EMPLOYMENT TRIBUNALS

Claimant: Dr Ambreen Malik

Respondents: 1. CAS Behavioural Health Limited
2. Signet Healthcare Limited

Heard at: Manchester **On: 23,24,25,29,30 April 2019; 1,2,3 May 2019 12,13 September 2019 28,29 November 2019 2,3,4,5,9,10 December 2019 10,11,12,13 February 2020 20,21 April 2020**

Before: Employment Judge Warren
Mr B McCaughey
Mr A G Barker

REPRESENTATION:

Claimant: Ms Murphy, Counsel
Respondents: Mr D Barnett, Counsel

JUDGMENT

The judgment of the Tribunal is that:

1. Subject to paragraph 2 below the claims of detriment following public interest disclosures are all out of time, and the Tribunal has no jurisdiction to hear them. They do not form part of a series of similar acts. It was reasonably practicable for the claims to be brought in time.

2. The claim of detriment for making public interest disclosures in relation to Dr Burton's email to the GMC link, on the dismissal of the claimant, is both in time and well founded. The claimant suffered a detriment because she had made a series of public interest disclosures.

3. The claimant was not automatically unfairly dismissed for making public interest disclosures and her claim under section 103A) Employment Rights Act 1996 fails.

4. The claim of unfair dismissal in contravention of section 94 Employment Rights Act is well founded and succeeds.

5. The claimant was dismissed without notice in breach of her contract.

REASONS

Background and Case Summary

1. The respondent is a national private healthcare provider. It operated around 27 sites nationally. At all relevant times Dr Romero was Managing Director or subsequently the Chief Executive Officer and the most senior employee. There was a leadership team comprising Dr Burton, consultant psychiatrist, Mr N Ruffley nurse and director and Mrs J Gibson, Human Resources Director all of whom reported to Dr Romero.

2. The claimant was employed from 2011 becoming, in 2013, a Consultant Psychiatrist for the respondent. She was the only Consultant Psychiatrist at Fountains Hospital, with sole responsibility for 37 patients. The hospital cared for vulnerable young adult males with psychiatric conditions linked to a history of addiction. Some of them were detained under the Mental Health Act 1983.

3. The claimant was dismissed for gross misconduct on 12 October 2017. She brings claims of unfair dismissal, automatically unfair dismissal for making public interest disclosures, whistle-blowing detriments, and breach of contract/wrongful dismissal.

4. This was a lengthy and complex case, and the Judgment has been substantially delayed, in part because of the impact of COVID-19, and in part because of the indisposition of Employment Judge Warren for which she apologises to everyone concerned.

The Evidence

5. The Tribunal was supplied with witness statements from all of the following: Dr Malik; Ayesha Rahim and Shakir Adam Lincoln on behalf of the claimant. Dr Rahim is a Consultant Psychiatrist working for the Lancashire Care NHS Trust as Deputy Medical Director. Mr Lincoln was the brother of M, the patient whose treatment led to the claimant's dismissal.

6. On behalf of the respondent evidence was received from:

- Serena Birtwhistle, at the material time the Interim Hospital Manager and a qualified Registered Mental Health Nurse.

- Lynne Ngaaseke, Hospital Manager at the material time.

- Andrew Parsons, solicitor representing the interests of the respondent at the relevant time.
- Kristy Watters, Senior HR Business Partner in the respondent's business.
- McAshraful Bari, Lead Clinician.
- Leslie Burton, then Group Clinical Director (now retired).
- Nick Ruffley, Psychiatric Nurse and Regional Operations Director.
- Robert Verity, Consultant Psychiatrist and interim then Group Clinical Director.
- Venkataramana Boyapati, Assistant medical Director and Lead for Learning Disability and Autism Spectrum Disorders and Consultant Psychiatrist.
- Lyn Elliott, Head of HR Operations.
- Tony Romero, Chief Executive Officer of the respondent.
- Jenny Gibson, HR Director.

7. All of the above named witnesses had supplied witness statements which were taken as read, and where appropriate, they were cross examined.

8. There was a substantial bundle of documents consisting of several thousand pages – it was not possible to count the exact number as they were indexed in a bizarre and novel format. With the assistance of respondent's counsel, we were eventually able both to move between the 12 volumes of ring-binders which this case necessitated. Page references in this Judgment relate to that bundle – all require a letter of the alphabet as well as a number to trace them.

9. The case was decided on the evidential test, the balance of probabilities. We found some of the witnesses totally credible and others less so, and there are comments relating to those whose evidence we found less credible within the Judgment and our conclusions.

List of Issues

10. The List of Issues to be determined by the Tribunal was as follows:

Protected Disclosures

1. The claimant's case is that she made the following protected disclosures. The respondent does not accept that all disclosures were made to the claimant's employer:

2. Disclosure 1

An oral disclosure on 17 September 2015 at a root cause analysis interview in to the death of patient AG about the discovery of foil containing a blue bag holding beige/brown powder in patient AG's room which the claimant believed to have been an illegal substance. (Particulars of claim paragraph 8; and further and better particulars of claim paragraph 3).

(a) Whether the claimant made the alleged disclosure;

(b) Was this disclosure of information to her employer?

(c) Did the claimant believe that the disclosure tended to show that:

(i) A criminal offence had been committed, was being committed or was likely to be committed;

(ii) A person had failed, was failing or was likely to fail to comply with any legal obligation to which they were subject;

(iii) The health or safety of any individual had been, was being or was likely to be endangered; or

(iv) Any matter falling within any one of the above had been or was likely to be deliberately concealed?

(d) If so, was that belief reasonable?

(e) Did the claimant believe that she was making the disclosure in the public interest?

(f) If so, was that belief reasonable?

3. Disclosure 2

An email on 17 September 2015 to Dr Romero, the respondent's Group Medical Director, which confirmed that the claimant had seen what she believed to be illegal substances that had been found in patient AG's room. (Particulars of claim paragraph 9; and further and better particulars of claim paragraph 4).

(a) *The same list of questions as arises from disclosure 1.*

4. Disclosure 3

An oral disclosure to Dr Romero at Raglan House in Birmingham on a date between October and December 2015 in which she asked for advice about how to proceed about the drugs found in patient AG's room at the coroner's inquest. (Particulars of claim paragraph 11; and further and better particulars of claim paragraph 5)

(a) *The same list of questions as arises from disclosure 1.*

5. Disclosure 4

An oral disclosure to Dr Romero at Rookery Hall on a date between November 2015 and January 2016 in which the claimant asked for advice regarding the drug situation of patient AG. (Particulars of Claim paragraph 11; and further and better particulars of claim paragraph 6).

(a) *The same list of questions as arises from disclosure 1.*

6. Disclosure 5

An oral disclosure on 8 March 2016 to Andrew Parsons, solicitor instructed by the respondent, in which the claimant asked when and how to mention her discovery of drugs in patient AG's room. (Particulars of claim paragraph 12; and further and better particulars of claim paragraph 7).

(a) *The same list of questions as arises from disclosure 1.*

7. Disclosure 6

An oral disclosure on 9 March 2016 to Andrew Parsons and Lynne Ngaaseke at the coroner's inquest in which the claimant said that if patient AG had died of a drugs overdose discovery of drugs on the unit was relevant to his death. (Particulars of claim paragraph 12; and further and better particulars of claim paragraph 8).

(a) *The same list of questions as arises from disclosure 1.*

8. Disclosure 7

An oral disclosure on 9 March 2016 during her evidence to the coroner's inquest in the presence of many employees of the respondent, in which the claimant gave her account of the discovery of the foil and the respondent's reaction to it. (Particulars of claim paragraph 12; and further and better particulars of claim paragraph 9).

(a) *The same list of questions as arises from disclosure 1.*

Whistle-blowing detriment

9. In each of the following listed detriments the questions to be decided by the Tribunal are:

(a) Whether the claimant was subject to the treatment alleged;

(b) Was this an act or a deliberate failure to act by the respondent?

(c) Was the claimant subjected to a detriment by the act or failure to act?

(d) Was it on the ground that the claimant had made one or more of the protected disclosures?

Detriment 1 – Requirement to attend a meeting on 21 March 2016 and suspension on 21 March 2016. (Particulars of Claim paragraph 14; and further and better particulars of claim paragraph 11).

Detriment 2 – A demeaning email sent by Dr Burton shortly after 21 March 2016. (Particulars of claim paragraph 15; and further and better particulars of claim paragraph 12).

Detriment 3 – Subjection to increased and unconscionable supervision after the claimant's return to work on 26 April 2016 and until approximately July or August 2016. (Particulars of claim paragraph 16.1; and further and better particulars of claim paragraph 13).

Detriment 4 – In the first week of May 2016, and continuing until April or May 2017, the claimant's access to support staff and secretarial support was removed. (Particulars of claim paragraph 126.4; and further and better particulars of claim paragraph 13).

Detriment 5 – From 26 April 2016 until 13 October 2017 the claimant was routinely undermined in front of her team and peers. (Particulars of claim paragraph 16.2; and further and better particulars of claim paragraph 15).

Detriment 6 – From April 2016 until July 2016 the claimant's team and hospital staff were encouraged to monitor the claimant and report back to management. (Particulars of claim paragraph 16.3; and further and better particulars of claim paragraph 16).

Detriment 7 – Over a period from May 2016 to July 2016 the respondent attempted to remove the claimant's role as Clinical Appraisal Lead without justification. (Particulars of claim paragraph 16.5; and further and better particulars of claim paragraph 17).

Detriment 8 – In August 2016 and April 2017 the respondent refused to provide the claimant with a pay rise. (Particulars of claim paragraph 16.6; and further and better particulars of claim paragraph 18).

Detriment 9 – In approximately May 2016 the claimant's request for funding to attend a Royal College conference in July 2016 as part of her ongoing training was refused. (Particulars of claim paragraph 16.7; and further and better particulars of claim paragraph 19).

Detriment 10 – The claimant's grievance against Dr Romero lodged on 10 May 2016 was not dealt with adequately or in accordance with the respondent's policy. (Particulars of claim paragraph 16.8; and further and better particulars of claim paragraph 20).

Detriment 11 – From 26 April 2016 until 13 October 2017 the claimant was ostracised from the wider team by management and

other members of staff. (Particulars of claim paragraph 44.1; and further and better particulars of claim paragraph 21).

Detriment 12 – in December 2016 and April 2017 the respondent tried to move the claimant to Delfryn Hospital in Mold. (Particulars of claim paragraph 44.2; and further and better particulars of claim paragraph 22).

2 later detriments were added :- 13 – the referral to the GMC and the terms used to describe the claimant to a GMC liaison officer

14 – the investigation, disciplinary and appeal procedure

10. Which complaints have been presented within three months of the act or failure to act, taking into account the provisions of ACAS early conciliation?

11. Are any complaints which occurred more than three months before presentation of the claim part of a series of similar acts or failures ending with those brought in time, if any?

12. If not, was it reasonably practicable for the complaint to be presented before the end of the three month period?

13. If so, was it brought within a further period that the Tribunal considers reasonable?

Unfair Dismissal

14. What was the reason for the claimant's dismissal?

    (1) The respondent contends that the claimant was dismissed for gross misconduct as set out in the grounds of resistance.

    (2) The claimant's case is that she was dismissed because of the protected disclosures she made as listed above (an argument which she maintains even if the Tribunal decides that they are not protected disclosures, in which case they are still an unfair reason for dismissal).

15. Was the reason for dismissal a potentially fair reason falling within section 98(2) of the Employment Rights Act 1996?

    (1) The respondent relies on conduct.

16. If dismissal was for a potentially fair reason, did the respondent act reasonably in treating it as a sufficient reason to dismiss the claimant, specifically:

(1) Did the respondent have a genuine belief in the claimant's guilt?

(2) Were there reasonable grounds on which to base that belief?

(3) Had the respondent carried out as much investigation as was reasonable in the circumstances?

(4) If so, was the dismissal within the range of reasonable responses available to the employer?

Wrongful Dismissal

17. Did the claimant commit an act of gross misconduct entitling the respondent to summarily dismiss her?

The Law

Automatically unfair dismissal

18. Section 103(A) ERA 1996. An employee who is dismissed shall be regarded for the purposes of this Part as unfairly dismissed if the reason (or if more than one, the principal reason) for the dismissal that the employee made a protected disclosure.

Whistleblowing detriments – section 47B ERA

19. Section 47B Employment Rights Act 1996 states:

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

21 Section 43(A) provides:-

"In this Act a "protected disclosure" means a qualifying disclosure (as defined by Section 43(B) which is made by a worker in accordance with any of the sections 43(C) to 43(H)".

22 Section 43(B) provides (as relevant to this case):-

"(i) In this Part a "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, 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

23 Section 43(C) provides:-

"(1) A qualifying disclosure is made in accordance with this Section if the worker makes the disclosure :-

(a) to his employer

24 For the purpose of there being a qualifying disclosure, it is not necessary that the information disclosed should be factually correct. Section 43(B) refers to information which in the reasonable belief of the employee tends to show one or more matters mentioned in Sections 43(B)1(a)to(f). Reasonable belief must be based on the facts as understood by the worker and it is possible for a person reasonably to believe something which is in fact untrue though the factual accuracy of the allegation may be an important tool in determining whether the worker held the necessary reasonable belief. The question for the tribunal is not whether the factual allegations were correct but whether the claimant held the reasonable belief that what he was disclosing showed a relevant failure. Darnton –v- University of Surrey [2003] IRLR 133.

25 Finally, the claimant must establish a causal link between the protected act and the dismissal and must establish, on a balance of probabilities that the protected act, or acts, was the reason, (or, if more than one, the principal reason) for the dismissal.

Time limits in whistleblowing cases

26. Section 48(3) Employment Rights Act ("ERA") provides that the claim must be brought within three months of an act or failure to act. That is of course now subject to adjustment for early conciliation. It further provides that where the act or failure to act is part of a series of similar acts or failures then the last such act or failure is the relevant date for limitation purposes.

The time limit may be extended (section 48(3) ERA) if it was not reasonably practicable to present a claim within three months and the claim was presented within a reasonable period thereafter.

Law relating to detriment

27. It is now clearly established that subjecting someone to a detriment means no more than putting that person under a disadvantage **(Ministry of Defence v Jeremiah [1979] IRLR 436)**. In **De Souza v Automobile Association [1986] IRLR 103**. The Court of Appeal held that before an employee can be said to have been subjected to a detriment the Tribunal must find that that by reason of the acts complained of a reasonable worker would or might take the view that he had thereby been disadvantaged in the circumstances in which he had thereafter to work. This definition now has been approved by the House of Lords in **Shamoon v Chief Constable of RUC [2003] IRLR 285**.

Wrongful dismissal

28. "Wrongful dismissal" is a complaint that the employer has dismissed the claimant in breach of contract, almost always without a period of notice to which the claimant was entitled. If the contract was for a fixed term with no provision for early termination, the period will be the unexpired part of the term. If the contract was (like the great majority of employment contracts) indefinite in duration, a Tribunal should assume that the employer would, on the date on which it terminated it, have done so in the way most beneficial to itself, usually by giving the minimum period of notice

permitted under the contract to terminate it: **Lavarack v Woods of Colchester Limited [1967] 1 QBD 278 (CA)**.

29. The issue which commonly arises on a complaint of wrongful dismissal is whether the employer was entitled to dismiss without notice because of gross misconduct by the claimant, or other conduct which under the terms of the contract entitled the employer to dismiss in that way. If at trial it proves that there was such conduct, the defence will succeed.

30. In assessing the seriousness of any breach, it is necessary to consider all the relevant circumstances including the nature of the contract and the relationship it creates, the nature of the contractual term that has been breached, the nature and degree of the breach and the consequences of the breach: **Valilas v Januzaj [2014] EWCA Civ 436**. In the context of employment contracts, the relevant circumstances include "the nature of the business and the position held by the employee": **Jupiter General Insurance Co Limited v Shroff [1937] 3 AER 67**.

31. If the conduct consists of disobedience, then "it must at least have the quality that it is "wilful": It does, in other words, connote a deliberate flouting of the essential contractual conditions": per Evershed MR in **Laws v London Chronicle Limited**.

32. As an alternative to deliberate wrongdoing, gross misconduct may also consist of very considerable negligence, traditionally called "gross negligence": a relatively modern example in this context is in **Dietmann v Brent London Borough Council [1988] ICR 842**.

33. While unfair dismissal is a purely statutory concept, for the purpose of which the Tribunal is required to consider what a reasonable employer would have done, and must not substitute its own views, wrongful dismissal rests on the common law, and a Tribunal trying such a claim is required to make its own determination of whether or not the claimant's conduct entitled the employer to dismiss without notice.

34. Where a consultant psychiatrist had admitted breaching patient confidentiality by having patient documents clearly visible during a train journey, and on other occasions dictating reports, including patient sensitive information, on trains, the findings of fact by the investigating officer were capable of supporting a charge of serious misconduct, but not one of gross misconduct: there was no material to support the view that the breaches were wilful, in the sense of being deliberate, and such breaches are qualitatively different from deliberate breaches of confidentiality such as discussing a patient with the media: **Chabra v West London Mental Health NHS Trust [2014] ICR 194 (SC)** and **Johnson and Unisys Ltd 2001 UKHL (13)**.

<u>Unfair Dismissal</u>

35. Section 98 Employment Rights Act 1996 provides:-

> (1) "In determining for the purposes of this Part whether the dismissal of an employee is fair or unfair, it is for the employer to show –
>
> a) the reason (or if more than one, the principal reason) for the dismissal; and

b) that it is either a reason falling within subsection (2) or some other substantial reason of a kind such as to justify the dismissal of an employee holding the position which the employee held.

(2) A reason falls within this subsection if it –

(a) relates to the capability or qualifications of the employee for performing work of the kind which he was employed by the employer to do,

b) relates to the conduct of the employee."

(4) "Where the employer has fulfilled the requirements of subsection (1) the determination of the question whether the dismissal is fair or unfair (having regard to the reason shown by the employer) –

a) depends on whether in the circumstances (including the size and administrative resources of the employer's undertaking) the employer acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the employee; and

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

36. It is for the employer to show the reason for dismissal and that it was a potentially fair one. The burden is on the employer to show that it had a genuine belief in the misconduct alleged: **British Home Stores v Burchell [1978] IRLR 379**. The Tribunal must consider whether that belief is based on reasonable grounds after having carried out a reasonable investigation but in answering these two questions the burden of proof is neutral.

37. In the words of the guidance offered in **Iceland Frozen Foods v Jones [1982] IRLR 439**:-

(a) the starting point should always be the words of section 98(4) themselves;

(b) in applying the section, the Tribunal must consider the reasonableness of the employer's conduct, not simply whether they consider the dismissal to be fair;

(c) in judging the reasonableness of the dismissal, the Tribunal must not substitute its decision as to what is the right course to adopt for that of the employer;

(d) in many (though not all) cases there is a band of reasonable responses to the employee's conduct within which one employer might take one view, another quite reasonably take another;

(e) the function of the Tribunal is to determine in the particular circumstances of each case whether the decision to dismiss the employee fell within the band of reasonable responses which a

reasonable employer might have adopted. If the dismissal falls within the band the dismissal is fair: if the dismissal falls outside the band it is unfair;

(f) The correct approach is to consider together all the circumstances of the case, both substantive and procedural, and reach a conclusion in all the circumstances.

38. The Court of Appeal in **Sainsbury's Supermarkets Ltd v Hitt [2003] IRLR 3** concluded that the band of reasonable responses test applies as much to the question of whether the investigation was reasonable in all the circumstances as it does to the reasonableness of the decision to dismiss. In **A V B [2003] IRLR 405** the EAT concluded that when considering the reasonableness of an investigation it is relevant to consider the gravity of the charges and the consequences to the employee if proved. Serious allegations of criminal misbehaviour must always be the subject of the most careful and conscientious investigation.

