EMPLOYMENT TRIBUNALS

BETWEEN

Claimant		**Respondent**
Dr Esha Sarkar	AND	University Hospitals Plymouth NHS Trust

JUDGMENT OF THE EMPLOYMENT TRIBUNAL

HELD AT Plymouth ON 4, 5, 6, 9, 10 and 11 November 2020
Meeting in Chambers 18 November 2020

EMPLOYMENT JUDGE N J Roper **MEMBERS** Ms R Hewitt-Gray
Mr I Ley

Representation

For the Claimant: **Mr G Powell of Counsel**
For the Respondent: **Mr S Keen of Counsel**

RESERVED JUDGMENT

The unanimous judgment of the tribunal is that the claimant's claims are dismissed.

REASONS

1. In this case the claimant Dr Esha Sarkar claims that she has suffered a number of detriments on the ground that she has made a protected public interest disclosure. The respondent asserts that some of the allegations are out of time, and in any event denies the claims.
2. We have heard from the claimant. We have heard from Dr Claire Bethune, Dr Andrew Whyte, Mrs Rachael Buller, Mrs Louise Tate, Mrs Christine Symons, Mr Richard Maguire and Mrs Teddie Trump on behalf of the respondent.
3. There was a degree of conflict on the evidence. We have heard the witnesses give their evidence and have observed their demeanour in the witness box. We found the following facts proven on the balance of probabilities after considering the whole of the evidence, both oral and documentary, and after listening to the factual and legal submissions made by and on behalf of the respective parties.
4. The Facts:
5. The respondent is an NHS Trust which provides healthcare services for patients at its main Derriford Hospital Site in Plymouth, as well as at other local hospitals and care centres.

The claimant Dr Esha Sarkar was employed by the respondent as a Specialist Registrar Trainee in Immunology from 6 July 2017. She was placed with the respondent as part of a specialty training programme.

6. There is a Reference Guide for Postgraduate Specialty training in the UK which is also known as the Gold Guide, and which sets out the different roles of UK health departments, which in summary are as follows.
7. 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. This includes promoting high quality education and training.
8. The GMC decides which doctors are qualified to work in the UK and oversees UK medical education and training. The GMC certifies doctors who have successfully completed a full GMC approved training programme by awarding them a Certificate of Completion of Training (CCT). Holding a CCT makes a doctor eligible to apply for inclusion on the GMC's specialist or GP registers. In order to be able to take up a consultant post in the NHS, a doctor is required to hold a licence to practise and to be listed on the GMC's specialist register.
9. The Medical Royal Colleges and Faculties develop the specialty curricula and assessments systems in accordance with the GMC standards. The Colleges and Faculties work closely with HEE to ensure that curricula are delivered at a local level and to support the quality management of training delivered within training providers. All doctors in specialty training must enrol and register with the relevant College/Faculty so that progress in the training can be kept under review and supported where required. Doctors in specialty training can access the educational portfolio, logbooks and assessment documentation for their specialty and eligible trainees can be recommended to the GMC for consideration of award of a CCT the end of the specialty training. The Colleges and Faculties also have a role in the quality management of the Annual Review of Competence Progression (ARCP) process.
10. HEE is responsible for implementing specialty training in accordance with the GMC approved specialty curricula. HEE's Postgraduate Deans work with Colleges/Faculties and local healthcare providers to manage the quality of the delivery of postgraduate medical training to GMC standards. The standards are normally set out in educational contracts between HEE and providers of postgraduate medical education such as the respondent Trust. Postgraduate Deans through their Training Programme Directors are responsible for developing appropriate specialty training programs and the GMC quality assures this process to ensure the training meets the GMC standards.
11. All trainees must accept and move through suitable placements or training posts (which could be with a number of different NHS Trusts) to which they have been designated as part of the specialty training programme approved by the GMC. The programme is a formal alignment or rotation of posts that together comprise a programme of training in a given specialty or subspecialty (such as immunology, which is the relevant speciality in this case). The programmes are managed by HEE Training Programme Directors or their equivalent and they have responsibility for managing their assigned specialty training programmes. This includes contributing to the Annual Review of Competence Progression (ARCP) process (for which see further below), helping the Postgraduate Deans manage trainees who might run into difficulties by supporting educational supervisors in their assessments, and in identifying remedial placements where required; and with relevant Directors of Medical Education, providing support for clinical and educational supervisors in the programme.
12. All trainees must have a named clinical and educational supervisor for each placement in their specialty programme. Normally these roles will be undertaken by different people but in some elements of rotation the same individual may provide both clinical and educational supervision. The GMC standards require that educational supervisors should be specifically trained for their role. As confirmed in the Gold Guide, an educational supervisor is a named trainer who is selected and appropriately trained to be responsible for the

overall supervision and management of the specified trainee's educational progress during a training placement or series of placements.

13. There is an educational agreement which sets out responsibilities for the trainee doctor and the Educational/Clinical Supervisor. The trainee doctor is responsible for taking active part in the appraisal process; visiting the E-portfolio website at least weekly to collect personal messages from trainers and supervisors; to achieve learning objectives by utilising the opportunities for learning providing everyday practice; attending all formal teaching sessions; undertaking personal study; utilising locally provided educational resources; and using designated study leave funds appropriately. Trainees are responsible for acting on the principles of adult learning by reflecting and building upon their own learning experiences; identifying their learning needs; being involved in planning their education and training; and evaluating the effectiveness of their own learning experiences.
14. The Educational/Clinical Supervisor is responsible for being available and taking active part in the appraisal process including setting educational objectives in a personal learning plan; ensuring that objectives are realistic, achievable and within the scope of available learning opportunity; ensuring help and advice is always available; ensuring that there is a "climate for learning"; and ensuring that an individual doctor's timetable allows attendance at formal teaching sessions, is appropriate for the relevant learning needs, and that there is a correct balance between training and service in the post. Any named Clinical Supervisor must be a trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback during a training placement.
15. There is a formally defined and approved process of assessment which supports the curriculum approved by the GMC. There is a range of defined and validated assessment tools which are used along with professional and triangulated judgments about the trainee's rate of progress. These assessment tools include: professional examination; direct observation of procedural skills (DOPS); case review; cased based discussions (CBD); multisource feedback (MSF); assessments in clinical skills facilities; clinical evaluation exercises; direct observation of nonclinical skills; and self-reflective learning logs.
16. The Gold Guide requires that trainees must: maintain a portfolio of information and evidence (the ePortfolio); reflect regularly on the standards of medical practice in accordance with GMC guidance on licensing and revalidation; respond constructively to the outcome of audit, appraisals and the ARCP process; undertake further training where required by the Postgraduate Dean; engage with systems of quality management and quality improvement in their clinical work and training; and participate in discussion in any investigation around serious untoward incidents in the workplace, and record reflection of those in their ePortfolio.
17. The Annual Review of Competence Progression or ARCP results in an "Outcome" following evaluation of the written evidence of progress and determines the next steps for the trainee. A satisfactory ARCP outcome confirms that the required competencies, together with ongoing conformance with the GMC's Good Medical Practice, have been achieved. The ARCP uses evidence collected by the trainee related to progress in the training programme. It is normally undertaken on at least an annual basis for all trainees in specialty training. Ahead of the ARCP the Educational Supervisor is required to prepare a structured report to reflect evidence that the trainee and supervisor agreed should be collected to reflect the educational agreement for the period of training under review. The ARCP panel is convened by HEE. It is a panel of at least three members and is normally chaired by the Chair of the Specialty Training Committee or one of the TPD's or Associate Deans or Directors. The employer therefore does not have a critical decision-making role. Where there are concerns about satisfactory educational progress, the employer should withdraw temporarily from the process whilst their trainee is being considered.
18. The ARCP panel will recommend one of eight Outcomes. The main ones include: Outcome 1 - Satisfactory progress - Achieving progress and the development of competencies at the expected rate; Outcome 2 - Development of specific competencies required - Additional training time not required; Outcome 3 - Inadequate progress - Additional training time required (which will extend the indicative core training programme and end date or CCT

date and which has consequential implications for the overall use of training and educational resources); and Outcome 4 - Released from training programme - with or without specified competencies. The ARCP panel will recommend that the trainee is released from the training program if there is still insufficient and sustained lack of progress despite having had additional training to address concerns over progress.

19. ARCP Outcomes can be reviewed and appealed. Trainees awarded an Outcome 3 or 4 have the right to appeal, and on receipt of an appeal request, the Postgraduate Dean will arrange for a review of the original recommendation. Where the review panel does not alter the decision of the original ARCP panel, the Postgraduate Dean will confirm with the trainee that they wish to proceed to an appeal hearing which will then be arranged. The appeal panel is independent of the original decision.
20. We have heard from Dr Claire Bethune who is employed by the respondent as a Consultant Immunologist and she is the respondent's clinical lead for immunology and allergy service. At all times relevant to these proceedings, there was one other consultant in this department, namely Dr Andrew Whyte, from whom we have also heard. Dr Bethune is the Educational Supervisor for immunology trainees who are placed with the respondent trust by HEE (the Deanery). She has been an educational supervisor since 2006, and as such her role is an appointment by the Deanery and not the respondent Trust.
21. The claimant Dr Esha Sarkar is a junior doctor in Training. She suffers from cerebral palsy and has restricted mobility. In 2010 she changed her area of specialisation from renal medicine to clinical immunology and allergy. She obtained a National Training Number for a substantive post in what is now HEE South West and was placed at the Southmead Hospital in Bristol from August 2011 to the end of February 2014. The claimant was then placed at the City Hospital Birmingham for six months from March to August 2014. HEE was then unable to find her a new placement until March 2015 when she was placed at the Victoria Infirmary, Newcastle upon Tyne. She was at Newcastle for a year, and then obtained a one year research post in Vaccine Immunity at Oxford University. She returned to training and was placed at the respondent Trust with effect from 6 July 2017.
22. The claimant did not progress in her training as successfully as she and others had hoped. She complains that she was victimised after she raised a concern at Bristol about a colleague's unprofessional behaviour and received negative feedback as a result. She asserts that as a result her e-Portfolio provided a one-sided view of her placements and carried "aggressive criticisms against me from one centre to another and was generating a negative bias against me in the close-knit small immunology community." It was not the role of this Tribunal to investigate these historic complaints, but we have seen detailed Educational Supervisors' Reports and ARCP outcomes as follows.
23. Dr Unsworth was the claimant's Educational Supervisor at Bristol, and he prepared his report for the period from 1 November 2012 to 26 September 2013. He did not accept that the claimant had participated in appropriate clinical activity and that her "clinical reasoning was at times confused, naive and often not properly documented or prioritised … Nor basic tasks (e.g. clinic dictation or result follow-up) completed in a timely way." He reported that the claimant had not agreed appropriate objectives in personal development and commented: "Following the ARCP last year, a clear and specific target was to reflect upon and improve team working and team communication. This has not improved, indeed relationships with several team members have deteriorated and are very poor. This target has not been achieved. Admittedly team dynamics are a two-way street, but part of the issue is whether Esha understands the reasonable behavioural expectations of the nurses, doctors and lab staff involved and indeed whether Esha is capable of changing her behaviour/attitudes, including an apparent inability to accept/understand feedback provided, never mind respond to it with positive development or behavioural change. Defensiveness and conflict has become the norm sadly." He concluded that the claimant had not provided evidence to demonstrate suitable progress against the curriculum required for this stage of her training, and marked her overall performance as "Well Below Expectations" which is the lowest mark. The two specific areas of concern were "(1) Behavioural - team working, communication, interpersonal skills, learning from mistakes,

responding to criticism and approachability; and (2) Reluctance to take on more training opportunities …"

