EMPLOYMENT TRIBUNALS

Claimant: Mr M P Poullis

Respondent: Liverpool Heart and Chest Hospital NHS Foundation Trust

Heard at: Liverpool in person **On:** 20 – 30 September 2022 and in chambers on 19, 20 October 2022 and 11 and 30 November 2022.

Before: Employment Judge Aspinall

Representation
Claimant: Mr Boyd, Counsel
Respondent: Mr Gorton, King's Counsel

RESERVED JUDGMENT

Summary of Decision

1. The claimant's complaint of unfair dismissal fails. The claimant was fairly dismissed for gross misconduct. Dr Morris had a genuine belief held on reasonable grounds that the claimant had falsified patient records, inappropriately cancelled care and inadequately documented care. The respondent had carried out such investigation as was reasonable in all the circumstances of the case at investigatory, disciplinary and appeal stages. The decision to dismiss was not a decision that no reasonable employer could be said to have reached, mitigation was considered but outweighed by the reasonably formed view that the claimant had not accepted the risk, inherent in his conduct, to patient safety and so could not be trusted not to engage in such conduct again, having already done so in a case in February 2019 whilst under investigation. The appeal process was fair and reasonable in all the circumstances.

2. The claimant had offered to submit to final written warning at appeal but the appeal officer Mr Jones formed the reasonably held view that the claimant had not accepted the risk to patient safety inherent in his conduct but had sought throughout the appeal to both admit and apologise for his conduct whilst also (i) blaming and seeking to incriminate others and (ii) seeking to justify his conduct as being free from risk of harm to patients. The appeal outcome fell within the range of responses of a reasonable employer.

3. The claimant's complaint of wrongful dismissal fails. The claimant's conduct in falsifying patient records, inappropriately cancelling care and inadequately documenting care, taken together, amounted to a repudiatory breach of his contract of employment such that the respondent was entitled to terminate his employment without notice.

Background

4. By a Claim Form dated 14 February 2020 and a subsequent Claim Form dated 7 May 2020 the claimant brought complaints of public interest disclosure automatically unfair dismissal and detriment, unfair dismissal and wrongful dismissal. He was a cardio-thoracic surgeon, and later cardiac surgeon, working for the respondent from 1999 until his dismissal for gross misconduct on 10 October 2019.

5. The respondent defended the complaints. The claims were consolidated. There were four case management preliminary hearings to attempt to clarify the complaints. The matter was listed for a 30 day hearing. After a series of redrafted grounds of complaint, an amendment application, and an appeal to the Employment Appeal Tribunal on a preliminary point, the complaints were finally set out in an Amended Grounds of Complaint dated 22 July 2022.

6. The claimant then withdrew the public interest disclosure complaints which were dismissed on withdrawal by EJ Cookson in a judgment promulgated on 3 August 2022. The complaints before the Tribunal for this final hearing were unfair dismissal and wrongful dismissal (notice pay).

The hearing

7. It was agreed that the hearing would address liability only.

8. The respondent stated its intention to make a costs application in respect of its costs in the withdrawn complaint.

9. The claimant had not prepared a Schedule of Loss. The claimant seeks reinstatement.

The List of Issues

10. The following list with appendices was provided by the parties:

Unfair dismissal

1. What was the reason for the Claimant's dismissal or if more than one the principal reason? In particular was it conduct, a potentially fair reason (see appendix below)?

2. Did the Respondent have a genuine belief in the Claimant's guilt in respect of the matters it relied upon for dismissing the Claimant (see appendix below)?

3. Was that belief formed on reasonable grounds (see appendix below)?

4. Had the Respondent carried out a reasonable investigation in forming such a belief? In particular, did the Respondent's investigation fall within the range of reasonable responses of a reasonable employer (see appendix below)?

5. Did the Respondent act reasonably in treating that reason as sufficient to dismiss the Claimant in all the circumstances (including with reference to the size and administrative resources of the Respondent undertaking and the equity and substantial merits of the case) as per section 98(4) ERA 1996 (see appendix below)?

6. Did the Respondent's decision to dismiss fall within the range of reasonable responses of a reasonable employer (see appendix below)?

7. Did the Respondent follow a fair procedure including with reference to the ACAS Code?

8. If the Respondent did not follow a fair procedure, to what extent, if any does the principle in *Polkey* apply?

9. To what extent, if at all, did the Claimant contribute to his dismissal?

10. What compensation should the Claimant be awarded in the event that it is held that his dismissal was unfair?

Wrongful dismissal

11. Was the Claimant guilty of an act or acts of gross misconduct entitling the Respondent to terminate his employment summarily?

