th July, there is little written to reflect the period I worked from the 7th June. In this period, I was due to have annual leave and was asked to cover alternative shifts to aid my training which I did. There is no acknowledgment of covering shifts with staff shortages.

Difficult as it is to inform you, I do not feel that Dr Sarah Eisen was fair to me over the weekend in May. I came away from that weekend feeling undermined

(similar to a very negative and detrimental experience of a weekend working with a junior Consultant in neonatology in 2011 which led to a chain of events after which I lost my Grid appointment in gastroenterology). On receipt of the report of 7th June, I had concerns of an untoward process similar to my experience in 2011 beginning to affect me, which does seem to be happening somewhat, although you and Dr Petropoulos try to reassure me that you want to see a good outcome for me.

Sadly, I am experiencing an adverse working environment, most recently occurring on Thursday 13th July in A&E. As part of this, I am worried about ongoing undue pressure to discharge patients too quickly from A&E eg a recent case of a girl who presented with several episodes of presyncope and signs of an abnormal pacemaker on her ECG, I wanted to place her on a heart monitor and ask cardiology to review the ECG but the Consultant was telling me to just discharge her, I disagreed with the Consultant, subsequently it was feedback to me by yourself as a negative event about my communication with the Consultant. In relation to me over investigating, as an example to the contrary, I had a case where I diagnosed measles clinically and it was confirmed with a swab for PCR detection, the consultant had told the parents it was not measles and had not ordered any investigations. On the 13th July, one of the nurses in A&E showed annoyance with me over a patient whom I decided to admit. Professor Sutcliffe confirmed the next day that this was an appropriate admission (I can do a reflective log for this case).

I am aware that the CQC identified issues of concern in the A&E Paediatric area. I have already mentioned that on the weekend long day, 21st May, with Dr Sarah Eisen, there was a stage when the department was becoming very busy with patients arriving, and there was no facility for stays for observations, nor capacity to admit from A&E and for these reasons, 3 transfer outs were being arranged simultaneously. I asked if events on this evening could be explored further rather than just criticising me.

I appreciate the discussion we had about duty of candour when I expressed concerns of hearing about a near disastrous event where a child was sent home from A&E and later diagnosed as having cervical cord compression and transferred to the Neurosurgeons.

I am sorry to send you this email, I hope the issues can be resolved and I can progress with my training.

89. In her evidence to the Tribunal about some of the matters referred to in this email, Dr Goh said that the claimant handled disagreements with colleagues in a challenging way; she would sometimes shout at consultants or nursing staff. She said that UCLH was awaiting an upgraded paediatric emergency department to address issues which had been identified posed by busy shifts and bed unavailability. She said that Dr Eisen had not said it was an exceptionally busy shift.

90. Dr Petropoulos wrote to Dr Prvulovich, copied to Dr Kingdon, forwarding the claimant's email and saying:

I have a troubled email from Claire Connolly an ST8 in paediatrics who the general paediatric team have significant concerns about. Camilla is very familiar with the situation. There is truth in some of comments about environment but other trainees manage with our support and we are awaiting a new paed ED next year.

The comments about Sarah Eisen are unjustified in our view. I attach an email with the concerns from that weekend. Sarah fed back to her far more gently than she could / should have in Leanne and my presence and then Leanne and I carried on with our meeting the details of which were uploaded in her portfolio.

I also heard from the consultant referred to in the ED that Claire spent the afternoon with one patient whilst the consultant treated the rest of children. It was thought that she was overcomplicating matters and she shouted at the consultant when challenged about decision making in front of other members of staff. She raised her voice in a similar way reported by nurses in the past. This was not taken up at the time as the consultants are increasingly worried about being accused of bullying. There are countless examples of poor performance unfortunately that are not all being shared with her so as not to 'break her'.

you are meeting soon.

I am here for two more days (with full on clinics) and she is not here so I won't be able to meet with her.

How do you recommend that I respond because if she does not CCT then she will be taking this all the way I am sure!

91. Dr Kingdon responded the same day:

I recognise how difficult this is. Firstly, I have had another look through her ePortfolio and want to reassure you that you are most definitely not the first department to raise concerns about her. She has had very significant issues flagged up since 2011 when she first came to London. There have been a few places where she has done OK (King's Liver and Homerton Neonates) but both these units are highly specialised and very consultant led – so, not surprisingly, she has managed reasonably.

All the other placements have flagged up concerns.

Secondly my advice to you is to continue what you've already been doing. You are being open and honest. You are being utterly consistent. As College Tutor you are supporting her Ed Sup at meetings. You are clearly documenting your concerns in her various reports on ePortfolio. This means

that there are no secrets from Claire and all the concerns are clearly being communicated with her, so she has a chance to remedy them.

Finally – I'd be interested to see what Liz thinks about how to respond to her. I would be tempted to pretty much send her an email along the lines of the one you sent us. Essentially acknowledging that Paeds A&E is less than perfect – but that other trainees are managing. Also that you have had feedback from the ED consultant etc etc. Just keep it fairly brief and to the point.

I am seeing her on Aug 16. I will gently start the discussion about how her experiences are likely to impact on her training progression and therefore the possibility of a delayed CCT – or no CCT at all, as she has already had >24 months extra training time. It is so often the case that these kind of issues become obvious in a General Paediatric setting. So I don't think you have anything to fear. We just need to keep the meticulous documentation on ePortfolio going and slowly develop the case for whether this trainee can be recommended for CCT or not.

92. Also that day, a consultant, Dr Chung, wrote to Dr Goh:

observation about Claire's performance of her two nights on call on Monday 17th and Tuesday 18th July.

Overall we were quiet and there were no problems with any of the clinical management of the children. However, Claire still needed to be reminded on each morning the standard format/approach to the handover and lacked some details on some of the patients especially results of investigations e.g., CSF results. Obviously some of these may not have been handed over to her properly from the previous on call team.

Also on Tuesday morning handover, she kept saying that there was not much to handover as if she did not want to hand over, which is not quite the right 'attitude'.

Dr Chung was the most senior paediatric consultant in the department.

93. On 21 July 2017, Dr Petropoulos responded to the claimant:

I am sorry that you are finding our observations difficult. We always said that in order to give you a chance to achieve competencies in keeping with an ST8 about to CCT that we would have to be very frank and honest and meet regularly to work on things. The truth is that there have been a number of concerns raised by consultants and nurses some of whom feel that by highlighting them to you they would be accused of intimidation so they have been holding back. This is a shame as we all just want the best for you.

...

Regarding the cardiac patient it is always OK to challenge a consultant. Dr Baki objected to your raising your voice at her and she felt that you were

taking an unnecessarily long time with one patient when the department was busy. She would have expected an ST8 to work more efficiently.

...

We have established that the ED area is too small and we do have to transfer patients out (as many units do when the wards are full). This is part of being a general paediatrician and something that we all deal with. Sarah does not recall the weekend being that different to many weekends that the team manage to cope with. All breaches are reviewed in the regular Breach Meeting. You would be welcome to join one if you have not done already. As explained at handover we have had to create systems to keep our department as safe as it can be. This includes the hotline card that is given to parents. I was quite shocked that you seemed not to know that we give it to parents given that this is covered at induction and was a learning point in the 72 hour review of the child who was sent home with a brain tumour.

I will be away for three weeks and it sounds like you should meet before with Leanne. Given the seriousness of your comments Leanne must be joined by either Jonnie Cohen, clinical Lead, Prof Hindmarsh, Clinical Director, Liz Prvulovich DPGME or Camilla as Head of School of paediatrics. You would be welcome to bring an advocate with you if you would like.