24. These behavioural and communication difficulties appear as a constant theme throughout the training records which we have seen. In particular, those supervising the claimant during her training at a number of different establishments have all consistently reported teamwork and communication difficulties, and in particular an inability to accept feedback or criticism and to respond to in a positive manner to assist in training and development. A constant criticism of the claimant has been that instead she reacts in a defensive and confrontational manner.
25. At her annual ARCP review on 27 September 2013 in Bristol the claimant received Outcome 3 Inadequate progress - Additional training time required. This meant that the claimant had to repeat the fifth year of her specialist training. The specific training needs identified and listed included improved team working and professional behaviour. Some two months later Dr Unsworth prepared a further Educational Supervisor's Report to 12 November 2013. He again concluded that the claimant had not provided evidence to demonstrate suitable progress. He noted that at the ARCP it was agreed that the claimant had to prioritise work on defined areas of weakness, including the need to reflect upon, understand and improve deficiencies in multi-professional team working skills. He raised concerns about the claimant's honesty, probity and health, and again marked her overall performance as "well below expectations".
26. Dr Unsworth prepared a further Educational Supervisor's Report from 12 November 2013 to 25 February 2014, in which he reported that the target set at the ARCP had not been satisfied. Again, he marked the claimant's performance as "well below expectations" and said that his report summarised the collective and documented views of all of the clinical and laboratory trainers and supervision group. Concerns continued with regard to the claimant's failure to respond constructively to criticism and her willingness to work with colleagues and improve multi-professional team working.
27. The claimant then moved to Birmingham for six months, and her next ARCP was to 31 August 2014. She received Outcome 2, (namely that her progress was unsatisfactory and development of specific competencies was required, but without additional training time being required). The competencies which were recorded as needing to be developed were: "communication skills, laboratory training, primary immunodeficiency clinical management".
28. The claimant also received Outcome 2 for her ARCP covering her training in Newcastle to the end of February 2016. There was a significant concern about the claimant seeing patients independently because of the way in which she interacted with patients, and at the end of her attachment in Newcastle a veto had been placed on her seeing patients independently. The claimant sought a review of that ARCP Outcome 2 decision. By letter dated 25 April 2016 HEE confirmed that the claimant's review was unsuccessful. HEE agreed that the claimant was making "satisfactory progress in clinical and academic areas, but you were still showing some need for further development and consolidation of behaviour in both team working and leadership which had been a recurrent theme throughout your training … The concern was that you had not adequately demonstrated any prolonged consistency in the key areas of team working and leadership to give any confidence that it was embedded in your everyday working. This is critical for a trainee at your stage of training."
29. This letter from HEE dated 25 April 2016 was signed on their behalf by Dr Bethune, who had been a member of the ARCP panel on 29 February 2016. Dr Bethune had also been a member of the ARCP panel on 12 September 2014 which had awarded the Outcome 2. Dr Bethune was therefore aware of the claimant and her training history before she joined Dr Bethune at the respondent Trust.
30. In 2017 Dr Bethune was asked by the Postgraduate Dean if the immunology department in Plymouth could take on the claimant's training. Dr Bethune was aware that there had been problems with the claimant's team working and communication in the other units where she had worked previously. Nonetheless Dr Bethune felt that her team would be able to provide the support which the claimant needed. She discussed the matter with her

fellow consultant Dr Whyte, and with the department's nurse consultant Sister Christine Symons (from whom we have heard). The three of them agreed that their team areas of clinical and laboratory would be in a position to support the claimant. They agreed not to discuss the claimant's previous issues regarding communication and team working with other colleagues so as to avoid any prejudicial views or difficulties in how they treated the claimant on arrival. The three of them were aware that accepting the claimant as another trainee would affect the time available for their other commitments, but nonetheless they all agreed to seek to assist the claimant in the hope of progressing her training.

31. Dr Bethune and the claimant had a detailed induction meeting in July 2017. They discussed her previous training records and discussed the breakdown in relationships which had occurred with the supervisors and trainers in Newcastle, Birmingham and Bristol and discussed the obvious need for avoiding a recurrence of the same issues. They agreed that a consultant would still accompany the claimant at clinics with individual patients for the first three months and thereafter to seek reports on the consultants by way of a Multi Consultant Report (MCR) in the hope and moving on from that arrangement. There was also a further ARCP/PYA (meaning penultimate year assessment) chaired by Dr Buckland in July 2017. The requirements of the claimant's training were clearly set out in this document to give the claimant the opportunity to demonstrate that she had made sufficient progress in these areas. This specifically included team working, communication, reflection and leadership skills. In addition, she was required to achieve all of the other curriculum requirements required by all trainees at that stage of training. Dr Bethune agreed to hold more frequent educational meetings than would normally have been the case in order to support the claimant's progress in these areas.
32. The position as at July 2017 was, in summary, as follows. The claimant had failed to make satisfactory progress with her Specialty Training. There had been a breakdown in the working relationships with the claimant in each of the three separate departments at Bristol, Birmingham and Newcastle. One consistent theme was that criticism and feedback was met by the claimant with defensiveness and even hostility, rather than as an opportunity to improve and progress, and that this had a direct impact on working relationships. Despite knowledge of these difficulties, the two consultants and consultant nurse at the immunology department in Plymouth (Dr Bethune, Dr Whyte and Sister Symons) readily agreed to accept the claimant's placement in the hope of assisting her to complete her training despite the fact that this would require further energy and time on their part. However, the training arrangements and obligations were obviously reciprocal, and although the respondent team was prepared to assist the claimant, it was also incumbent on the claimant to show marked and evidential improvement in the areas in which she had been identified as failing. At the risk of using the vernacular, the claimant was very much "in the last chance saloon".
33. There is a practice in an immunology department to undertake a graded dose challenge procedure on a patient, known as a "challenge". This requires informed consent of the patient and involves controlled administration of a substance as the only conclusive way of disproving allergy to that substance. The decision to challenge involves balancing the risk of the challenge (because the patient may have a reaction), against the benefit of knowing that if tolerated, the medication in question will help to manage the patient's medical condition. The dosing is graded so that there is a slow increase in the amount given to the patient in order to minimise any consequences in the event that there is an allergic reaction to that substance. The challenge can also be graded from administering the drug as a simple skin test, to an intradermal test under the skin, and then intravenously.
34. On 20 July 2017 Dr Whyte observed and assessed the claimant obtaining informed consent from the patient for a challenge which was conducted as a Direct Observation of Procedural Skills (DOPS) assessment. Dr Whyte felt that the claimant's personal manner and communication with the patient were good and that the claimant was "competent to perform the procedure unsupervised and deal with complications." However, Dr Whyte was unclear exactly how the claimant had taken the patient's full history, and on recapping with the patient it emerged that she had received a significant new diagnosis some two weeks previously which might have meant that the challenge itself was unnecessary. Dr Whyte's

feedback to the claimant suggested that the new diagnosis had been missed and more attention should have been paid to ensuring that the history given by the patient was fully documented. The claimant did not dispute that assessment at the time, which is why Dr Whyte agreed that she was competent to perform the procedure. Nonetheless, the claimant subsequently contended that this DOPS assessment was inaccurate and that this was a deliberate "false assessment" by Dr Whyte. Having heard from Dr Whyte we reject the claimant's assertion that he lied about this matter and deliberately gave a false assessment as subsequently alleged by the claimant.

35. There was then a serious incident involving a patient known as JH on 10 August 2017 which led to a Datix report by the claimant which forms the basis of her claim before this tribunal. Datix is the respondent Trust's incident reporting system. All staff have a duty to report all incidents and near misses (regardless of severity) where a patient or a member of staff or the public may suffer unexpected harm or injury, either on hospital premises or where health care is being provided. It is a computerised system which is aimed at being a "no blame" process. The person making the report is asked to assess whether the harm or potential harm is "minor", "moderate", or "severe". If the risk is assessed at moderate or severe then consequential matters will arise, including reporting the incident to the claimant under the respondent Trust's duty of candour. The Datix reports are relatively commonplace and the immunology department normally puts in a few such reports every month through clinical incidents and near misses. These are then reviewed at regular management meetings in order to implement learning and improve procedures where appropriate. The point of the Datix reports is that incidents are investigated, learning is identified, and action can be taken to prevent recurrence. The statutory duty of candour now applicable to NHS Trusts applies to the respondent and others in cases of moderate or more severe harm, which then requires a patient to be provided with an account of the incident.
36. The patient JH was an 83-year-old woman with complex comorbidity and who suffered from arthritis and also required an operation to remove her gallbladder. On a previous occasion on 12 January 2017 she had received a steroid injection from her GP into her knee joint in order to alleviate the symptoms of arthritis (the index incident) but had suffered a serious adverse reaction, namely anaphylaxis. The steroid drug which had been administered at the time of the index reaction was depomedrone, and a local anaesthetic had been used namely lidocaine. The anaphylaxis had been treated in accordance with normal guidelines but that treatment had included another steroid namely hydrocortisone. Dr Stokes is a GP who is a Specialty Doctor in allergy who works in the respondent's immunology department one day a week. She reviewed the treatment which JH had received in the emergency department. It was not clear whether JH had tolerated the hydrocortisone at the time, because it was also possible that hydrocortisone (being a steroid in the same family from depomedrone) had effectively doubled the severity of the reaction she was already having to depomedrone.
37. At a multidisciplinary team meeting (MDT) on 2 March 2017 the personnel in the immunology department discussed JH's case in detail and decided to invite her in for skin testing to various drugs in order to investigate the problem (on the basis that the drug to which JH had reacted so severely would be either the lidocaine, the steroid, or the skin antiseptic). JH then attended the immunology department for skin testing (the first stage of investigating) on 9 June 2017. Dr Whyte noted that she was taking prednisolone, another steroid, meaning that she was definitely not allergic to this steroid. She then underwent skin tests but it became clear that she had a positive skin test result (suggesting allergy) to a different steroid namely triamcinolone, but not depomedrone. These results were reviewed at an MDT on 22 June 2017 and it was agreed that further investigation was required, first to check that the GP had not actually used triamcinolone by mistake; secondly to confirm whether further investigation and a potential challenge could be avoided altogether; and thirdly to identify any alternative steroids which might assist the claimant's condition. JH then attended on 6 July 2017 bringing confirmatory detail of the original drug (which definitely was depomedrone) but because she had not been told to

withhold her antihistamine medication the skin testing could not proceed. She was sent home.

38. JH's case was discussed again that afternoon in an MDT on 6 July 2017, at which Dr Bethune, Dr Whyte and the claimant were all present. Dr Bethune had documented that discussion was due with the claimant with regard to a potential steroid challenge. Dr Whyte recalls that there was an agreed plan to the effect that they would undertake skin testing and challenge the lidocaine. If this test was positive and "the culprit" turned out to be lidocaine all along, then it would appear safer to challenge the depomedrone. However, if the skin test for lidocaine was negative and the claimant did not react to this drug, then this would leave a difficult decision regarding which steroid to challenge with (although triamcinolone had already been eliminated on 9 June 2017). The background to the need for potential challenge was of course that JH required steroid treatment of some sort to address her arthritic pain, but she had had a severe reaction when a steroid injection had been used previously at the index incident.
39. On 11 July 2017 Dr Whyte telephoned JH to discuss the options and it was agreed that JH had an urgent clinical need for the use of steroids. He recognised that JH was at risk of significant adverse outcome, and therefore documented in the notes that they should implement an amended and more cautious protocol. Normal procedure would be to administer 1% of the full dose first, then 10%, and then 100%, in case of any adverse reaction. In this case Dr Whyte decided to start at 0.1% (or 1/1000th of the dose) so that any adverse reaction would be less severe.
40. The challenge was arranged for 10 August 2017. Dr Bethune was on leave. Dr Whyte and the claimant were present, as were other members of the immunology team namely Dr Lucy Leeman (specialist Registrar) and Mr John Dixon a Band 6 Nurse Specialist. Mr Dixon carried out some skin testing with the same outcome from the previous skin tests. JH was then reviewed by the claimant to obtain her informed consent and the claimant was administered depomedrone by way of the agreed challenge. For some reason Dr Whyte's direction that the initial challenge dose should be 0.1% was overlooked and she received the more usual first dose of 1%. JH developed a possible small local reaction. The claimant then administered the second dose (10%) and within five minutes JH developed anaphylaxis. She became very ill and the claimant had to supervise her urgent resuscitation which she did successfully in accordance with the recommendations of the Resuscitation Council UK, namely administering oxygen, adrenaline, chlorphenamine (an antihistamine), and hydrocortisone (an additional steroid where someone reacts to a steroid) together with a salbutamol nebuliser because JH was wheezing. JH then began to recover. The claimant did not discuss this matter with Dr Whyte. The first he heard of the matter was when Dr Leeman overheard the nebuliser and investigated early that afternoon and informed Dr Whyte. He attended immediately to review the situation and JH by that stage was feeling much better. Dr Whyte then discussed with Dr Leeman whether a Datix report form should be raised, and they agreed that it should, but Dr Whyte was sensitive to the risk of appearing critical of the claimant's management. He therefore telephoned Dr Bethune (although she was on leave) because Dr Bethune knew about JH, and also knew about the claimant's training progress and goals. Dr Bethune agreed that a Datix report should be raised and thought it best for the claimant to lead on it because she was closely and directly involved on the day and it would give the claimant an opportunity to demonstrate leadership, communication and problem solving.
41. There was then a normal morning meeting in the Department on 11 August 2017 at which Dr Whyte asked the claimant to submit a Datix in respect of the incident involving JH. There was an exchange of emails between Dr Whyte and the claimant. Following that meeting the claimant emailed Dr Whyte to say: "Thanks for the quick chat regarding the event and I shall write down the reflection from a learning perspective and upload on my ePortfolio. I shall discuss with Claire when she is back. I think it will be reasonable to do a Datix of the various aspects of this event and I feel that this should be done from a holistic perspective and would prefer discussing this before submitting. I'm happy to do it." Dr Whyte agreed and suggested meeting times to discuss the matter.