APPENDIX

The sub-issues which C relies upon in support of his assertion of procedural and/or substantive unfairness include but are not limited to: [R does not agree this. C was ordered by the ET to reframe his claim in ordinary unfair dismissal. Having done that, the below must stand as the exhaustive statement of particulars of why C asserts that his dismissal was unfair]

Further, all the below matters are to be assessed by the reasonable standards of an employer and are not matters that the ET can substitute its view for that of the employer.

General Issues

1. Changing the terms of reference from the version accompanying the letter on 22.1.18 to the version on 20.9.18? Did this impact on the fairness of the process and ultimately the decision to dismiss?

2. If the disciplinary allegations were serious enough to ultimately justify dismissal, taking no action at the time they were discovered in April 2017 – this is not part of C's pleaded case and cannot therefore be advanced by C.

3. If the disciplinary matters were serious enough to ultimately justify dismissal, not suspending or placing restrictions on C's practice. This is not part of C's pleaded case and cannot therefore be advanced by C. In any event, did the failure to suspend or place restrictions on C's practice impact on the fairness of the process and ultimately the decision to dismiss?

4. The new terms of reference were provided to C on the evening of 20/9/18 prior to C's investigative meeting on 21/9/18 – did this give C insufficient time to prepare for that meeting and if so, did that impact on the fairness of the process and ultimately the decision to dismiss?

5. Did R respond to C's request post his investigation meeting set out in his email of 30.11.18? If so, was that unreasonable or unfair and did that materially impact on the fairness of the process and ultimately the decision to dismiss?

6. Did R act unreasonably or unfairly in not re-interviewing C after C had on 11/1/19 suggested that the timeline/root cause analysis for one of the disciplinary cases (patient 922204) was incomplete and inaccurate? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

Request for information

7. Did C request missing information in emails of 3.12.18 and 19.12.18? If so, did R fail to respond to those requests? If so was that alleged failure unreasonable or unfair and did that materially impact on the fairness of the process and ultimately the decision to dismiss?

8. Did R fail unreasonably to respond to C's email of 26/9/19 to C's request for further information in respect of (i) PFT's and (ii) surgical site markings? This is not part of C's pleaded case and cannot therefore be advanced by C.

   In any event, did R fail to respond and was the alleged failure reasonable or not? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

Designation of allegations under MHPS

9. Did R act unreasonably in treating the allegations as matters of conduct rather than capability?

10. Did R fail to consider C's request to have the terms of reference reviewed by an external Thoracic Surgeon and/or was R obliged to seek such an opinion under MHPS? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

Grievance

11. When did C raise a grievance with regard to the matter proceeding as a conduct and not capability set of issues? R submits this was only raised 20/5/19

12. When C raised his grievance with regard to this matter, did R act unreasonably by failing to give proper consideration to C's grievance and/or failing to hold a proper grievance hearing? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

Dismissal panel and hearing

13. The decision to appoint Dr. John Morris as and/or Dr. John Morris holding the role of Chair of the Disciplinary Panel in light of a previous matter where C had been requested to provide an opinion regarding one of Dr. Morris' patients which C believes had a negative impact on their relationship. This is not pleaded by C and C is invited to indicate where he raised this issue with R. In any event, did R act unreasonably or unfairly in appointing Dr. John Morris to the role and did that materially impact on the fairness of the process and ultimately the decision to dismiss?

14. Did the Case Investigator present the disciplinary case in a partisan manner, using terms such as "gross negligence" where there was no harm to patients? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

Safe site issues

15. Did R act unreasonably at the disciplinary hearing by failing properly to consider the EPR data provided by C which allegedly showed that 222 safe site forms had been created for patients prior to hospital admission and/or contrary to the Trust's procedure of which 122 were completed by individuals other than C? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

16. Did R act unreasonably at the disciplinary hearing by failing to properly respond to C's request to undertake a more forensic review of the safe site forms? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

17. Did R act unreasonably at the disciplinary hearing by failing to ask, as part of the investigative process and/or at the disciplinary hearing whether C's colleagues had completed site verification forms prior to admission and/or post-admission, but prior to marking the patient? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

18. Did R act unreasonably at the disciplinary hearing by omitting from the disciplinary process a consideration of system entries where the site verification document and admission dates were the same? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

19. Did R act unreasonably at the disciplinary hearing by failing to take account of C's contention that the Trust's internal site verification procedures were not part of LocSIPP and that the site verification issue was not strictly about 'never events' or patient safety? This is not part of C's pleaded case and cannot therefore be advanced by C.