39. The parties referred to the following further case law:-

- **Roldan v Royal Salford NHS Foundation Trust [2010] IRLR 721 (CA)**

  The gravity and seriousness of the consequences of a finding of guilt affects the level of thoroughness required in the investigation; Where there are diametrically conflicting accounts of an alleged incident with little corroboration either way, the employer is not obliged to simply believe one account and disbelieve the other per Elias LJ *"it is particularly important that employers take seriously their responsibilities to conduct a fair investigation where…. the employee's reputation or ability to work in his or her chosen field of employment is potentially apposite".*

- **Taylor v Alidair Ltd [1978] IRLR 82**

  The job of a pilot was one in which such a degree of professional skill was required is so high and the potential consequences of the smallest departure from that high standard so serious that one failure to perform in accordance with those standards is enough to justify dismissal.

- **Johnson v Unisys Ltd [2001] UKHL13**

  The implied term of trust and confidence does not apply to dismissal or to the way in which the employment relationship terminated.

- **Ashcroft v Haberdashers' Boys' Aske's School [2008] IRLR 375**

  The same principles set out in **Dedman v British Building and Engineering Appliances Ltd [1974] ICR 53 CA**, applies equally to employment consultants as to solicitors. An adviser's negligence or delay in presenting a claim is ascribed to the claimant applies equally where the advisor is not a solicitor.

It may be that a finding that it was not reasonably practicable to bring a claim in time where the claimant was reasonably awaiting the outcome of an internal appeal decision.

- **Kuzel v Roche Products Ltd [2008] EWCA Civ 380**

  The unfair dismissal provisions of Part X of the ERA, which included the inserted protected disclosure provision in section 103A, presupposed that, in order for the Tribunal to establish whether within section 98(1) the dismissal was fair or unfair, it was necessary for it to identify only one reason or one principal reason for the dismissal; that that reason was a question of fact for the employment Tribunal as a matter of direct evidence or of inference from primary facts established by evidence; that, while it was for the employer to show the reason and whether it was fair or justified, the employee might assert there was a different reason for the dismissal, such as the making of protected disclosures, and would have to provide evidence in support, but was not obliged to prove that that dismissal was for that different reason in order for the claim to succeed. If the employer failed to satisfy the tribunal as to its reason for the dismissal, it was open to the Tribunal to find that the reason was as asserted by the employee, but was not obliged to do so.

- **Cavendish Munro Professional Risks Management Ltd v Geduld UKEAT/195/09**

  For the purpose of the ERA there is a distinction between 'information' and an allegation. In order to fall within the definition of a qualifying disclosure in section 43B (1) there had to be 'a disclosure of information'; the ordinary meaning of giving information was to convey facts, and a disclosure had to be more than a communication.

- **Chesterton Global and another v Nurmohamed [2017] EWCA Civ 979**

  In addressing section 43B of ERA the Tribunal has to ask (a) whether the worker believed, at the time he was making it that the disclosure was in the public interest, and (b) whether, if so, the belief was reasonable (this was prior to the amendment in 2013). There may be more than one reasonable view as to whether a particular disclosure was in the public interest. Whilst the worker must have a genuine (and reasonable) belief, that does not have to be his predominant motive in making it if that the disclosure is in the public interest.

  Relevant factors could include; the numbers in the group whose interests were served; the nature of the interests affected; the extent to which they were affected by the wrongdoing disclosed, the nature of the wrongdoing disclosed and the identity of the alleged wrongdoer.

- **Karen Kilraine v London Borough of Wandsworth [2016] UKEAT 0260**

  A disclosure must be sufficiently factual and specific before the worker making it stands to qualify for whistleblowing protection.

- **Ibrahim v HCA International Ltd [2019] EWCA Civ 2007**

  A claimant alleging whistleblowing must have the opportunity to give evidence directly on the point of whether they had a subjective belief that they were acting in the public interest at the time of making the disclosure.

- **Royal Mail Group Limited v Jhuti [2019] UKSC 55**

  Is the disclosure the reason or if more than one the principal reason for the dismissal.

  When an inanimate company makes a decision, it can be difficult to identify the reason, the real reason for the dismissal and the invented reason. If a person in the hierarchy of responsibility above the employee has deceived the decision maker by inventing a reason the deception should not infect the reason for the dismissal – the real reason, the whistleblowing.

  The Tribunal has considered the provisions of the ACAS code of practice to disciplinary and grievance procedures.

The Facts

40. The claimant is a Consultant Psychiatrist. She was employed by the respondent from 2012 up to and including 13 October 2017. In August 2015 the claimant was employed at Fountains Hospital when a patient ("AG") was admitted. AG was a known substance misuse risk. On 24 August he had visitors who were allegedly drug dealers. AG was not searched when they left, and on the following day on 25 August 2015 AG was found dead in his room. A subsequent post-mortem revealed that he had traces of an illicit substance in his blood, but that he had died of natural causes.

41. At some point that day the claimant was approached in a corridor of the hospital by two staff members whom she has been unable to identify, holding a foil folder in the size of a razorblade to reveal a blue freezer bag containing a powder. They advised it had been found in the deceased patient's room. The claimant advised them to place them in the controlled drugs safe and to ensure it was not left there indefinitely. Immediately afterwards she sent an email to Leslie Burton her line manager) and Nick Ruffley to indicate that a bag of what she believed to be heroin and burnt foil had been found in the patient's room. She believed that that would be dealt with by management as it was an operational issue and not a clinical issue.

42. On 17 September 2015 a root cause analysis investigation was undertaken, and the claimant informed Mr R, the interviewer, about what she had seen. Mr R was an independent third party, brought in by the hospital to undertake a 'root cause analysis' He appeared surprised and discussed it with Lynne Ngaaseke, a manager. She contradicted the doctor and said that no illegal substance had been found, saying it was "all Chinese whispers". The claimant informed her that she had seen the fold with drugs inside, but Ms Ngaaseke remained dismissive and indicated that it would be unfair to ask the staff about it.

43. The claimant then, on the same day, attempted to contact her line manager, Dr Leslie Burton, to raise her concerns. He was on leave and unavailable, as was the person who covered for him. She then made a disclosure by email to the Assistant Medical Director, Dr Bari, and to the CEO, Dr Tony Romero. Dr Romero's reply the following day by email was to start with, "Are you telling me you will go to the police?" and ended with, "Do you know the implications of what you are saying?". The claimant felt intimidated and bullied.

44. Dr Romero did, however, set up an enquiry panel and 20 staff members were interviewed. The claimant was not one of them, nor were the police contacted, nor the deceased's family. In spite of this Mr Ruffley advised the claimant that staff on duty, police and the deceased's relatives had been interviewed, and no-one corroborated her observations. On three occasions the claimant was asked to apologise to members of staff. She refused because she knew what she had seen.

45. In March 2016 the claimant was called to attend the coroner's inquest into the patient's death. She had previously discussed the evidence that she would be giving to the coroner with Dr Romero, and asked for advice on how to proceed over the drugs found (as she believed it). His reply was that she should "do not make your life complicated" (bundle A pages 345-346).

46. The day before the inquest on 8 March 2016 the claimant met with Mr Parsons, a solicitor, at a briefing arranged for staff members due to give evidence the following day. The claimant asked him when and how to mention her discovery of the drugs. Mr Parsons indicated that it was not relevant to the patient's death (bundle A pages 357-360). The claimant was left believing that the respondent was trying to cover up the discovery of drugs.

47. Prior to the start of the inquest on 9 March 2016 Mr Parsons and Ms Ngaaseke had a conversation with the claimant in which Mr Parsons advised the claimant that if she mentioned the discovery it would affect her credibility and that she must have mis-remembered the event. He went on to indicate that if she told the court about it, it would affect Mr Parsons' credibility. The claimant approached the coroner's clerk to ensure the coroner was asked to raise this issue with her. When asked about it by the coroner she narrated the sequence of events and her observations, including explaining that the subsequent internal enquiry did not corroborate her claim.

<u>Detriment 1</u>

48. On 17 March 2016 the claimant was called to a meeting on 21 March with Dr Burton. The claimant had an NHS appointment which she had been waiting for, for months. She asked for the meeting to be moved and was told that she was expected to cancel the appointment and attend the meeting. She felt she had no choice and did so.

49. On 21 March 2016 the claimant met the Group Medical Director, Dr Burton, and the Regional Operations Director, Mr Ruffley. She was advised there had been a breakdown of trust and she was being suspended because of the evidence she had given at the coroner's inquest. She was told that the coroner had threatened to refer Mr Parsons to his regulator, and that Fountains was to be investigated by the police for hiding evidence and 'higher ups were very upset by it'. This was confirmed in writing by a letter on the same date, which stated that she was

suspended pending an investigation into the evidence she gave at the inquest and the effect it had had on relationships at Fountains.

50. On 29 March 2016 the claimant was interviewed by the respondent's Human Resources team.

51. On 7 April 2016 the claimant was advised that no action was being taken against her, a line was being drawn under the investigation and that a meeting would be arranged with her line manager for her return to work. A meeting was duly set up on 25 April, not with her line manager but with then Group Clinical Director, Dr Tony Romero. Her line manager was present but as a silent observer. During the meeting she was advised that she had been suspended not because of the evidence she had given but because of the effect of what she had said on the nursing unit and how it was impacting on the staff. Mr Romero decided in that meeting that when she returned to work she should have two monthly supervisions by Dr Burton and by Dr Bari – Dr Bari regarding her clinical work and Dr Burton regarding her behaviours.

Detriment 2

52. The claimant returned to work on 28 April 2016. There appeared no obvious reason why she should not have returned immediately. On her return to work she discovered that an email had been sent about her by the Group Medical Director to all of the doctors within the organisation. It was admitted by Dr Romero that this had not been done before. Although the email was unavailable to the Tribunal to see, the respondent admitted that it was an email informing all of the doctors of her suspension. Her return to work was not similarly reported to all of the doctors.

53. The claimant found it humiliating as she was unaware of such an announcement being made in relation to any other doctor in the entire time she had worked for the business. Dr Burton admitted that he had sent the email and that he had never done so before when suspending a doctor.

54. The claimant later raised a grievance in this regard and the outcome was an apology, a concession that it was wrong, and an offer to allow her to attend Board meetings to re-assert her status and reputation. In fact the evidence was that she was only invited to one such meeting, and although she intended to attend a second she was advised that she did not need to, and the work she had prepared would be dealt with by another doctor.

55. At the end of the two week internal investigation, there was no report published and no outcome. The claimant was simply invited to return to work. The respondent accepts that this was a detriment following her whistleblowing to the coroner.

Detriment 3

56. Before the claimant returned to work, Drs Bari, Burton and Romero met and agreed a course of action. On her return, Dr Burton increased her supervision from six monthly to twice weekly, although the claimant was advised that it would be twice monthly. Dr Bari was asked to supervise the claimant's clinical work. He read this as requiring him to attend ward rounds, observe and criticise her, and Dr Burton increased his supervisions by phoning the claimant every week. Dr Burton told the Tribunal that he did not intend Dr Bari to supervise the claimant's ward rounds, but

Dr Bari wrote to the claimant to say that was how he would supervise her. From 15 June 2016 he would attend the ward round, with no stop or review date set. Dr Burton accepted in cross examination that this could be seen as overbearing. It is still unclear why it was considered appropriate. Dr Burton asserted that it was to support the claimant (page 345). However, following his concession in his cross examination it would seem that both men were overbearing in their supervision.

57. Prior to her evidence to the coroner, the claimant had been supervised only twice a year. She felt harassed. She described this level of supervision as unjustifiable and unnecessary. She believed it was deliberate to harass her, undermine her authority and affect her confidence. She complained to Dr Burton about how Dr Bari's supervision was making her feel, and it stopped.

Detriment 4

58. In May 2016 the claimant alleged that her access to administrative support was removed. The evidence of the respondent was that her administrative support, Julie Parker, did not get on with her, withdrew cooperation and that another admin assistant began to help in 2015. However, before the inquest, she was moved to assist Payroll, which left the claimant without secretarial support. This was after the first alleged whistleblowing but before the inquest. There was no evidence that the claimant then received further secretarial support or that action had been taken in relation to Julie Parker's reluctance to work with the claimant.

Detriment 5

59. On 30 May 2016 Lynne Ngaaseke undertook two series of decisions upon which the claimant considered she should have been consulted. Ms Ngaaseke agreed in her evidence that a potential new patient should be discussed with the claimant, and that patient discharges should be as well. In fact in this particular case Ms Ngaaseke did not feel the need to discuss the potential new patient, because the patient did not meet the hospital criteria in any event. She did not account for the patient discharges without consulting the claimant. This appeared to be an arrogant and discourteous set of acts by Ms Ngaaseke who clearly, from her demeanour and tone in her evidence, had no respect for the claimant or her status as lead clinician.

60. In May 2016 the claimant was asked by Ms Ngaaseke and Dr Bari to collect her own patient notes and to summon her own patients when holding appointments with them, rather than asking the nursing assistants to bring them to her. Ms Ngaaseke gave evidence that all of the other doctors collected their patients and notes and she was simply asking the claimant to fall in line. Such a request had never been made before of the claimant and the timing, immediately after the claimant's return to work after suspension, led to the claimant believing this was a detriment. We agreed with her.

61. Also in May 2016 the claimant, the lead clinician, was criticised (for the first time) for being late for work, by Lynne Ngaaseke.

62. Further, in May 2016 Ms Ngaaseke placed the claimant under pressure to prepare reports to two week deadlines, for the first time. It was accepted by the respondent witnesses that this had been fairly relaxed in the past.

63. The claimant considered that these individual issues may have been minor, but taken together it looked like a picture of an individual (Ms Ngaaseke) who clearly was antipathetic to the claimant, suddenly introducing a concatenation of administrative changes which cumulatively left the claimant feeling that she was being undermined. It seemed to the Tribunal to have been intended by Ms Ngaaseke, who was using her position when she could, to do just that.

Detriment 6

64. There were three further troubling incidents. It would seem from the evidence that the respondent's attitude to the claimant changed after she made the disclosures, and these three incidents are evidence of that.

65. It was reported by a cleaner that the claimant had left a screen open in her office while speaking to a patient in there. It beggared belief that either the patient or the cleaner would normally refer such an incident to anyone, and in fact it was reported to Dr Bari.

66. It was then accepted by the respondent that Dr Bari had asked team members for specific feedback about the claimant, and he then told her what had been said. This was justified by the respondent on the grounds that minor clinical issues had come to light during the claimant's suspension. It is significant that there were no serious clinical issues and that these minor issues were such that they were never really discussed with the claimant at all, and the Tribunal remains unaware of their detail. It seems disproportionate to have staff reporting covertly on a consultant behind her back, a real undermining and divisive issue and from a doctor who in real terms was the claimant's equal, not her senior. It did not support the respondent's case that Dr Bari's role was to help the claimant to reintegrate into the team.

Detriment 7

67. The claimant, as well as being a clinician, had responsibility as the Clinical Appraisal Lead for the respondent. After she gave evidence at the inquest she was invited to give this up by Dr Burton, who said he believed that she was overworked. She objected and retained the role. She believed that this was because she had given evidence at the inquest and that this was retaliatory, occurring around the same time as the other detriments above.

68. We found Dr Burton's explanation bizarre and considered it far more likely that he was trying to reduce her influence and role in the organisation.

Detriment 8

69. At the end of 2015 the claimant received a substantial pay rise, from £105,000 to £125,000. The respondent disputed her entitlement to a further pay rise in 2016, as she had not taken on any additional duties in the meantime. In fact the pay rise was given to the claimant in 2015 after she had sent the disclosures by email about what she had seen in the bag. The claimant believed that she should have received a pay rise the following year and that she was singled out in refusing it. The respondent's evidence was that in 2017 no-one got a pay rise because the business was in a difficult economic situation.

Detriment 9

70. The claimant asserted that she had been refused the opportunity and funding to attend a medical conference. The claimant initially said that this was without reason but later accepted that she had been told there was a lack of funds. Dr Romero gave evidence that he believed she had been the year before and that there was insufficient budget to send every doctor every year. He did not check the records and in fact she had not been the previous year.

Detriment 10

71. The claimant alleges that her grievance was not dealt with in accordance with company policy. On 10 May 2016 the claimant lodged a formal grievance with Mr Asaria, the then Chief Executive Officer. She alleged that she had suffered retaliation as a result of making disclosures.

72. Over the following months the CEO sent a number of placatory holding letters. He was trying to sell the company at the time. He took no action himself to deal with the matters. Eventually he delegated the issues to Dr Romero, who arranged with Ms Jenny Gibson to meet the claimant. He suggested that the claimant start to attend Board meetings, as referred to above, and he also invited the claimant out for dinner.

73. Following the dinner Dr Romero believed that matters were not being further pursued. Taking the doctor out for dinner was not part of the company's grievance procedure. The respondent acknowledges that this was not handled as it should have been and that to handle it in the way that it was amounted to a detriment. The claimant did not, however, pursue the issue further or seek an appeal, although it was offered.

Detriment 11

74. In March 2017 there was an attempted suicide in the hospital. The claimant believed that there had been negligence on the team and said so, and both Ms Birtwhistle and Ms Keeley were rude and dismissive towards her. The claimant had never experienced either lady behaving in this way towards her prior to her suspension.

75. From March 2016, when the claimant gave evidence to the coroner, the claimant had noted a change in attitude towards her generally, and this was the first example of these two particular individuals being rude and dismissive.

76. The claimant had been invited, as part of the reconciliation following her grievance dinner with Dr Romero, to attend the Clinical Board meetings in an effort to restore her status within the organisation. She was invited twice and attended the first. She did not attend on the second occasion because she was told by Dr Verity she was not needed at the meeting, and that the preparation she had done would be delivered by him, thus completely subverting the apparent intentions of Dr Romero to increase her standing, following her return from suspension.

77. The third clinical meeting was to have occurred around the time of the incident which led to the claimant's dismissal, and she did not attend. The claimant said, and we believed her, that she was not invited. The respondent has provided no evidence to suggest the claimant was invited. If she had been invited we are in no doubt that the appropriate invitation document would have been included in the bundle.

Detriment 12

78. The claimant asserted that she was asked to consider moving to another hospital. She accepted that the respondent had a contractual right to move her and that her commute would have been of a similar time. She had worked at that hospital before. Dr Burton raised it with her. The claimant did not suggest that the offer was attached to any threat or consequence on refusal. She refused the offer and there was no comeback.

Detriment 13

79. The respondent referred the claimant to the GMC on 18 October 2017 after an incident, which is described in more detail below, led to her dismissal for gross misconduct.

80. The respondent denied in evidence referring the claimant to the GMC maliciously or without justifiable reason, but did accept the referral to the GMC is a detriment.

Detriment 14

81. This was the process which the claimant says led to her dismissal. We have made findings of fact about that procedure in the next section of this judgement

The Unfair Dismissal

82. The claimant had a patient ("MP") who was compulsorily detained with serious ongoing mental health issues. He had a diagnosis of resistant paranoid schizophrenia from 2000 onwards. He had been hospitalised for most of the subsequent time, managing only 18 months in the community. He was at a high risk of physical aggression, and high risk for non compliance with medications. He had a fear of the side effects of some of the drugs which were prescribed for him. It was not known if this fear was clinically observed. He used his perception of the side effects to get his medication changed frequently or to not take medication at all. He was admitted to hospital (under a Mental Health Compulsory Order) and was taking a fortnightly dose of a drug known as "ZD" (with other drugs). From day one he refused to cooperate with the administration of his drugs. The claimant reduced some of the tablets until they were stopped.

83. Whilst on ZD the patient was seen to improve and he was given unescorted leave in the community in July 2016. He however continued to complain about side effects and made a formal complaint that the claimant had refused to change his medication. The claimant believed that without ZD he would relapse. The ZD was replaced by another drug ("RC"), and the patient became increasingly psychotic and lost his independence.