42. Notwithstanding this agreement, the claimant then submitted the Datix without discussing it with Dr Whyte. This may have been because she was unable to save the document as a draft. In any event, at 10:12 am on 14 August 2017 the claimant submitted her Datix report W125388. This is the protected public interest disclosure upon which the claimant relies for the purposes of these proceedings.
43. The claimant completed a description of the incident in her Datix under the heading of Details. There were four sub- paragraphs. The information provided was as follows: "The incidence is the occurrence of anaphylaxis in a high-risk patient. (a) A 83-year-old woman with significant cardiovascular comorbidities developed anaphylaxis as a result of challenging to a drug that she had previously reacted to. The previous reaction was medically observed in the primary care but was dismissed as "steroid flush" which resulted in the anaphylaxis. The drug in question, methylprednisolone has been implicated in more than 40% of steroid hypersensitivity. Alternative safe drugs such as hydrocortisone or other preparations are available. Consequence of the incidence: the patient was successfully resuscitated at the E Unit but suffered harm/damage. The damage can be categorised as "moderate" but no residual/long-term damage from the anaphylaxis is anticipated. (b) in the process of anaphylaxis management the patient was administered hydrocortisone which carried a "theoretical" risk of hypersensitivity. This was done without re-establishing safety as it was uncertain whether the patient had received hydrocortisone after the index reaction with methylprednisolone … Other factors that have contributed to the event of anaphylaxis: (c) lack of a structured risk stratification of the individual patients at MDT where challenges are planned … (d) lack of recording of the challenge protocol or any deviation from the standard protocol at the MDT - consequence: failure to highlight the drugs that need to be avoided in a specific case in general and this case in particular can result in administration of unwanted drugs and escalate risks." The claimant had assessed the severity of this incident as "minor", although she did refer to "moderate" damage at the end of her paragraph (a) above.
44. Immediately after raising this Datix, the claimant emailed Dr Whyte at 10:32 am on 14 August 2017 and stated: "Appreciate the opportunity of raising this Datix to express and record my concerns about the case. I wasn't aware that the form didn't provide a "save" option and hence I had to submit the form without discussion as I had earlier indicated. I've taken a holistic approach to reporting of the Datix and have viewed the event from its entirety. I'm hoping that such an approach will trigger reviews at various levels including decision-making and drive changes to avoid causing harm to patients or putting them at potential risk". The claimant went on to explain what she had included in the Datix report including the comment "Induction of a completely avoidable anaphylaxis in an elderly patient with a high risk of adverse outcomes such as death".
45. When a Datix form is raised, the Details section is emailed automatically to a number of preset recipients, depending upon the department. Dr Whyte had also received the Details section of the Datix report automatically. Dr Whyte responded by email to the claimant as follows: "I'm afraid you seem to have missed the point of the Datix - there were numerous discussions, communications, skin test results, and additional clinic appointments with her of which it doesn't sound as though you are aware (that's why I thought discussing it would be helpful first). It reads (no doubt unintentionally) a little like you're apportioning blame. It's not anybody's fault; there was a process issue in the challenge pathway that failed, leading to missing the 1/1000th dose, and giving the hydrocortisone. We (all) need to learn from it and change the processes through which challenges go, so that it doesn't happen again. The point of a Datix is to highlight learning points for next time and generate solutions. In this case it is a near miss, which highlights areas in the challenge pathway at which that can be avoided in future." Dr Whyte then set out in detail the issues as he saw them, and set as his ideas for possible solutions. He concluded by saying: "I think I should be able to login and modify it after discussing with you, but I think we need to modify the tone to make it less like apportioning blame and look at the process. I will see if I can find you this afternoon we can have a bit more of a discussion."
46. The claimant then responded: "Apologies if the Datix had appeared to be apportioning any blame. As the challenge decision was taken at MDT I'm not sure what is meant by "blaming"

as it was a collective decision. If the decision turns out to be wrong for whatever reason, it needs a review. I do not see the complexity here I'm afraid … I had taken history prior to consenting the patient which I wasn't able to document as a result of time constraint and I had gone through the notes to update myself with the investigations/discussions undertaken …"

47. Dr Whyte then raised a separate Datix form himself in connection with the same incident on 15 August 2017 (Datix report W125450). He gave a detailed explanation of the incident and the history and recommended that there should be clear MDT outcomes, including written protocols and notes, risk assessment of procedures, and rescue medications and adhesive stickers to be produced and attached to the notes. He assessed the severity of the incident as "moderate" (rather than "minor" as suggested by the claimant in her Datix). He then emailed the claimant on 15 August 2017 to confirm: "I have raised the Datix. I have asked Christine [Nurse Consultant Sister Christine Symons] to forward it to our staff to reflect and discuss. You will hopefully be able to see the difference in detail and solutions. I agree if a serious event occurs we must review the circumstances, but that needs to be more reflective on the whole process rather than directed simply at whether it was right or wrong to undertake the challenge … It was unfortunate that you didn't have time to document the history you took - written documentation is vital for every encounter we have." Later on 15 August 2017 the claimant emailed Dr Whyte and copied in Dr Bethune. She stated: "I agree in hindsight, it would have been useful to record the history and the notes." She gave an explanation why she did not document it at the time and confirmed that she was happy to make a retrospective entry. The claimant again asserted that: "it was extremely worrying that a Datix was being raised to hydrocortisone (only), when the anaphylaxis itself in a high-risk patient is a major concern. The question here therefore is "whether the anaphylaxis was avoidable or not" hence the importance of the decision review." On 16 August 2017 the claimant then completed a retrospective entry in patient JH's clinical notes (which she marked as retrospective) which included the history regarding the index reaction from the patient.
48. Mrs Symons then commenced an investigation. The claimant's Datix had been submitted under pathology rather than the immunology clinical unit, and Mrs Symons therefore decided to close the claimant's Datix form, and to use Dr Whyte's subsequent Datix form as the basis of the investigation into the same incident.
49. Both Dr Whyte and Dr Bethune were subjected to extensive cross-examination in connection with the decision to subject JH to the challenge procedure, and the extent to which this was justified and/or explained in her patient notes. They both conceded that the were occasional omissions or inaccuracies in JH's notes, and that the process of completion of her notes was "sub-optimal". For instance, on occasion discussions were had between senior colleagues in the department following repeated MDT meetings and reviews, without these discussions or decisions then being properly recorded in the notes. As a result of the Datix investigation recommendations and improvements have now been made. However, they were both adamant that the senior personnel in the Department were fully aware of the detailed circumstances of JH and that a collective decision to subject JH to the challenge procedure had been discussed at length, and decided upon for good clinical reason. It was also clear that Dr Whyte was of the view that the claimant had failed to document her consent clerking of patient JH before the challenge, because she had accepted that this was the case. She subsequently gave a different version.
50. It is also clear that Dr Whyte was concerned about the claimant's behaviour in connection with the Datix. He was not concerned that she had raised a Datix report. On the contrary, Dr Whyte encouraged the claimant to do so because the circumstances merited a report, and he felt that the claimant and her training record would benefit from the process. The claimant had acted very professionally in coping with patient JH's anaphylaxis, and had a good opportunity in the context of her training requirements to give evidence of clinical expertise, communication and teamwork. Dr Whyte wanted and encouraged the claimant to submit the Datix for these two very good reasons. Instead the claimant had agreed to discuss a Datix report but then did not do so, and then submitted one which was critical of

the team decision and apparently seeking to apportion blame, rather than taking opportunity to improve procedures and team communication.

51. There was then a Morbidity and Mortality meeting in the Department on 30 August 2017. Dr Leeman sent an email to the Department confirming that the two Datix reports from the claimant and Dr Whyte refer to the same incident, and that Dr Whyte's version W125450 was the final version. Agreed learning points included that the decision to proceed with a challenge either in an MDT or on the day of the challenge should not be made without the full written notes available; risk stratification should be documented more clearly in the MDT; in this case in retrospect a positive challenge was avoidable; and that it was important that a documented and focused patient history should be retaken on the day of the challenge.
52. It is also worth noting that the claimant's ongoing training continued despite these events and her Datix report. She was still undertaking the agreed training plan and the ongoing requirements to provide evidence that she was meeting her training objectives continued in any event. Against this background both Dr Bethune and Dr Whyte requested confidential feedback from other members of team in connection with the claimant's communication and team skills, and the team dynamic.
53. For example, following an Educational Supervisor's meeting between Dr Bethune and Dr Leeman, by email dated 8 September 2017 Dr Leeman reported to Dr Bethune that the claimant had initially been warmly welcomed into the Department by the whole team but that the atmosphere soon began to sour. She said "In one MDT Esha was visibly disengaged from proceedings and appeared angry. She was rude to a member of the nursing staff and in doing so also refused to do a simple documentation job that I'd asked her to do." She also stated: "Esha can be very intense in discussions and can bring up a big topic without much warning. There have been a few occasions where she has shown little regard to whether it was a good time for me to have that discussion or not. I've walked away from conversations feeling admonished, foolish or interrogated at various times." She concluded by saying: "One of the hardest things to deal with is inconsistency. For periods of time she can be nice, communicative, respectful, complimentary and humorous, but following any hint of disagreement she turns defensive and shunts blame or accusation onto others."
54. Dr Bethune also had two Educational Supervisor's meetings with the claimant on 1 September 2017 and 6 September 2017. At the first of these the notes record that they discussed the anaphylaxis incident. The claimant recorded that she felt she had been accused of wrongdoing in the light of the administration of hydrocortisone and that her concerns had not been discussed appropriately. Dr Bethune was of the view that Dr Whyte's emails had been balanced and considered but the claimant disagreed with this, and despite being rather taken aback by this approach, Dr Bethune agreed to review the correspondence. She also pointed out that the claimant had been required to file a minimum of two Reflections each month and these had to be filed in the claimant's training ePortfolio. This had been agreed at the claimant's induction appraisal and her training Personal Development Plan but the claimant had failed to comply with this training obligation. Indeed, she had only filed one Reflection in the previous 6 to 8 weeks since July, and that was a criticism of the process rather than a genuine Reflection.
55. The notes of the second of these meetings on 6 September 2017 record Dr Bethune's views, including: "There is some evidence of appropriate reflection with learning highlighted, however I am concerned that there may be some factual inaccuracies, I would like to give ES the opportunity to review the document … Plan to continue to do two reflections per month, focusing on self-reflection and learning (two reflections for September needed as these two were from August) … There are two areas where I am concerned that the standard of practice demonstrated by ES have not been at the level that I would expect at this stage of training (15 months before the completion of training) … The first relates to attention to detail and clinical practice … I also have concerns regarding attention to detail in assessment of patients prior to challenge testing. This was highlighted as an important learning outcome following the DOPS undertaking with Dr Whyte on 20 July 2017 … The second area where I am concerned that ES's practice does

not reflect the standard that I would expect at this stage of training relates to her responses to advice or suggestions that her management practice could have been different or improved. The tendency on a number of occasions has been to deflect the focus of discussions onto others, not to address the fact that there may have been improvements or learning points she could have taken herself. This has had a negative impact on a number of members of our team individually and that affected the team dynamic by inhibiting open and honest discussion. It is also making it very difficult to develop a constructive supervisor training relationship."

56. The notes of the second meeting on 6 September 2017 also recall the following comments from Dr Bethune: "ES's response to Dr Whyte's emails following the suggestion that a Datix should be written regarding the use of hydrocortisone in a patient with a potential steroid allergy was to focus on others' decisions and behaviour. ES had felt that her concerns about the "avoidable anaphylaxis" had been ignored and her intention in the Datix and emails was not to apportion blame. Esha suggested there was intention for cover-up by other members of the team and that she was being "gagged" … Following Dr Leeman's email offering support in the case of future need for medical backup ES's response was to criticise Dr Leeman's behaviour during the acute reaction … When CB [Dr Bethune] had suggested at our educational supervision meeting (1/9/17) that ES should always take a full up-to-date history when consenting a patient for challenge, ES suggested that she had not been told this … CB did however remind her at that meeting following a DOPS with Dr Whyte it was clearly documented that a pre-challenge consent requires a full review of the patient's history in case of changes since the previous review. ES apologised but wanted to document that it was an emotional meeting."
57. Dr Bethune was sufficiently concerned about these developments to involve Dr Hannah Hunter, a consultant haematologist and the Service Line Head. Dr Bethune asked Dr Hunter to investigate the departmental concerns and the claimant's concerns concerning the anaphylaxis incident. Dr Hunter met with the claimant on 12 September 2017. In an email to Dr Hunter on 13 September 2017 the claimant doubted the factual accuracy of the Datix form submitted by Dr Whyte. Dr Hunter confirmed to the claimant by email dated 20 September 2017 that she had read all the Datix and email correspondence and concluded: "I can find no evidence of either blame directed specifically at you … or a cover-up. A duty of candour letter has been done and the event was discussed extensively in the M and M [the Morbidity and Mortality meeting], with action points and a QIP to follow." Dr Hunter also emailed Dr Bethune on 20 September 2017 to give her reflections about the claimant. These included: "I have to say I think her response to the whole thing seems to be out of proportion to what occurred. You could interpret her Datix report and the subsequent emails to be highly defensive. I can find no evidence of direct criticism but I think that was very much what was perceived by her … I reviewed the notes, there is absolutely no documentation for her either before or after the event … I do not think this is acceptable. There is no evidence she was actually involved at all that day in the formal medical record … Her style of email writing and indeed her direct conversational style is very confrontational, her manner isn't easy and her communication skills poor …"
58. Three consultants (Dr Bethune, Dr Whyte and Mrs Symons) then prepared Multiple Consultant Reports (MCR's) for the claimant in advance of a further Educational Supervision meeting on 27 September 2017 between Dr Bethune and the claimant. Dr Bethune recorded that they agreed there was no longer any suggestion or concerns regarding patient interactions or clinical management plans and that therefore the claimant could now have patients booked to her in a clinic (which ended the arrangement from Newcastle that the claimant had to have a consultant with her when she saw patients). However, it was also recorded that there was a consistent theme in all three MCRs of issues relating to communication and team working, which were the same areas which were cause for concern at the last ARCP. Dr Bethune explained that this needed to improve dramatically if the claimant were to demonstrate that she was working at a level appropriate for trainee only 15 months from CCT. Without evidence of improvement Dr Bethune confirmed that it was unlikely that the claimant would pass her next ARCP.