94. On 3 August 2017, Dr Goh held a supervision meeting with the claimant and Dr Cohen and discussed her development needs and objectives, setting out what assessments she needed to do within three months. She reminded the claimant to complete her MSF and suggested she contact at least six consultants for feedback. On the same day the claimant emailed Dr Goh challenging the account given by Dr Cohen of two cases which were expressed to be of concern. Dr Goh said in evidence that this showed the claimant failing to see that these cases were representative of themes.
95. On 8 August 2017 Dr Baki raised a concern about the claimant not noting that a baby might be an infection risk.
96. On 11 August 2017, the claimant wrote up her reflections on the case Dr Baki raised. Dr Goh's evidence was that she was concerned that these reflections seemed to place blame on others.
97. On 16 August 2017, the claimant attended a support meeting with Dr Kingdon and Dr Shephard.
98. At around this time, the consultant body including Dr Goh agreed that the claimant should be removed from night shifts.
99. On 29 September 2017, the claimant had a case based discussion with Dr Petropoulos. Dr Cohen joined and informed the claimant that she was being removed from night shifts. Dr Goh emailed the claimant that evening to

express support for the claimant given that the meeting must have been difficult, and offering to meet with her.

100. On 30 September 2017, the claimant emailed Dr Goh saying she had not been told details of the concerns about her or which consultants were at the meeting at which concerns were expressed.

101. Dr Goh forwarded the email to Dr Petropoulos and Dr Cohen:

Claire's reply - looks like she:

1) Wants specifics... and is not reflecting on the bigger picture/message as she has done before.

2) Is finally seeking help for herself.. which is great.

3) Still thinks there is hope... rather than meeting me to discuss how to proceed, she wishes to almost ignore your conversation and return to previously agreed goals.

102. The claimant received an MSF document at the end of September 2017 which included some positive comments but also raised some of the same concerns as had been discussed in meetings with the claimant.

103. On 4 October 2017, Dr Petropoulos wrote to the claimant about her removal from nights:

Thank you for meeting with Dr Cohen and me on 29/9/17 following our session to complete a case based discussion which had an educational focus. Our subsequent meeting with Dr Cohen was an opportunity to discuss how to proceed with night time on call as we move into a period where winter pressures often result in busy nights and the need for the night SpR to manage a large volume of patients safely and efficiently. The review with Dr Cohen had not been planned but was opportunistic following a routine meeting of the consultant general paediatricians on 28/09/17 where all trainees were discussed routinely as part of the agenda.

This was the first such meeting after the summer break. There was collective consultant concern about how you would manage busy night time on calls safely based on our experience of working with you to date. You asked me to invite Dr Cohen into the meeting to explain this in more detail.

I completed some notes at the end of the day.

Before Dr Cohen joined us I had asked you how you thought that you would handle managing night shifts now that the shifts will become busier and also asked if you had a back to work interview following leave as I was aware that you had been off sick after the last set of nights.

You let me know that:

- You only had one day off sick post nights and therefore were not due a back to work interview.*

- *You found night shifts acceptable as you said that it is usually reasonably quiet after 11pm.*
- *You are doing fine and had no concerns about being on call.*
- *You wanted the subsequent discussions to take place with Dr Cohen who then joined us.*

Dr Cohen and I explained that

- *The collective general paediatric consultant opinion having worked with many trainees between us in the past is that you are an outlier in terms of risk appetite and speed of work. Whilst your knowledge base to draw upon is very good, you seem to request more tests than other trainees and are more cautious with patients, observing them in the Emergency Department for longer than may be necessary or requesting admission that may not be needed thus preventing sicker patients from being admitted. We worry that whilst the patient who you are personally attending to will be safe, and we certainly don't want you to work outside your personal comfort zone until you have let us help you develop practice in this area, there will be other patients in all clinical areas that you are responsible for who you have no situational awareness of and who may come to harm. For the safe management of all our patients moving forwards, we as a consultant body have agreed that you should come off night shifts until we are reassured that you can lead busy shifts and demonstrate to us the ability to manage patient flow and acuity across the service safely.*
- *As College Tutor I am personally responsible for your welfare and training. The focus of my attention is to keep both you and our patients safe and to ensure that you receive an appropriate level 3 program. You have objectives from the general paediatric post over the past 6 months that I believe have not been met yet. I was curious as to why you turned down the opportunity to stay in general paediatrics to complete those objectives.*
- *You have the opportunity to show to us that other staff including a range of consultants, trainees and nurses who you have worked with regularly over the past months have confidence in your practice. We had hoped that by now we would have seen a 360 MSF assessment report as per guidance following the meeting with Dr Cohen and Dr Goh on 2/8/17 and you are due to send out invites in the near future.*
- *We have not been singling you out. All trainees are discussed in a systematic way – it is not unusual that one or two trainees at a time are not on the night rota for various reasons whilst we work on areas that need support or development. We see this as a formative exercise.*

In response:

- *You reported some positive meetings recently; your meeting with Dr Jo Begent who will be clinically supervising you in the adolescent post and your meeting with Dr Camilla Kingdon, Head of School of Paediatrics who you met with in August. You said that you understood from Dr Kingdon that your training was progressing and that if extra time was needed there was the possibility to apply for this to the GMC. You said that you had been offered a clean start at a different post for September 2017, something that we were unaware of but that you did not take this up.*
- *You asked for specific examples where your performance came into question and asked why we did not highlight concerns between August and the meeting though I did explain that we have not met over the summer and that this was the first such meeting after a break.*
- *You said that you previously highlighted to us that you have perceived that consultants have undermined you and said that this has affected your confidence as did the case of a patient you sent home at the beginning of the post who represented to a different unit with raised intracranial pressure due to a brain tumour. You stressed that you have never been involved in an SI nor have there been any formal complaints directed towards you.*
- *You reported that being on call at UCLH feels unsafe as it is too busy and that an SHO had also highlighted this to you.*
- *You said that previous MSFs have been satisfactory. At Chelsea and Westminster you said that you were assessed as above average in various domains and that here has never been cause for concern and you challenge the feedback from UCLH on your e-portfolio.*
- *You said that you struggle with symptoms of anxiety and that after the last set of nights you were worried about how you will cope with the next set. You would value accessing help from Occupational Health as this is affecting your wellbeing.*

Dr Cohen and I advised that:

- *We wish to support you and your welfare is paramount in our decisions as is the safety of our patients.*
- *Dr Cohen will make a formal referral to Occupational Health to address concerns about anxiety that you have raised.*
- *Dr Cohen said that as Clinical Lead he has taken the decision based on his direct observations and what he has heard from the other consultant general paediatricians to take you off the night shifts but that this will be reviewed on a regular basis and before your next set of nights are due in mid October. A favourable 360 MSF from a range of professionals who have had experience with working with you in this post will give him confidence to reconsider as will seeing you take the lead in some ED sessions under consultant supervision and he urged you to discuss this with your supervisors.*

- *The majority of our senior trainees on call manage the flow and patient dependencies well and have not raised the same concerns as you about the service being unsafe.*
- *There remains an option to return to general paediatrics if the adolescent team agree in order to work on relevant competencies so that we can help you better.*

You welcomed the opportunity to meet with an Occupational Health consultant and Dr Cohen has completed a referral, however you would not like to take up the offer of transferring to general paediatrics. There may however be an option to take up some general ED sessions and you can consider this.

You will meet regularly with Dr Goh your Educational Supervisor and Dr Begent who will be clinically supervising you in the adolescent post at 0.6 WTE. It may be that coming off nights gives you more opportunity to meet targets set from both areas as you would be working directly with consultants more frequently. You may also wish to vary your days in order to make the most of opportunities as they arise.

I also want to reflect that over the past six months or so particularly when presented with negative feedback you have made reference to feeling undermined or have highlighted what you believe is unsafe practice in our department either by email or in person. Your feedback is surprising as such concerns are not reflected in GMC or RCPCH feedback where the department has been given positive reports especially for the general paediatric service. Other trainees have not raised similar concerns and for some of the shifts that you have referred to consultants and nurses had individually reported back contemporaneously with their own version of events. Whilst I take on board your concerns, I cannot at the present time support your view but you are welcome to escalate your concerns as I previously advised either to Prof Hindmarsh who is our Clinical Director or Dr Prvulovich who leads PGME at UCLH. I hope that I can reassure that I reached my conclusion without discrimination and sympathetically.