84. The patient's brother (who gave evidence) became increasingly concerned about his brother's condition. He was an impressive witness, honest and straightforward, and clearly had always been close to his brother, and was supportive of him.

85. One option for an alternative drug ("O") was discounted by the claimant as inappropriate, because had the patient returned to the community, the Community

Mental Health Team were unable to supervise its use. The claimant considered that ZD was the only realistic option to manage his risks, his aggression and to prevent further relapses.

86. The claimant wanted to use the patient's time in the secure unit to assess the side effects that ZD might actually cause. She believed that his perception of side effects may not have been realistic.

87. The claimant considered giving ZD covertly so that the patient did not know what medication he had received. This would establish the validity of otherwise of his claims of side effects.

88. In June the claimant met with Ms Birtwhistle and MP's brother (his nearest relative) to discuss his medication. His brother is a Company Director and visits MP nearly every day when he is in hospital.

89. After MP came off ZD in February 2017 his brother became increasingly concerned at MP's deterioration. He raised it several times with Ms Birtwhistle and eventually threatened to make a complaint. Throughout a later meeting with Ms Birtwhistle she blamed Dr Malik, who was on holiday. He demanded a meeting with Dr Malik, who cut short her family holiday and returned the following day to meet him.

90. Mr Lincoln suggested covertly administering ZD, as it had been an unqualified success before. He wanted to have his brother take ZD again and did not want it administered using force, because there was a real likelihood of MP having to return to an intensive care unit without it, and it was a chance to establish whether or not the side effects were genuine. By then MP could not give informed consent and had no capacity at all. Mr Lincoln noted that Ms Birthwhistle agreed with Dr Malik that covert administration could be tried.

91. It was agreed in the short-term, until the covert administration of ZD had been set up, that O would be administered. MP agreed to take O. A few days later Mr Lincoln was advised by Ms Birtwhistle that O was a drug which could not be given in the community, and so there would be a best interests meeting which would be arranged for the covert administration of ZD. This was arranged for 24 July.

92. Ms Birtwhistle discussed the claimant's plan with Mr Ruffley as Dr Malik wanted to know what the process was. Mr Ruffley said they had to be sure that O could not be used as it was a really good medication, but with monitoring issues for the community team. Mr Ruffley said they had to be sure that it was not a viable option and that policy and procedure would have to be followed and the appropriate best interests meeting and discussion take place.

93. On 26 June 2017 Ms Birthwhistle informed the Multi Disciplinary Team (MDT) of the proposed treatment plan. Present at that meeting was Ms Keeley, Ms Birthwhistle, the claimant, a student, and a mental health administrator (Julie Parker). They discussed plans for medication and the need to arrange a best interests meeting. A second opinion was to be requested ("SOAD") and MP's capacity was to be assessed. There is no note (page F399) of any dissention or surprise at the discussion about the covert administration of ZD.

94. On 10 July 2017 the claimant was informed by Serena Birthwhistle that MP had become aggressive and stopped taking his O medication. They could no longer wait for the planned best interests meeting and planned immediately to proceed to covertly administer ZD. Mr Lincoln, MP's brother, agreed to the administration because he had first-hand experience of the aggressive behaviour of MP whilst his schizophrenia is at its worst.

95. There was a discussion between the claimant and Mr Ruffley by telephone. The claimant gave her rationale for the covert administration. Mr Ruffley did not ban the claimant from undertaking the covert administration. We did not accept his evidence that he counselled obtaining legal advice. We preferred the evidence of the claimant in this regard. Serena Birthwhistle was in agreement with the plan. We do not accept this was an informal chat. Serena Birtwhistle went through the proposal and Mr Ruffley knew from the claimant what she planned, and why. In cross examination Mr Ruffley admitted saying that if everyone was in agreement he would have gone along with it. At that point, everyone who had been consulted appeared to be in agreement in that there is no evidence at all of anyone saying otherwise.

96. In Mr Ruffley's view, covert administration should only be used in threatening situations where the patient lacked capacity. That was exactly the situation now developing and faced by the claimant.

97. In a supplemental email sent at 19:35pm on 10 July, Mr Ruffley said to the claimant and Ms Birtwhistle:

> "I think we need to clarify that particular issue. If that is indeed the case, we need to be very clear that covert administration of medication is an acceptable alternative in the circumstances."

98. The claimant replied ten minutes later (B122B). She replied that her team had explored every possible solution, including liaising with the Home Team re the administration of O. She had documented everything:

> "Please rest assured that everything will be by the book and of course we shall keep you posted." (B122A)

99. We considered that Mr Ruffley was an active participant in the eventual decision to administer covertly, rather than an innocent bystander shocked at what he was subsequently told, as he told his own senior management subsequently and later the Tribunal.

100. Later in his evidence Mr Ruffley changed his mind to say that the issue of supervision in relation to the alternative drug, O, was really an issue of NHS funding, and not a matter which should have been taken into consideration. We neither saw nor heard any evidence that the claimant was told this directly at the time. Even if he had done so, his professional qualification as a psychiatric nurse may not have carried the weight of the claimant who was a consultant psychiatrist.

101. We do not find that Mr Ruffley's evidence with regard to asserting that a legal opinion be sought was actually said to the claimant at the time. We have found this to be a back-covering comment inserted with hindsight.

102. The claimant completed the capacity assessment for MP. She was complying with the respondent's procedure for covert administration of medication policy (D48 and 92-95 and F164-5). She concluded that MP lacked capacity. Ms Flowers, a forensic psychologist, carried out a second assessment and reached the same conclusion.

103. At this time MP was accepting alternative medication and everything was on track for a best interests meeting on 24 July.

104. The claimant requested a second opinion approval doctor (SOAD) regarding the covert administration of medication. In fact the SOAD (Dr Brown) approved the treatment plan on 14 July, but (page B117) confirmed that he did not give an opinion on the covert administration of the drug as that was not his role and would never be so.

105. His report is at F1, 170 and shows the date of his visit to 14 July, where he met and spoke to Natalie Hooper, nurse, and Catherine Flowers, psychologist. The patient expressed a view that he was not interested. The patient was described by Dr Brown, presumably on the input of Ms Flower and Ms Hooper, as lacking capacity, and presenting a non inconsiderable risk to others. On 9 July the patient had become non compliant with his medication, and on 10 July he assaulted staff. At this stage he had drugs administered under restraint.

106. MP was now, according to the claimant, at high risk of aggression and she was concerned for the safety of staff and other patients. Over four days MP was given three different antipsychotic drugs to minimum effect. The claimant had two options:

(1) to administer ZD; or

(2) to use a short acting series of drugs which would have meant four or five injections of three different antipsychotic drugs within a span of six days, which would have presented a risk of physical harm compounded by MP having a heart condition.

107. The claimant knew MP responded well to ZD and opted for that choice as it was a long acting drug. She then had to decide how it was administered. She was already underway with a plan for covert administration, and she knew that MP would not accept ZD and that he lacked capacity. She believed it should be administered covertly. She discussed it with Serena Birtwhistle, explaining the NICE guidelines which made provision for covert administration in emergency situations where it was not possible to wait for the best interests meeting. She explained her plan at Serena Birtwhistle's request to the Regional Operations Director by telephone and email, and with the patient's brother. On 11 July she discussed it with the Multi Disciplinary Team and Serena Birtwhistle.

108. After their agreement Serena Birtwhistle sent emails to the community responsible clinician (Dr Rahim) and to the care co-ordinator (Ms Cohlwadia), referring to having no option left but to administer ZD covertly (page 108F1). The pharmacist agreed that they were happy with the decision to place him back on ZD. At page F213 Dr Rahim agreed and Ms Cohlwadia at page B22E. The plan remained to discuss ongoing treatment on 24 July.

109. On 11 July Ms Christie informed all support and nursing staff that on 14 July the patient as to be given ZD weekly and (in capital letters and underlined), "MP must not be made aware prior to the administration under any circumstances of the drug being administered". There is no suggestion at that point that any of the staff referred back either to Ms Christie or the claimant to query or express concern at this instruction.

110. On 11 July at night MP again became violent and had to be restrained. The claimant was advised the following day and discussed the situation with Serena Birtwhistle, Head of Care, and it was agreed by them that the physical risk to the patient, staff and other patients was high, and due to the gravity of the situation covert administration could no longer wait until 24 July as planned and agreed. It was agreed that it would be administered covertly and immediately.

111. Dr Malik believed she had the support of the team and of Mr Ruffley to go ahead, and she instructed the covert administration of ZD, which was given under restraint on 12 July. MP did not ask what drug he was being given and he was not told what drug he had been given. An immediate improvement in the patient's behaviour was noted, and he did not complain of any side effects from the injection.

112. The claimant said she could not update the patient's notes as she was not at the hospital that day, but she then admitted that she did not update the notes between 13 July and 19 July, citing a heavy workload and issues with IT.

113. By the second injection on 19 July the claimant had written SOAD approval, and on this occasion Ms Christie (despite her sending the earlier email) chose, without further consulting the claimant, to tell the patient that he was being administered ZD.

114. The following day the patient began to complain of side effects.

115. The claimant was deeply upset at this, and accosted Ms Birtwhistle and Ms Christie by phone. She used an expletive, but apologised later the same day. After a few minutes the claimant was accosted herself by Ms Birtwhistle and Ms Keeley, both accusing the claimant of not having involved them in the decision about covert administration nor making them aware of the plan. It was a heated conversation and the claimant was left in tears.

116. We find as a fact that both were involved in the decision to undertake covert administration of ZD. Serena Birtwhistle in particular was involved at every stage and did not express any reservations or dissent. Ms Keeley had been copied in to many of the emails relating to it,and was part of the initial meeting at which it was agreed.

117. The claimant then met with the patient and Ms Keeley and she advised him that he had not been given ZD. In effect she asserted that she was withholding information about the treatment in his best interests.

118. On 20 July Ms Keeley updated the patient's care plan to confirm that covert ZD had been administered and to confirm that there was a best interests meeting to be held on 24 July. The patient was not given access to his records nor was he to be made aware of the injection that would be supplied (B26).

119. On 23 July Serena Birtwhistle sent around a copy of a brief guide to covert medication (from the CQC). The CQC guide did not cover the same ground as the hospital's own guide, nor that of the GMC to which the claimant was bound, to the people who were to attend the best interests meeting the following day.

120. The CQC guidelines require that the provider had a policy on covert medication, beyond requiring that the terms of the Mental Capacity Act 2005 were met. However, the Mental Capacity Act 2005 does not apply to patients detained under the Mental Health Act, unless it relates to their physical wellbeing.

121. The claimant relied upon the hospital's own clear policy (F2 page 314). The Tribunal noted that it did not require that a legal opinion be sought. Briefly, it required that the covert administration of medication could only be undertaken with a patient who lacked capacity. It noted the NMC statement that:

> "There may be certain exceptional circumstances in which covert administration may be considered to prevent an individual from missing out on essential treatment.
>
> In such circumstances the considerations required that the best interests of the individual must be considered at all times, the medication was essential for the individual's health and wellbeing, or for the safety of others, and the decision to administer a medication covertly should not be considered routine and should be a contingency measure. All the nurses needed to be made aware of the purpose and implications and have the opportunity to contribute to the multidisciplinary discussion. A nurse could refuse to administer covertly. There should be an open discussion among the MDT and the patient's family."

122. This policy was approved specifically by Dr L Burton who later appeared to be a serious critic of the claimant's actions when she followed his policy.

123. On 24 July the best interests meeting took place. Around that time Serena Birtwhistle began an extraordinary series of emails with the claimant in which she alleged that she had not agreed to the covert administration, that was the problem, and that the nurses had not been involved in meaningful discussions. The claimant pointed out that the Head of Care represented the nurses in meetings, and that there had been robust discussions and agreement with her which equated to liaising with the nurses.

124. On 24 July the claimant sent a clear email to Ms Birthwhistle saying that it had been discussed with the patient's brother, the community RC, and on ward rounds, when either Serena Birtwhistle or a member of the nursing team was always present.

125. The Tribunal noted that there was an input from nursing staff at the MDT on 26 June, right at the outset of the process, at which Serena Birtwhistle had been present.

126. The best interests meeting could not proceed because the administrator had failed to invite the independent capacity advocate (technically not needed, because the patient's brother represented his interests generally, and had already suggested and agreed the covert procedure). Instead it was treated as a professionals' meeting. It is noteworthy that again there was no dissent from the claimant's

decision (including from Ms Keeley, who was present). The decision taken was to continue to administer ZD covertly, set up a best interests meeting, seek legal advice and look further into community monitoring for O as an alternative medication.

127. On 26 July the claimant emailed the senior team about covert administration (B46/7). She sought the advice of the team, describing it as an urgent matter. She set out the medical history and explained that she had just been advised that the nurses wanted to be able to tell him what was being administered as they were not willing to lie to him. Dr Malik explained that this would be counterproductive and he would end up in psychiatric intensive care or suffering unnecessary distress such that he would have to be restrained every week. She asked for their thoughts and advice on covert administration as it was apparently an unknown concept to the nurses. (The hospital's own policy, signed by Dr Burton the previous year, made it clear that the nurses should be aware of the appropriate procedures).

128. Dr Burton replied in the early hours of the morning, commenting that he felt very uncomfortable and asking if she had SOAD approval (she did), and whether she had sought a legal opinion (not required under his policy). He qualified this as not so much covert as telling a lie. His policy makes provision for these very circumstances. He asked about the paperwork being in order and whether the community RC supported in writing (yes they had, in the minuted professionals' meeting). In a slightly later email he confirmed that he did not know what the GMC policy was, despite owning the hospital's policy, which one might assume would mirror the GMC position. He further advised that no additional ZD medication be administered until a lawyer had advised and further consideration of O had been undertaken. It is fair to say that he was unaware that the community RC had already written off O as a feasible alternative option.

129. Dr Malik complied with Dr Burton's instructions. The outcome was a serious deterioration in MP's condition, leading to complaints from his brother.

130. Later on 26 July Dr Burton raised some further issues with the claimant, and she was able to confirm that a SOAD opinion had been sought and legal advice was requested and underway. Dr Malik confirmed she intended to explain to the patient exactly what had happened, including the change of medication.

131. The claimant met with Dr Burton, Mr Ruffley and Ms Birtwhistle. There are no minutes of this meeting, but the care plan was updated. Dr Malik persuaded the meeting to keep the patient on ZD but agreed to stop giving it covertly. She later explained this to MP, who refused to take ZD, and was told it would be taken under restraint.

132. Dr Malik then met for a care plan meeting with the coordinator and wider MDT team to explain the new care plan. The care coordinator confirmed that the claimant had complied with Lancashire Care NHS Foundation Trust's policy on covert administration.

133. On the evening of 27 July, the claimant was suspended by Dr Burton by telephone, following guidance from Jenny Gibson that he should do so. Jenny Gibson was the HR Director who worked closely with Mr Romero.

134. The claimant was called to an investigative meeting on 9 August held by Dr Verity and Mr Powell. Dr Verity had been involved in the suspension and

investigation in 2016. Mr Powell, a nurse by profession, had not. Dr Verity and Mr Powell prepared an investigation report. They interviewed Parker, Taylor, Flowers, Birtwhistle, Keeley, Christie and the claimant. They did not interview the SOAD, Rahim, Kohlwadia or the patient's brother. These were all of the people in fact whom the claimant asserted she had consulted in accordance with the hospital policy.

135. The investigation led to a finding that the claimant be the subject of a disciplinary hearing (B120). The background asserted that the patient had been administered ZD on two occasions covertly, against legislation, national guidance and company policy; that on both occasions he was falsely told it was a different drug, and that the doctor had acted unprofessionally and in an abusive manner towards colleagues. Senior management were of the opinion that there was a lack of clear evidence that the covert regime had full agreement of the hospital's multidisciplinary team, or that it had adequately been discussed at a best interests meeting with appropriate representation. Legal advice had not been sought to ensure that the actions were reasonably proportionate and legal. The regime had been stopped by the Medical Director pending further investigation, when it became apparent that legal advice had not been sought. The investigation began from this inaccurate and partial interpretation.

Looking at the findings

136. The investigators found that the rationale for covert administration was not robust, there being no evidence the doctor had addressed the concerns in the guidelines issued by the RCP, the NMC and the Mental Health Act Code of Practice. We noted as a Tribunal they made no reference at all to the hospital's own policy with which the claimant was working and which had been authorised by Dr Burton. They found that scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there was no incompatibility. If clinicians had concerns about a potential breach they should seek senior clinical or legal advice. Dr Malik did not consider that necessary. She was sure that what she was doing complied with the hospital's policy, which as explained was not mentioned as part of the investigation.

137. The claimant was accused of failing to consider section 63 of the Mental Health Act 1983. On examination this merely gives the right to give medication without the patient's consent. Clearly this had not been actually studied by the investigation team who may have found more guidance in section 58 of the Mental Health Act, which they failed to mention, but which does refer to obtaining a second opinion from a SOAD. The claimant had referred the case to a SOAD who had visited the hospital and within the referral there was reference to covert administration. Dr Brown told Dr Verity that a SOAD would never comment on covert administration.

138. The investigation failed to establish that the claimant had consulted the MDT and nursing staff, even though the Tribunal found ample evidence that she had done so. Either they did not look at it or were blind to it and accepted at face value the evidence they received, for instance, from Serena Birtwhistle and Ms Christie, both of whom had been involved in the meetings and sending emails discussing the issue. It is worthy of note that no nurse (other than the administering nurse on the

second occasion) or doctor, apprised of the claimant's plans, chose to object until after the senior management team became involved.

139. The investigation team did not interview the patient's brother who played a very active part in supporting the patient, and whose idea it had been in the first place. He absolutely supported the claimant in her plan. Instead the investigators found there had been a failure by the claimant to obtain advocacy for the patient. Advocacy is generally only needed where there is no active participation and cooperation from a close member of the family.

140. Three members of staff made statements that the claimant's conduct was coercive and abusive. This related to the one conversation after the patient had been told what had been administered to him, and the claimant had found out. The claimant, it was said by Ms Christie, was angry that the patient had been told and said, "shit" at one point. She described it as just an explosion, but that the claimant had not been angry with her but angry that he was not to be told and she had told him. Ms Christie described the claimant calling her and she did apologise and said that she was frustrated, "She gave me the opportunity to tell her how I felt". She does not suggest that the claimant was abusive.

141. Serena Birtwhistle was interviewed and apparently exaggerated Ms Christie's reaction, talking about her shaking, tearful and upset. Ms Christie makes no mention of this at all in her evidence. Ms Birtwhistle alleged that Dr Malik was furious, shouting and cursing, but she could not remember the words used, which we find inherently unlikely. She then described a heated conversation in which she denied knowing about the covert administration.

142. This, in the light of the documents available, is a clear lie and it is perhaps understandable that the claimant was upset. It is notable that throughout Dr Verity's interview with Serena Birthwhistle he asked mainly leading questions regarding simply "yes" and "no" answers, enabling Serena Birtwhistle to bypass her obvious involvement in the decision making process. This could not be an open and fair investigation. To compound the matter, the conclusions of the investigation do not follow the findings of fact made by them

143. (Page B130) The investigators agreed that the claimant had used appropriate medication. Dr Romero later strongly disagreed with them.

144. The consulting of the management structure, it was said, was poorly executed, because the wider MDT were not consulted, even though there is clear evidence of meetings of the MDT at which it was discussed. There was also evidence by email referring to the same. It was suggested that her clinical rationale was not supported by evidence, to address the concerns of national guidance. It was not made clear in the investigation report what national guidance was being referred to. If it had "referred to" in the above, then it would appear that the investigators did not read the guidance and have made a leap of faith.

145. At this point it is also to be mentioned that there was no reference at all to their own hospital policy. The investigation into the claimant also made reference to a failure at all levels with staff not being aware of the policy.