    In any event, did R to take account of C's contention that the Trust's internal site verification procedures were not part of LocSIPP and that the site verification issue was not strictly about 'never events' or patient safety? If so, was this unreasonable by R, and how did that impact on the fairness of the process and ultimately the decision to dismiss?

20. Did R have grounds to believe and therefore to conclude at the disciplinary hearing that C was guilty of gross misconduct in relation to the completion of documentation relating to patients?

Cancellation of patients

21. Did R act unreasonably at the disciplinary hearing by failing to undertake any or any reasonable assessment of the reasons for C's cancellation of patients? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

22. Did R act unreasonably at the disciplinary hearing by confining the analysis as to cancellation of patients to the year of the investigation only? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

23. Did R act unreasonably at the disciplinary hearing by failing to take reasonable account of elective reasons put forward by C for the cancellation of patients which were outwith C's control? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

24. Did R have reasonable grounds to believe and therefore to conclude at the disciplinary hearing that C was guilty of gross misconduct in relation to the cancellation of patients charge?

Documentation of care

25. Did R act unreasonably at the disciplinary hearing by failing to take reasonable account of C's explanations as to the charge that he failed to adequately document care? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

26. Did R have reasonable grounds to believe and therefore to conclude at the disciplinary hearing that C was guilty of gross misconduct in relation to the failure to adequately document care charge?

Cumulative charges

27. Did R have reasonable grounds to believe and therefore to conclude at the disciplinary hearing that C was guilty of gross misconduct in relation to all 3 matters that formed the basis of the charges that C faced before the panel?

Other alleged failings

28. Did R fail to consider (properly or at all) as part of the disciplinary hearing C's addendum to his original statement of case? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

29. Did R fail to consider (meaningfully or at all) at the disciplinary hearing C's written responses to all of the disciplinary allegations? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

30. Did R decide that the appropriate sanction for C was a final written warning, but in fact dismiss C?

Appeal process and hearing

31. Did R decide prior to the appeal hearing not to consider any new evidence? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

32. Did R as part of the appeal process fail to respond to C's historic requests for further information? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

33. Did the appeal panel gear itself towards seeking inculpatory evidence as opposed to anything inculpatory and exculpatory? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

34. Did R act unreasonably in adding Dr. Mansour onto the appeal panel when he was not a surgeon and did not specialise in cardiothoracic surgery? This is not part of C's pleaded case and cannot therefore be advanced by C. If it was, what was the effect of this that Dr Mansour's understanding of C's appeal grounds would be limited? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

35. Did the appeal panel fail to properly take into account the evidence that had been missing before the disciplinary panel? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

36. Did the appeal panel fail to properly consider the additional documentation provided by C? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

Safe site issue -appeal hearing

37. Did the appeal panel act unreasonably at the hearing by failing properly to consider the EPR data provided by C which allegedly showed that 222 safe site forms had been created for patients prior to hospital admission and/or contrary to the Trust's procedure of which 122 were completed by individuals other than C? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

38. Did the appeal panel act unreasonably at the hearing by failing to properly respond to C's request to undertake a more forensic review of the site forms? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

39. Did the appeal panel act unreasonably at the hearing by failing to ask, as part of the hearing whether C's colleagues had completed site verification forms prior to admission and/or post-admission, but prior to marking the patient? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

40. Did the appeal panel act unreasonably at the hearing by omitting from their hearing consideration of system entries where the site verification document and admission dates were the same? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

41. Did the appeal panel act unreasonably at the hearing by failing to take account of C's contention that the Trust's internal site verification procedures were not part of LocSIPP and that the site verification issue was not strictly about 'never events' or patient safety?

    This is not part of C's pleaded case and cannot therefore be advanced by C.
    In any event as a matter of fact, did R not take this into account and was it unreasonable for R not to take this into account? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

Cancellation of patients – appeal hearing

42. Did the appeal panel act unreasonably at the hearing by failing to undertake any or any reasonable assessment of the reasons for C's cancellation of patients? If so, how that materially impact on the fairness of the process and ultimately the decision to dismiss?