With respect to your feedback about the CQC, you are also welcome to attend ED leads meetings where you can see how CQC and other feedback that you brought up in your July email to me is managed and how the service is further developed to maintain the safety for our patients whilst we prepare to move to a larger department.

I am available to meet with you to discuss any of the contents of this letter and once again want to reinforce to you that that both your welfare, training and our patient's safety are paramount in any decisions made. I also wanted to reassure you that any conversations or meetings that have taken place regarding your training and welfare have always been intended to be sympathetic and non judgmental. We have tried to offer you more frequent

and comprehensive supervision sessions in order to help you meet the standards required ahead of your CCT date.

104. On 5 October 2017: Dr Petropoulos wrote to Dr Goh: *Of course I feel terrible having had to send the letter to Claire and really hope that she is OK. I heard that she will not be coming in today.*

As we have discussed individually it is important to lay out the concerns formally.

105. Dr Kingdon was copied into this correspondence. She said she noted that the claimant had been given appropriate advice as to how to escalate her concerns about unsafe practice within the Trust. They were matters which were within the Trust's remit to address and the respondent would not get involved unless a trainee had exhausted the Trust's procedures and issues remained unresolved. In any event the respondent was not a regulator and had no remit to investigate the Trust even where safety concerns were raised.
106. We heard evidence from the respondent's witnesses about the effect on a trainee of not doing night shifts. Dr Kingdon told us that some trainees with disabilities for example might just do twilight shifts. Competences which might typically be achieved during night shifts could be achieved in other ways where necessary. A decision to remove a trainee from night shifts was one for an employing trust; the consultants at the trust are in the best position to assess the safety issues. A decision of that sort would not be taken lightly as it would impact on other staff and possibly require expenditure by the trust on locum cover. Dr Round told us it was a decision of last resort for a trust because of the service provision issues which were created. The respondent could not interfere in an operational decision of this kind.
107. On 6 October 2017, there was a meeting between the claimant, Dr Goh and Begent to discuss the competences the claimant needed to develop and to formulate a plan for her to work on them.
108. On 9 October 2017. Dr Begent emailed Dr Goh about the meeting:
Might be too late but think we should tell occ health that she had clearly talked to us about extreme anxiety about patient management and managing the department (at a time when it has not been that busy)
She has also spoken of poor sleep (and texted us at 4am) making her late
109. On 13 October 2017, the claimant attended a support meeting with Dr Kingdon. Dr Kingdon expressed concern that the claimant would not be able to achieve CCT by September 2018 due to numerous outstanding Level 3 competences. She made it clear that the claimant was at risk of an outcome 4 and discussed possible alternative career options for the claimant.
110. On 11 November 2017, Dr Petropoulos emailed Dr Goh and Dr Sutcliffe about the claimant, saying that the claimant had been told by Dr Goh and Dr Petropoulos that she might not CCT. That was not, she said, about doing

nights. Competences could be developed on other shifts. What was concerning was the claimant's inability to work unsupervised. Dr Petropoulos said that she was happy for Dr Goh and Dr Sutcliffe to keep reassessing the situation and put the claimant on unsupervised work if safe to do so.

111. Dr Sutcliffe had been copied in as the claimant had reported that he was very happy with her work and said that she was fine in A and E. His response indicated that that was not correct and he said that he suspected that there was some manipulation in her behaviour:

We need to stick together and make sure we follow procedure, and then we can avoid the potential for Lawyers at Dawn

112. On 12 November 2017, Dr Kingdon wrote to Dr Whiteman, the postgraduate dean, about her concerns that the claimant would not CCT.

113. On 29 November 2017, Dr Baki forwarded to Dr Goh some positive feedback about the claimant from a senior nurse. There was more positive feedback about the claimant from Dr Petropoulos on 9 December 2017.

114. On 15 December 2017, Dr Goh emailed relevant consultants asking for feedback on the claimant. She also emailed the claimant suggesting they meet for a comprehensive catch up about her progress in the new year.

115. Also that day there was an email from Dr Salt to Dr Goh about the claimant:

Last Wednesday when Claire was covering ED I asked her in the morning to call a mother who was seen in ED the night before. The mother (who had seen me before in clinic for a different problem) had called Jackie to speak to me because she was worried her child had Kawasaki's. I ask Claire to call the mother to discuss her concerns and bring back to ED if necessary. Claire did not get back to me at all and went to teaching. The mother called Jackie again in the afternoon because no one had got back to her. I got the message at 5. I called the mother and left a message and asked her to come back to ED if she was concerned. She came back that night and saw Christina and was treated for Kawasaki's.

Feedback - if you have not been able to complete a task you have to tell the person who asked you that you have not been able to do it.

116. On 18 December 2017 there was an email from Dr Cohen to Dr Goh in which he gave details of two recent cases in which the claimant had been involved and raised concerns about the claimant's handling.

117. In December 2017, Dr Petropoulos was aware that the claimant might be alone over Christmas and invited her to join her family Christmas. The claimant accepted in cross examination that this was a kind gesture but not that it was inconsistent with Dr Petropoulos being 'out to get her' due to the public interest disclosure. The claimant said that people could act in different ways at different times.

118. The consultants corresponded in late December about the possibility of the claimant being put back on nights. Dr Begent was unconvinced that there had been 'big steps forward' but thought that night shifts might be necessary to boost the claimant's confidence and 'see where we are'.
119. Dr White was unconvinced that 'she is any better with decision making / patient management'. Asked in cross examination about these concerns, the claimant said that she suspected Dr White would have known about her public interest disclosure. We had no evidence to suggest that other consultants did know about the public interest disclosure.
120. On 27 December 2017, the claimant wrote to Dr Goh saying asking if their progress review could be done on paper and not recorded in her eportfolio.
121. There was some discussion at the end of the year between Dr Goh and Dr Petropoulos about whether the claimant should be allocated a new educational supervisor. Dr Goh said she was happy to continue or to hand over.
122. On 10 January 2018, there was a meeting between the claimant, Dr Goh, and Dr Begent. The claimant wanted written feedback in advance and Dr Goh said feedback would be discussed at the meeting. The claimant disagreed with things that were said about particular cases. Dr Goh told the Tribunal that she was concerned that the claimant's recollections conflicted with those of consultants or appeared to be unlikely. The claimant was also told a decision had been made that she could go back on nights so that they could assess her abilities before her ARCP. The claimant was asked to open her MSF to a wider range of people. That same day the claimant fractured her ankle and she commenced sickness absence on 13 January 2018. In her notes of the meeting, Dr Goh included positive feedback and feedback which had raised concerns:

Specific concerning feedback:

- Patient with abdo pain, breeched waiting in ED for CAMHS review (Claire had deemed this was not needed urgently) despite planned review soon. Claire was positive about the learning points she had taken from being involved in this case.

- Infant with failure to thrive, mother had been making up bottles incorrectly – now improving since health visitor input. Consultant did not agree with Claire's decision to admit the child and that this child could have been managed in the community. Claire still persisted with the decision to admit. She explains this is because she noticed Uncapped (hence unsterile) bottles in the mother's bag – but did not question her about these. Claire was also worried about the mother's mental state.

- Consultant had asked Claire to telephone a family to arrange review for a child with suspected Kawasaki's disease. Claire left for afternoon teaching session without updating/handing over to the team. Mother called the

secretaries later in the evening, worried about her child and said no one had called her – the consultant then rang the mother who subsequently brought the child into ED for assessment – the child was treated for suspected Kawasaki’s disease. Claire says she did call this mother and that the mother refused to come in that day. Claire also said that the consultant would have worried about this child even if she had updated her, but did eventually recognise that she could have communicated better in this instance.