146. The mental health administrator was Julie Parker, and the investigators concluded that she was not consulted regarding the legal aspects of the plan. The

Tribunal failed to see why this was an issue. Ms Parker was appointed to assist the claimant with her administration, and to suggest she needed to be consulted made no sense.

147. The action plan which followed suggested that the claimant be invited to a disciplinary hearing for failing to adhere to the standards of the GMC, about which there was no reference in the investigation. As a further disciplinary issue, the claimant was accused of failing to adhere to company policies and procedures. This could only relate to the hospital policy which is never mentioned in the investigation, and the claimant appeared in the evidence to be the only person who had actually paid it any attention. She was accused of abusive and threatening behaviour, the conclusions drawn were 'abusive and coercive', but the invitation suggested 'threatening behaviou'r, apparently elevating the allegations to something even more serious. The invitation to the disciplinary hearing changed the charges again. They became:

(1) failure to adhere to company policies and procedures and appropriate professional standards (not one of the findings of the investigation in relation to the use of covert medication);

(2) failure to obtain appropriate authority (no suggestion of what that would be) to use covert medication, there having been no mention at all of the need to obtain authority;

(3) the use of abusive and threatening behaviour towards colleagues when challenged about the use of or disclosure of covert medication – there has been no evidence at all seen by the Tribunal that anyone ever suggested that the claimant was threatening in her behaviour.

148. The hearing was originally to be chaired by Mr Ricky Holland, Regional Operations Director. That was subsequently changed to Dr Boyapati. He admitted in his evidence that he was inexperienced, he had not chaired a hearing before. He was at the same working grade as the claimant. He accepted that he received guidance from Jenny Gibson. The clear impression of the Tribunal was that he did not reach any independent decision and was out of his depth, with little understanding of disciplinary procedures.

149. The invitation to the hearing offered the claimant the right to be represented, and warned her that she may be dismissed. The claimant did not have a copy of the disciplinary policy and could not access the intranet as she had been suspended.

150. The claimant received a copy of the investigation report with attached documents, and documents which were subject to patient confidentiality would be made available to her at the hearing. Jenny Gibson appears to have sent the file to Dr Boyapati although her email (page 154A) is apparently missing content.

151. The disciplinary hearing took place on 12 September 21017. The HR representative present was Kate Killelay, with Kelly Williams as notetaker. Dr Malik represented her own interests.

152. The claimant wanted to give evidence in support of her case for each allegation but was refused this chance until Dr Boyapati had asked a list of pre-prepared questions. The claimant expected a statement of the case against her

from management, and Mrs Gibson confirmed in her evidence that that would be normal procedure. In fact she was only asked pre-prepared questions. She confirmed in her answers that there would be no requirement in the policies to consult her line manager, and that in fact she had consulted Dr Burton on the first injection. She confirmed that she had consulted the MDT, the community RCX, the pharmacist, the care coordinator, a SOAD, and the patient's brother: all of the people in the guidelines.

153. The claimant made it clear that although section 63 of the Mental Health Act was referred to in the report, in fact the patient was detained under section 3 of the Mental Health Act and he did not have capacity. She explained that she felt she could not wait for the meeting on 24 July because it was an emergency, but she had confirmed that she contacted everybody and all were in agreement by 11 July. She confirmed that she had complied with NICE guidelines, CQC and the hospital policy, and in her mind had complied with all aspects relating to the patient, legal, company and her Professional Body policies.

154. The claimant confirmed she had asked the SOAD for authorisation for covert administration of ZD, and she had received authorisation from him.

155. Dr Boyapati makes much of the fact that the SOAD did not specifically authorise covert administration but simply agreed generally to her request. He was not aware of the conversation that Dr Verity had had to the effect that Dr Brown would not have mentioned covert directly and would not have specifically authorised it, as it was not his role.

156. The claimant explained that there had been two meetings at which covert medication had been discussed: on 23 and 26 June, a meeting at which there was discussion with the nurses, Ms Birtwhistle and Julie Parker amongst others, about arranging the best interests meeting. She confirmed that she had consulted the pharmacy who were only interested if the medication was to be crushed rather than injected. She was asked why she did not contact lawyers, and pointed out that in all the guidance she used at no point did it say to consult the legal team, and she "didn't find them very helpful as they waffled". She had criticised one of the lawyer's conduct towards her in the inquest some 18 months before, and was concerned that it would look as though she had an agenda. She considered that the guidance from the Royal College, NICE, GMC and the company policy had all been complied with.

157. The guidelines she followed, she said, indicated that drugs could be given in food or drink or in disguised form, and she was giving ZD disguised in an injection. After questioning the claimant provided the evidence on which her defence was based, and she could see no reason to seek further guidance.

158. The claimant expressed concern that despite providing evidence of the staff being consulted on the morning, in meetings, the investigation report made no mention of it. She made it clear she had done what she needed to to set up a best interests meeting but that the medical secretary had forgotten to invite the patient's advocate and his brother had sent apologies.

159. As part of the investigation, Dr Burton volunteered that the claimant wanted the patient out of the hospital because she had been assaulted by him. The claimant pointed out that that did not happen and it made it sound as though she had a personal vendetta. She simply described this as "the wrong evidence".

160. In summary, in the disciplinary hearing the claimant pointed out that she did everything by the book. Dr Verity did not know the RCP guidelines, although he cited them, along with misapplying the Mental Health Act. He had failed to check minutes of meetings and to check people's evidence against emails. She specifically accuses the hospital manager, Ms Birtwhistle, of lying, along with her Mental Health Act administrator, Julie Parker, and Dr Burton. She insisted that she had not been abusive or threatening.

161. The claimant pointed out that using the word "shit" in her telephone conversation with Ms Christie and not directed to Ms Christie as she confirmed. She noted that Dr Burton used the word "fuck" in not dissimilar circumstances in an email in the middle of the night to her. Both were at the time frustrated, shocked and vexed. She was asked if she had tried to bring forward the best interests meeting and confirmed that she had but it was not possible, and that Dr Rahim would have been able to confirm that. Jenny Gibson sent an email to Dr Burton, Mr Ruffley, Dr Romero and Mr McQuaid in which she created some wording to send to Dr Malik in terms of why "we" had decided to dismiss her. She also sent a copy to Mr Boyapati "so that he is aware".

162. Jenny Gibson was not the HR representative at the disciplinary hearing and did not credibly explain her intervention at this point, when given the opportunity. The rough notes of the reasons to dismiss were produced by Ms Gibson and sent to Dr Boyapati to approve. She selected very few issues and ignored the balance of the allegations and evidence. She gave a very partial account. The letter made no mention of the policy of the hospital, the NICE guidelines or the CQC (presumably because they could not say that she had failed to comply with them). Dr Boyapati made no reference at all to the detail of Dr Malik's rationale, simply saying he would not have done that. It is completely unclear what he means by using RZ as against O, because the sentence involved a double negative. He said he would want the administration to be approved and confirmed but does not link such statement to any office or policy guidelines, and nor does he give detail of who should approve and confirm it. He had not realised the SOAD would never comment on covert administration, believing in fact that the SOAD had actually failed to give approval. The email can be read either way, and he chose to take the adverse reading against the claimant. He took one comment allegedly made by the claimant that Dr Burton was useless. In cross examination he admitted that she had not said that, and his use of the word "useless" reflected badly on her. He was concerned that she relied on the Royal College of Psychiatrists' guidance which he had obtained subsequent to the incident.

163. We noted that the investigation relied on these alleged guidelines, although we believe that had the investigators actually researched the issue, they would have found out they were no longer relevant (per the RCP)and that their reliance on the policy was disingenuous. This seriously affected their credibility.

164. Furthermore, the claimant was then accused by Dr Boyapati of becoming aggressive and intimidating towards the staff. The Tribunal noted that at each iteration of this incident the words describing her behaviour became more aggravated and exaggerated. What started as some shouting with the word "shit", which was described as not directed at the individual concerned, by the individual concerned, had become aggressive and intimidating behaviour, and that this could be perceived as bullying. He made no mention of the fact that both the alleged

victim and claimant agreed that she swiftly apologised. It is hard to see how it can be described as bullying when the victim herself said that it was not directed at her but at the situation. He then provided a general statement that the whole process was without authority, not in accordance with procedure and unnecessary, and had led to a breakdown of trust and confidence with the claimant. There was no reference in the half page summary to any of the evidence supplied to him by the claimant suggesting her innocence or any attempt to balance the weight of the evidence.

165. Dr Burton on receipt of the draft thanked Ms Gibson for "a good email". Dr Boyapati on receipt made a few minor changes. It is however completely clear that Dr Boyapati did not provide the wording as suggested by Ms Gibson, and that in fact the wording was hers.

166. On 29 September Jenny Gibson advised Dr Boyapati that she had met the claimant, advised her of the outcome and that she was dismissed. The claimant asked for the wording of the dismissal, but as there was an alternative option put forward, Ms Gibson said she could not issue a formal letter but that she would provide a summary. The summary, she said, was essentially from Dr Boyapati so the claimant should 'have a read so that she was aware'. In fact it is clear that Dr Boyapati played almost no part in preparing the summary.

167. After her disciplinary hearing the claimant was told that she was being dismissed for gross misconduct. In fact the letter of dismissal was delayed until 13 October. In the meantime, she requested the outcome of her appraisal which was almost completed in July, and which made reference to an ongoing complaint about the covert administration (page 184). Other than that, the appraisal sings her praises, "competent and caring clinician, popular with her colleagues and a team player with good leadership".

168. On the day of the claimant's dismissal she was referred to the GMC by Dr Burton. In that letter there are a number of untruths. The first is that Dr Malik had not sought a SOAD opinion, when Dr Brown had confirmed that she had. Dr Burton suggested that the best interests meeting was not arranged until the programme of covert medication was embarked upon, which was not true as the meeting had been set up before the programme began, and Dr Burton had been informed by the claimant of her intentions and she had consulted with colleagues. He makes reference to the fact she did not seek a legal opinion, but failed to mention that the hospital's own policy (which was signed off in his name) did not require that a legal opinion be obtained. He alleged that Dr Malik had been dishonest with the patient by covertly administering a drug without initially telling him what it was, and which stretched the arrangements made, to obtain other people's agreement.

169. Her appraisal in fact suggested she was popular with the staff, and to extend the altercation on the day of the second injection to becoming "bullying" we find to be a gross exaggeration.

170. Mr Burton's assessment of the situation with the GMC could not be regarded as honest and objective. An email sent by him on 13 October to Kate Harrison (Liaison Officer for the GMC) suggests a far from impartial stance. He described the claimant as "an opinionated woman", and alleged there were rumours of bullying (contradicting her glowing appraisal from 17 July). None of her past actions which

had caused concern would have merited a referral to the GMC, suggesting he had been waiting for this chance.

171. On 13 October the claimant asserted that her dismissal was a detriment because she had whistle-blown at the inquest and before. On 16 October the claimant presented an appeal (page B247).

172. Dr Boyapati had conversations with Dr Romero, Mr Ruffley, Ms Gibson and Dr Burton before he reached his decision to dismiss. Despite his protestations that the decision was his alone, it would seem that others played a substantial role in the decision to dismiss (page B248).

173. The claimant appealed through her solicitors, suggesting they cannot have formed a reasonable belief in misconduct. The investigation overlooked issues she had raised in the investigation and in the decision to dismiss. She asserted she had been dismissed because of the whistleblowing in 2016. She suggested that the investigation was not reasonable or proper, and that the delay in reaching a decision had been substantial and unnecessary. She asserted that she had been dismissed as a result of her public interest disclosures and that the outcome was predetermined. She was only confirmed as dismissed after she had threatened to bring a grievance.

174. On 20 October the claimant was invited to an appeal hearing. Dr Romero undertook the appeal. Jenny Gibson, assisted him. She had been involved at various stages in the disciplinary process, apparently without any obvious reason. Lynne Elliott attended with Dr Romero at the hearing. Subsequently the claimant decided not attend the hearing, leaving it in Dr Romero's hands, as she had ongoing health issues with her eyes and was practically housebound at the time. The outcome letter was sent to the claimant on 16 November 2017 and unsurprisingly, bearing in mind Mrs Gibson and Dr Romero's input into the decision to dismiss, the appeal was not upheld.

Closing Submissions

175. The closing submissions from the parties were extensive. The claimant's closing submissions ran to 28 pages and 65 paragraphs. The respondent's closing submissions ran to 102 pages and 321 paragraphs. Counsel for the respondent did point out that there were 15 hearing days, evidence from 16 witnesses, 1250 pages of documents among just three of the bundles (six in real terms). The closing submissions from the respondent were sufficiently long that they required an index. Both sets of submissions were extremely helpful,nd were supported by oral submissions.

<u>The Claimant's Submissions</u>

176. The claimant reported to the respondent on 27 August 2015 that a bag of heroine and burnt foil was found in a deceased patient's room. That report marked the beginning of the end of her career with the respondent. The claimant brought that citing of the bag of heroine to the external investigator's attention on 17 September. The external investigator was unaware of that until the claimant did so, and she had a professional duty to do so. Dr Romero made the quantum leap that the claimant was making allegations that other staff were lying or hiding or had destroyed the bag of powder. The claimant made no such allegation. Dr Romero

also indicated to a number of parties that he suspected the claimant's report might be false or malicious – indicating that if found without evidence, he would report her to the GMC. He did in fact do so on 12 October 2017.

177. The claimant asserts that the internal investigation into this incident was deficient in that Mr Ruffley, who knew of the threat of the GMC referral by Dr Romero, did not ask the same series of questions of the claimant as to other staff, and further did not investigate with the police who had been and searched the deceased patient's room. The claimant never accepted the outcome of the investigation: that there was no bag of powder.

178. At the subsequent inquest the claimant sought advice from Dr Romero on how to proceed about the drugs in advance of giving evidence. She did so on two separate occasions: firstly between October and December 2015 and then again in November 2015 and January 2016. Dr Romero admitted that he told her not to make her life complicated. The claimant believed it was a clear indication that she should remain silent on the whole issue. Dr Romero's explanation that he was only concerned about her professional credibility rather than concern on the effect on the respondent's reputation is not credible.

179. The claimant informed the respondent's lawyer on the day before the inquest and again on the morning. When the claimant had given her evidence and the coroner expressed concern, Mr Parsons wrote to coroner stating that they were only aware at the last minute that the claimant wished to give that evidence. In fact the respondent did have advance notice that she wished to give this evidence. She did not consider that she had been mistaken.

180. With regard to the subsequent investigation and suspension, it was clear that the terms of reference for the investigation were "for the evidence you gave at the inquest into patient AG's death and the effect this has had on relationships at Fountains". There was an allegation that she had breached trust and confidence. She went out of her way, it appears, to essentially "drop us in it".

181. The respondent witnesses in evidence in the Employment Tribunal tried to say (in a "surprising attempt") to indicate that the suspension investigation looked into the aftermath of the inquest and to the effect on relationships and a need to diffuse the situation, as opposed to primarily why the claimant she did i.e. did she do so maliciously.

182. The claimant made a series of protected disclosures, they were made in the public interest and they were reasonable. In relation to the disclosures made to Dr Romero between October and December 2015 and 2015/January 2016, the claimant asserts that she made those disclosures to Dr Romero. This was not conceded by the respondent but Dr Romero accepted in evidence that the claimant had sought advice from him in respect of the giving of evidence regarding the bag of powder at the forthcoming inquest. The claimant's evidence should be preferred in that she says she raised it twice. In her grievance on 10 May 2016 she referred to having "thrice" asked for advice from Dr Romero. These are made out as public interest disclosures.

<u>Public interest disclosures 5-7 (pre inquest and inquest)</u>

183. These were not conceded by the respondent but Mr Parsons did accept he was paid as a lawyer to advise the staff on the forthcoming inquest, to answer questions on procedure and questions the staff may have regarding their expected evidence, and that the claimant raised her evidence with Mr Parsons in the course of obtaining legal advice.

Disclosure 6 – on 9 March 2016 the oral disclosures to Lynne Ngaaseke and Mr Parsons

184. The respondent had advance notice that she would give evidence regarding the powder, and it was clearly a disclosure to her employer and to a relevant legal adviser.

Disclosure 7

185. This was the evidence at the inquest. Several of the respondent's employees were there and heard her evidence. The respondent has not suggested that it was not reasonable or not made in the public interest.

186. The claimant then, it is alleged, suffered a series of detriments. There was a meeting 25 April 2016 between Dr Romero, Dr Burton, Dr Bari and HR. It was admitted in cross examination that the attendance was heavy-handed. The claimant was on suspension at that time. Dr Romero, Managing Director at the time, agreed it was not his normal practice to attend such a meeting. This was really about the claimant's return to work. The claimant's case is that it was an attempt by Dr Romero and Dr Burton to make it clear to the claimant that should she step out of line again there would be consequences. She would have additional monthly clinical and other supervision by Dr Bari (who had no role in relation to her prior to the suspension) and Dr Burton, her current line manager. Dr Bari gave evidence that he did not understand why he was being asked to clinically monitor the claimant.

187. The claimant then relies upon a series of detrimental treatments that followed (2-14). The claimant 's case is that the first suspension and investigation into the claimant which began on 21 March 2016 was the first in a serious course of detrimental treatment which she says culminated in her dismissal on 12 October 2017. She described it as "walking around with a target on her back since the day she gave evidence in the coroner's court". No-one else was suspended or investigated following the inquest. The investigation concluded on 20 April and the claimant was told that no further action would be taken and no disciplinary proceedings followed. She was, however, required to attend the meeting on 25 April 2016, and until that time she remained suspended from work. There was no proper or just reason for the continuation of that suspension beyond 20 April.

Detriment 2

188. This related to Dr Burton sending a demeaning suspension email to all other medical staff and the consultant psychiatrists. There was no evidence that the respondent or Dr Burton had ever taken such a step before in relation to a consultant psychiatrist who was suspended. It was noted that Dr Burton failed to write to the recipients of his first email to confirm that the claimant had been cleared of any charges. Dr Boyapati was one of those who had received the email and not been told that she had been cleared. It was a poor investigation with no written record of any findings in the bundle, no explanation whatsoever for the absence of a report in

any form within the bundle. Dr Romero confirmed it was not his decision that no further action would be taken and that the claimant should return to work.

Detriment 3

189. The claimant was subjected to increased and unconscionable supervision following her return to work on 26 April 2016. This was outside any performance procedure and was unjustified.

190. At the meeting she was told that there would be monthly supervision by both Dr Bari and Dr Burton. It transpired that this was weekly, with Dr Bari attending her ward rounds. Dr Burton accepted in evidence that it could be seen as overbearing. Overbearing supervision is expressly identified within the respondent's own procedures as an example of bullying.

Detriment 6 – Monitoring

191. Ms Ngaaseke and Ms Birtwhistle both accepted they were asked by Mr Burton to monitor the claimant, and that the claimant was not to their knowledge aware that this was being done following her return from suspension. There was no evidence produced that other employees were subjected to supervision and/or monitoring in the way that the claimant was.

Detriment 4 and Detriment 5 – access to support and secretarial staff and undermined in front of her team and peers

192. Dr Burton accepted in his evidence that normal practice would be to ask the relevant respondent clinician (RC) prior to changing a patient's medication. This was not done and it undermined the claimant in front of her peers.

Detriment 7

193. The Employment Tribunal is asked to prefer the claimant's evidence that Dr Burton did suggest the claimant relinquish her lead role in appraisals without justification and attempted to remove her to another unit at Dalfryn.

Detriment 8 and Detriment 9

194. The Employment Tribunal is asked to prefer the claimant's evidence in these regards, in that the claimant did not receive a pay rise which was entirely consistent with the course of treatment she had been subjected to, and that Dr Burton's evidence was to his rationale for not funding her attendance at a conference was unconvincing. In cross examination he accepted the claimant's evidence that she had not attended a prior AGM contrary to his statement to that effect.