43. Did the appeal panel act unreasonably at the hearing by failing to take reasonable account of elective reasons for the cancellation of patients which were outwith C's control? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

44. Did the appeal panel act unreasonably at the hearing by confining C's explanations in respect of failing to document care? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

Documentation of care – appeal hearing

45. Did the appeal panel act unreasonably at the hearing by failing to take account of C's explanations in respect of failing to document care? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

Generally

46. Did the appeal panel unreasonably fail to take account of C's written responses to the disciplinary allegations? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

47. Did the appeal panel have reasonable grounds to believe and therefore to conclude at the hearing that C was guilty of gross misconduct in relation to the cancellation of patients charge?

48. Did the appeal panel have reasonable grounds to believe and therefore to conclude at the hearing that C was guilty of gross misconduct in relation to the failure to adequately document care charge?

49. Did the appeal panel act unreasonably by rejecting C's appeal?

Documents

11. There were 21 lever arch files with 7827 pages as the bundle for this case. They had been prepared before the claimant withdrew his public interest disclosure allegations and it was agreed at the case management hearing with Employment Judge Cookson that the parties would not incur additional cost reconfiguring those files but would instead prepare a reading list relevant to the unfair and wrongful dismissal complaints so that the Tribunal could read relevant documents.

12. The Tribunal read all of the documents on the agreed reading list together with numerous pages from the bundles to which it was taken during cross-examination or on its own enquiry. The Tribunal extracted all of the documents the disciplinary panel saw and all of the documents the appeal panel saw.
13. Important amongst those documents were pages 6367 and 6368 which were a table with 100 rows of entry and 5 columns. That table showed the 98 occasions on which it was not disputed that between April 2015 and April 2017 the claimant had completed SVP forms prior to the date of patient admission. This document is important because this was the table before the disciplinary panel.

14. The Tribunal also saw a document at page 3835.1 which was a bigger data set, unfiltered, of all 222 SVP forms completed prior to point, not date, of patient admission, for any of the thoracic surgeons. It included same day (but prior to admission on system) SVP forms and included data for patients whose procedures did not require SVP and for those whose admission dates were entered in error. The Tribunal also saw 3835.2 which was a reproduced and expanded version of the table at 3835.1 so that the final column was clearly legible. Dr Morris had seen a version of the unfiltered data set at 3835.1 prior to the disciplinary hearing but it was the admitted instances of SVP completion at pages 6367 and 6368 on which he and the panel had relied.

15. There were additional documents produced during the hearing. Some were a clearer copy of documents already in the bundle. The following new content documents were admitted: a report, named “C Add1” and an email exchange “C Add 2”.

16. The Tribunal thanks Mr Boyd and Mr Gorton for their skillful navigation of the bundles and the provision of an Opening Note (by the respondent) and written Closing Submissions and attached authorities. The Index to the bundle of documents and the chronology were also vital tools for navigating the documents.

Application for specific disclosure

17. The claimant had written to the Tribunal to say that it would make an application for specific disclosure but following discussion between the parties none was made.

Timetabling

18. A timetable was agreed.

Reasonable adjustment

19. There was no requirement for any reasonable adjustment.

Oral evidence

20. The Tribunal had a statement of 399 paragraphs which stood as the evidence in chief of the claimant. The claimant was cross-examined by Mr Gorton.

20.1 The claimant often had to be asked to focus on answering the question and often had the same question put to him 3 or more times. His tendency was to respond with depth of medical information to seek to justify his conduct and explain why only he or a medically qualified person or thoracic surgeon would understand his response. Although he presented this as an attempt to be helpful this was his way of avoiding answering where to answer might involve making an admission. He did this when asked if he was responsible for the decision to cancel a surgery or not. He avoided answering by saying that the anaesthetist was equally responsible for patient care or also responsible before eventually accepting that the decision was his. The claimant also avoided answering in relation to a question about the fact that a capability route would result in remediation training and never end in dismissal. He said that he was not sure about that. He was not credible on this point. The Tribunal finds he knew exactly what the range of potential outcomes for conduct and capability issues were because he and his representatives had pressed continually for the matter to be classified as capability precisely so as to avoid disciplinary sanction.