123. On 19 February 2018, the claimant’s MSF came through to Dr Goh: she forwarded it to Dr Petropoulos. She noted that there was a comment in the MSF relating to manipulation of feedback. Her view was that that the claimant selected colleagues and peers she thought would provide positive responses. Some of the less positive feedback included:

‘she can take a long time with individual patients and then can lose situational awareness of other patients not realising when her colleagues are taking up the slack’

‘...she also struggles to keep all the balls of a busy ward in the air and keep the momentum up...’

‘She does not always take on her fair share of work as she is slow.’

‘Clare finds it hard to accept constructive feedback, even if it maty, at times, feel negative.’

124. There was correspondence that day between the claimant and Dr Goh. Dr Goh had told the claimant that Dr Goh’s own feedback would be ‘a formal collation of feedback from the consultant body’. The claimant said: *Is it possible to obtain copies of the email feedback from the Consultants as anonymised comments? As this represents feedback from all the Consultants (as compared to my MSF) - and this feedback would be helpful for further planning.*

125. Dr Goh responded saying some of the feedback was ‘collected verbally’ and that some had been delivered at previous meetings:

The email feedback formulates only part of the overall feedback from the consultants, as some of this was also collected verbally.

We have met with you regularly to deliver all the feedback (some very difficult) to you in as thoughtful and supportive manner as possible.

We had also asked you to invite all consultants (as well as all senior nursing staff and all your peers) to complete your MSF - this was try to obtain as rich as possible information regarding your performance.

126. Dr Goh had asked Dr Petropoulos and Dr Begent if she should try to send the claimant a ‘sanitised version’ (by which she told the Tribunal she meant an anonymised version) of the email feedback from consultants.

127. Dr Begent said:

I have them all in one file so could do – the cases won't be very anonymous but to my mind the comments are exceedingly fair if a little exasperated.

The harder hitting stuff could be properly anonymised

I think we should as it will add weight to our argument that we really think about what is going on but be very clear to state that the preferred mechanism would have been her 360 but we knew she had not used this approach as it was intended.

We should send a copy to her and to Camilla at the same time so effectively it is another reflective assessment tool ??

128. Dr Goh's evidence to the Tribunal was that she eventually decided that the emails should not be shared as the majority of providers of feedback were identifiable. She said that she was concerned that providing the emails would lead to the claimant attempting to unpick every case or render providers of feedback open to allegations or inappropriate reprisal.

129. The claimant said in evidence that she was frightened that there was further criticism that she could not see and that was what upset her. That was something which had happened before.

130. On 20 February 2018, the claimant returned from sickness absence and on 21 February 2018, she had a trainee support meeting with Dr Opute and Dr Brathwate. Dr Kingdon had intended to be present at this meeting but found herself double booked. On 23 February 2018, the claimant met with Dr Goh. The claimant said her ARCP was on 1 March and they arranged to meet again on 28 February.

131. Dr Goh drafted the educational supervisor's report and sent the draft to Dr Begent and Dr Petropoulos who confirmed that they were happy with content and thought it was fair:

Educational supervisor's declaration

Having reviewed the trainees Portfolio please comment on any areas of excellence or any areas for improvements

This last year has been very challenging, the process of performance management started very early on in the post when it became clear Claire was a struggling trainee. She has felt 'watched' and this has contributed to her feeling more anxious - we commend her on the effort she has put in and she has made definite progress as a result of this. This progress has unfortunately been hindered by sick leave, but this is been out of all our control. We have tried our best to support Claire as a consultant team: helping her set learning objectives, meeting with her regularly and have always tried to convey feedback (both negative and positive) in as supportive and kind manner as

possible. We offer Claire to swap her Adolescent medicine post for General Paediatrics, but this she rejected. As she was struggling we made the decision to remove her from night duties, in the hopes that this would allow her more time in General Paediatrics.

Based on our observations and her MSF - Claire has good medical knowledge, she is a kind and caring doctor, who is thorough in her assessment of the individual child in her care. Her skills in managing multiple patients within the acute Paediatric service have improved but still fall far from a level expected for a trainee at her level. She is risk averse in her clinical assessment and management. As she has had to focus on improving clinical skills, she has had less opportunity to further the wider skills necessary to become a consultant e.g. audit/QI/teaching – and so has fallen short in meeting the requirements here. Claire clearly has a good relationship with and is valued by many of our junior team members. Claire has generally responded defensively to negative feedback, and has accused several members of our team of intimidation - this has brought with it a degree of discomfort to consultant colleagues when working with her.

Sadly, despite the measures put in place, Claire's performance still falls short of that expected for a trainee at her level. She has not met requirements with regards to assessments (set together during our support meetings) and the curriculum.

132. On 1 March 2018, the claimant attended the ARCP panel meeting. Dr Kingdon chaired the meeting; she said it was a 'difficult and emotional meeting for the claimant'.
133. The panel recorded a number of competences the claimant needed to develop. They informed the claimant that she was at risk of losing her National Training Number in September 2018 if those requirements were not met. She was awarded an outcome 2.
134. On 12 March 2018, the claimant asked for a review of the outcome 2. Dr Kingdon said she was surprised, as the claimant was aware from their discussions that she had been at risk of an outcome 4. She said that she considered it showed severe lack of insight into the claimant's progress in training.
135. In March 2018 Dr Petropoulos took over as the claimant's educational supervisor. On 8 March 2018, the claimant commenced a period of sickness absence.
136. On 13 April 2018 the review panel upheld the ARCP outcome 2. The claimant's appeal had focussed on what she felt was a lack of consistency between the educational supervisor's declaration and other evidence of her performance. The review found:

Your most recent MSF does indeed highlight many areas of good practice, as well as areas where you have improved over time. However it also highlights

areas for development which chime entirely with the developmental comments made by your Educational Supervisor in your trainer's report from February 2018.

137. On 26 April 2018, the claimant was assessed by occupational health and signed off for a further six weeks. The claimant was due for a further ARCP in summer 2018 but Dr Kingdon requested that she be reviewed in the winter round instead.
138. On 6 June 2018, Dr Petropoulos wrote to Dr Kingdon saying that there was uncertainty as to when the claimant would return and asking whether the claimant could be supernumerary from September so that they could focus on her training needs. Dr Kingdon was supportive of that proposal and on 8 June 2019 she made a case for supernumerary funding to be provided for the claimant. The claimant attended a support meeting with Dr Kingdon on 12 July 2018 and they discussed a phased return to work for the claimant and a bespoke training programme during a period when the claimant would hopefully be supernumerary. Dr Kingdon explained to the claimant it would be her last chance to progress and achieve CCT. Dr Kingdon expressed to Dr Petropoulos her concern that even with supportive measures the claimant was likely to receive an outcome 4 due to the available training time and the large number of capabilities she had yet to consistently demonstrate. On 16 July 2018 the availability of supernumerary funding for the claimant was confirmed. The claimant returned to work on 3 September 2018.
139. Dr Petropoulos sought to meet the claimant regularly and arranged for her to undertake out of hours work so she could demonstrate relevant capabilities. After a 27 November 2018 supervision meeting between the claimant and Dr Petropoulos, Dr Petropoulos recorded:

Claire has been growing in confidence and has been doing some late and long day shifts. Some of those shifts have been particularly busy with multiple priorities and Claire has been coping well with these.

Time keeping is not perfect but has improved significantly.

We have had a conversation recently relating to anxiety levels feeding off on junior members of staff and I think this has been taken on board. During one occasion when Claire was anxious at the beginning of a shift she was upset with a colleague.

The ED appeared more busy than what it was - this was addressed between the trainees and subsequent to that there was a far more positive shift whereby Claire was described as a pleasure to work with and 'completely on it' – which has also been my experience recently. I have seen Claire grow in confidence in the past few months which is what we were looking for at the beginning of this six month period.