Detriment 10 – failing to deal adequately or at all with the claimant's grievance

195. The claimant's grievance was against the respondent and specifically Dr Romero: it simply was not dealt with and not dealt with in a reasonable timescale. The claimant raised the fact that she had suffered retaliation because of her disclosures in breach of the respondent's whistleblowing policy. This was not investigated and the only outcome letter from Mrs Gibson in the bundle left the alleged retaliation issue live. Mrs Gibson gave evidence that there was a further

letter, which she had not referred to in her statement, but it was not in the bundle. This was particularly unconvincing. The only inference is that the respondent failed to deal with the grievance because of the nature of the allegations.

Detriment 11

196. The claimant says she was ostracised and that the respondent ended her attention at Clinical Board meetings which had supposed to put right the impact of the suspension, and subsequent email to her colleagues advising of the same, on her reputation.

197. In relation to the second suspension, there was no attempt to speak to the claimant to get her side of the story, as the respondent accepted it would be normal practice to do so. The suspension was a kneejerk reaction without proper and justifiable reason on the facts. They decided at the outset that the appropriate allegation was misconduct only, and gross. Jenny Gibson agreed that the main focus of her explanation of the reason for suspension was the claimant's alleged dishonesty.

198. The investigation itself identified a lack of training at all levels in relation to the issue and the first recommendation was to remedy this. The investigators failed to interview Dr Brown, the SOAD, as other witnesses were investigated, and there was no interview statement, only a brief email from Dr Verity. The patient's family were not interviewed, and nor was Dr Rahim, the community RC. The investigation made no recommendation as to whether this was capability or conduct or at what level. Dr Verity did not believe that the administration of the two injections amounted to covert administration at all.

199. The decision to proceed to a disciplinary appeared to involve Nick Ruffley, Jenny Gibson and Dr Burton. The respondent witnesses did not agree as to whether Dr Boyapati was involved. Mr Ruffley and Dr Burton should have played no part as they had become witnesses to the investigation on the issue of whether the claimant had consulted the managers.

The Disciplinary Hearing

200. The claimant felt it was one-sided. The respondent's procedure anticipated that the investigator may present any supporting facts and materials to the disciplinary hearing. No-one presented the management case. Paragraph 3.9 of the procedure stated that "the employee will be entitled to be given a full explanation for the case against him or her". This was not done at the outset of the hearing, which Mrs Gibson accepted would be normal practice. The respondent did not call any witnesses to the hearing, nor did they inform the claimant in advance that she was entitled to do so. The respondent did not provide the claimant with a copy of the disciplinary policy, relying on the fact that it would have been on the intranet. The respondent accepted that the claimant would not have access to the intranet whilst suspended.

201. The respondent chose Dr Boyapati despite knowing that this would be his first disciplinary hearing. He was thrown in at the deep end. No sufficient or credible reason was given as to why they chose an inexperienced peer of the claimant to make this decision. Dr Boyapati obviously felt unable to even make the decision as to what to say in the appraisal document on his own. The inference is that the

respondent chose Dr Boyapati as he was not sufficiently experienced or senior to challenge the respondent's chosen direction of travel. Dr Boyapati did not feel confident making the decision on his own, even with the attendance in the hearing of an experienced HR professional, Kate Killelay.

202. Dr Boyapati considered the decision to dismiss to be a joint one: Nick Ruffley, Dr Burton, Jenny Gibson and himself. He spoke to both Dr Burton and Mrs Gibson separately to take advice on the decision prior to making it. He took advice specifically from Mrs Gibson on the substance of the decision, not merely procedural matters, and he took advice on whether it should be gross misconduct or something less.

Detriment 13 – Referral to the GMC

203. Dr Burton was motivated by his view that the claimant had lied about seeing a bag of powder. He inappropriately brought this issue up when being interviewed during the disciplinary investigation, and referred to it under the guise of "past concerns" in an email to the GMC. His referral was, on the fact of it, based on alleged dishonesty on his view that the injections in question could not have amounted to covert administration and therefore involved dishonesty. Dr Boyapati confirmed in evidence that he found that the injections could amount to covert administration, and he made no finding that dishonesty was involved on the claimant's part in her administration of the injections. The referral to the GMS was thus malicious and unjustified.

Detriment 14

204. The respondent has not clearly identified who made the decision to appoint Dr Romero as the appeal officer. Dr Romero gave the impression that he had simply been asked to hear the appeal. On the face of it Dr Boyapati, someone not on the senior management or leadership team, was the dismissing officer. There was no need to appoint Dr Romero as there were other employees who were more senior to Dr Boyapati.

205. It was clear from the respondent's witnesses that there was a perception at the time that they needed to find someone more senior than Dr Burton, which supports that Dr Burton was party to the decision to dismiss. Dr Romero was neither impartial nor appropriate, and the claimant had made serious allegations of retaliation for whistleblowing against him which remained un-investigated. He had already seen an analysis of the reason for suspension, which went beyond notification of the fact of suspension, a full draft of the dismissal letter before the decision was finalised and communicated on it. The appeal hearing departed from the normal practice in that they did not meet face to face, there was no notetaker and no record of deliberations, apart from the outcome letter. The outcome letter was apparently drafted during the hearing.

206. The lack of file notes, memos and summaries of significant conversations was striking. These included there being no written record of the outcome of the 2016 formal investigation into the claimant while she was suspended. There has been no explanation for its absence. There is not one file note or record of discussions between Jenny Gibson, Dr Romero, Dr Burton, Nick Ruffley and Dr Boyapati. There was no record of Mrs Gibson's conversation with Dr Romero regarding the serious

allegations the claimant had made of retaliation due to the whistleblowing against Dr Romero.

207. The Employment Tribunal is asked to find that the treatment and ultimate dismissal was because of the claimant's disclosures in 2015 and 2016. Had that not been the case, the claimant would have been spoken to prior to being suspended to get her side of the story before consideration of suspension and launch of the subsequent investigation. The investigators were misled by Mr Ruffley, who informed them that he did not know that the proposed course of action involved injections or any of the detail (which he admitted in cross examination that he did). It was a one-sided disciplinary hearing.

208. The disciplinary hearing and decision make no mention of the lack of training at all levels identified by the investigators. This was relevant both to the nature of the appropriate allegations i.e. conduct or capability, and the relevant sanction. Dr Boyapati mentioned the claimant's length of service and training she would have received in her career, but does not specify what that was. There is no mention that the claimant was working under pressure with an agreed heavy workload. Dr Boyapati alleged she was too great a risk to patients. There is no evidence of this. The claimant followed the instruction she was given to change the medication immediately, there was no complaint from the SOAD who had a duty to do so if he thought the patient was at risk, the community RC nor the family. There was no evidence presented as to any harm they considered the patient had come to as a result of the incident. The respondent did not regard it was a serious incident or a serious untoward incident, and it was not the subject of even a debrief. Dr Boyapati ignored the alternative obvious interpretation of the email with regard to SOAD authorisation, that as matter of course the SOAD would not approve covert administration, not that he objected to the proposal.

209. The investigation was tainted by misleading evidence of in particular Mr Ruffley. The disciplinary hearing was not conducted fairly nor did it seek to properly resolve areas of dispute. The dismissing officer found that the injections were potentially covert administration contrary to the investigation. The dismissal letter focussed on breaches of procedure but did not find that the claimant was not seeking to act in the best interests of the patient, nor that she intentionally or wilfully was seeking not to apply procedures. The dismissal letter's finding that the claimant had said that her manager was useless was not supported by the minutes of the meeting, in which she had described that she found Dr Burton unhelpful previously.

210. Dr Boyapati made a serious allegation during cross examination that he thought the claimant was attempting to mislead him in the disciplinary hearing, although he did not address that in his findings nor assert that in his statement to the hearing.

211. The entire investigation and dismissal process had features that were admittedly not consistent with normal good practice. The investigation and disciplinary hearing were evidently unsafe and unreliable. The respondent had not established a fair reason for the reason and the balance of evidence supported that the reason was not only not gross misconduct, but the principal reason for the dismissal were the protected disclosures. There were eight listed departures from normal practice.

212. This was a case which required a high level of thoroughness and rigour in standards of procedural fairness bearing in mind the Court of Appeal in **Roldan**, because it was a case where dismissal would have serious consequences for the employee.

213. There were acute conflicts of facts in relation to whether or not the SOAD had approved or objected to the proposed administration, and also whether it was unreasonable for the claimant not to have contacted her line manager prior to the administration.

214. The case against the claimant started to unravel as it proceeded. The claimant produced evidence at the disciplinary that the RCP guidance relied upon by the investigation, to suggest covert administration was never appropriate for a schizophrenic, was confirmed by them that it was not their position and that the guidance should not be relied upon. The investigation clearly relied heavily on that document in concluding that the second injection could not, even in principle, amount to covert administration. Dr Boyapati disagreed with that in that he thought firstly that the injections were potentially within the principle of covert, and he made no finding of a breach of the duty of candour and no finding that there had been a breach of section 63 of the MCA. The shift from the investigators considering that the injections could not amount to covert administration to the ostensible dismissing manager finding that they were potentially covert and a breach in respect of the applications of the procedures, was a significant shift in the case against the claimant.

215. The claimant pointed out that the respondent's procedures did not require her to gain approval of her line manager and the assertion that Ms Keeley and Ms Birtwhistle did not know that the administration was covert when the claimant was able to point out the emails from Ms Birtwhistle which expressly refer to the plan to administer the medication covertly the day before the first injection, and the email from Ms Christie to all nurses in capitals stating that the patient was not to be told the drug he was receiving. Dr Boyapati believed that this alone, i.e. not informing the patient of the drug, amounted to covert administration. This was a clear acute conflict of facts which Dr Boyapati did not seek to resolve: he simply believed Ms Birtwhistle and the other nurses despite the clear evidence to the contrary.

216. The RCP confirmed that the note relied upon so heavily by Dr Verity was neither their position or guidance at the time or now, and that the conflict regarding SOAD approval and regarding whether the staff were aware of the plan for the injections to be covert meant that the case against the claimant had begun to unravel. Doubts clearly emerged.

217. The procedural unfairness was not subsequently cured. If the investigation and in any event Dr Boyapati had interviewed Dr Brown, the SOAD, they would have had the benefit of his explanation as to whether he did in fact object to the proposed covert administration. They had no evidence before them that he made any objection subsequently.

218. On the facts there were persons in the hierarchy of responsible persons, in particular Mr Ruffley, Dr Burton, Dr Romero, who determined that the claimant should be dismissed for the reason of her earlier protected disclosures. They hid behind an invented reason which the ostensible decision maker adopts. The reason for the dismissal was the hidden reason rather than the invented reason. The

degree of manipulation in the case was significant. It included Serena Birtwhistle ageing a timeline with Nick Ruffley: this was not covert administration. Nick Ruffley deciding to suspend and investigate, being party to both decisions. He also drafted the terms of reference and did not list whether any senior manager knew of the plan to administer covertly in the list of things that the investigating officers were asked to do, nor did he include himself on the list of potential witnesses. Mr Ruffley had had pre-administration conversations individually with both Ms Birtwhistle and Dr Malik.

219. Mr Ruffley confirmed to the Employment Tribunal that these conversations led to the plan on the 10th before the first injection, of administering ZD both by injection and covertly. In stark contrast he misled the investigatory interview. When asked specifically, "did you realise it was an injection" Mr Ruffley said, "no, I didn't even twig, I didn't realise, I didn't need to know that level of detail at that point". If the investigators had known that Mr Ruffley had had pre-administration discussions with the claimant and Serena Birtwhistle, that factor may have led to the investigators nor recommending that the matter warranted a disciplinary hearing. If Dr Boyapati had known that it should have affected his assessment of the seriousness of the claimant's conduct and performance. If the investigation had considered that Nick Ruffley had had pre-administration discussions with Dr Malik and Serena Birtwhistle, that may have proved exculpatory. Dr Boyapati found that the claimant had failed to consult her line manager, also giving the impression that the claimant had said he was "useless". She accepted in evidence that it was not her words.

220. There was no finding in the dismissal letter which disputed that the claimant was seeking to act in the patient's best interests at all times. There was no finding that the claimant deliberately or wilfully sought to breach any relevant procedures in the administration of the injections. This was on the face of it a first offence of a consultant psychiatrist who had a clear disciplinary record. The finding of gross misconduct was not within the range of reasonable responses, even with the issue of manipulation put to one side.

221. In conclusion, it was submitted that the facts were similar to **Jhuti** in that there is significant evidence of manipulation of the material before the dismissing officer at the disciplinary hearing. There is also evidence that the decision to dismiss was not in reality that of the dismissing officer alone, and that it was a joint decision of Dr Burton, Jenny Gibson and Dr Boyapati. If the Employment Tribunal did not accept that there was effectively a joint decision/attribution and finds that the dismissal was decided upon by Dr Boyapati and that he had dismissed in good faith for another reason (gross misconduct covert administration), the evidence of manipulations and the interference in the ultimate decision in Dr Burton and Jenny Gibson was such that this Employment Tribunal is required, following **Jhuti**, to penetrate through the invention rather than allowing it to infect its determination.

222. The Employment Tribunal is asked to find the following claims proved:

(1) Automatically unfair dismissal (section 103A of the Employment Rights Act 1996);

(2) Ordinary unfair dismissal;

(3) Detriments from the first suspension to the referral to the GMC and failure to uphold the appeal; and

(4) Wrongful dismissal.

223. Ms Murphy on behalf of the claimant then made oral submissions.

224. The claimant made disclosures about the bag of powder to the inquest. She did discuss it with Mr Parsons and when she did so Lynne Ngaaseke (a manager) was present. Mr Parsons himself relayed his account of the conversation with the claimant to the respondent. The claimant was at the time being called to give evidence on behalf of the respondent and her evidence could be seen as being a disclosure given to the employer as there were members of staff from the employer, including managers, present.

225. Mr Barnett made the point that if there had been a powder there the police must have missed it and/or it had been stolen. Without evidence, it could simply have been lost.

226. In order to find a reasonable belief, Mr Barnett would say that her memory was so poor that it became implausible. In fact her evidence was that there were a large of staff and she could not remember who it was, which was entirely plausible. The Tribunal is entitled to take into account this was a locked rehabilitation facility for addicts with an interest in obtaining drugs which had been found in the unit. The patient had had visitors the day before and had offered drugs to other patients. The respondent was suggesting that the claimant was dishonest, which is quite a thin line.

227. On the issue of whether or not the disclosures were in the public interest, the Tribunal was reminded that Dr Malik was responsible for vulnerable adults and that she said if the matter was not solved she would go to the police and the CQC (A2-216), she specifically asked the coroner's clerk to ensure that she was asked about it. The claimant thought it was her duty, and she was not cross examined about that. She believed she was obliged to whistle-blow by the policy and she did so.

<u>Jhuti</u>

228. There is no dispute between the advocates on the law, and it is clear from the outset that the claimant's case had always been that Dr Romero and Dr Burton had been heavily involved in what subsequently happened to her. .

229. It was accepted by the claimant that a large number of the detriments were out of time but the referral to the GMC and the appeal against her dismissal were in time. The issue therefore falls to be decided under section 48(4) ERA: do the series of detriments extend over a period? If the claimant can show a relevant connection between the acts which make it just and reasonable for them to be so treated they become part of a series. A series of disparate acts can be similar dependent on the facts: they do not have to be a generic series of similar acts. The claimant's case is that the detriments on which she relies are all connected in that way i.e. they overlap by person and they are generally given under the umbrella of support, for instance supervision, monitoring, etc. They are all connected as they all relate to her work and the treatment she received.

230. In regard to the disclosures, the claimant wished to make a few points.

231. The claimant refuted the allegation that she had deliberately not made records at the relevant time. This was not put to her at the time of her dismissal and was not part of the findings at dismissal. The claimant gave evidence that some notes were made not by her but by colleagues. There is no evidence that she did differently for other patients. She was working at another hospital dealing with an emergency, had IT issues, and it was therefore understandable that her notes were made up afterwards: there was nothing to suggest she did so deliberately. To do so would be to suggest dishonesty, and that was not put to the claimant at the time.

232. Turning to the application of **Jhuti** and the principal reason for dismissal, it was suggested by the claimant that this was a similar case to **Jhuti** because there was a manipulation of the material and some of the evidence and the decision to dismiss was actually the joint decision of the dismissing officer, Dr Burton who had been a witness to the investigation, and Jenny Gibson. It would not be normal to speak to an HR officer who was to at the hearing and no reason was given for failing to go to the HR officer who was experienced and who was at the hearing. Jenny Gibson influenced the decision, going beyond process and procedure, and it is not for Human Resources to decide the level of misconduct or the outcome. This was not just manipulation as in **Jhuti**: there was a joint mind in reaching the decision to dismiss, infected by disclosure of the powder. This was actually worse than the facts of **Jhuti**.

233. If the Tribunal does not find this was a joint decision, the evidence of manipulation and interference requires invention rather than simply infecting the determination. But for the alleged public interest disclosures then there may have been sufficient evidence that there could have been a warning on performance or conduct. This was a case where the public interest disclosures caused a dismissal which was going beyond the range of reasonable responses.

234. Ms Murphy suggested she may seek leave to recall the claimant to deal with some of the matters raised in Mr Barnett's closing submissions. There then followed a short debate in which Mr Barnett asserted that if the claimant were to be allowed to be recalled to "plug holes in her evidence", then he would like to recall some of his witnesses. There was a debate between the two advocates about who had cross examined whom and what should have been challenged when it was not.

235. We noted that both parties were well represented by competent counsel throughout and there was no application to extend the list of agreed issues beyond the outset of the case. We concluded that we had heard quite enough evidence to decide this case without looking further. The

Respondent's Submissions

236. The respondent deals firstly with the alleged disclosures, the first being the oral disclosure to Mr R during the RCA investigation when she, for the first time, said that she saw a blue bag containing beige/brown paper. The respondent does not dispute that she said it, and in her witness statement for the first time the claimant mentioned Ms Ngaaseke entering the room and hearing her repeat it. The claimant said that although Ms Ngaaseke was brought into the room by Alan R she was not in the room when she (Dr Malik) first referred to the blue bag.

237. The respondent contends this was not a qualifying disclosure because Dr Malik did not have reasonable grounds to believe there was a bag of powder. The respondent's case is that she had not seen it. They asked the Tribunal to conclude this on the basis that in an email on 17 September to Dr Bari and Dr Romero the claimant said she was shown it by a staff member and within three hours had changed her account to two staff nurses. She has consistently told everybody since, including at the inquest and during her suspension investigation meeting, that it was two support workers. In cross examination she explained this shift (one to two) on the grounds that the more she thought about it she realised there had been two staff members.

238. The claimant named two individuals as being potentially those who showed it to her: firstly Gillian (who was established not to be on shift at the time) and secondly Alana Greaves, but she had been on a ward round at the time. The claimant then said she could not recall, and by the date of the inquest said she could not remember the names of the staff. Dr Malik accepted there were only seven or eight nurses employed at Fountains and that she had worked for several years and she knew all their names. Bearing in mind how unusual this was, it seemed not to be the sort of detail that she would get wrong.

239. The respondent's better explanation is that on the balance of probability Dr Malik imagined the whole incident. Assertions are made that Dr Malik had multiple further opportunities to identify the female staff member or members who had shown the powder: the independent investigation at the inquest and at the investigation meeting following her suspension in 2016. The respondent asserts that her inability to remember them is implausible. Subject to that, it is accepted that the disclosure of the information does tend to show a criminal offence has been committed, but considers that there is no evidence that the claimant believed her disclosure was in the public interest. Indeed at her investigation meeting it is alleged that after she had given evidence at the inquest she said she was not whistleblowing she was giving fact. The Tribunal was reminded that it is for the claimant to establish that she believed the disclosure to be in the public interest at the time. The respondent asserts that there is a question of whether Dr Malik reasonably believed the disclosure was in the public interest as an issue for each and every disclosure, and certainly within seven of the disclosures.