59. On the following day 28 September 2017 the claimant emailed Dr Bethune and Dr Whyte in connection with the recording of the consent clerking for patient JH and her medical notes. She confirmed that her consent clerking sheet was misfiled in the rheumatology section. She suggested that: "I hadn't realised that the consent clerking document was missing. I entered a detailed history of the patient as advised subsequently. In my consent clerking I have noted that the patient had received hydrocortisone previously and was on prednisolone at the time of the challenge. I have also documented the high-risk nature of the challenge to the patient. I have filed the consent clerking document in the immunology section now."
60. It is clear that given her earlier explanation Dr Whyte did not fully believe her. He responded by saying: "I have to say I'm quite surprised by this. You had said to me on 15/8 that "in hindsight it would have been useful to record the history in the notes" and that you "hadn't viewed the situation as potential anaphylaxis where documentation would assume importance". You said that "due to the rapidity of events and the notes being taken away it was not possible to document it subsequently" and that you were "happy to enter them in retrospect indicating the entry date". You did write a retrospective note subsequently so wouldn't that time have been better spent looking for the contemporaneous documentation? If you did indeed take the history for an hour then I would be very surprised if you have forgotten this so soon after the challenge. The patient also doesn't recall any history being taken which if it took an hour would be most unusual, although she will be coming in for her next challenge on Tuesday so I will confirm with the patient and her daughter then. Furthermore, you said that you documented the "high-risk nature of the challenge" although you "didn't view the situation as potential anaphylaxis" and didn't raise any concerns at the time." They exchanged further emails in the same vein on 4 October 2017.
61. Meanwhile on 3 October 2017 the claimant met with Clinical Nurse Specialist Mrs Trump (from whom we have heard) in connection with feedback which had been provided as part of the recent MCR's. The claimant sent an email to Mrs Trump on 8 October 2017 by way of her summary of that conversation. She explained that she had been told that her behaviour had been found to be inappropriate and unprofessional and that one of her comments at an MDT meeting (involving Mrs Trump) was said to have been sarcastic and dismissive. Mrs Trump said that she was unable to recall the comment or the context.
62. Mrs Trump was concerned that a confidential feedback process had been made public, and subsequently provided a detailed note by way of feedback on that meeting with the claimant and her subsequent email. She recorded: "I was asked some time ago to provide feedback about Dr Sarkar. I was asked by Sister Symons as she was collecting feedback for Esha. I was told this feedback would be confidential which meant that I felt more able to tell Christine how I felt and to be honest ... She said that Andrew Whyte had commented that at a MDT she (Esha) has spoken to me in an inappropriate way and reported it to Christine. She wanted to tell me her details of this incident. She was very condescending. My reaction was that this incident is in the past should be left there. I said that I had no idea who had raised this and that I couldn't recall the exact incident she referred to as she was unable to give specifics. I felt that I wanted to get out of the room and that there was no reason for this situation. We work as a team and I am happy to speak to anyone but this situation felt uncomfortable. I said we can all have "off days" let's forget it and move forward. I felt I needed to lighten the conversation. I felt very pressurised into giving specific answers that she wanted. I didn't feel listened to and I didn't feel able to say what I wanted to say. I felt like it was more of an interrogation than a chat! I felt that she would not have listened anyway. She just disregarded anything I had to say. … Life continued for a few days, nothing further was said about this meeting between us. I then received an email (one and a half pages long) on 8/10/17 which I read on 9/10/17. The email detailed Esha's recollection and interpretation. This left me feeling absolutely wretched. I was shaken, shocked and really worried that this was going to escalate to something really horrible, all from being asked for confidential feedback which I didn't expect to hear anything back from. This impacted my performance for the whole day … I went home thinking that I would be unable to continue working with Esha in this department if behaviour like this carried on.

This whole event has left me feeling concerned for our team. I feel that I have to watch my back because the email was so unexpected and I am worried she's monitoring everything. I'm left feeling I and possibly us as a team are now being judged by her with everything we do. I don't feel confident that this is the type of relationship that would be supportive if any mistake were made or if there was any difference of opinion …"

63. It also seems that Mrs Trump complained to Dr Leeman about this incident, who reported it to Dr Whyte. Dr Whyte informed Dr Bethune of the background prior to a further Educational Supervisor's meeting between Dr Bethune and the claimant which took place on 11 October 2017. It seems clear to us by this stage that the relationship between the claimant and Dr Bethune as her Educational Supervisor had effectively broken down. The claimant stated that she did not feel that she was supported by Dr Bethune's educational supervision and that it was her view that Dr Bethune was ignoring her perspective and blaming her and that she felt that the team were colluding against her. At the end of the meeting the claimant suggested that Dr Bethune was out of her depth with the situation and needed help. Dr Bethune advised the meeting was no longer constructive and that the conversation should be ended. Dr Bethune suggested that the next educational supervision meeting should have a member of the Deanery team present to provide support to the claimant.
64. A further ARCP review meeting was also imminent. The claimant emailed Dr Bethune on 17 October 2017 to question the prospective date for that meeting on 10 November 2017 and suggested: "I would anticipate that a mediated meeting between us as proposed by you will not happen any time soon."
65. In the meantime, Dr Bethune had asked Dr Whyte to provide his reflections on the team to HEE/the Deanery, and he sent an email to Mr Squires of HEE on 26 October 2017. That email including the following comments: "I have worked with Esha since 6 July 2017, and over that period have interacted with her more or less daily in various ways… Over the first few days things were settled and I have no recollection of any issues, however my relationship with Esha changed fairly suddenly on 10 August following a reaction during a graded dose challenge … Esha sent an email mid-morning saying she wanted to do a comprehensive Datix from a holistic point of view. We were to discuss it before submission, but Esha accidentally submitted it before discussion. Esha forwarded me a copy of the Datix saying that she appreciated the opportunity of raising this Datix "to express and record my concerns about the case". However, when I read her description my first reaction was to feel quite offended by the strong emphasis placed on criticising the original decision to challenge, while also self-justifying the administration of the hydrocortisone. It was repeatedly framed as a platform for Esha to express her own concerns about our (very considered) decision to proceed with the challenge, rather than being a mechanism for team reflection on our processes. I felt very much as though I was being personally blamed for the reaction … Through a subsequent series of emails I felt increasingly frustrated and misunderstood … I tried to be calm and considered in my replies but I found it impossible to introduce any new perspective or clarify anything without being blamed further. I eventually realised that Esha was not taking notice of any other perspectives, so I took the approach of rewriting the Datix (the original had been submitted under pathology rather than the clinical unit, and had therefore been withdrawn). I had hoped this might allow me to show in a single coherent way that I wasn't trying to apportion blame, although in subsequent emails I felt further criticised and blamed. I did want to conclude the matter on a positive note, so my final contribution was to point out that Esha had been calm and competent in managing the patient, for which she thanked me. In summary I felt criticised and hurt by seemingly being told that I (on behalf of the team) was wrong to challenge (even negligent …) … As a result of these interactions I started doubting my own practice and doubting decisions which on reflection are sound and justified. Even as a senior colleague in MDT's I'm slightly reluctant to make suggestions in MDT in case they are criticised (this has not happened verbally but both I and others have noted the very negative body language). However, I'm more concerned about junior staff, some of whom have felt disempowered by Esha's interactions and are reluctant to participate in discussions … In summary, I think that since Esha arrived in July there has been increasing uneasiness and

disruption in the team. Staff are "walking on egg shells" and the disharmony is taking an emotional toll on a number of staff members, with some crying (at home but also at work). I don't think the situation is sustainable in its current form. However, I don't know how to restore the team to its usual functional state without removing Esha from the Department, which would honestly be very detrimental to her training needs."

66. There was then a meeting between the claimant and Mr Squires of HEE on 25 October 2017 and the claimant agreed to a suggestion of mediation within the immunology department.
67. In the meantime, the situation was taking its toll on Dr Bethune who had become ill as a direct result of these developments. Dr Bethune was sufficiently ill to attend the respondent's Occupational Health Department. The claimant's new ARCP date was planned for December 2017, and Dr Bethune was concerned that the mediation or HR processes might drag on beyond the ARCP date in December and that she felt it impossible to carry on as the claimant's Educational Supervisor beyond the ARCP date. The difficulty was that there was no one else available in the Department to act as the claimant's Educational Supervisor.
68. Dr Bethune had attended an appointment with Dr Johnston, a Consultant Occupational Position in the respondent's Occupational Health Department on 10 November 2017. Dr Johnson reported that Dr Bethune was "reporting exceptionally high levels of anxiety and distress which are having a significant impact on her both inside and outside work. The cause of the stress would appear to be her interaction with one particular medical registrar for whom she is the educational supervisor. It would not be appropriate in this context to discuss the behaviour of this particular trainee in any detail, however, from Claire's report, it would appear that this individual's behaviour is highly abnormal and is also causing problems with other members of the department."
69. On 24 November 2017 Dr Bethune emailed Mr Squires of HEE/the Deanery to the effect that she was not able to provide educational or clinical supervision of the claimant after the ARCP which was planned for 21 December 2017. She assumed therefore that the claimant would no longer be able to work in immunology in Plymouth after that date and asked for confirmation. She explained that it was important that the plan to move the claimant elsewhere within the respondent or to transfer to a different immunology department elsewhere was communicated to the claimant.
70. Dr Bethune then put in chain a Summary Multi Source Feedback (MSF) process whereby 14 members of the clinical and administrative staff with whom the claimant had consistent interactions were asked to provide their feedback. 10 of these 14 colleagues gave feedback that the claimant was either "below" or "well below" overall professional competence expectations. Dr Bethune and the claimant were due to meet at an Educational Supervisor's meeting on 5 December 2017. On 27 November 2017 Dr Bethune informed Mr Squires of HEE that she proposed releasing the results of the MSF on 4 December 2017 and to inform the claimant at their forthcoming meeting on 5 December 2017 that she was unable to continue to supervise her.
71. Dr Bethune's final Educational Supervisor's Report on the claimant followed that meeting on 5 December 2017 and covered the period from 5 July 2017 to 4 December 2017. Dr Bethune's overall assessment was that the claimant's professional competence was "well below expectations". Included in the examples was reference to the DOPS observation from 20 July 2017 as a need for more attention to taking details of a patient's history, and the claimant's Datix form. The MSF process was noted, with the majority of respondents reporting that overall professional competence was below expectation (seven reporting overall professional competence to be below the standard expected for this stage of training and three respondents well below expectations). The lowest scoring sections were attitude to staff and team player skills in which 10 respondents reported the claimant to be below or well below the standard expected. The extensive free text comments included in the MSF highlighted problems relating to communication, approachability, team working and respect for other staff members. The behaviours had had a negative effect on the team dynamic as well as making others struggle to contribute to the claimant's training effectively. Dr Bethune noted that the personal development plan objectives which had

been agreed to had not been achieved by the claimant. She had failed to draw up a plan as advised at the Penultimate Year Assessment (PYA) and at subsequent educational supervision meetings and that progress had not been made in achieving these training requirements. The ARCP/PYA requirement to undertake regular reflective practice in order to improve team working and communication had not been achieved and it was noted that despite the claimant agreeing that she would submit Reflection reports focusing on her areas of weakness on a two-weekly basis, the claimant had filed only eight reports in the Reflection section of the ePortfolio since starting in Plymouth during a period of 21 weeks.