Claire has been doing general paediatric out patients and making sensible plans for patients – letters can be more concise and this will be worked on using DOC

Claire has attended leadership training

One area for improvement is to be clearer to the attending regarding management plans and summaries of patients seen but again this has been improving

In the next couple of months Claire will need to:

- 1. Undertake MSF ASAP*
- 2. Safeguarding CBD – try and get as much level 3 experience as possible*
- 3. QI – including offering to teach*
- 4. APLS is about to expire – book on a course*
- 5. Undertake a range of out of hours – late / long day / nights in 2019 – demonstrate that can work independently and under pressure.*
- 6. Continue to build on what she has achieved in the last few months*

140. On 10 January 2019, Dr Petropoulos emailed the paediatric consultants asking for specific feedback on the claimant ahead of the ARCP panel. Dr White said that the claimant had retracted an invitation for consultants to contribute to the claimant's 360 review; he said the claimant was chaotic and unreliable and failed to appropriately follow up patients and manage documentation. He copied Dr Petropoulos into an email he sent the claimant about a patient he said she had failed to properly document.
141. On 22 January 2019, there was a meeting between the claimant and Dr Petropoulos to discuss her progress before the ARCP panel meeting. Dr Petropoulos said that the claimant had been performing reasonably well in the run up to Christmas but issues had begun to recur after that.
142. This meeting was covertly recorded by the claimant. When the claimant provided a transcript for the purposes of the Tribunal proceedings, she had edited the transcript to remove some sections where she seemed to accept criticisms. The claimant said in evidence that the parts she deleted were open to misinterpretation and irrelevant.
143. The part of the meeting which the claimant said was a detriment was Dr Petropoulos' comments that *"some people have concerns, not so much about your clinical knowledge and whatever, but about resilience and how because we all know what we hold and what we deal with as consultants how are you going to cope with the juggling and whatever"*.
144. The context was that there was a discussion about whether Dr Petropoulos had seen the claimant's latest MSF. She had not. The claimant thought the MSF was negative and was trying to work out who had made particular

comments and Dr Petropoulos said she would be getting feedback at an upcoming consultant's meetings and that:

I know that some people have said some people have concerns, not so much about your clinical knowledge and whatever, but about resilience and how...

Because we all know what we hold and what we deal with as consultants and thinking actually how are you going to cope with the juggling and whatever.

145. Dr Petropoulos' next remark is: *Not from what we've seen. So basically that's not part of the assessment. But just thinking through it all, because I know that there are differences in opinion and I think there's also recognition. I think the difficulty is that there is recognition that you've had a very, very long journey. ...*

And part of the conversation that I've had with Sarah as [College tutor] is you've got progression. You've got where you've come from and you've got all the mental health stuff, which I don't know how much of it was addressed early on, or what could have been done better earlier on and us all gunning for you.

We really want this to be a success, but if we say acceptable for everything, is that a safe decision?

146. Dr Petropoulos had said earlier in the conversation that she thought previous feedback including her own from before Christmas had been quite positive.

147. Later the two discussed the recent MSF and this exchange occurred:

.....Okay. Well, reading through it to me gives me a balanced view of what I'm seeing. A combination of what... I am sure.....you'll probably find that your peers and juniors will tend to give quite nice feedback anyway, a bit of recognition probably coming from some of the consultants about and anxiety getting in the way and just maybe being a bit slower than others and sort of over investigating and so on which all goes with the anxiety side of things. And one slightly more 'out there' person giving tougher feedback.

Claire: I thought I had managed that since I came back and I didn't think it was an issue since I came back.

Dr Petropoulos: I think it still is. I think it's a huge improvement

148. On 24 January 2019, at a general paediatric consultants' meeting. Dr Petropoulos asked for feedback on the claimant and made notes including the following:

Claire has tried very hard this year and has made progress from last year but the collective opinion of the consultants was that Claire is not yet functioning as a rounded level 3 trainee ready for CCT – this is with regret because we

were really hoping that she would succeed and earlier in the post thought that she was making some progress.

150. There then follows what seemed to us to be a very detailed and apparently balanced account of the claimant's performance and this summary of comments:

- *Good*

- o *Knows a lot*

- o *Nice manner with families*

- o *Caring*

- o *Pleasant*

- o *Some comments about better use of tests recently*

- o *Some reports of good teaching*

- o *Hard working and kind*

- o *Some report of increased confidence and nice rapport with families*

- *Not so good*

- o *Judged as not functioning at level 3*

- o *Managing her own stress*

- o *Prioritisation of investigations / over investigation*

- o *Confidence*

- o *Completion of tasks*

- o *Reluctance to be in charge*

- o *Some reports of not seen to teach*

- o *Raising of voice*

- o *Doesn't like being watched and perceived as 'hiding'*

- o *Reports of juniors avoiding her*

151. On 30 January 2019, the claimant wrote to Dr Kingdon asking for additional training time and to be moved from UCLH to undertake that further training.

152. 10 February 2019, the claimant emailed Dr Petropoulos and asked what the feedback from the consultants' meeting had been. Dr Petropoulos said amongst other things: *We have had some supportive meetings along the way and you were showing some real progress but as I explained when we last met that progress does not seem to have been sustained.*

153. On 11 February 2019, the claimant wrote to Dr Petropoulos:

As you are aware I am in great difficulty in my training. My confidence and well-being has plummeted in the last 2-3 weeks, and my mother has been critically ill recently, so I am near a point when I went off sick from work last year. I hope I can be at a point to have a reference to return to work in Ireland as a Registrar level (as I had been before I ever came into the training system here) - do you think I can be helped with this? Are the Consultants happy with me working at the level of a Registrar?

154. The claimant and Dr Petropoulos met that day to complete paperwork for the ARCP. They discussed some of the content of the notes of the consultants' feedback. The claimant became upset and what Dr Petropoulos described as confrontational when Dr Petropoulos tried to talk about a safeguarding case which Dr Eisen said the claimant had not followed through. Dr Petropoulos said that they did not go through all the feedback given the claimant's response. Dr Petropoulos completed the educational supervisor's report with the claimant including parts which indicated that the claimant's performance in particular areas was below standard.

155. On 19 February 2019, the ARCP panel met. The panel was Dr Round, Dr Shephard and Dr Opute; we were told that it was unusual for the panel to consist of three senior educators but it was constituted in this way because the outcome was potentially serious for the claimant. The claimant was not present at the panel meeting, at which she was awarded an ARCP outcome 4.

156. Dr Round said in evidence that the claimant needed to demonstrate to the panel that the targets previously set were addressed with clear and consistent evidence. What they found was that claimant only had seven work place based assessments when they would have expected to see about twenty.

157. There was insufficient evidence that the claimant was progressing as required. The evidence did not suggest that the educational supervisor's report was inaccurate or unfair. Dr Round said they noted some positive comments in the claimant's eportfolio and took into account mitigating features such as the claimant's sick leave, phased return and additional training time.

158. Because the claimant had already had an additional 24 months training time awarded, an outcome 3 was not an option for the panel. In any event Dr Round's view was that further training time would have been futile in any event.

159. Dr Round's evidence to the Tribunal was that he was not aware of the claimant's public interest disclosure.

160. On 19 February 2019 at 16:54, Dr Kingdon sent the panel a spreadsheet in which she calculated the claimant's time in training; we saw a copy of this document.