240. The respondent further alleges that even if Dr Malik did believe it was in the public interest she lacked reasonable grounds for that belief. In particular because there is nothing unusual about a heroine addict dying from an overdose (although that is not what the post-mortem report showed) and Dr Malik could not reasonably have believed that a heroine addict dying from an overdose was in the public interest, and therefore this was not a protected disclosure. It was not made to her employer: Mr Rosenbuk was an external investigator. Lynne Ngaaseke could not be regarded as the employer because she was not senior to the claimant.

241. There were three exceptions. The respondent contended that the disclosure to a person who is not more senior falls outside the Employment Rights Act 1996. The claimant did not fall within any of the exceptions, and Ms Ngaaseke, who may or may not have heard the disclosure, could not be the employer.

<u>Disclosure 2</u>

242. This was the information in the email dated 17 September to Dr Romero. The respondent accepted that it disclosed information which tended to show a criminal offence had been committed, but the respondent asserts that Dr Malik did not have reasonable grounds for believing it tended to show a criminal offence had taken place and she was mistaken. There was no evidence that the claimant believed the disclosure was in the public interest at the time she made it, and even if she did believe it was in the public interest she had no reasonable grounds for that belief.

Disclosures 3 and 4

243. These were the oral disclosures to Dr Romero in Raglan House and Rookery Hall.

244. The decision to suspend was based on the reaction of the staff and the tension at the hospital cause by the claimant failing to identify the people whom she had seen with the bag of powder and hence leading to the suspicion of lying or theft being cast by Dr Malik on her colleagues at Fountains hospital. Neither of these are on the ground of a protected disclosure.

245. There was some evidence (considerable) of the difficult relationships at Fountains hospital which were discussed with Dr Malik in cross examination and which she largely accepted. It was put to her that there was a real issue about members of staff being able to carry on working with the claimant after the inquest, and Dr Malik said that she agreed that is what they said but she did not agree that that is what she had seen. She never ever had any problem with any staff and nor did anyone say anything to her. As a result of this comment the respondent asserts that the claimant was not being ostracised to her face or "sent to Coventry", or anything similar.

246. The respondent asserted that evidence in support of the tension being the reason for the suspension on the advice of Christie Watters by Dr Burton because the staff at Fountains were upset and angry that she had mentioned again seeing a bag of heroin in the possession of a member of staff. Mr Ngaaseke had reported that the staff were upset at the implicit allegation that they had hidden the drugs and not told the truth. The decision to suspend the claimant was to take her out of the situation and to try to diffuse it, and it was agreed with Mr Ruffley for the benefit of the patients.

247. It could not be in the public interest as she had no reasonable grounds for the belief and so this was not a qualifying disclosure. Further, if it was a qualifying disclosure it was not protected because Mr Parsons was the respondent's lawyer and the disclosure was not to Dr Malik's employer.

248. Could Mr Parsons fall within section 43C(2) which provides that a worker who, in accordance with the procedure whose use by him is authorised by his employer, makes a qualifying disclosure to a person other than his employer, is to be treated for the purpose of this part as making the qualifying disclosure to his employer?

249. The respondent's whistleblowing policy authorises disclosure to the police, local adult protection units, to their confidential independent hotline and arguably to public concern at work. It does not authorise disclosure to a solicitor instructed in litigation and therefore the claimant is not covered by section 43C(2).

250. There then falls a question as to whether it falls within section 43D, "a qualifying disclosure is made in accordance with this section if it is made in the course of obtaining legal advice".

251. The respondent asserts that the purpose of the discussion was for Mr Parsons to provide general advice on substance and procedure. In cross examination Mr Parsons that he was there to act for the company and provide a level of information for those attending court in terms of remit, running order and the issues that the coroner was likely to be interested in, and that individuals may routinely have questions about their individual particular evidence. Mr Parsons agreed that they may, and he may or may not be able to advise them.

252. The respondent interprets this as Dr Malik not obtaining legal advice but obtaining procedural advice and advice on how best to present evidence. It asserts that this does not fall within section 43D. Mr Parsons was the respondent's lawyer not Dr Malik's lawyer, and it applies to advice obtained from the worker's lawyer.

Disclosure 6 – the oral disclosure to Mr Parsons on the morning of the inquest on 9 March 2016

253. This is indistinguishable, says the respondent, from the previous disclosure with the same questions being involved.

Disclosure 7 – the evidence to the coroner

254. This is in similar terms. The claimant's cross examination was referenced in relation to this with Mr Barnett asking her whether, whilst giving her evidence, she was disclosing not only to the coroner but to the other people in the room, and she agreed that she was not disclosing to other people in the room, so that even if the respondent's representatives heard her evidence the disclosure of information was not to them, which would mean the evidence given to the coroner, even if a qualifying disclosure, was not protected.

255. The two members of the hospital staff present at the time were Serena Birtwhistle in her capacity as Interim Hospital Manager, having taken over from Ms Lynne Ngaaseke, who was also present, but neither were more senior than the claimant and so a disclosure could not be a protected disclosure.

256. The respondent then turns to the detriments.

Detriment 1 – the first detriment was the requirement to attend a suspension meeting and being suspended

257. It was accepted that the fact of the suspension on 21 March was a detriment, as was being called to a meeting which entailed cancelling a hospital appointment which the claimant had. Dr Burton accepted in cross examination that he knew she had an eye appointment and nevertheless wanted the meeting to go ahead.

258. The respondent asserts that neither of these were on the grounds that the claimant had made a protected disclosure, and that the trigger for the suspension was the evidence given at the inquest not the earlier disclosures.

259. The respondent asserts that the ground for not postponing the meeting was not the fact the claimant had made a disclosure to the coroner but that Mr Ruffley and Dr Burton wanted to meet her in order to suspend her and it was the only time they could do so. The claimant agreed in cross examination that they were busy people with busy diaries, and it was important to deal with the suspension as promptly as reasonably possible.

Detriment 2 – the suspension email to other colleagues

260. It was common ground that an email notifying the consultants about a colleague consult and suspension had only been sent in respect of Dr Malik and not in regard to any other consultant. Dr Malik gave evidence that she did not see a copy of the email but she was told about it by three colleagues. The email told the other consultants that the claimant was not to be contacted.

261. In cross examination Dr Malik agreed that her line manager had a legitimate purpose in sending the email to the doctors because she was the Clinical Appraisal Lead and the others needed to know not to contact her.

262. In the outcome of the grievance it was noted by the respondent that Jenny Gibson acknowledged that the company was wrong, apologised to Dr Malik and invited her to attend Clinical Board meetings in an attempt to re-assert her prestige within the company.

263. The respondent contends that the suspension email was not sent on the grounds that the claimant had made a protected disclosure: it was sent on the ground that it believed it had a legitimate business interest in notifying consultants that the Lead Appraiser was unavailable.

Detriment 3 – the increased supervision following the return to work

264. It is common ground that the supervision was increased to six monthly to at first twice weekly, when the claimant was told it would be increased to twice monthly not weekly.

265. The respondent asserted that it was not accepted that Dr Bari accompanying the claimant on ward rounds amounted to a detriment. Dr Burton's weekly support calls were considered to be helpful and not a detriment. This supervision took place between the claimant's return from suspension in April 2016 and July/August 2016, a period of 3-4 months.

266. Ms Ngaaseke gave evidence this was normal for supervision to increase for a few weeks after return from suspension and not unique to Dr Malik.

267. The claimant said the most likely explanation was on the ground that she had made a protected disclosure. The respondent asserts that this was a support mechanism to help the claimant. This was done in the spirit of Lynne Ngaaseke, Vanessa Keeley, Serena Birthwhistle, Alana Greaves and Catherine Flowers having a problem with working with the claimant, evidence taken while Dr Malik was suspended.

268. Dr Burton in cross examination said the reason for the increased supervision was to ensure a smooth and harmonious working relationship on her return to work and so that if difficulties did arise they could be dealt with quickly.

269. Dr Romero, then Clinical Director, said in cross examination in the Tribunal that everyone was expressing high emotions and he wanted to calm everybody: he did not want to lose the doctor and he did not want to lose the manager because they were both very important to the hospital.

270. As soon as the claimant complained of overzealous supervision by Dr Bari it was stopped and the respondent asserts that as Dr Bari was not cross examined on the issue of how frequently he attended ward rounds, the evidence that he gave to the Judge's question of how often he attended should be accepted as two or three times over the whole period. Dr Malik did accept that as soon as she complained it stopped. The respondent asserted that the additional supervision was not because of any protected disclosures.

271. Dr Burton did accept that he was annoyed by the claimant's approach to the bag of heroine, and the respondent asserted that her approach was intransigent. The Tribunal is invited to believe that this openness reflects well on his credibility. It was pointed out that Lynne Ngaaseke was also given an extra layer of supervision as they were worried about the personality.

Detriment 4 – the removal of secretarial support

272. He claimant accepted this support was informal, and that Julie Parker withdrew her cooperation.

Detriment 5 – being undermined in front of the team in May 2016

273. Lynne Ngaaseke indicated in cross examination that she would generally consult the claimant with regard to declining referral and she should be consulted for some assessments and referrals, and that prior to 2 May the usual practice was for those referrals to go to the claimant, and Ms Ngaaseke agreed. She asserted further that the decision to accept a patient lies with the Hospital Manager because only the manager can comment operationally as to whether they can accept, regardless of clinical input, and that it would not be Dr Malik's decision. Ms Ngaaseke said it would not be unusual to decline without clinical input. She considered in this case that operationally she could not support the patient so it would have been a waste of time to discuss it with anybody else.

274. The respondent therefore asserts that the declining of the patient referral was not on the grounds of the claimant's protected disclosure but because the hospital lacked capacity.

275. There was an incident on 5 May 2016 when Lynne Ngaaseke submitted a list of discharges without consulting Dr Malik. Ms Ngaaseke's evidence was that she did not make a decision in this regard: this was purely an administrative act and she did not consult anybody else either.

276. In May 2016 the claimant was instructed not to ask nursing assistants to bring patients and records to the interview rooms. Ms Ngaaseke said doctors normally

did it themselves. The claimant said that because of her high workload she always the nursing staff to help.

277. Ms Ngaaseke did admit that on that particular day they were extremely busy and she told the support workers that they were so busy on the floor covering allocations that they were not to take notes to Dr Malik.

278. Ms Ngaaseke accepted that she did not go and see Dr Malik, who was in the same building that day, and explain it to her because she was busy doing something else.

279. The respondent asserts that the incident was de minimis and was not on the ground that Dr Malik had made a disclosure. It was simply that the hospital was busy.

280. In May 2016 Ms Ngaaseke criticised Dr Malik for being late to work. In cross examination the claimant admitted that she was sometimes late to work but she would not accept the respondent's case that her lateness impacted on appointments or meetings or on ward rounds.

281. Ms Ngaaseke denied reprimanding the claimant. The claimant asserted that she had been able to do this for five years and it was only brought up after suspension. The respondent says this was not a detriment and is what should and would have happened in the normal course of things, and even if it is a detriment it is not on the grounds that she had made a protected disclosure. It was not mentioned in her grievance.

282. In May 2016 the claimant was told she had to comply with requirements to file reports two weeks before meetings or hearings. The respondent says that Dr Malik was told to give reports to Ms Parker for typing one week, not two, before meetings or hearings. This was dispensation from the normal two weeks. Dr Malik accepted that in cross examination, and she confirmed she was late with reports regularly and that this was because of her workload.

283. The respondent says the fact the claimant was given the opportunity only to submit within a week and not two weeks made this not a detriment and it was not on the grounds that she had made a protected disclosure.

<u>Detriment 6 – monitoring the claimant and reporting back to management</u>

284. These related to leaving a computer screen on while speaking to a patient when only a cleaner was in the room. With regard to staff feedback, Dr Bari told the claimant that he would do that and it was not an action taken on the ground the claimant had made any disclosure: it was on the ground there was tension.

<u>Detriment 7 – the attempt to remove the claimant's Clinical Appraisal Lead role</u>

285. The reality is that the role was not removed and an attempt to subject a worker to a detriment is not the same as subjecting a worker to a detriment. The claimant gave evidence of her undisputed heavy workload as she was responsible for 37 patients when an NHS consultant is normally only responsible for 20-25 patients, and she worked an average of 56 hours a week. She confirmed she had complained of overwork. She agreed she had declined an offer of flexible working,

asking instead to reduce her hours to 9.00am-5.00pm. She was offered a junior psychiatrist she confirmed, but refused the same.

286. Dr Burton offered to take away the role of Lead Appraiser immediately after the claimant gave evidence at the inquest, he says to ease her workload and not because of the events following the patient's death.

287. The respondent asserts that there is no detriment and certainly nothing on the grounds of a protected disclosure. The fact that the role was not taken away corroborates that this was not a retributive act.

Detriment 8 – being refused a pay rise

288. The respondent accepts that a failure to give a pay rise if one would otherwise be given is a detriment, but it asserts that the claimant was not due to be given a pay rise so there is no detriment in not being given it, and it was unrelated to any disclosure she had made, evidenced by the fact that the £20,000 pay rise she had received in 2015 was awarded after she sent the email, and the respondent reminded the Tribunal that Dr Romero's evidence was that in 2017 they were in a difficult economic situation and they did not increase anybody's salary.

Detriment 9 – refusing the request to go to the conference

289. The claimant asserted that her request to attend The Royal College conference was refused without reason, but then went on in her further information to accept that the reason given was lack of funds. She provided no evidence to support her case that she would have been sent but for the protected disclosure.

290. Dr Malik attended the conference in any event at her own expense and asserted that she had seen other employees of the respondent there. However, she has never disclosed the names of those other employees and accepted that the respondent had been unable to check its records to see if it had paid for them.

291. The respondent asserts that this was no detriment because the claimant was no going to go anyway.

Detriment 10 – the grievance not dealt with in line with company policy

292. The respondent accepts that it dealt with Dr Malik's grievance in a less than ideal way and in breach of its own grievance procedures. It denies doing so on the grounds that she had made a protected disclosure. The claimant insisted that her grievance be handled by the then CEO, Saleem Asaria. Dr Malik agreed that they had had a telephone call lasting five minutes on 19 May, and "I said that unless I had a meeting with Saleem and the grievance was sorted I was going to sue them". Mr Asaria became engaged in the sale of the business to Signet and the meeting never took place.

293. Dr Malik said she would be dropped a line by Jenny Gibson, saying that he was busy and they were trying to arrange a meeting.

294. The respondent therefore asserts that the reason for the delay, while not reflecting well on the respondent, was not that the claimant had made a protected

disclosure: it was that the claimant insisted on the CEO hearing her grievance and he did not have the time to conduct what was plainly a complex investigation.

295. Up to January 2017 the claimant refused to have Jenny Gibson (who was offered) as an alternative. However, in January 2017 Ms Gibson held the grievance meeting and there was an apology over the suspension email, the claimant was invited to the Clinical Board meetings, and there was a resolution dinner in a restaurant with the claimant and Mr Romero. This is criticised by the claimant as failing to grapple with the substance of the grievance, and the respondent accepts that she is right and offers levels of mitigation relating to timing and the appropriate "clear the air" dinner.

296. Ms Gibson firstly left the Romero part of the grievance open and secondly offered a right of appeal. The claimant did not appeal and did not re-open the grievance.

297. The respondent accepted that it handled the grievance in a less than ideal fashion, and accepted that amounted to a detriment but asserts that it did not do so on the grounds that the claimant had made a protected disclosure.

<u>Detriment 11 – being ostracised/rude response to a complaint about patient treatment</u>

298. The claimant alleges that there was an incident involving a patient which led to near death. The claimant told Serena Birtwhistle and Vanessa Keeley that this was due to the negligence of the nursing team. She asserted that they were dismissive and rude to her, raising their voices.

299. The respondent asserts that this was not a detriment and that Serena Birtwhistle was simply being firm. Over 12 months had passed since the inquest and this was Ms Birtwhistle getting irritated by an unreasonable if not irrational approach to an incident by Dr Malik, and allowing her irritation to show.

300. The Clinical Board Meetings were held quarterly and the claimant agreed she was invited to two of them, and accepted that the Appraisal Lead had never attended before.

301. The respondent's case was that her attendance was not clinically necessary but followed the outcome of her grievance in January 2017. She was invited to two meetings, and it is common ground she did not attend the second meeting, she says because she was unavailable. She alleged then that Dr Verity had told her she would no longer be required to attend. The respondent asserts that Dr Verity had said she need not attend the meeting, not that she could not attend.

302. At the third meeting in July 2017 the claimant did not attend, she says because she was not invited. The respondent's witnesses were not challenged on the point, and it occurred over exactly the same days that the covert medication issue blew up.

303. The respondent contends there was no detriment because this was almost 18 months after the claimant's evidence at her inquest and had nothing to do with a protected disclosure.

Disclosure 12 – trying to force the claimant to move to another hospital

304. The claimant put this as trying to force a move. In her further information she said she was asked to consider moving. When it was put to her she confirmed that she was asked to consider moving. She had originally worked at Delfryn Hospital and her commute would have been similar.

305. The respondent noted that Dr Malik accepted that her employer had a contractual right to move her but it never happened. Dr Burton accepted he raised the possibility of a move with the claimant and Dr Malik accepted that she was not threatened with any consequence if she refused.

306. The respondent therefore asserts that it could not be a detriment.

Detriment 13 – the referral to the GMC

307. This referral took place on 18 October 2017 and it is asserted by the claimant that Dr Burton made the referral maliciously and without justifiable reason. It was agreed that Dr Burton was under a professional obligation to report any prima facie matter of professional misconduct. He was the authorised officer to do so. The investigation had recommended considering referral to the GMC and there was then a disciplinary hearing which found Dr Malik to be guilty of serious professional misconduct and dismissed her. Dr Burton genuinely believed in her guilt, his email referring to her as "potentially a bully", past actions causing concern and opinionated is not malice but the level of Dr Burton's concern.

308. In the actual referral there is no reference to the claimant being a bully and no reference to past actions.

309. The respondent agrees that referral the GMC is a detriment, but in this case it was not done maliciously or without justifiable reason. It was not on the ground that the claimant had spoken up at the inquest some 18 months earlier: it was on the grounds that there was a serious question over her professional conduct.

Detriment 14 – from July 2017 the process leading up to the claimant's dismissal

310. These were two additional issue, 23.1 and 23.4 from the draft amended List of Issues.

311. The first was the claimant's suspension on 27 July 2019. It was agreed with the respondent that that is self-evidently a detriment. The evidence supports a finding it was Jenny Gibson who had decided to suspend the claimant. Jenny Gibson said she advised about suspension. Dr Leslie Burton told the Verity panel investigation that suspension was Jenny Gibson's decision. That is also contained in his witness statement.

312. The respondent asserted that it was not very credible that Jenny Gibson took that decision on the ground that the claimant had made a protected disclosure over 18 months earlier. The more likely reason was that an incident had occurred which was a matter of considerable concerned to the senior management team. The respondent asserts that it was the discovery of the covert application of ZD that was the ground for the suspension rather than the whistleblowing.

313. In cross examination the claimant said that she believed that the respondent had decided to sack her for whistleblowing during the investigation, and the decision to suspend her was not because of the whistleblowing.

314. The second new issue raised was the inadequacy of the appeal decision. The appeal decision, the respondent says, is detailed, indeed more so than the dismissal letter, and not inadequate. Dr Romero was not questioned by the claimant's representative on the five page appeal letter. It would be a fanciful leap to say this was on the grounds of any protected disclosure. In any event matters concerning the appeal are not capable in law of amounting to a detriment.