72. Dr Bethune concluded that she had overall concerns about the claimant as follows: "In addition to the concerns above regarding the level of knowledge and its interpretation, as well as the failure to engage with ePortfolio and the curriculum, I am particularly concerned about Dr Sakar's attitude to other staff members, her communication with other members of the team, and effect this has had on the wider team. This is well documented in the MSF and MCR. In addition to causing considerable stress to individuals within the Department this has a negative impact on the team dynamic affecting communication across the team with an inevitable effect on patient management. The failure to work effectively with the team and to take advice and learn from others in the multidisciplinary team may have contributed to Dr Sakar's failure to achieve the competency requirements in terms of knowledge and application of knowledge in a clinical setting.
73. The claimant's final ARCP meeting took place on 21 December 2017 and was conducted by a panel appointed by HEE. The panel were Dr Sarah Johnston (Consultant/External Advisor); Dr Matthew Buckland (SAC Representative/External Assessor and Chair); Dr Geoff Wright (Associate Dean), and Mr Bill Wylie (Lay Representative). The HEE panel's decision was that the claimant was given an Outcome 4, that is to say a recommendation for removal from the training programme. The concluding comments included these observations: "This is the fifth training centre that the trainee has been placed at, because of continued difficulty in training. Going back to the start of the portfolio there have been issues with both competence and conduct. At the PYA six months ago reflective practice was highlighted as being very poor and the trainee was encouraged to attend the PSU for support and work on reflection. At the time the trainee said that reflection was "pointless" and "tedious", this has been further highlighted in the failure to engage with appropriate reflection in the intervening six months. A number of critical incidents have occurred involving the trainee over time at different trusts and the trainee apparently has limited insight into their own involvement in these and has not evidently learned from them, despite appropriate support … A current critical incident appears to have caused significant workplace issues, with complaints from multiple staff members and very poor multisource feedback. Despite significant input at many centres, the trainee appears to lack the basic requirements of good medical practice, and the concerns regarding patient safety would need to go to the JRCPTB medical director if an appeal against the outcome 4 is lodged and were to be successful, since the panel has grave concerns for patient safety if the trainee were to continue to practice and in the view of the panel based on the available evidence, this individual is not likely to ever reach the standard required for independent practice … The current trainer was not involved in the panel so that the panel discussion was based on the portfolio evidence and not biased due to current failed trainee/trainer relationship which was evident from portfolio contents. The non-biased/open approach to assessment, maximised the chance of a trainee in difficulty having a fair outcome."
74. The claimant submitted an appeal against this Outcome 4 decision. Mrs Hulbert of the respondent's HR department and Mrs Dawe of the respondent then met with the claimant on 19 January 2018. They informed the claimant that the respondent was unable to provide her with an Educational Supervisor and therefore there was no suitable training environment as required under her training contract. The claimant was informed that the HR department had "sought alternative meaningful temporary work within our Quality Assurance Department" and the claimant was moved to this team on about 19 January 2018. The claimant was informed that she would not be disadvantaged by the loss of training time and that effectively the training "clock" would effectively stop while she was undertaking this alternative work.

75. Nonetheless the claimant was removed from clinical work. It was accepted on behalf of the respondent at this hearing (and we so find) that this ongoing removal from clinical practice had the effect of "deskilling" the claimant.
76. The claimant then raised a formal grievance on 14 February 2018. It was a lengthy document with nine pages of allegations and 26 enclosures which totalled over 100 pages. The gist of the claimant's complaints were that her working environment had turned hostile following the anaphylaxis incident and her grievances related to events following that incident. She alleged that she been subjected to detrimental treatment on the grounds that she had made her Datix report but also included other allegations to the effect that she been criticised about her mobility, appearance and other issues; and that there had been a refusal to cooperate with a reasonable workplace adjustment. The claimant expressed her desired outcomes to be a written response to the concerns raised; review of the respondent's policies; a written apology for stress and upset; a request to see Dr Bethune's occupational health advice; and for the respondent to propose a resolution to enable her to resume working in the immunology department.
77. The claimant appointed Mrs Rachel Buller, from whom we have heard, to hear the claimant's grievance complaint. Mrs Buller is a Service Line Cluster Manager, and her role is focused on the operational, financial and strategic management of patient services. She is not a qualified clinician. She was assisted in an administrative capacity by Mrs Ellen Nagle from the respondent's HR Department.
78. Mrs Buller, Mrs Nagel and the claimant met on 1 March 2018, with the claimant's BMA representative who could only participate by telephone because of adverse weather. Another meeting was then arranged for 7 March 2018. Following that meeting the claimant confirmed that she wished to present further documentation which she did on 8, 9 and 13 March 2018. There was then an exchange of emails between Mrs Nagle and the claimant in which Mrs Nagle confirmed that she was making appointments to interview various witnesses and she wished the claimant to confirm that she had presented all documents which she wished to be included. The claimant then replied that she intended to supply additional documents which she had done by 19 March 2018.
79. Mrs Buller then interviewed and obtained signed statements from Dr Whyte, Dr Bethune, Mrs Symons, Mrs Trump, Dr Hunter, Mrs Lilley, Mr Wong, and Dr Leeman. During this process Mrs Nagle kept the claimant closely informed as to the progress of the investigation. Mrs Buller made her decision and set out her reasons for the outcome in a letter dated 8 May 2018. Mrs Buller then arranged a meeting to discuss this with the claimant, and the first opportunity at which the claimant and her BMA representative were available was on 22 May 2018.
80. Mrs Buller had perceived the grievance to consist of five separate aspects, and her conclusions were as follows. Grievance Point A was that the claimant had been "asked to change a datix" by Dr Whyte. This was partially upheld to the extent that Dr Whyte had indeed discussed modification of the Datix with the claimant. The claimant did not contend in her grievance that Dr Whyte had "instructed" her to change the Datix (as is now alleged in these proceedings).
81. Secondly, Grievance Point B was that clinical risk management had been obstructed. Mrs Buller rejected that allegation and found that there was nothing to indicate that anything was being hidden by Dr Whyte as alleged. In particular Dr Whyte had submitted his own Datix which had shown an increase in severity level and had highlighted the near miss incident. In addition, action was taken to arrange a duty of candour letter for the patient which was further pursued in an MDT meeting.
82. Thirdly, Grievance Point C was the claimant's allegation that Dr Bethune had been an irresponsible Educational Supervisor and that her supervision had changed from being supportive to critical when defending the actions of colleagues. Mrs Buller rejected the allegation that Dr Bethune was an irresponsible educational supervisor. Support had been identified through the Deanery which had included additional supervisory meetings.
83. Fourthly, Grievance Point D related to the leadership of a Quality Improvement project (which is not an allegation which is pursued as part of this claim). This aspect was partially upheld because Mrs Buller considered that Dr Bethune had not clarified who the doctor

was with regards to the project, and Mrs Buller made it clear that the relevant Dr was Dr Davis.

84. Finally, Grievance Point E responded to the claimant's allegations that the workplace was hostile and that she received criticism from a number of the team and that she been subjected to unsubstantiated and continuous criticism. The claimant made a number of wide-ranging allegations in broad terms, and not just that she received this criticism because of the Datix which she had filed. She contended that continued criticisms were directly related to her personal appearance and mobility issue. Mrs Buller rejected these allegations and in particular noted a significant amount of work being undertaken prior to the claimant's commencement in the immunology department and that a number of workplace adjustments have been considered and implemented prior to her arrival.
85. During her cross-examination Mrs Buller conceded the because she was not clinically qualified she would be unable to make a professional assessment as to the safety of any drug challenge, or about the administration of a drug, or whether hydrocortisone was right or wrong as a treatment. She conceded that she could look at the process adopted with regard to the claimant's supervision but would not know if it was appropriate in a medical sense. She also conceded that whereas she had found that Dr Whyte had not expressed the view that the claimant was dishonest, there was a suggestion that he maintained a question about the claimant's honesty with regard to the claimant's clinical consent clerking with JH.
86. The claimant then sought a review of Mrs Buller's decision, which Mrs Buller thought more appropriately should be dealt with by way of an appeal process. The claimant's response by way of her letter dated 5 June 2018 was therefore treated as an appeal. There was then a slight delay in arranging an appeal hearing because of difficulty in identifying a date when relevant senior panel members would be available to hear it, as well as the availability of the claimant's BMA representative. There was then an appeal hearing, and the appeal outcome letter was dated 21 August 2018. Grievance Points A and B were not successful, but with regard to Grievance Points C, D, and E, the appeal panel concluded that there was a failure to carry out a thorough investigation and this aspect of the claimant's appeal was upheld. The reason for this was that the investigation had not involved an independent clinician with appropriate educational experience so that the grievance had not been considered by someone fully aware of the procedures and documentation required during medical training. This was despite the fact that neither the claimant nor her BMA representative had ever asked that her grievance should only be investigated by someone who was suitably clinically qualified.
87. Subsequent to that decision the parties have been unable to agree how to resolve matters. Their ongoing disagreement resulted in a meeting with the respondent Trust's Chief Executive and the claimant, and a suggestion that there might be a separate investigation. For reasons which were not made clear to us this does not seem to have happened. The claimant contends that there has been no independent investigation into the serious medical incident which she highlighted in her Datix, which point Mr Maguire conceded in his evidence. Nonetheless the respondent's clinicians remain of the view that they fully reviewed the position following Dr Whyte's Datix report and subsequent team meetings, which did result in a changed protocol and safety procedures. In any event, any ongoing dispute does not form part of the claim before this Tribunal.
88. Finally, before concluding our findings of fact, we make the following findings with regard to the claimant's character and attitude. There is a particularly telling exchange of emails between the claimant and Dr Whyte between 17 and 24 October 2017. On 17 October 2017 Dr Whyte reminded the claimant that she been instructed to write a letter about a patient's immunodeficiency at an MDT meeting approximately one month previously on 19 September 2017. The claimant was off work but checking her emails, and Dr Whyte was unable to find that letter and asked the claimant if it had been dictated but not yet typed. On 18 October 2017 the claimant confirmed that "I have drafted a letter but was waiting for the histology report and the recent clinic review letter from Dr Bhatt. I have only just received them. I wanted to make sure that I wasn't missing anything. I shall incorporate the histo. report and release the letter." Dr Whyte responded on 18 October 2017: "Thanks

could you please send your draft or let me know where it is? I'll turn it into the post-TC letter and send it now." The claimant responded that she did not bring patient letters home because of data protection issues, but the draft could be "on my personal drive in my account or draft of the Big Hand both of which are my private areas and not accessible to other people". Dr Whyte responded to the effect that he had then checked with the administration staff and there was nothing in the Big Hand dictation folder and that the claimant was not allowed to store patient specific data on her personal drive, and that all documents related to a patient must be available to others especially while she was away and not in inaccessible private areas.

89. This seems to us to be a straightforward issue thus far. Dr Whyte was not the claimant's Educational Supervisor, but he was a supervising consultant. The claimant had apparently failed to act on a requirement a month previously to send a letter, and he was checking the position. On being told that the claimant had prepared a draft, he offered to complete it and send it. The claimant then suggested it was stored in a private area, which Dr Whyte told her was inappropriate practice.
90. The claimant then responded with an email on 23 October 2017 (on her return to the Department) which challenges Dr Whyte's position in a number of respects. She raised issues of sensitive information on the respondent Trust's network and challenged Dr Whyte for the source of his advice that draft letters could not be kept on the protected personal H drive in the respondent's system and saying that she wished to escalate that issue. She challenged whether a draft letter should be used for clinical purposes. She suggested that self-typed letters accounted for less than 1% of her output and wanted to know whether that figure was deemed to be appropriate. She repeated that she wished to see the histology report, and then went on to discuss the nature of the draft letter and challenged Dr Whyte's assumption that it was a clinic letter and challenged him to confirm under the respondent's guidelines that a letter from an MDT required prioritisation over a clinical question. What she singly failed to do was to produce the draft letter requested which was several weeks overdue, which, it soon became clear, she had failed to prepare in the first place.
91. Dr Whyte responded on 23 October 2017 explaining the position to the claimant in more detail and offering her training on various issues. This prompted a reply from the claimant on 24 October 2007 which was a response running to more than a page and a half of closely typed text, in which she challenged and questioned the various points and policies raised. Within the very close detail of the challenges in this email, the claimant conceded that: "The purpose of the personal draft in question was a reminder to myself to make sure that the MDT letter on the patient is not missed". Dr Whyte responded on 24 October 2017 as follows: "Thanks for the reply. You made a lot of points on some of the details, but I think you have missed the main issue. You had a task from MDT to write a letter, and weeks later it still hasn't been done. I had assumed that by now it would be sent, or that you would at least have a draft written (hence my original request), but it seems you have not even got further than a personal note to yourself. It's not good enough. If you have a task (be it writing a letter, chasing a CT scan, looking at blood results) it should be done promptly and without delay."
92. We found this to be an illuminating snapshot of the difficulties caused by the claimant's character and attitude. The claimant had been told repeatedly that she had to work on communication and team skills in order to pass her training, and had been warned repeatedly about a defensive and hostile attitude to being challenged. On this occasion she was challenged as to whether she had sent a patient letter several weeks previously as required. Instead of conceding that she had not done so, she reacted to that challenge with lengthy emails of her own which were defensive and challenging to her supervising consultant.
93. This was consistent with the manner in which the claimant gave evidence on occasion before this tribunal. She frequently failed to answer straightforward questions, and met them with a question or challenge of her own, or a requirement to be provided "with evidence" before making any concession. We can easily see why various educational supervisors, trainers, and colleagues found her character and attitude to be both frustrating

and exasperating on the one hand, to defensive, challenging and hostile on the other. Dr Bethune knew about the claimant and her training difficulties before she joined the respondent's department in Plymouth. We have no reason to doubt Dr Bethune's evidence that she wished to help the claimant to complete her training despite the fact that this would require further time and effort on the part of senior personnel in her department. She and her colleagues tried their best to help the claimant in this respect, but within a matter of weeks the claimant's character and attitude was such that trying to provide supportive and encouraging training had made Dr Bethune ill, and the clear advice from Occupational Health was that Dr Bethune should no longer act as the claimant's Educational Supervisor because doing so was having an adverse effect on her health and well-being. Mrs Trump had also become ill as a result of her dealings with the claimant and had received similar advice from Occupational Health. Our findings of fact and conclusions should clearly be seen in this context.