161. Dr Shephard's evidence was that this document was not received until after ARCP panel had met and did not form part of the panel's deliberations. Dr Shephard said that she did a calculation herself as to how much time the claimant had had in training. She said that the question of how much training time the claimant had left was not relevant as the outcome 4 was awarded because the claimant had not achieved what she had been required to achieve by the March 2018 ARCP panel. They were aware that the claimant had not exhausted all of her training time at that point. They had no information directly provided by Dr Kingdon at the time they deliberated.
162. On 4 March 2019, the claimant rotated to Whittington Health NHS Trust whilst she pursued an appeal against the outcome 4. The first stage of the appeal was a review by the original panel. Dr Round said the panel met and reviewed the original decision and the claimant's 80 page appeal document. They looked at two issues; had the claimant provided sufficient information to be awarded an outcome 1 and had she been adequately supported in her training. On 20 March 2019, Dr Round confirmed that the panel decision remained an outcome 4.
163. On 2 April 2019, the claimant appealed the outcome 4. The hearing took place on 4 July 2019 and was chaired by Dr Ahluwalia. The panel was a large panel made up of a diverse range of individuals. Dr Round attended to provide an overview but was not involved in the decision making. The claimant presented her appeal and was asked questions by the panel. Dr Ahluwalia said that Dr Kingdon provided no information directly to the appeal panel and in particular made no statement to the appeal panel about the claimant's time left in training.
164. The appeal panel was concerned that it could not understand the calculations of the claimant's time in training and asked for clarification as the claimant had raised this as an issue. Dr Round considered it was inappropriate for him to provide the calculation as it was his original calculation which was being criticised. The respondent's case management team provided further information and the panel reconvened on 10 July 2019.
165. The appeal panel concluded that the claimant was not able to meet the required standard in any time frame and on 12 July 2019, the claimant was informed that the outcome 4 was upheld.

Law

Public interest disclosure detriment

166. A worker has a right not to be subjected to a detriment by any act or deliberate failure to act on the part of his or her employer done on the ground that the worker has made a protected disclosure under s 47B ERA 1996.

Causation of detriment / burden of proof

167. Where the employee complains of detriment under various provisions of the ERA 1996, including s 47B, the tribunal will consider the complaint under s 48. S 48(2) provides that it is for the employer to show the ground on which any act or deliberate failure to act was done.

168. The worker must show:

- that he or she made a protected disclosure / act falling within s 44 and
- that he or she suffered less favourable treatment amounting to a detriment caused by an act, or deliberate failure to act, of the employer
- a prima facie case that the disclosure / s 44 act was the cause of the act or deliberate failure to act which led to the detriment.

(International Petroleum Ltd v Osipov & others 2017 WL 03049094, EAT and Serco Ltd v Dahou 2017 1RLR 81, CA)

169. Once the worker has done that, the employer must show:

- the ground on which the act, or deliberate failure to act, which caused the detriment was done
- that the protected disclosure played no more than a trivial part in the application of the detriment (Fecitt v NHS Manchester [2012] ICR 372, CA).

170. A detriment is anything which an individual might reasonably consider changed their position for the worse or put them at a disadvantage. It could include a threat which the individual takes seriously and which it is reasonable for them to take seriously. An unjustified sense of grievance alone would not be sufficient to establish detriment: EHRG Employment Code, paras 9.8 and 9.9.

Time issues

171. For detriment claims under s 48 ERA 1996, there is a three month time limit for the claim to be presented to the employment tribunal. Where an act or omission is part of a series of similar acts or omissions, the three month limit runs from the last of them: s 48(3)(a) ERA 1996. An act may also be regarded as extending over a period under s 48(4), in which case time runs from the last day of the period over which the act continues.

172. If the tribunal is satisfied that it was not reasonably practicable for a claimant to present the claim within three months of the acts complained of, it should consider the complaints if they were presented within such further period as the tribunal considers reasonable: s 48(3)(b).

Submissions

173. We received oral submissions from all of the legal representatives and written submissions from Ms Newbegin and Ms Keogh. We took these submissions into consideration in reaching our conclusions but refer to them below only insofar as is necessary to explain our reasoning.

Conclusions

Issues: Did C make a protected disclosure for the purposes of s43A?

1. *Did C disclose information which, in the reasonable belief of C, was disclosed in the public interest and tended to show one of the matters set out in s 438 ERA 1996?*

2. *C relies on the information she contends was set out in the 3rd to 5th paragraphs of an email of 19.07.17.*

3. *Did C reasonably believe that the disclosure of information was in the public interest because it related to the alleged endangering of the health and safety of children in an NHS hospital?*

4. *Did C reasonably believe that the information disclosed tended to show that the health or safety of any individual has been, is being or is likely to be endangered: s433(1)(d) ERA 1996.*

174. The respondent conceded that this was a public interest disclosure and we had no reason to go behind that concession on the evidence we heard.

Issue: 5. The email was sent to Leanne Goh and Christina Petropoulos who were Educational Supervisors, C contends the disclosure was within section 43C ERA.

175. There was no dispute that the disclosure was made to the claimant's employer.

Issue 6. It is accepted by R that only for the purposes of section 43K(1) ERA the Claimant was a worker.

176. Again we had no reason to go behind this concession.

Was C subjected to a detriment done on the ground that C had made a protected disclosure?

Issue: 7. Was C subject to the following treatment?

7.1. *C was removed from night shifts in October 2017. The HEE failed to object to the Claimant being removed from nights without proper justification particularly in*

light of the effect the removal from nights would have on the completion of her training

177. It was not in dispute that the claimant was removed from night shifts for a period and that the respondent did not object to that removal.
178. Was that removal 'without justification', as alleged by the claimant?
179. The circumstances were that the claimant herself was expressing anxiety; consultants had raised safety concerns and it was the collective consultant opinion that the claimant should come off nights.
180. There was plenty of evidence which appeared to support the consultants' views. We were entirely unable to say that a body of medical professionals made a decision relating to patient safety 'without justification', when there was ample documentary evidence to support the reasoning.
181. In terms of the effect the removal from nights would have on the claimant's completion of her training, the evidence we heard was that the claimant would not be disadvantaged by not performing nights for a period and it was apparent that the situation was kept under review and a plan made to return the claimant to night shifts once it was safe to do so. The claimant was returned to night shifts before the ARCP panel.
182. It was a fact that the respondent did not object but we also accepted the evidence that it would not have been appropriate for the respondent to become involved in an operational decision of this kind concerning patient safety.

Issue 7.2. C alleged she was undermined;

183. Before looking at the specific allegations of undermining, we observe that it is inevitably difficult for a Tribunal to assess whether feedback on performance is proportionate and fair in the highly complex and specialist medical context. It was clear to us that such feedback needs to be frank, clear and detailed so a trainee can progress.
184. One of the claimant's repeated complaints was that she was not always given specific examples of what she had done wrong. The respondent's position was that the claimant would receive feedback as issues arose but that when at meetings general themes were presented, the claimant would look for specific examples and challenge the accuracy of the accounts given by others. Her supervisors saw this as a lack of insight and it chimed to some extent with evidence of the claimant's experience in earlier placements. She had either been unlucky in repeatedly receiving unfair feedback or there was indeed an issue in terms of her own insight.

Issue: 7.2.1. In October 2017 by Dr Petropoulos and Dr Kingdon making negative comments to C about her abilities when they informed her that she was to be taken off nights

185. The negative comments relied on were those recorded in the letter about the meeting:

The collective general paediatric consultant opinion having worked with many trainees between us in the past is that you are an outlier in terms of risk appetite and speed of work. Whilst your knowledge base to draw upon is very good, you seem to request more tests than other trainees and are more cautious with patients, observing them in the Emergency Department for longer than may be necessary or requesting admission that may not be needed thus preventing sicker patients from being admitted.

186. The claimant accepted that Dr Kingdon had not been at this meeting and had not made these comments.

187. This was certainly critical feedback which Dr Cohen and Dr Petropoulos perceived as constructive and the claimant considered to be negative. The criticism could be characterised as 'negative' since it was critical.

Issue: 7.2.2 In January 2018 Dr Goh told C that there were emails with criticisms of her when no emails were sent or produced

188. We could see that at the meeting certain criticisms were raised with the claimant and we saw the emails which underlay some of the criticisms. It is correct that Dr Goh made a decision not to disclose the emails themselves to the claimant.