Time issues for the detriment claims

315. The ET1 was presented on 12 January 2018 with an early conciliation form submitted on 18 October 2017, and the early conciliation certificate was issued on 23 October 2017. Therefore, any act taking place before 8 October 2017 is on the face of it out of time.

316. The only detriments plainly within time are therefore part of detriment 14 (the inadequacy of the appeal decision, which occurred on 17 October 2017) and detriment 13 (which was the referral to the GMC on 18 October 2017). All other detriments are asserted by the respondent to be out of time. The only saving provision to that would be whether they formed part of a series of similar acts or failures. They would still have to culminate with one or both of the "in time" detriments.

317. Section 48(3) of the Employment Rights Act 1996 provides that the claim must be presented within three months of an act or failure (with the possibility of extension), and provides that, "where that act or failure is part of a series of similar acts or failures" then the last such act or failure is the relevant date for limitation purposes. This test is different to that in discrimination, which refers to conduct extending over a period.

318. The suspension part of detriment 14 took place on 27 July 2017 and detriment 11 (the Clinical Board meeting on 25/26 July 2017) fall within three months of 17 October (the earliest of the potentially in time detriments). As to the detriments not made out of the merits, the Tribunal cannot go back before 18 July (three months before 17 October), ruling out all other detriments.

319. Even if the 25, 26 and 27 July 2017 detriments are allowed in as part of a series, there are no detriments for the period in the three months before 25 July, being 26 April 2017 to 25 July 2017. The prior Clinical Board meeting was 24 and 25 April.

320. It follows, therefore, that even if the above detriments succeed on their merits there are no other detriments which form part of a series. The gap breaks the series, and no detriments before 26 April 2017 can be considered. The case of **Bear Scotland v Fulton** is cited by the respondent as involving similar principles of unlawful deductions from wages.

321. The respondent further asserts that the detriments are not similar acts, and this is fatal to the claimant's attempt to bring in the earlier detriments within section 48(3) of the Employment Tribunals Act 1996. It is the act or failure that has to form

part of a series, not the respondent's motivation behind that act. Because none of the earlier detriments form part of a series of similar acts or failures, the Tribunal lacks jurisdiction to determine the earlier claims.

Not reasonably practicable – extension of time

322. If the respondent is right, the claimant is forced to fall back on section 48(3) of the Employment Rights Act 1996, which provides that the Tribunal can extend time if it was not reasonably practicable to present the claim within three months, and the claim was presented within a reasonable period thereafter (the same as the unfair dismissal test).

323. The respondent points out the following factors which suggest it was reasonably practicable to present earlier claims. The claimant was a member of the MDU until dismissal and the BMA until 2016. She confirmed she had access to legal advice at all relevant times. In September 2015 she told Dr Romero she had considered getting advice from the BMA and MDU. The claimant as a doctor would, as asserted, whilst knowing the different time limits for employment claims, understand the concept of time limits for litigation. The claimant told Jenny Gibson that she was taking legal advice in May 2016 and in June 2016 she emailed Ms Gibson saying, "my lawyer has a deadline to meet regarding further course of action". At her grievance hearing on 4 January 2017 the claimant raised the prospect of going to court, which in cross examination she confirmed would have been a whistleblowing claim arising from being suspended due to the evidence she gave at the inquest. She was actively contemplating such a claim in early January 2017 but chose not to bring it until January 2018. In cross examination she asserted that in June 2016 she made a decision not to issue proceedings in respect of whistleblowing.

324. The respondent contends it was reasonably practicable for Dr Malik to bring the earlier detriment claims within three months of each alleged detriment. She had been contemplating litigation from the very start, the date of her suspension, and she had legal advice. It was reasonably practicable for her to bring proceedings earlier and she chose not to.

Unfair dismissal – the principal reason for the dismissal, whether it was conduct or protected disclosure

325. If the Tribunal concluded that the principal reason for dismissal was whistleblowing it did not matter whether the respondent also genuinely believed in misconduct. If the Tribunal accepted the principal reason was the covert administration of medication without following procedures it seemed self evident that the respondent had an honest belief that that occurred.

Did the respondent have reasonable grounds (section 98(4))?

326. The respondent reminds the Tribunal of the relevant policies related to the claimant's decision making:

(1) The Mental Health Act Code of Practice:

> "A SOAD certificate must clearly set out the specific forms of treatment to which they apply and the only exception is if treatment is immediately

necessary to save the patient's life, alleviate serious suffering or prevent patients behaving violently, and this test is a strict test. The fact there is an urgent need for treatment is not enough."

(2) The Care Quality Commission Covert Medication in Mental Health Services Policy:

"Covert administration is only permitted as part of an agreed management plan and following a documented best interests meeting (there is no exception here for urgent treatment)."

(3) NICE guidelines:

"There should be a best interests meeting, including Care Home staff, the pharmacist and a family member or advocate agreeing, and also recording the reasons. In an emergency there should be informal consultation."

(4) The Royal College of Psychiatrists statement on covert medicine:

"Covert administration of medication in patients with schizophrenia and other severe mental illnesses where patients can learn and understand that they will be required to take medication is unacceptable." (MP had schizophrenia)

(5) Cygnet's internal policy:

"Covert medication can only take place after full disclosure with the MDT and a comprehensive record made of the decision. There is no exception built in for emergencies." All must agree, including carers, relatives, advocates, care coordinator and the MDT, which includes the pharmacist. Dr Malik agreed in cross examination that if any one of the carer, the relative, the advocate, the care coordinator or the pharmacist were not in agreement with covert application then she would be in breach of the policy.

Flowchart

327. This is to be discussed each week at a ward round with the team and the decision refreshed each week and redocumented. Dr Malik did not claim, either at the investigation or disciplinary hearing, that she had consulted the MHS Code of Practice or the CQC guidance. She mentioned it for the first time in her disciplinary interview four weeks later.

328. The respondent invites the Tribunal to reject the claimant's evidence that she consulted the respondent's internal covert medication policy in the hours or days before 12 July as inaccurate. Ms Birtwhistle said that people could not access old policies after the acquisition of Signet some six months earlier without requesting them centrally. When that was put to Dr Malik in cross examination she said she had seen the covert administration policy before 3 July. The respondent suggests that is not consistent with her saying she saw it in the hours and days leading up to 12 July.

329. It was noted further that Dr Malik had asked Ms Birtwhistle for a copy of the policy on 24 July. Dr Malik says she read the covert policy around the time of the professionals meeting, which was 24 July.

330. The respondent suggests that in the light of this the claimant was not truthful about having read that particular policy and her claim to have read other guidelines and codes should be viewed with reservation.

331. The claimant argues that the RSP statement is out of date. If she had discovered that at the time it would be different, but it would seem she only took steps to investigate and undermine the statement for the purpose of the disciplinary hearing.

The lack of authorisation by the SOAD

332. The Second Opinion Approval Doctor is appointed by the Care Quality Commission. The SOAD here was Dr Adrian Brown. They act as an important safeguard to ensure best treatment is provided and acceptable standards of medical practice are observed for patients who lack capacity to decide for themselves. It was agreed that a SOAD opinion was not needed to change MP's medication to ZD because he had had it before.

333. The only purpose of the SOAD opinion was to authorise the covert application of that medication. The form was completed by Dr Malik on 10 July 2017 and asked for authority to administer ZD covertly. On 12 July Dr Malik authorised the changeover of medication to ZD whilst withholding that from MP. By 12 July the SOAD had not visited, let alone given permission for covert administration.

334. The respondent had reasonable grounds for believing that Dr Malik authorised the covert administration of ZD on 12 July without permission from the SOAD.

335. On 14 July the SOAD visited and issued his certificate. It is silent on the issue of covert administration. Dr Malik said she assumed without checking with him that he had authorised it.

336. The respondent had reasonable grounds to believe that the SOAD report did not authorise covert administration of ZD and the claimant ought to have realised that.

337. On 24 July at the professionals meeting the claimant told the gathered professionals that she was waiting for SOAD. That was not true: she did have a SOAD certificate.

338. The respondent had reasonable grounds for believing Dr Malik did not share the certificate because she knew it made no mention of authorising covert administration and she did not want to be challenged.

339. In an email on 25 July Dr Malik made no mention of obtaining SOAD authorisation. This was further ground entitling the respondent to believe the claimant had not obtained authority for covert application from the SOAD.

340. Dr Adrian Brown told the respondent he had not given an opinion about covert medication, and the respondent was entitled to take that at face value.

341. The respondent was entitled to believe that the claimant had failed to comply with the requirement under the Mental Health Act to get the consent of the SOAD and had deflected attempts to question her about it, both at the professionals meeting and when questioned by Dr Burton.

The lack of consultation with the family

342. It is clear that Dr Malik had discussed the possibility of covert medication of ZD with MP's brother three weeks before 12 July. There is no written record of MP's brother expressing any view on covert medication.

343. On 10 July 2017 the brother spoke to Serena Birtwhistle and agreed to the change of the medication of ZD, but there is nothing in the notes to suggest this was proposed to be on a covert basis.

344. Full knowing participation of a family member is required by the CQC guidelines, the NICE guidelines and the hospital's own policy.

345. The respondent was entitled to form the view that the documentation did not support and indeed undermined Dr Malik's assertion that MP's brother consented to covert administration of ZD, and that he did not consent to covert administration before a SOAD certification was in place.

Lack of consultation with a Hospital Manager

346. Serena Birtwhistle gave evidence the employer that she knew there had been a discussion about covert medication with MP's brother but it had not been expressly agreed to. There would be a best interests meeting first. She had said she did not know that the injection was to be covert. The respondent was entitled to believe that evidence.

347. The respondent further asserts that there is nothing in writing to suggest that Serena Birtwhistle that ZD was to be given covertly, and that she did not consent on the two occasions the drug was so administered. This was evidence that the disciplinary panel was entitled to accept at face value.

348. The disciplinary panel was unaware of the fact that MP's brother, Mr L, believed that Serena Birtwhistle told him that there was a plan to administer ZD covertly on 10 July 2017. In cross examination he confirmed that he could not be sure about 10 July as the date. This evidence was not in front of the disciplinary panel.

349. The respondent had reasonable grounds to believe that Dr Malik had not consulted with the Hospital Manager over her decision to administer ZD by deception.

Lack of consultation with Head of Care, Vanessa Keeley

350. Vanessa Keeley was asked to administer ZD immediately on 12 July by Dr Malik. There was nothing in writing or in any of the replies from the claimant to suggest that she knew that the ZD was going to be given covertly.

351. The disciplinary and appeal panel were told by her that she had not been given any information to say that ZD should be given covertly on 19 July, and she believed there was to be a best interests meeting first.

352. The respondent was entitled to accept Vanessa Keeley's evidence on this point and it had reasonable grounds for its belief that Dr Malik failed to consult her.

Lack of consultation with the forensic psychologist, Catherine Flowers

353. The respondent acknowledges there is no statutory or regulatory requirement to consult with the forensic psychologist, but she was a senior member of the team who could have been consulted. The claimant's evidence was that she did speak to Catherine Flowers about raising covert administration in a best interests meeting. Catherine flowers said she did not recall an MDT meeting about covert application of the medication, nor did the SOAD discuss it with her.

354. The respondent accepted that Catherine Flowers' assistant, Natalie Booth, was present at some of the morning meetings, however Dr Malik did not raise that at the time of the investigation or disciplinary hearing. In cross examination Dr Malik accepted that Catherine Flowers might not have been aware about giving ZD covertly on 12 July.

Lack of consultation with care coordinator, Abu Cohlwadia and Community Psychiatrist, Dr Ayesha Rahim

355. The medical notes of the incident on 12 July indicate that it was discussed with both of these individuals via email and both agreed. The email contained the discussion. It was sent by Serena Birtwhistle to Dr Rahim and Mr Cohlwadia. Dr Malik accepted that the email was ambiguous. It made no reference to covert administration at all. The respondent had reasonable grounds therefore to believe that neither had been consulted about the proposed plan. Dr Malik was concerned that the respondent rejected her evidence about Dr Rahim and Mr Cohlwadia consenting without interviewing them. She accepted in cross examination she did not ask for them to be interviewed or bring them forward herself as witnesses.

356. At the health professionals meeting on 24 July Mr Cohlwadia said that there should be a best interests' assessor to look at covert for the future. This would seem consistent, the respondent said, with him having already consented to covert administration. This provided reasonable grounds for the respondent to reject Dr Malik's account that she had permission.

The agreement of the nursing staff

357. This was required by NICE guidelines. The nursing staff knew that there was a future intend to administer ZD covertly but there had been no agreement. During the investigation interview the claimant was asked if the nursing staff were signed up. She did not provide an answer. The respondent was entitled to form the view that Dr Malik knew the nurses were waiting for the best interests meeting.

Lack of consultation with the pharmacy

358. Dr Malik requested ZD for injection on 11 July. Nothing on the form requesting it put the pharmacy on notice that she intended to administer it covertly.

She asserted that she discussed covert administration with them over the phone. The contemporaneous notes of the conversation said Dr Malik had a long conversation discussing all the options available.

359. The consent of or consultation with the pharmacy concerning covert administration is required by the CQC, the NICE guidelines and the respondent's own covert administration policy. The respondent had reasonable grounds for its belief that the claimant had not complied.

Lack of consultation with Dr Leslie Burton, her line manager

360. In her disciplinary interview Dr Malik was asked whether she went to her line manager as the first port of call. She avoided the question, describing him as "not helpful". She was then asked if she contacted anybody else, such as Dr Bari, and again did not answer the question.

361. The respondent had reasonable grounds to believe the claimant had failed to consult with her line manager.

Lack of consultation with parties to MP's mental health plan

362. The plan indicated treated authorised by a SOAD had been requested to authorise two antipsychotics. It did not mention the SOAD being asked to approve covert administration. Dr Malik in cross examination simply said her secretary got it wrong.

363. Whether that was true, the respondent had reasonable grounds for believing there was no discussion by the parties to the mental health plan about covert administration.

Lack of consultation with the mental health advocate

364. The respondent asserts that this is required by CQC guidelines, NICE guidelines and the hospital's own policy. There was no discussion with the mental health advocate accepted by Dr Malik so the respondent had reasonable grounds for its belief that this was the case.

Failure to seek legal advice

365. The respondent accepts there is no obligation in the documentation to seek legal advice, but it contends as a matter of common sense that Dr Malik should have obtained it. The claimant accepted that she had not obtained legal advice, and the respondent had reasonable grounds to believe she had not taken it.

Shouting at nursing staff

366. The respondent had reasonable grounds to believe that Dr Malik had been shouting and screaming at Susanne on 20 July. She accepted she had been shouting and indeed that she had engaged in mild swearing. She did this during the disciplinary interview. No-one suggests this was the principal reason for the dismissal nor that it would have justified dismissal on its own.

The claimant's explanation to the respondent

367. The respondent had reasonable grounds for rejecting the claimant's assertion that she had to administer ZD covertly because of MP's assault on three people and the fact that he had been spitting on someone. The respondent had grounds for rejecting her explanation that it was necessary to switch immediately to the covert application of ZD. There was an opportunity to attempt MAPA ("Management of Actual of Potential Aggression"). This can involve distraction, mild or major restraint or rapid tranquilisation.

368. The claimant could have consulted with as many people as possible beforehand. She did not. She could and should have contacted her line manager for immediate advice. She could and should have disclosed to her line manager that she had engaged in covert medication, but she waited 14 days after 12 July before sending her email on 25 July. She could and should have recorded her justification ion MP's medical notes at the time but she did not record the clinical notes for another eight days. She should have completed a section 62 Mental Health Act urgent treatment form as she knew it was required. She did not complete the form on or after 12 or 19 July.

369. The respondent further asserts that ZD was not a solution to the problem. Drs Verity, Boyapati and Romero suggested that other medication would have been more appropriate.

370. The respondent then looks at various emails from Dr Malik before concluding that all of the arguments put forward in the hearing were before the disciplinary and appeal panels and Dr Boyapati had to make a decision, as did Dr Romero, and they concluded that Dr Malik had not sought appropriate consents before administering ZD covertly, and so the respondent had reasonable grounds for rejecting the claimant's explanation that the appropriate consents could be foregone because of the urgency of the situation.

A reasonable investigation

371. The claimant was suspended on the day that she revealed what had happened on 27 July. She accepted that the terms of reference were broadly reasonable. The investigators interviewed numerous people and the conclusion and recommendations of the report was one that they were entitled to reach.

The Appeal

372. The claimant was advised of a right of appeal and she chose to do so. During the appeal she asserted there was inadequate investigation and the true reason for the dismissal was the protected disclosure. She does not however suggest that the sanction of dismissal was unreasonable. When the respondent asked for further details of the claimant's appeal her solicitors were unhelpful in their response. Dr Malik did not attend the appeal meeting but she could have asked for a postponement, sent a representative or put in written submissions. She did not.

373. Dr Romero conducted a thorough review and reached a decision, which was fully reasoned and addressed the issues that the claimant had raised. This rectified any procedural defects that may have arisen due to lack of thorough investigation at an earlier stage.

374. The respondent asserted that the identity of Dr Boyapati and Dr Romero as disciplinary and appeal officers was perfectly reasonable, because the first choices in both cases were unavailable. The respondent's evidence was that there was nobody else.

375. The respondent asserts that although the respondent was criticised for not supplying a copy of its disciplinary policy, Dr Malik did not request one. The respondent contends that it is likely that Dr Malik did have a copy of the policy.

376. The respondent asserts that the comment by the claimant allegedly that Dr Burton was "useless" when in fact she had said "not helpful" did not taint the process sufficiently to render the dismissal unfair.

377. The respondent conceded that there was some lack of clarity in the evidence about who took the decision to dismiss. Dr Boyapati in evidence initially said it was him, but it was conceded that he consulted others, saying he did so after he had made the decision. Leslie Burton thought he was part of the decision making process. Jenny Gibson accepted Dr Boyapati rang her to discuss his decision. Both Dr Burton and Ms Gibson denied involvement on influence in the substance of the decision. The respondent asserts this was a routine situation where a relatively inexperienced dismissing officer discussed a decision he intended to take with other people. In any event if this did cross a boundary the procedural flaw was corrected on appeal.

378. In the dismissal letter Dr Boyapati considered whether he would have followed the same course of action. He described himself as using his own standards as a barometer. In effect he was a reasonable clinician, and the respondent therefore submits that in the light of the above it followed a reasonable procedure.

<u>Was dismissal within the range of reasonable responses?</u>

379. The respondent asserted that the claimant in cross examination accepted that the respondent saw what she had done as a serious breach of medical ethics. She did however later reverse her position, saying they should have done the investigation properly.

380. If Dr Malik accepted that she could reasonably be seen as having committed a breach of medical ethics, it must be within the range of reasonable responses to dismiss. The respondent conceded that Dr Boyapati's appraisal was inconsistent with his assertion that the claimant had been dismissed for gross misconduct. In cross examination he explained that he had sought advice from Dr Burton before ticking the box to say that he had no concerns about the claimant's fitness to practice at the date when the appraisal was completed.

381. The respondent asserted that the reaction of the key players could be seen in their emails during the night of 25 and 26 July – Mr Ruffley expressed shock and outrage; Dr Burton expressed surprise and concern. Dr Boyapati considered other sanctions short of dismissal but concluded he had to dismiss because of Dr Malik's lack of reflection and remorse.

382. The Tribunal is then reminded of The Royal College of Psychiatrist's guidance, which says at paragraph 14 that covert medicine is not suitable for patients with schizophrenia. It matters not that the guidance turns out to be

outdated, because Dr Malik did not check first. This amounted to really serious professional misconduct.

The principal reason for the dismissal: conduct or protected disclosure?