94. The claimant commenced the Early Conciliation procedure with ACAS on 19 March 2018 (Day A), and the Early Conciliation Certificate was issued on 11 April 2018 (Day B). The claimant initially tried to present these proceedings on 10 May 2018. She was unrepresented at the time. These initial proceedings were rejected because of a suggested defect on the originating application form. The rejection was on the basis that box 8 of the originating application had no ticks in it. Given that the claimant had given information in box 9 as to unfair dismissal and potential discrimination, and box 10 with regard to information to regulators in protected disclosure cases, the reasons for this rejection seem curious to say the least. In any event, the claimant sought reconsideration of that rejection and remedied the suggested defect, and these proceedings were subsequently accepted as having been correctly presented, but only with effect from 30 May 2018.
95. Having established the above facts, we now apply the law.
96. The Law:
97. Under section 43A of the Employment Rights Act 1996 ("the Act") a protected disclosure is a qualifying disclosure (as defined by section 43B) which is made by a worker in accordance with any of sections 43C to 43H.
98. Section 43B(1) provides that a qualifying disclosure means any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show one or more of the following – (a) that a criminal offence has been committed, is being committed or is likely to be committed, (b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject, (c) that a miscarriage of justice has occurred, is occurring or is likely to occur, (d) that the health or safety of any individual has been, is being or is likely to be endangered, (e) that the environment has been, is being or is likely to be damaged, or (f) that information tending to show any matter falling within any one of the preceding paragraphs has been, or is likely to be deliberately concealed.
99. Under Section 43C(1) a qualifying disclosure becomes a protected disclosure if it is made in accordance with this section if the worker makes the disclosure – (a) to his employer, or (b) where the worker reasonably believes that the relevant failure relates solely or mainly to – (i) the conduct of a person other than his employer, or (ii) any other matter for which a person other than his employer has legal responsibility, to that other person.
100. Under section 47B of the Act, a worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure.
101. Under section 48(2) of the Act, it is for the employer to show the ground on which any act, or deliberate failure to act, was done.
102. We have been referred by the claimant to the following authorities which we have considered: Jesudason v Alder Hey Children's NHS Foundation Trust [2020] EWCA Civ 73; Shamoon v Chief Constable of Royal Ulster Constabulary [2003] ICR 337 HL; Ministry of Defence v Jeremiah [1979] IRLR 436 CA; Harrow LBC v Knight [2003] IRLR 140 EAT; Serco Ltd v Dahou [2017] IRLR 832; Fecitt and Ors v NHS Manchester [2012] ICR 372 CA; Reynolds v CLFIS UK Ltd [2015] EWCA Civ 439; Flynn v Warrior Square Recoveries Ltd UKEAT/0154/12; Arthur v London Eastern Railways [2007] ICR 193; Lowri Beck

Services Ltd v Brophy EWCA (12 December 2019 Unreported); Marks & Spencer Plc v Williams-Ryan [2005] IRLR 562 CA; Adams v British Telecommunications Plc [2017] ICR 382. We were also referred to Harvey Division CIII, 8.

103. We have been referred by the respondent to the following authorities which we have considered: Arthur v London Eastern Railway [2007] ICR 193; Blackbay Ventures Limited t/a Chemistree v Gahir UK/EAT/0449/12/JOJ; Ibekwe v Sussex Partnership NHS Foundation Trust UKEAT/0072/14; Jesudason v Alder Hey Children's NHS Foundation Trust [2020] EWCA Civ 73; Fecitt and Ors v NHS Manchester [2012] ICR 372 CA; Oxfordshire County Council v Meade UKEAT/0410/14; Shamoon v Chief Constable of Royal Ulster Constabulary [2003] ICR 337 HL; and Unilever UK Plc v Hickinson UKEAT/0192/09.

104. The Procedural History and the Issues to be Determined:

105. The claimant first presented her originating application for these proceedings on 10 May 2018. The claim form was rejected because it was defective, and the claimant applied for reconsideration and remedied that defect. The claim form was accepted by the Tribunal on 30 May 2018. The claimant relies on one protected public interest disclosure, but asserts that she has suffered 26 different detriments on the ground of that disclosure. The first 24 of these detriments are arguably out of time. There were a number of case management preliminary hearings, and the parties were reminded of the dicta in Hendricks v Commissioner of Police for the Metropolis [2003] IRLR 96 CA, to the effect that they should attempt to agree a list of issues and to formulate proposals about ways and means of reducing the areas of dispute, the number of witnesses, and the volume of documents. They were encouraged to make attempts to keep the proceedings within reasonable bounds by concentrating on the most serious and the more recent allegations.

106. The parties then agreed that a proportional way to proceed was for the claimant to choose five detriments of the 24 which were arguably out of time, together with detriments 25 and 26 which were within time, and to proceed to hearing for the claim relating to these seven detriments to be heard in the first instance (referred to as the Chosen Detriments). The remaining allegations of detriment all remained live issues, but were stayed with the consent of the parties pending resolution of the seven Chosen Detriments. The parties expressly consented to this course of action and further agreed that this was in accordance with the principles derived from HSBC Asia Holdings BV & Anor v Gillespie UKEAT/0417/10 and Tarn v Hughes (& Ors) UKEAT/0064/18.

107. The Protected Public Interest Disclosure:

108. The claimant relies upon one protected public interest disclosure, namely her Datix report into the anaphylaxis incident suffered by patient JH as explained in detail above. We find that in that Datix report the claimant disclosed information which tended to show that the health or safety of an individual had been endangered. Patient safety is clearly a matter of public interest, and we find that in making that disclosure the claimant reasonably believed it to have been in the public interest. That disclosure satisfied the provisions of section 43B(1)(d) of the Act, and was a qualifying protected disclosure. The Datix reporting system is the respondent's internal procedure for reporting such incidents, and that disclosure was made by the claimant to her employer. It therefore became a protected public interest disclosure by virtue of section 43C(1)(a) of the Act. The respondent conceded during the course of these proceedings that the Datix report was a protected public interest disclosure. There was some suggestion at this hearing that this concession might be retracted, but in the event there was no such application. We have no hesitation in finding that the claimant's Datix report in question was a protected public interest disclosure.

109. Detriment:

110. We have been reminded on behalf of the claimant that detriment will be established if a reasonable worker or employee would or might take the view that the treatment accorded to them had in all the circumstances been to their detriment. Per Sir Patrick Elias at paras 27 and 28 of Jesudason, "It is now well established that the concept of detriment is very broad and must be judged from the viewpoint of the worker. There is a detriment if a reasonable employee might consider the relevant treatment to constitute a detriment.

The concept is well-established in discrimination law and it has the same meaning in whistle blowing cases." It is not necessary for the worker or employee to show that there was some physical or economic consequence flowing from the matters complained of (see for instance Shamoon). A worker or employee is subjected to a detriment if he or she is put at a disadvantage (see for instance MoD v Jeremiah)

111. Burden of Proof and Causation:

112. Under section 48(2) of the Act, it is for the employer to show the ground on which any act, or deliberate failure to act, was done. Where an employee has made a protected public interest disclosure and has been subjected to detriment by an act, or deliberate failure to act, the employer must prove on the balance of probabilities that the act, or deliberate failure, complained of is not on the grounds that the employee had done the protected act. This requires an analysis of the mental processes (conscious or unconscious) which cause the employer so to act (see Harrow LBC v Knight). If the employer fails to discharge this burden the tribunal may draw an adverse inference against it. As for causation, section 47B will be infringed if the protected disclosure materially influenced (in the sense of being more than a trivial influence) the employer's treatment of the whistleblower (see Fecitt and Ors v NHS Manchester). Sir Patrick Elias in Jesudason suggested that the causation test is more aptly described as a "reason why" test. The liability enquiry must be to the mental processes of the decision-makers, why they made the decisions and did what they did, and not as to a broad "but for" analysis of events (Harrow LBC v Knight). The Tribunal must look at the motivation of the manager or person doing the act or deliberately failing to act and so imposing a detriment, and consider whether he or she was motivated (in a way that was more than trivial) to act as he or she did by the protected disclosure (see Reynolds v CLFIS UK Ltd).

113. The Seven Chosen Detriments and Our Decision:

114. The claimant originally prepared a schedule setting out 26 alleged detriments which are numbered consecutively. Unfortunately, they are not in strict chronological order. The Chosen Detriments set out below refer to the number of the alleged detriment in the claimant's original schedule. We maintain that numbering and the order in which they appear (rather than chronologically), because that is how they have been referred to during the course of this hearing. These alleged seven Chosen Detriments are now set out below.

115. However, before we examine each of these in detail, we make the following general points. We find it inherently unlikely and highly improbable that any of the respondent's personnel from we have heard would commit any act, or deliberately fail to act, on the ground of the claimant's Datix disclosure. In the first place the claimant was actively encouraged to submit the Datix report. Dr Bethune thought she should be encouraged to do so, and Dr Whyte and Dr Leeman thought so too. There were two good reasons for this: first, it was normal procedure and the appropriate thing to do for reasons of patient safety and potential improvement of procedures; secondly, it provided a very good training opportunity for the claimant to prove examples of clinical expertise, team working and her involvement in the development and improvement of the respondent's procedures. The second point relates to the breakdown of relationships and the negative reports about the claimant which led to the ARCP Outcome 4 and her removal from the training programme. It is not the case that the claimant's deficiencies suddenly became apparent after the date of the Datix report. On the contrary, the claimant had demonstrated for a number of years in a number of different hospitals the same identified performance issues which were below or well below normal expectations in her training. These included from time to time a lack of clinical expertise, failure to take responsibility for her own Reflections and filing of training information; and a worrying tendency to react to any perceived criticism with a defensive and hostile nature, leading to a severe disruption of the team dynamic. All of these professional deficiencies already existed before the claimant joined the respondent's team, and again became readily apparent in the short time that the claimant was with the respondent. They simply cannot be said to be new or imaginary deficiencies which had arisen merely because she submitted a Datix report when encouraged to do so. Against this background we find as follows.

116. First, Detriment 2 is said to have occurred on 14 August 2017. The claimant alleges that she "was instructed to modify the adverse incident report (datix) by Dr Whyte within two hours of the disclosure. The claimant felt pressurised into acting against conscience."

117. The respondent's response is: "Dr Whyte did not "instruct" the claimant to modify the Datix. Dr Whyte set out in an email to the claimant: "I think I should be able to login and modify it after discussing with you, but I think we need to modify the tone to make it less like apportioning blame and look at the process. I'll see if I can find you this afternoon and we can have a bit more of a discussion.""

118. We find that this alleged detriment simply fails on its facts. It is not the case that Dr Whyte instructed the claimant to modify her Datix report. The detail of his response by email to the notification of the Datix is at paragraph 45 above. He pointed out his view that the incident was nobody's fault and wished to discuss the matter with the claimant as it looked as if it was apportioning blame. He did not instruct the claimant at any stage to modify her Datix. In any event, his motives for seeking a discussion on the issue was just the tone of the claimant's Datix which seemed to apportion blame, and was simply not on the ground that the claimant had raised the Datix, which of course he had encouraged to do in the first place.