Issue: 7.2.3 .In March 2018 in a meeting Dr Kingdon repeating unfair criticism from 2017 and giving C an adverse outcome of a "2",

189. The unfair criticism said to have been repeated was that contained in the final paragraph of the letter of 4 October 2017 from Dr Petropoulos to the claimant:

The collective general paediatric consultant opinion having worked with many trainees between us in the past is that you are an outlier in terms of risk appetite and speed of work. Whilst your knowledge base to draw upon is very good, you seem to request more tests than other trainees and are more cautious with patients, observing them in the Emergency Department for longer than may be necessary or requesting admission that may not be needed thus preventing sicker patients from being admitted. We worry that

whilst the patient who you are personally attending to will be safe, and we certainly don't want you to work outside your personal comfort zone until you have let us help you develop practice in this area, there will be other patients in all clinical areas that you are responsible for who you have no situational awareness of and who may come to harm. For the safe management of all our patients moving forwards, we as a consultant body have agreed that you should come off night shifts until we are reassured that you can lead busy shifts and demonstrate to us the ability to manage patient flow and acuity across the service safely.

190. A document the claimant produced to clarify her complaints said this:

At the ARCP panel meeting on the 1st March 2018, Dr Kingdon repeated the unfair criticisms seen in the letter of Dr Petropoulos of the 4th October 2017. In the list of concerns at this ARCP p.817, it can be seen that much of the criticisms is a rewording of the criticisms when taking me off nights in October 2017. In the section 'brief summary of concerns' p.817, on the last line, Dr Kingdon's comments "no evidence functioning as ST8" this in contrast to information on the MSF p 2201 (used for this ARCP). Other emails in the bundle show Dr Kingdon referring to me in an undermining way in relation to this ARCP (e-mail 14th March 2018 17.44hr p.892)

191. It was clear to us that themes raised in the 4 October 2017 letter were also apparent in the educational supervisor's report for the ARCP and indeed in other evidence contained in the claimant's eportfolio. The educational supervisor's report said:

Feedback from the MSF and the consultant body has found it challenging to keep all the balls in the air. The general consensus of the consultants is that Claire's clinical assessment and management tends to be more risk averse. Claire disagrees this is the case.

There have been circumstances out of our control i.e. a significant amount of sick leave, that have really made it more difficult for Claire during her time here.

192. Dr Kingdon was one member of a panel which looked at this evidence and concluded inter alia that there was no evidence the claimant was functioning as an ST8. It was not so much that Dr Kingdon *repeated* the criticisms as that she and the panel as a whole took them into account in reaching their conclusions on the claimant's performance and the appropriate outcome. The criticisms the claimant specifically referred to were certainly part of the reasons why the panel reached the view it did.

193. As to whether the criticisms were unfair, the evidence we had did not establish that there was any unfairness. The matters raised by Dr Petropoulos were reflected in feedback from various stages of the claimant's training and

were supported by reports from various consultants about particular cases or shifts and from the claimant's MSF feedback, drawn from a variety of individuals. The claimant did not put forward any evidence which persuaded us that these consistent criticisms, made by individuals who provided a great deal of support to the claimant, were unfair.

Issue: 7.2.4 .In November 2018 in a meeting with Dr Petropoulos who unfairly criticised C for seeing A&E as being busier than it was in reality

194. In her document clarifying this claim, the claimant wrote:

I was concerned in this meeting by Dr Petropoulos expressing (and noting in her record) that I had seen an ED shift to be busier than it actually was. This had been a busy ED shift with shortages of staff and the attending Paediatric Consultant had not come down to ED in the morning nor had the registrar in the ED that morning called this Consultant to make him aware of issues. There were high numbers of patients to be seen, some of whom were high risk in the Paediatric area (e.g. a haemodialysis patient with haematemesis who had missed dialysis and was already waiting over 2 hours for initial bloods to be taken). I felt that Dr P was reverting back to being overly critical of my judgement on levels of risk within the department and I felt this to be undermining.

195. We looked at the note of this discussion. The meeting appears to have been supportive and Dr Petropoulos was providing positive feedback. As part of a discussion about the claimant's anxiety levels, they discussed a situation where the claimant was anxious as a result of the apparent busyness of the ED. However the claimant addressed the issue and the result was a positive shift and another trainee praising the claimant, praise which Dr Petropoulos said reflected her own experience.

196. It was put to the claimant in cross examination that this was not a criticism of her but a positive piece of feedback. The claimant said that it was incorrect to suggest that she saw the ED as busy when it was not – she said that the ED was busy and there was a shortage of staff and that it was being suggested that she was unable to assess and perceive and manage in busy situations.

197. That latter suggestion was nowhere apparent in the note which was almost wholly positive. The claimant was concerned about what she perceived to be the injustice of the suggestion that she over-estimated the busyness of the ED, however we could see no real criticism in the note and we were not persuaded it was unfair.

Issue: 7.2.5.In January 2019 Dr Petropoulos unfairly criticised C's capability

198. These were the comments Dr Petropoulos made in the meeting that “*some people have concerns, not so much about your clinical knowledge and whatever, but about resilience and how because we all know what we hold and what we deal with as consultants how are you going to cope with the juggling and whatever*”
199. The context of this comment is that the claimant and Dr Petropoulos were discussing the claimant’s eportfolio and the fact that Dr Petropoulos needed to get input from the other consultants at an upcoming meeting. The claimant had had a period of apparent improvement but then concerns about performance had recurred. It was very clear to us from the transcript as a whole that Dr Petropoulos was seeking to be kind to the claimant whilst managing her expectations about what the feedback was likely to look like.
200. The comments did not seem to us to be unfair; they reflected the evidence which had repeatedly come from a variety of sources. The claimant needed to know what the consultants were likely to say.

Issue: 7.2.6. In February 2019 Dr Round (relying on information provided by Dr Petropoulos and Dr Kingdon) at the meeting for annual review unfairly criticising C’s capability relying on the same unfair criticisms that had been made of C’s non-clinical capabilities since Cs disclosure in 2017.

201. These were the same criticisms which were reflected in the claimant’s eportfolio for the 2018 ARCP panel. We found that these criticisms were not unfair. Dr Round and the panel were obliged to take into account what was on the eportfolio in reaching their conclusions and they did so.

Issue: 7.3. The Respondent (HEE) did not investigate C’s concerns set out in a record of a meeting held on 19 September 2017 (the report was dated 4 October 2017).

202. Dr Kingdon was copied in to this correspondence. Neither she nor anyone else at HEE investigated the matters raised by the claimant.

Issue: 7.4 C was released from her training program on 19 February 2019, given an outcome 4 ARCP (annual review competency progression) C alleges that Dr Kingdon relayed incorrect information to the panel, including about the time C had spent on training.

203. The claimant was released from training after receiving an outcome 4. We could not see any inaccuracy in what Dr Kingdon had said in her document about the claimant’s time in training, which in any event had not been seen and was not relied on by the panel when it made its decision.

Issue: 7.5. The outcome of the appeal, C was informed of the outcome on the 12 July 2019. C alleges that Dr Kingdon relayed incorrect information to the appeal panel including about the time the C had spent on training.

204. The allegedly incorrect information relied on was that the claimant had been granted 24 months of additional time. By the time of the appeal, Dr Kingdon's document which included this information was available. Dr Ahluwalia in any event relied on a calculation done by the case management team. The information was not incorrect – the claimant had been granted an additional 24 months of training time, albeit she had not yet exhausted that extended time.

Issue 8. Was the treatment detrimental?

Allegation 7.1

205. The removal from night shifts only lasted a short period. We accepted that it was a supportive measure and one reasonably felt necessary for patient safety. It did not prevent the claimant achieving necessary competences.

206. Our conclusion was that this treatment could not reasonably be regarded as a detriment, although we accepted that the claimant felt it was detrimental. We concluded that that feeling amounted to an unjustified sense of grievance in the circumstances we found.

Allegation 7.2.1

207. We concluded that this was not a detriment. Based on the evidence we heard, the feedback and reasons given to the claimant were justified as part of the learning process; they were true, fair, proportionate and constructive learning points.

208. We accepted that true criticism may well be upsetting but it is also necessary for training; the reasonable employee would not consider that she had been put at a disadvantage by fair constructive criticism.