383. The respondent asserts that the principal reason for the dismissal was not a protected disclosure but what Dr Malik did in July 2017. There had been a time lag between March 2016 and October 2017, between the last disclosure and the dismissal. The more likely explanation was that the claimant was dismissed because the senior managers were shocked at her willingness to deceive a patient over their medication without the necessary consents, and her failure to show remorse. Further, there had been earlier opportunity to dismiss the claimant if the respondent had wanted to. For example, the fallout following her disclosure at the inquest would have justified a dismissal for "some other substantial reason". The respondent further contends that despite the seriousness of the patient's death Dr Malik's evidence at the inquest was not sufficiently momentous for the respondent to harbour a grudge over 18 months.

384. If disclosure at the inquest is held not to be a protected disclosure and it was not that which was the principal reason for the dismissal, then the claimant's whistleblowing claim must claim. The respondent has consistently said the principal reason for dismissal is conduct. There is an argument that this is about performance. The respondent does not agree with the claimant on her assessment of this. Even if this was performance it would have justified dismissal. (**Taylor v Alidair [1978] IRLR 82**).

385. If the Tribunal thinks that Dr Boyapati was influenced during his conversation with Dr Burton and Ms Gibson, and that they were influenced by the whistleblowing, then that does not necessarily mean any protected disclosure was the principal reason for the dismissal. It makes it a factor. Dr Boyapati said he was the principal decision maker and made up his mind before speaking to Jenny Gibson or Dr romero

386. It was only after she was dismissed that Dr Malik looked for a reason for her dismissal that did not entail fault on her part. One of the suggestions made is that Dr Malik may have been dismissed because of Serena Birtwhistle's misleading evidence – this would not be because of whistleblowing. Similarly, Nick Ruffley stopping the medication of ZD because he was trying to avoid getting into trouble.

Breach of Contract

387. The claimant is seeking her notice pay for wrongful dismissal. Her employment contract provides for a notice period of three months. She was in serious breach of the Group policy on covert medicine. Her contract requires her to comply with all procedures and protocols. Her conduct was a fundamental breach of contract, both of the express term and the term of trust and confidence. It was further fell within examples of gross misconduct in the disciplinary policy. She was further guilty of an act of very serious misconduct in failing to make contemporaneous records, making up the notes for 12 July and 20 July.

388. The respondent submits that the brother's evidence that he suggested covert administration of ZD should be accepted. Dr Malik went along with this because there had been a previous complaint about Dr Malik when the brother had been

dissatisfied with his brother's treatment. The decision was driven by the family and not clinical necessity, and that is why there is an absence of consultation and paperwork. In fact this is not relevant, the respondent says, to the fairness of the dismissal because the respondent did not have it in mind, but it may be relevant at a later stage to contributory conduct.

389. Following the written submissions above Mr Barnett made some oral submissions in support. He raised four points:

i. Dealing with the case of Jhuti (referenced below), for the claimant to have reasonable belief, otherwise there are no reasonable grounds to say that a criminal act had been committed. If she believed she saw one or two people with heroine, and the police missed it but her memory is so poor that she cannot remember who showed her the powder, nor whether it was one or two people who did so, as a reasonable clinician one would have expected that she would have taken steps to ensure the safe disposal of the drugs or that they were reported to the police. It must follow that a support worker decided to steal the bag of heroine or lied about it. All of that has to be true for the claimant to have a reasonable belief, and on the balance of probabilities she is implausible. Even if her belief is genuine, she is mistaken and there are no reasonable grounds for it. If that is the case, it was not a public interest disclosure.

ii. There is no evidence that she believed it was in the public interest. The burden of proof lies with Dr Malik. The mere fact that the claimant feels strongly about it does not make it in the public interest.

iii. This relates to the first covert injection. Dr Malik asserted that she had discussed it with Mr Raheem and the care coordinator and both had agreed with the plan for covert administration. The clinical record was completed some days later by her on 20 July, and the respondent asserts that it was created for the purpose of creating a paper trail to justify her actions. The claimant gave three explanations as to why the notes were not completed at the time:

(i) that she was busy (the respondent agrees that it was true she was overworked);

(ii) that on the afternoon she was working from another hospital and she could have accessed the notes and updated them by computer, but she did not do so; and

(iii) that she had IT problems, but the respondent asserts that she made other entries (pages 98/99) but did not make this entry.

390. The respondent asks the Tribunal to find that the real reason was that the covert administration was not recorded because Dr Malik knew she did not have the appropriate consents. This is not relevant to fairness because it was not relied on at the time but is relevant to the breach of contract claim, because a responsible clinician who does not keep clinical notes but creates them retrospectively to deflect responsibility for her actions is in fundamental breach of contract justifying summary dismissal.

Conclusions

391. In general terms the Tribunal considered that the claimant told the truth about what she had seen about the drugs wrap. We struggle to see why she was lie over it. She had no motive to make it up and lots of opportunities to say she was mistaken, and she made her life very complicated by not taking the obvious and easy route out.

392. With regard to the unfair dismissal and the investigation, it was very clear that Ms Birtwhistle did not like the claimant – it came out in the manner in which she gave her evidence about the claimant. Similarly, Dr Burton. We found Mr Ruffley to be less than truthful, and noted that there was evidence that he had lied in the investigation in that he denied he knew about the covert plan, and there was clear evidence in the emails that he did. The claimant was suspended the first time for no obvious reason and the second without any discussion with her. She had no personal access to the disciplinary procedure, and was not offered a copy.

393. Jenny Gibson suspended the claimant, and one would have expected that as the most senior HR person in the business she would have known better. Ms Gibson throughout kept absolutely no notes at all of her part in any of the disciplinary, dismissal or appeal process, but there was clear evidence that she was talking to people through emails and verbally influencing the outcome, even writing the letter of dismissal and seeking the approval of most of the senior management team.

394. During the disciplinary hearing the claimant had been advised she could bring witnesses or ask for witnesses to attend, but she was not given an invitation containing the details of the allegations against her and nor was she offered a copy of the disciplinary policy. The management case was not put to her during the disciplinary hearing.

395. The selection of the dismissing officer was of concern to the Tribunal. He was at the same level as the claimant (a peer), he was inexperienced and uncertain. This was a career changing case for his peer. The reality was that the claimant was actually dismissed by committee and not by the dismissing officer in any event. His evidence revealed his uncertainty. He introduced a new charge and ignored some of the earlier charges. His reliance on the policy from 2004 was inappropriate as it was out of date. The College of Psychiatrists specifically said it should not be relied upon. There was no evidence that he went step by step through the process followed by the claimant, comparing it with the actual relevant policies. There was no evidence that he considered anything the claimant said, or noted that none of her supporting witnesses had been interviewed.

396. The HR appointed officer had no input into the process, being usurped by Jenny Gibson, who actually wrote the dismissal letter. Jenny Gibson's lack of notes is a striking glaring omission and a hole in the evidence which was never explained. We struggled to understand how she wrote the letter of dismissal during a telephone call as she asserted– it is hard to see how it could have been drafted as a running conversation. It does not read like that, although that is how she says it was produced.

397. Turning to the contract, was there a breach of confidence and trust? None of it was clear-cut. There were three different reasons given for dismissal in the

respondent's position – that of the investigator, the dismissing officer and the Chief Executive Officer as the appeal officer. How could that be gross misconduct? It was known that the claimant had consulted a range of people, she had an exemplary record and the appraisal completed at that time was very good. It was known that the drug ZD did not harm the patient and the brother approved and encouraged its usage.

398. Dr Burton subsequently thought that the claimant was dishonest and told the GMC – a defamatory comment and one questions the motive behind that. He suggested that she had used the word "useless" about her line manager when she had never said any such thing. He was responsible for the increased supervision, which was oppressive.

399. We found Dr Romero's actions to be less than honest. We noted he chose to undertake the appeal himself, which he could have delegated to a manager immediately below him. We noted that the grievance was never heard – and is still outstanding to this day – and that Dr Romero was responsible in effect for nearly all of the actions taken by the other parties, through Jenny Gibson.

400. We turn now to the List of Issues dealing with each in turn, the specifics of the case.

Protected Disclosures

Disclosure 1

401. We find that the claimant did make a disclosure on 17 September 2015 at a root cause analysis interview into the death of patient AG. This disclosure was made to a third party employed by her employer to investigate the incident. In the light of that we find that this disclosure of information was made to her employer. It tended to show that a criminal offence had been committed, as the foil contained a blue bag holding a powder which was believed to have been an illegal substance. The fact that the powder had allegedly been found in the deceased's room, and he was a heroine addict, who had had visitors the night before and who had offered drugs to other members of the patient cadre, suggested the belief was reasonable.

402. The claimant did believe that she was making the disclosure in the public interest: she had no other reason to make it. Her belief was that it was in the public interest and that belief was reasonable. This was a unit containing drug addicts and the finding of a Class A drug within the unit would be in the public interest.

Disclosure 2

403. This related to an email on 17 September 2015 to Dr Romero in which the claimant confirmed what she had believed about the drug. All of the same questions can be answered in all of the same way as in disclosure 1, and we therefore find this was a public interest disclosure.

404. This also relates to disclosure 3 to Dr Romero, and disclosure 4.

Disclosure 5

405. The disclosure to Andrew Parsons, solicitor to the respondent, is slightly less obvious. However, again, Andrew Parsons was employed by the respondent to provide support and advice to those of the respondent witnesses who were going to give evidence at the inquest into the death of the patient. All of the same criteria apply to the previous disclosures. Andrew Parsons was there as a representative of the respondent and of the witnesses. As such, therefore, we consider that he was in effect providing legal advice to the claimant (and indeed she did seek his advice) and we therefore find this to be a qualifying public interest disclosure.

Disclosure 6

406. The same applies to the discussion on 9 March at which Lynne Ngaaseke (a manager in the respondent's organisation) was present. Again, a qualifying disclosure as made boith to the lawyer and a hospital manager.

Disclosure 7

407. Exactly the same can be said of disclosure 7 when a number of employees of the respondent were present when the claimant gave her account. The disclosure was made to the coroner but also to Mr Parsons, who was present, and employees of the respondent. The same applies to disclosure 7 as to disclosures 5 and 6. This was a qualifying public interest disclosure.

Detriments

408. We turn then to the detriments that the claimant alleges, and we find that the requirement to attend a meeting on 21 March and her suspension immediately after giving evidence at the inquest and making a series of disclosures was a detriment. The claimant was made the subject of increased and unconscionable supervision which appears to have been "misunderstood", and does not appear to have been designed to assist her but to make her life less tolerable. There were far more regularly supervisions than would normally be the case, being followed on ward rounds and the staff being asked to feed back to her manager without her knowledge, were not proportionate responses to support her.

409. This continued to a grievance which was not dealt with in accordance with the respondent's policy and remains outstanding to this day.

410. We found that allegations of routine undermining were made out (detriment 5) on the evidence we heard, but not detriment 4 (which appears to have been a simple happenstance).

411. For the sake of clarity we find that the claimant suffered detriments in relation to her public interest disclosures as follows:_ Detriments 1,2,3,5,6,7,10 and 11.

412. Similarly, the offer to provide the claimant with a pay rise was justified by the respondent in credible terms. The refusal of the claimant's request for funding to attend a Royal College conference was also justified. Neither of these appeared to be a reaction to the claimant's disclosures

413. We have found no evidence that the claimant was ostracised from the wider team by management or other members of staff, or that the offer that was made to move the claimant to a different hospital was a detriment.

414. We do not therefore find that the claimant suffered detriments because she had made public interest disclosures in the alleged detriments numbered 4,8,9,or 12

415. We find that all of these complaints were out of time in relation to this case. They all, in the list provided above, were more than three months (plus early conciliation time) before the presentation of the claim. We did not find them in any event to be a series of similar acts or failures which ended with those brought in time. The detriments were spread amongst a number of protagonists, and were each unique in its own nature. The only common feature was an apparent dislike of the claimant following her refusal to back away from her allegations that there had been a wrap of an illicit drug shown to her a couple of days after AG's death, with what the respondent witnesses seem to have assumed was an implicit allegation of theft of the drug by another member of staff.

416. The claimant was legally represented fairly early in her dispute with the respondent, and was also a member of the Medical Defence Union at the outset. She could have sought assistance sooner to establish if she needed to bring her claim by a particular time.

417. We do not therefore find that any of these claims is in time, we find that it was reasonably practicable for the complaint to be presented before the end of the limitation month period and that it is not reasonable to extend that period.

418. We do, however, find that the additional detriment, of Dr Burton's reference to the GMC on the day of dismissal was a detriment and is in time. The features contained within that referral and the note that he sent to the GMC link, were unpleasant and untrue, and formed a second detriment. They clearly reflected his view of the claimant following the earlier public interest disclosures. These were detriments because of an earlier public interest disclosure, and we find this to be both in time and made out. We note that the claimant's appraisal did not reflect his damning assertions about the claimant.

419. If the respondent is concerned as to how we have reached this decision, we rely on the description of the claimant which clearly comes from the argument she had with the two nurses on the day that the patient was told what his injection had been. The description of the claimant during that has escalated throughout the case from her expressing her view of the situation crossly to the comment made in the referral to the GMC.

Unfair Dismissal

What was the reason for the claimant's dismissal?

420. The respondent says the claimant was dismissed for gross misconduct as set out in the grounds of resistance. The claimant's case is that she was dismissed because of the protected disclosures she had made, even if the Tribunal were to decide that they were not protected disclosures they were.

421. The Tribunal has found that the disclosures coloured the way in which the dismissal was handled. Although the claimant was not dismissed for making public interest disclosures, it was clear that senior management were not happy with the situation and that her conduct in relation to the covert administration of ZD was used to establish a reason for dismissal. The disclosures acted as a backdrop.

Was the reason for dismissal a potentially fair reason?

422. The respondent relies on conduct which is a potentially fair reason.

Did the respondent act reasonably in treating it as a sufficient reason to dismiss the claimant?

Did the respondent have a genuine belief in the claimant's guilt?

423. We find that the investigation and disciplinary procedure were fatally flawed. In particular Mr Ruffley, who was dishonest in his information to the investigation and to the Tribunal. The decision making process was disreputable. The involvement of Jenny Gibson throughout, the use of a peer of the claimant in a huge organisation with a number of senior positions above hers, and the failure to interview any of the witnesses put forward by the claimant during the investigation caused serious flaws.

424. In addition, the evidence obtained from Nurse Christie and Ms Birtwhistle showed a serious case of back covering by both of them. The emails from Nurse Christie made it clear that the nursing staff were not to tell the patient which drug he was to be given. She was the one who then told him what the drug was that he was being given, against the claimant's instruction, and without consulting her first. Serena Birtwhistle had been in all of the meetings at which discussions were held about the proposal to administer covert ZD. There is no record of her objecting at the time (nor from anybody else in those meetings), and yet she denied knowing this was going on.

425. It was clear that neither the investigators nor the disciplinary officer not the appeal officer looked at their own hospital policy, because the claimant had followed that to the letter. Until the administration of the drug covertly, the claimant would have had no idea that anybody was objecting to the process. She had followed a logical process which was to have led to a full meeting of interested parties. However, she found herself using an exception, when the patient's behaviour deteriorated to the point where neither staff nor patients were safe in his presence.

426. The view of the investigators and the disciplinary officer was that the claimant should have used an alternative process by restraining the patient and administering ZD against his will. The view of Dr Romero in the appeal was that she should have used the drug O. Considerable research had been done into the drug O, and it had already been established that this could not be administered long-term as the patient could not be given it in the community. This was not a finding of either the investigation, nor the disciplinary officer. The claimant was anxious to ensure that ZD was given, as was the patient's brother, who was well aware of the fact that the patient actually responded very well to it, although had beliefs of adverse effects.

427. On the face of it this sounded more like an argument over the best treatment for a patient. The claimant was the consultant responsible for the patient. She had followed the hospital policy. She was entitled therefore to assume that she had the agreement of all of the people whom she was required to consult, before she undertook the covert administration.

428. Not to look closely at the emails and minutes and meetings which would have led the investigators to the same conclusion as the Tribunal who saw them, is not reasonable. This was an investigation that could be career ending for the claimant

(and indeed may still be). It required the utmost care and detail which it did not receive in accordance with the case of **Roldan**. The investigators were not helped by the dishonesty of Serena Birtwhistle and Mr Ruffley. However, any investigation should have uncovered the reality of that situation. It would have been obvious if the respondent had looked at the paperwork, that while Nurse Christie was sending an email to all of the nurses advising them that the patient must not be told what drug he was being administered, at the same time she was the very nurse who did tell him without consulting the claimant first. These were not difficult issues to resolve. They were blatant on the papers. We note that Dr Boyaparti considered the decision to dismiss to be a 'joint one' i.e, not his alone. It was taken by Jenny Gibson, Dr Romero, Dr Burton and Dr Boyaparti.

429. In the circumstances we cannot find that the respondent held a genuine belief in the claimant's misconduct.

430. The matter was then compounded by Jenny Gibson's involvement. She appears to have written both the dismissal letter and the appeal letter, and we find it more likely than not that she did both make the decision and write the decisions with Dr Romero. That cannot be within the range of reasonable responses, and shows a litany of bad faith.

431. The claimant was unable to attend her appeal because she was unwell. Dr Romero allegedly heard the appeal in her absence. He made a decision with regard to the administration of the drug O which had not been discussed with the claimant and was never put to her before the decision was taken. Jenny Gibson was again involved. There are no file notes at all of any discussions between her and any of the other people involved in the investigation, dismissal or appeal. We find that to be quite extraordinary for a senior HR manager. There were no notes either from Dr Romero of his part in the appeal, simply the letter we believe was prepared by Jenny Gibson which was signed by him. We do not say he played no part in that decision, but we find it to be a collaboration between Jenny Gibson and Dr Romero. The claimant, as she believed, did not stand a chance of the dismissal being overturned.

432. We would like to make it clear that we do not blame Dr Boyapati for his part in the dismissal. We find that he was simply Dr Romero's voice and led by him and the others into reaching the wrong decision, in a similar way to the decision maker in **Jhuti** . The difference here was that there was no plan to dismiss the claimant, or to 'create' circumstances as in Jhuti), until she created the opportunity which was used by the respondent to then develope a situation where she could be dismissed. It was done by only interviewing those who sided against the claimant, telling lies to the investigation and the tribunal, and by Drs Romero, Jenny Gibson and Dr Burton ensuring that the script for the dismissal and appeal was theirs.

433. We do not therefore find that the respondent has proved on the balance of probabilities that there was a potentially fair reason for the dismissal or further that a fair procedure was followed. There may be an argument to follow on the issue of contribution. We do not find that the claimant was dismissed because she made public interest disclosures i.e. automatically. It is clear that this was however the general background to the respondent's senior managers disliking her, and later seizing an opportunity to dismiss her.

434. We do not find the claimant guilty of gross misconduct in the light of our findings above. We therefore find that the respondent was in breach of contract in

dismissing the claimant for gross misconduct. We find that the claimant followed the hospital's policy and took note of the other policies. The policy of her employer was noted to be signed by Dr Burton but he appeared to have little or no knowledge of its content. We find it more likely than not that the hospital's own policy was not actually read by the investigators, the dismissing offer or the appeal officer, and we are sure that Dr Burton was unaware of the contents of the policy that was signed off in his name. The reason for the dismissal was adequately explained in the venomous and dishonest tone of the email to the GMC link. A careful analysis of the steps she took showed that she had complied with every step required of her under the respondent's own policy in the particular circumstances of M. Prudence may have suggested that other steps could be taken, taking legal advice for instance, but there was no requirement on her to do so. There was no evidence of wilfulness, or of gross negligence. The evidence suggested she was doing the best she could for her patient, as her contract required, and within the policies and statutes under which she was required to work The claimant was thus dismissed without notice in breach of contract.

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Employment Judge Warren
Date 1 February 2021

RESERVED JUDGMENT AND REASONS
SENT TO THE PARTIES ON
2 February 2021

FOR THE TRIBUNAL OFFICE