119. Secondly, Detriment 10 is said to have occurred on 3 April 2018. The claimant alleges: "Ms Teddie Trump confirmed to the respondent's investigators that the single interaction with the claimant was reported by Dr Whyte. She denied having raised this issue to the individuals who had accused the claimant of serious and frequent unprofessional behaviours in the MCR or to Dr Whyte. Ms Trump's evidence at the stage 2 investigation rules out her role in reporting the interaction and confirms that it was Dr Whyte who had reported it. Dr Bethune or Ms Symons hadn't observed the interaction (Dr Bethune was on annual leave and Ms Symons was busy elsewhere and hadn't attended the meeting). The accusations in the MCR could only happen as a result of collusion between Dr Whyte, Dr Bethune and Ms Symons as Ms Trump was not a party to it. The gravity of the accusations in the MCR and the Educational Supervisor Report subsequently were therefore based on Dr Whyte's interpretation/inappropriate escalation of the (single) interaction. Following the single interaction (with Ms Trump) which had occurred soon after the disclosure (14 August 2017) the claimant experienced hostility/antagonism from Ms Trump (e.g. opposition to a reasonable workplace adjustment on 25 August 2017) and the team (e.g. criticisms/fault finding on 6 September 2017). The claimant believes that the hostilities/antagonism were influenced by the unjustified escalation of the interaction by Dr Whyte, which had incited difficulties in the work environment for the claimant. The detriment is that Dr Whyte inappropriately escalated this interaction as a retaliation to the claimant having expressed concern about (Dr Whyte's decision on) the challenge agent, in the disclosure."

120. The respondent's response is that: "It is denied that the feedback given in the MCR was false or that this was an inappropriate escalation of a single incident. The respondent considers the reports to be honest and accurate. It is denied that Dr Whyte inappropriately escalated a single interaction between the claimant and Teddie Trump as a retaliation to the claimant having expressed concern about Dr Whyte's decision on the challenge agent, in the Datix. The MCR reports were written independently. It is denied that there was collusion".

121. We initially found this allegation difficult to understand. The "single interaction" to which the claimant refers relates to her discussions with Mrs Trump. In fact there was no "single interaction". It seems originally as if Mrs Trump had given feedback in response to a request about her interactions with claimant which she was told would be confidential. There seems to have been an issue on one occasion at which the claimant may have been rude to Mrs Trump which Mrs Trump considered to be "water under the bridge". Nonetheless it seems to have featured in general feedback for the Multi-Consultant Report process in late September 2017. The claimant then challenged Mrs Trump in person about what she had said on 3 October 2017, which she followed with an email on 8 October 2017. Mrs Trump then produced a report on 11 October 2017 setting out her distress at the way in which the claimant had approached her. The circumstances all fed into the evidence which was given in the course of the claimant's grievance. Given this alleged detriment is

said to have occurred by the claimant on 3 April 2018, it appears to be the case that the claimant alleges that Dr Whyte "escalated" this "single interaction" to the claimant's detriment during her grievance investigation.

122. The claimant has not alleged as a pleaded detriment that the MCR process in September 2017 was an inappropriate process initiated with the purpose of unearthing exaggerated or inaccurate information against her in order to use the information to her disadvantage. In any event we find that it was an appropriate process which the respondent was entitled to use in order to collate information to address the claimant's perceived training deficiencies on an evidential basis. This process did not focus merely on one report or any "single interaction" with Mrs Trump. All the staff were asked to comment on the claimant's communication skills which is entirely appropriate given that this was consistent with the principal deficiency which earlier trainers including Dr Buckland had identified.

123. We do not find therefore that any stage Dr Whyte "escalated" any "single interaction" between the claimant and Mrs Trump. The negative comments about the claimant's communication skills resulted from an appropriate feedback process involving all members of the team. We accept that this negative feedback could well amount to a detriment to the claimant, but it cannot be said that Dr Whyte's actions, or the general feedback process, were undertaken by the respondent on the ground that the claimant had made her Datix report. There were communication issues in the team; the claimant had been told on a number of occasions that she needed to improve communication and team working skills to pass her training; and the feedback process was undertaken to assist in analysing any improvement or otherwise in this respect. The comments made by Dr Whyte, and the other two consultants Dr Bethune and Mrs Symons, were not untrue, fabricated, or the result of collusion. They were an accurate reflection of the individual feedback from other members of the team, which had been reasonably requested in the context of the claimant's training programme. In our judgment the request for, the creation of, and the reliance on this feedback (including any interaction with Mrs Trump) were all an essential element of the claimant's training programme, and it had nothing to do with the claimant's Datix report. We therefore dismiss this allegation of detriment.

124. Thirdly, Detriment 12 is said to have occurred on 29 September 2017. The claimant alleges: "The consent clerking of the anaphylaxis patient was misfiled in the medical notes. When the document was retrieved from the rheumatology section of the notes (28 September 2017) the claimant was subjected to a process of email interrogation by Dr Whyte which lasted until 4 October 2017. A clear allegation of document tempering was subsequently made by Dr Whyte (3 May 2018) to the respondent's investigators by stating that the consent clerking was not contemporary. The accusation was false and had no justification or evidence behind it. It was a detriment resulting from Dr Whyte's views of the initial disclosure. The interrogation and the false accusation had lowered the claimant's professional standing amongst the claimant's peer group."

125. The respondent's response is that: "It is denied that there was any interrogation of the claimant or that any false accusation was made by Dr Whyte."

126. We find that the claimant's position with regard to the recording of her consent clerking with the anaphylaxis patient JH was inconsistent and disingenuous. The claimant had initially told Dr Whyte that she did not have time to document the patient history which she said she had discussed during the consent clerking process. In her email on 15 August 2017 the claimant commented "I agree in hindsight, it would have been useful to record the history and the notes." She agreed to make a retrospective entry. The claimant accepted in cross examination that it was reasonable for Dr Whyte to assume on this basis that she had not documented the patient history. It was only after the Educational Supervision meeting on 27 September 2017 (following the Multiple Consultant Reports) that the claimant changed her position and suggested that her consent clerking sheet was misfiled in the rheumatology section. This is why Dr Whyte raised concerns about the claimant's position as to whether the consent clerking was contemporary. We do not accept the Dr Whyte made an allegation of "document tampering". He did ask the claimant to explain the position (which we hardly find to be email "interrogation"), and did express concerns subsequently as to the procedures originally undertaken by the claimant. To the

extent that this amounts to a detriment we reject the contention that it was on the grounds of the claimant's Datix report. Given the claimant's change of position, which is either confused or disingenuous, Dr Whyte had every right to investigate the position and to make the comments which he did. They were not made on the ground that the claimant raised her Datix report and we also reject this allegation of detriment.

127. Fourthly, Detriment 13 is said to have occurred on 27 September 2017. The claimant alleges: "The claimant was accused of dishonesty concerning the care of the anaphylaxis patient (in writing) by Dr Whyte in the MCR. The accusation was in contradiction to the documentation of the patient's care in the medical notes. In the stage 2 investigation subsequently, the above accusation was justified by blaming the claimant for inconsistencies in the claimant's account of patient care (3 May 2017). The care of the patient described in the email communications between the claimant and Dr Whyte however, provides no evidence of any inconsistency in the claimant's account of patient care. The false accusation had lowered the claimant's professional standing amongst the claimant's peer group. The written accusation in the MCR on the ePortfolio, gave evidence of serious and unprofessional behaviour of the claimant in patient care to HEE at the ARCP (21 December 2017)."

128. The respondent's response is: "The claimant was not accused of dishonesty. Dr Bethune reported in the Educational Supervisor's report (5 December 2017) that "I have not been made aware of specific concerns relating to Dr Sarkar's honesty, probity and health." Nor was there any false accusation made by Dr Whyte. The feedback provided by Dr Whyte in the MCR (27 September 2017) was balanced, identifying positive aspects as well as points of concern in an eight-page document."

129. We do not accept the claimant's premise that there was "no evidence of any inconsistency in the claimant's account of patient care". As explained in more detail under Detriment 12 above, we find the claimant's change of position with regard to the patient notes to be either confused or disingenuous. Simply put, the claimant changed her position as to what had happened. In any event, the claimant was not accused of dishonesty. As the respondent points out, Dr Bethune in her Educational Supervisor's report makes it clear that there were no specific concerns relating to the claimant's honesty or probity. It is true that Dr Whyte made enquiries as to exactly what had happened with regard to the consent clerking patient notes which the claimant either did or should have made contemporaneously. However, to the extent that this amounts to a detriment (which is by no means certain), we find that the actions taken by Dr Whyte, and his feedback in the MCR, were made as a result of the claimant's own inconsistency, and not on the ground that she had made a Datix report.

130. Fifthly, Detriment 14 is said to have occurred on 6 September 2017. The claimant alleges: "At the educational meeting on 6 September 2018 [meaning 2017], the claimant raised objection to Dr Bethune's accusation that the claimant had refused to learn from feedback from a DOPS assessment by Dr Whyte (20 July 2017). The claimant raised the objection as the DOPS assessment itself was inaccurate. Dr Bethune however dismissed the claimant as untrustworthy and used the DOPS assessment to substantiate the written accusation in the educational meeting document (6 September 2017) on e-portfolio (detriment 5). The DOPS assessment and the educational meeting document (6 September 2017) were used as evidence of the claimant refusing to learn from feedback, in the Educational Supervisor's Report (5 December 2017). Dr Whyte's evidence on the stage 2 investigation subsequently, has confirmed the claimant's position about the inaccuracy of the DOPS assessment. The dismissal of the claimant as untrustworthy and the de facto trust in Dr Whyte that was evidenced by continuing to use the DOPS as evidence against the claimant, shows the less favourable treatment of the claimant by Dr Bethune without any justification and in absence of robust proof. The less favourable treatment of the claimant would not have happened without the disclosure. The repeated use of the DOPS as evidence against the claimant on the e-portfolio had validated the false assessment. The less favourable treatment by Dr Bethune provided false evidence of poor professional practice of the claimant to HEE at the ARCP (21 December 2017)."

131. The respondent's response is: "It is denied that Dr Bethune dismissed the claimant as untrustworthy. It is denied that the claimant was accused by Dr Bethune of "refusing to learn" from feedback from a previous DOPS assessment by Dr Whyte at the educational meeting (6 September 2017). It is denied that there was any "false accusation" made against the claimant."

132. We deal with the DOPS assessment by Dr Whyte in paragraph 34 above. We have found that on 20 July 2017 at the DOPS assessment Dr Whyte was entirely justified to give feedback to the claimant that the new diagnosis had been missed and more attention should have been paid to ensuring that the history given by the patient was fully documented. The claimant did not dispute that assessment at the time. We have already rejected the assertion that Dr Whyte can be said to have lied about the matter or deliberately given a false assessment. This matter was raised by Dr Bethune at the Educational Supervisor's meeting with the claimant on 6 September 2017, and although Dr Bethune did not actually accuse the claimant of "refusing to learn" from the DOPS, Dr Bethune did raise concerns "regarding attention to detail in assessment of patients prior to challenge testing. This was highlighted as an important learning outcome following the DOPS undertaking with Dr Whyte on 20 July 2017 …" In other words, Dr Bethune was explaining that she has ongoing concerns about the claimant's abilities in this regard, despite them having been brought to her attention, including at the earlier DOPS assessment.

133. We accept that the claimant suffered a detriment by way of the negative feedback in this supervisor's report which forms part of the background information giving rise to the subsequent HEE ARCP decision. The claimant asserts that this would not have happened without the Datix disclosure. We reject that assertion. Both the original DOPS assessment by Dr Whyte, and the Educational Supervisor's Reports from Dr Bethune, gave rise to reasonable evidence-based conclusions which were not reached by Dr Whyte or Dr Bethune on the ground that the claimant made her Datix report. We therefore dismiss this allegation of detriment as well.

134. Sixthly, Detriment 25 is said to have occurred from 14 February 2018. The Claimant alleges: "The claimant submitted a grievance notification to require an investigation into the victimisation that she suffered following the disclosure and the adverse clinical incident related to the disclosure, to the HR Department of the respondent (14 February 2018). Ms Rachel Buller and Ms Ellen Nagle undertook a poor quality investigation which had to subsequently be appealed as it was not thorough, ignored key facts and raised more questions. The appeal hearing panel (10 August 2018) recommended a reinvestigation of the victimisation which has not yet started. The claimant is unaware of a single individual responsible for the conduct of the grievance investigation but any individual involved was aware of the disclosure as this was a part of the grievance. The conduct of the grievance investigation has been delayed at every stage and has been of poor quality. The length of time being taken to conclude a proper grievance investigation by the respondent is exacerbating the damage to the claimant, by extending her time out of training and preventing her from resuming her career. This would not have happened if the disclosure had not been made."

135. The respondent's response is: "The claimant submitted a grievance dated 14 February 2018 and this was subsequently investigated by Ms Rachel Buller and Ms Ellen Nagle at stage 2 of the respondent's grievance procedure. An outcome was provided in a letter dated 8 May 2018. Some parts of the claimant's grievance were upheld; other parts were not upheld. An appeal panel identified following a hearing on 10 August 2018 that there should be a new investigation into some aspects of the grievance as it was felt that the previous investigation was not thorough in relation to those points. It is denied that the quality of the original grievance investigation by Ms Buller and Ms Nagel was poor on the grounds of the protected disclosure; or that any delay has been on the grounds of the protected disclosure."