Allegation 7.2.2

209. The claimant was not shown the emails themselves but the substance of the concerns raised in the emails was put to her.

210. We concluded that there was no detriment. The claimant had a fair opportunity to consider and respond to the concerns raised. She knew from experience that all relevant material which would be taken into account would have to be on the eportfolio so her fear that there might be other criticism in emails which she did not know about was not a rational fear.

Allegations 7.2.3 – 7.2.6

211. We concluded that all of these matters were fair criticisms necessary delivered in the context of a structured training programme. The claimant could not have a justified sense of grievance about these matters and we concluded that they did not constitute a detriment

Allegation 7.3

212. The claimant was given advice about how to take her concerns forward within the Trust; she was given that advice both about her concern that she was being undermined and in relation to the safety concerns she raised. She did not pursue the matters within the Trust and did not explain why she did not do so.
213. We concluded that the claimant could have no legitimate sense of grievance about the advice she was given or the fact that the matters were not separately investigated by the respondent. The matters were not matters within the respondent's remit and the claimant could have had no legitimate expectation that they would be investigated by the respondent. This treatment did not amount to a detriment

Issues 7.4 and 7.5

214. We did not find these allegations made out on the facts so it follows that they did not amount to a detriment

Issue: 10. If C was subjected to a detriment, was it on the ground that C had made a protected disclosure?

215. Because we found there were no detriment, we were not obliged to consider whether the matters complained of happened because the claimant made a protected disclosure. Nonetheless, in case we were wrong as to whether certain matters amounted to a detriment, we went on to consider causation, applying the guidance in Osipov.
216. Did the claimant satisfy us that there was a prima facie case that any of the matters complained were materially caused by the protected disclosure?
217. We looked carefully at the evidence which we had.

218. We bore in mind the evidence which we had as to who knew about the protected disclosure. The evidence was that Dr Goh, Dr Petropoulos and Dr Kingdon all received the email. The claimant thought that other consultants who provided negative feedback about her knew but we could see no evidence to suggest that was the case.
219. Mr Otchie said that Dr Sutcliffe's reference to 'lawyers at dawn' showed Dr Sutcliffe knew about the protected disclosure; however the case was not pleaded on the basis that the other consultants had criticised the claimant because of her protected disclosure and the parties had not prepared the case on that basis. In any event, Dr Sutcliffe could have been referring to any type of claim. The claimant at that stage had been having health issues, so if anything specific was in Dr Sutcliffe's mind, it might have been a disability discrimination case. Equally he might have been anticipating a claim of some nonspecific kind.
220. In support of submissions that criticisms of the claimant and her failure to complete her training must have been caused by the protected disclosure, Mr Otchie pointed to:
- The claimant's impressive academic qualifications;
 - The fact that other medical professionals generally accepted that she was a caring and dedicated doctor.
- He submitted that those factors were inconsistent with the claimant getting an outcome 4.
221. We were not able to accept that submission; it was clear to us that a consultant requires a very broad range of skills and attributes, not just good academic qualifications and the qualities of being caring and dedicated.
222. Mr Otchie pointed to some instances where the respondent's witnesses accepted that the claimant had undertaken reflective learning in respect of incidents. However the point was that some of the underlying incidents were of very significant concern even if the claimant was subsequently able to reflect on them. It was clear from the documents and her own evidence that there were many incidents where the claimant disputed the account given by others and was not undertaking reflective learning.
223. Mr Otchie pointed to some improvements the claimant had made and good feedback she had received. Unfortunately, there was also still poor feedback and evidence that the claimant had not met targets set for her. Dr Alhuwalia's evidence was that for an ST8 trainee about to CCT, one would expect to see a whole string of 'excellents' in the eportfolio. Mr Otchie also pointed to the fact that, as the respondent's witnesses admitted, outcome 4s are relatively rare.
224. We also considered, when asking the question whether there was any prima facie evidence that the protected disclosure played a role, what motivation Dr Goh, Dr Petropoulos and Dr Kingdon would have had. We noted that the

concerns the claimant raised were not specifically about any of these individuals. In the case of Dr Kingdon, the concerns were not even about Dr Kingdon's employer, the respondent. The claimant's explanation in evidence that 'people have an instinct to be defensive' and that Dr Kingdon might have been defensive about having sent the claimant to the UCLH placement did not seem to us to go very far as an explanation.

225. We noted also that the claimant was told how to pursue her concerns; these did not seem to us to be the actions of someone who was looking to repress her concerns or subsequently to punish her for having raised them. The perception the witnesses had was that the claimant raised issues to deflect criticism from herself.

226. We also took account of the very significant support provided to the claimant by all three doctors, including but not limited to the large number of meetings held with her, Dr Petropoulos asking her to Christmas and the pursuit of supernumerary funding for her.

227. In relation to the individual allegations, some particular features which also influenced our view that there was no prima facie case included:

7.1: This was a decision of the consultant body, especially Dr Cohen: individuals who did not know about the protected disclosure. There was evidence before and after the protected disclosure which demonstrated why the decision was made. It was not a decision which was convenient for the Trust. The respondent's failure to object had no logical connection with the protected disclosure and in any event it was not the respondent's place to object in a operational decision of that kind.

7.2.1: It seemed to us that the remarks were made to assist the claimant to improve her practice, which was inconsistent with Dr Petropoulos seeking to subject the claimant to a detriment because she had made a protected disclosure.

- 7.2.2: Dr Goh's reasons for not producing the emails seemed to us to be cogent. The claimant knew the substance of the emails, as she accepted in cross examination. If there was no disadvantage to the claimant, it was hard to see how the motive could have had anything to do with the protected disclosure rather than the reasons advanced by Dr Goh.
- 7.2.3 – 7.2.6 7.2.6: The criticisms before and after the protected disclosure were very much about the same issues.
- 7.3: This was clearly not a matter for the respondent to investigate. The contemporaneous documents do not suggest the claimant had any expectation that the respondent would investigate.

Issue 11: Are any of the complaints out of time?

224. It was not necessary for us to consider this issue and it would have been too artificial for us to decide it in the alternative, given our findings.

Issue 9. If C was subjected to detriment, was R liable for the acts of the person carrying out the alleged detriment pursuant to s47B(1 A) ERA 1996?

225. We invited submissions from the parties as to whether, if we did not decide the substantive issues in the claimant's favour, we should go on to consider the agency issue. Ms Keogh had attended to represent the claimant in respect of that issue only and we are conscious that this is a issue which may arise in other cases. The claimant's position was that we should decide the issue; the respondent's position was that we should not.

226. Ultimately we decided not to make a decision on the issue:

- It was not necessary to our other findings to make findings about whether there was an agency relationship between the respondent and Dr Petropoulos and Dr Goh;
- Ms Newbegin said, and we accepted, that the issue might not have been ventilated as thoroughly as it should have been if it was going to provide an example for other cases. The claimant had only provided her skeleton argument explaining how she put her case very shortly before the full merits hearing;
- We were not in any event persuaded that the issue was not fact sensitive. It may be that different Trusts had materially different LDAS or materially different relationships with the respondent. We simply did not have the evidence to form a view on that issue;
- Even in relation to the issue as it pertained to the case in front of us, we had a collection of policy and other documents which we were not persuaded was complete. Some documents appeared to be out of date; at least one other was for a different geographical region. We had for example a GMC document – Recognising and Approving Trainers 2013 which it emerged was an aspirational document relating to the GMC's then plan to accredit and approve trainers. The powers of accreditation envisaged were not conferred on the GMC and the document was withdrawn in January 2016. The Managing Trainees in Difficulty document which we saw was a document from a different Local Educational Training Board;
- We concluded that the exercise would not benefit the parties or anyone else and would be a waste of Tribunal resource.

Employment Judge Joffe
London Central Region
05/06/2022

Sent to the parties on:
06/06/2022

For the Tribunals Office