136. As we understand it the claimant complains of a poor grievance process because of the delay involved, and the fact that the matter needs to be reheard by someone who is clinically qualified. In the first place we do not find that there has been any undue delay in

the grievance process. The claimant's grievance took between February and May 2018 to be investigated and decided upon. During this time there was some delay caused by the claimant by way of repeated addition of documents, and the unavailability of her BMA representative. It was a complicated matter which had to be investigated thoroughly and responsibly. Following the grievance decision in May 2018 and the claimant's appeal, the matter again had to be reinvestigated and decided upon, with the outcome then being made in August 2018. We do not accept that the claimant suffered any detriment by way of any undue delay in the process simply because it took between February 2018 and August 2018 to investigate and hear both the initial grievance and the appeal.

137. In addition, it is worth noting that the process was a thorough and independent process which partly upheld some aspects of the claimant's grievance.

138. The difficulty lies in the absence of someone clinically qualified in that process. The appeal panel decided that aspects A and B of the grievance appeal were rejected, but that aspects C, D and E should be reheard by someone clinically qualified. We note that neither the claimant nor her BMA representative requested this from the outset, but nonetheless we accept that the claimant has suffered detriment by way of the need to rehear these aspects of her grievance before someone clinically qualified, not least because the respondent has conceded that she becomes gradually de-skilled whilst not being able to return to training.

139. However, we consider it frankly ludicrous to suggest that the respondent acted (or failed to act) to delay the grievance and/or to provide someone clinically qualified in the grievance process (particularly when the claimant never asked for it), on the ground that the claimant made her Datix disclosure. There was no requirement under the respondent's procedures to have someone clinically qualified to hear it; the claimant and her BMA representative failed to request the same; and it became a recommendation of the appeal panel in an attempt to consider more clinically certain aspects of the claimant's grievance. There is simply no evidence that any of the respondent's officers (including Mrs Buller from we have heard who chaired the grievance initially) carried out the grievance in any particular detrimental way on the ground that the claimant had submitted a Datix report. We have no hesitation in rejecting this alleged detriment as well.

140. Finally, the seventh Detriment 26 is said to have occurred on 18 January 2018. The claimant alleges: "After the claimant was given a Type 4 outcome (i.e. a recommendation for removal from the specialist training programme) by HEE at the ARCP (21 December 2017), the claimant was removed from the specialty (18 January 2018) by the respondent. The ground for this was a withdrawal of supervision by Dr Bethune (after the ARCP). Removal from the specialty resulted in a discontinuation of training of the claimant and her deskilling. This is a clear detriment and would not have happened but for the disclosure and the subsequent exaggerated and false reporting by the respondent as described above. The discontinuation of the claimant's training was in contradiction to the rules of the specialist training programme, where trainees can continue their training until the outcome of an appeal against the Type 4 outcome. The claimant's training was discontinued prematurely, by Ms Hulbert who acted on behalf of the respondent. The detriment is that a trainee who had not made a disclosure of the type made by the claimant would have been allowed to continue their training pending the appeal (and that appeal would have been concluded within a reasonable time). The prolonged period of time that the claimant has been forced to spend out of the training programme will delay career progression with financial consequences and risks the claimant losing her clinical skills."

141. The respondent's response is: "The claimant was placed in an audit role pending an appeal process against the ARCP decision by HEE. Dr Bethune was advised by Occupational Health that she should cease to act as the claimant's Educational Supervisor because of concerns about the impact on Dr Bethune's health. It was not possible for the claimant to be assigned to another supervisor (which was a decision made by HEE and not by the respondent). It is denied that this was on the grounds of the claimant's protected disclosure."

142. In the first place we accept that the ARCP Outcome 4 conclusion that the claimant should be removed from her specialist training is a detriment which the claimant suffered.

In addition, the claimant has also suffered detriment by being unable to continue with her training pending any appeal against that ARCP Outcome. The claimant asserts that she would have been allowed to continue with her training pending the appeal if she had not made her Datix disclosure.

143. We disagree with that assertion for a number of reasons. If Dr Bethune's inability to continue as the claimant's Educational Supervisor is the reason why the claimant could not continue in her training then this cannot be said to be on the ground of the Datix disclosure. In the first place Dr Bethune was ill and advised by Occupational Health to discontinue as the claimant's Educational Supervisor, and we accept her evidence that this is why she did so. She did not take this decision on the ground that the claimant had made her Datix disclosure. Secondly, the respondent's immunology department is a small department and there was only one Educational Supervisor, namely Dr Bethune. Her resignation from that role meant there was no other potential Educational Supervisor to continue with the claimant's training simply because of the pre-existing size of that department. The fact that there was no other potential Educational Supervisor clearly has nothing to do with the claimant's Datix report. In any event, the decision that the claimant could not continue in her training in the respondent Trust's immunology department pending her appeal was not a decision made by the respondent. It was a decision made by a separate body, namely HEE/the Deanery, in accordance with the national training requirements and guidelines.

144. In conclusion we cannot find that the claimant would have been allowed to have continued in training in the respondent Trust's immunology department pending her appeal, but for her raising of the Datix report. We deal with the conclusion of the HEE ARCP panel in paragraph 73 above, which was a panel entirely independent of the respondent's immunology department, but again note that part of their conclusion was as follows: "Despite significant input at many centres, the trainee appears to lack the basic requirements of good medical practice, and the concerns regarding patient safety would need to go to the JRCPTB medical director if an appeal against the outcome 4 is lodged and were to be successful, since the panel has grave concerns for patient safety if the trainee were to continue to practice and in the view of the panel based on the available evidence, this individual is not likely to ever reach the standard required for independent practice …"

145. This is plainly why the claimant was removed from her training position. In addition, it was clearly a decision of an independent HEE panel, and not any act or deliberate failure to act on the part of the respondent. We have no hesitation in rejecting this final detriment that the claimant was removed from her CCT training, and not allowed to continue training pending her appeal, on the ground that she made the protected public interest disclosure (the Datix report) upon which she relies.

146. In conclusion therefore, the claimant's detriment claims under section 47B of the Act as presented to this tribunal are all dismissed.

147. <u>Out of Time:</u>

148. These claims were also defended on the basis that some or all of the claimant's allegations were presented out of time.

149. Section 48(3) of the Act provides: "an employment tribunal should not consider a complaint under this section unless it is presented – (a) before the end of the period of three months beginning with the date of the act or failure to act to which the complaint relates or, where that act or failure is part of a series of similar acts or failures, the last of them, or (b) within such further period as the tribunal considers reasonable in a case where it is satisfied that it was not reasonably practicable for the complaint to be presented before the end of that period of three months.

150. Section 48(4) provides: "For the purposes of subsection (3) – (a) where an act extends over a period, the "date of the act" means the last day of that period, and (b) a deliberate failure to act shall be treated as done when it was decided on."

151. With regard to the time points, we have been reminded on behalf of the claimant that "act" and "detriment" are different concepts (although often they may be the same thing). As Langstaff P observed in <u>Flynn v Warrior Square Recoveries Ltd</u> "The act, or the

deliberate failure to act, must be a cause of the detriment. The act or the failure to act, has to be done on the ground specified by the employer. The detriment, however, is coincidental, or consequent upon, the act or deliberate failure to act. The distinction between cause and effect is essential to bear in mind because of the terms of section 48 …" In addition, the Court of Appeal analysed the approach to be taken with regard to "a series of similar acts" for the purposes of these time provisions in Arthur v London Eastern Railways (at para 31) " … The acts occurring in the three-month period may not be isolated one-off acts, but connected to earlier acts or failures outside the period. It may not be possible to characterise it as a case of an act extending over a period within section 48(4) by reference, for example, to a connecting rule, practice, scheme or policy but there may be some link between them which makes it just and equitable for them to be treated as in time and for the complainant to be able to rely on them. Section 48(3) is designed to cover such a case. There must be some relevant connection between the acts in the three-month period and those outside it. The necessary connections were correctly identified by Judge Reid QC as (a) being part of a "series" and (b) being acts which are "similar" to one another."

152. We have also been referred on behalf of the claimant to Lowri Beck Services Ltd v Brophy for authority for the proposition that the test of reasonable practicability is to be given a liberal interpretation in favour of the employee, as earlier noted in Marks & Spencer Plc v Williams-Ryan. In addition, the fact that a first rejected claim had been lodged in time was not of itself dispositive of whether it had not been reasonably practicable to lodge the subsequent validly instituted claim within time, see Adams v British Telecommunications Plc.

153. In this case the claimant commenced the Early Conciliation procedure with ACAS on 19 March 2018 (Day A), and the Early Conciliation Certificate was issued on 11 April 2018 (Day B). The claimant initially tried to present these proceedings on 10 May 2018, but they were rejected. These proceedings were subsequently accepted as having been presented on 30 May 2018. Any act or omission which took place before 8 February 2018 (which allows for an extension of 23 days under the Early Conciliation provisions) is potentially out of time. Alternatively, if the proceedings had been accepted on 10 May 2018, then any act or omission which took place on or after 20 December 2017 would have been within time.

154. The claimant has given us a detailed explanation as to the rejection of her first set of proceedings and how these were remedied on consideration. However, the claimant has not given us any evidence as to why it was not reasonably practicable for the claimant to have issued these proceedings prior to her first attempt on 10 May 2018. The claimant was unrepresented when she sought to present the proceedings on 10 May 2018, and there appears to be no valid reason which we can see as to why they were rejected at that stage. She sought reconsideration of that decision promptly. We are unanimous that it is in the interests of justice to conclude that the proceedings should be deemed to have been validly presented on 10 May 2018. The effect of the Early Conciliation provisions as they apply on the facts of this case (and the dates of the Early Conciliation Certificate as actually obtained) is therefore that any act or omission which took place before 20 December 2017 is arguably out of time.

155. We find that the last two detriment claims relied upon by the claimant (Detriments 25 and 26) (if they had been successful) would have been within time for the following reasons.

156. Detriment 25 relates to the formal grievance submitted by the claimant on 14 February 2018, which was after 20 December 2017 and therefore within time. In any event the claimant complains that "the grievance investigation has been delayed at every stage and has been of poor quality. The length of time being taken to conclude a proper grievance investigation by the respondent is exacerbating the damage to the claimant, by extending her time out of training and preventing her from resuming her career." The claimant complains of an ongoing process which took until August 2018 before the appeal hearing was heard. The proceedings were clearly within time to complain of detriment arising from that ongoing process.

157. Detriment 26 complains of the claimant's removal from her specialty training on 18 January 2018 as a result of the previous ARCP Outcome 4 decision. The claimant's proceedings are clearly within time in respect of that decision. In any event, the respondent has accepted that removal from training has an ongoing deskilling effect on the claimant's clinical skills. The detriment complained of is the claimant's deskilling, which was clearly ongoing after this date, and continued during May 2018 when the claimant issued both sets of proceedings. If successful, we would have found this alleged detriment was therefore within time as well.

158. With regard to the earlier detriments we find as follows. The first detriment, Detriment 2, relates to the events of 14 August 2017 and is out of time. The second detriment, Detriment 10, would have been out of time to the extent that it relates to interactions with Mrs Trump between August and October 2017, but arguably relates to Dr Whyte's evidence during the grievance investigation in April 2018, and to that extent is within time.

159. The third detriment, Detriment 12, relates to events between 29 September and 4 October 2017 and is out of time.

160. The fourth detriment, Detriment 13, relates to Dr Whyte's comments on 27 September 2017. To that extent it is out of time. However, to the extent that the comments are said to have been relied upon by the HEE at the ARCP hearing on 21 December 2017 it could be said that the comments gave rise to a detriment on that later date, which is within time. The same can be said of the fifth detriment, Detriment 14, which relates to Dr Bethune's comments on 6 September 2017 and her subsequent Educational Supervisor's report on 5 December 2017. These are out of time, but if the detriment alleged is that these comments gave rise to the decision of the ARCP, then they are within time.

161. In any event, these claims were not successful, and to the extent that any detriments are out of time it cannot be said that there is any series of acts which are similar to each other such as to bring them within time, and these claims would have been dismissed in any event for that reason.

162. For the purposes of Rule 62(5) of the Employment Tribunals Rules of Procedure 2013, the issues which the tribunal determined are at paragraph 1; the findings of fact made in relation to those issues are at paragraphs 4 to 94; a concise identification of the relevant law is at paragraphs 97 to 103; how that law has been applied to those findings in order to decide the issues is at paragraphs 104 to 146; and the out of time issues of been addressed at paragraphs 147 to 161.

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Employment Judge N J Roper
Dated 18 November 2020

Judgment sent to Parties on

_____24 November 2020__

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