20.2 The claimant's inconsistency lead to an assessment of him less than forthright on key points. The claimant did not admit inappropriate cancellation of care. The claimant sought to justify one of his cancellations on the basis that he could not operate as all the notes were missing, so it would not be safe to proceed. But, Mr Gorton put to him, an SVP form had been filled in on the Friday for that patient and the claimant had said that he would see all the notes and radiology before completing an SVP form. He had said in his witness statement *I would check my personal patient notes and information to make sure all investigations had been carried out. I would check what operation was listed to be performed and whether the operating list was correct. If I was satisfied that all was correct, I would then click I had marked the patient, prior to going and doing so.* The claimant said that the reason he had done SVP forms on Friday was to *ensure that I had reviewed the patients' information properly in order to reduce the risk of errors.* How could he have both checked all the notes thoroughly so he was happy to do an SVP form (albeit in advance of marking the patient) and yet had to cancel because there were no notes ? The claimant said in cross examination *you've caught me on a technicality. I didn't need notes as I had radiology and could do site form from radiology.* He shifted his position, having been caught out, and would not accept that one or other of his positions could not be accurate.

20.3 A further example of the claimant being less than honest was put to him in cross-examination. The Tribunal finds that the claimant made a statement in his application for a clinical Excellence Award in August 2017 (that he had gone in on a Sunday to see patients) and that he gave evidence to the Tribunal that from 2015 when he married, that was no longer his consistent practice. The Tribunal finds that he said what he needed to say in August 2017 to get the award and he said what he needed to say on this point in this case to seek to justify his completion of SVP form prior to marking the patient. It did not seem to matter to him that they were different positions, only that each response served the purpose for which he needed it at the time.

Overall, the claimant remained calm and courteous in his responses, even when pressed about his honesty and integrity.

21. The Tribunal had a statement of 93 paragraphs which stood as the evidence in chief of Dr John Morris, Consultant Cardiologist, Associate Medical Director at the respondent since 2015. Dr Morris made the decision to dismiss the claimant. Dr Morris was cross-examined by Mr Boyd. Dr Morris answered the questions put to him in a straightforward way and explained how and why, for him, the responses given by the claimant at the disciplinary hearing lacked sincerity. The Tribunal notes the candour of Dr Morris and his focus not on any opinion or advocacy of the management representatives at the disciplinary hearing but on the representations, oral and written made by the claimant himself in response to each of the exemplar cases of Patients A to E in the disciplinary allegations.

22. The Tribunal had a statement of 74 paragraphs which stood as the evidence in chief of Professor David Justin Wright, Consultant Cardiologist. Professor Wright was the case manager in the disciplinary case against the claimant. Professor Wright was cross-examined by Mr Boyd. Professor Wright gave his evidence in an open and helpful way.

23. The Tribunal had a statement of 77 paragraphs which stood as the evidence in chief of Dr Justin Ratnasingham, Consultant Anaesthetist and Intensivist, and Divisional Medical Director for Clinical Services. Mr Ratnasingham was the investigating officer in the disciplinary case against the claimant and prepared the Investigation Report. Dr Ratnasingham was cross-examined by Mr Boyd. Dr Ratnasingham was a witness who was very open but also careful to be entirely accurate in his responses. He was focused on the question and meticulous in his attention to relevant detail.

24. The Tribunal had a statement of 17 paragraphs which stood as the evidence in chief of Mark Stephen Jones. Mr Jones was a non-executive director at the respondent and chaired the appeal hearing in the claimant's case on 20 July 2020. Mr Jones gave his evidence in a helpful way. A significant amount of time had elapsed between the appeal hearing and his evidence at Tribunal so that he was vague on some points but had a strong and clear recollection of the matters that he been persuasive for him in the decision making in the claimant's appeal. He reiterated a number of times that what had mattered to him, and his appeal panel members, was the impact of the claimant's actions on his patients and colleagues.

Who's who

25. The following are the initials by which the Tribunal will refer to relevant people in this Judgment.

AM	Mr Amit Malik, Senior Data Analyst
AO	Prof Aung Oo, Associate Medical Director – Surgery (until May 2017)
FR	Ms Fiona Ross, HR Business Partner
GH	Mr Graham Hyde, Data Analyst
HK	Mrs Hayley Kendall, Divisional Head of Operations - Surgery
JAS	Mr Julius Asante-Siaw, Thoracic Surgeon/Clinical Lead for Thoracic Surgery (from March 2018)

JM Dr Morris	Dr John Morris, Associate Medical Director - Medicine
JR	Dr Justin Ratnasingham, Case Investigator / Clinical Lead for Critical Care then Associate Medical Director – Clinical Services (from April 2021)
JW	Prof Jay Wright, Case Manager / Consultant Cardiologist / Director of Research
MJ Mr Jones	Mr Mark Jones, Non-Executive Director
MK	Mr Manoj Kuduvalli, Associate Medical Director – Surgery (from May 2017)
The claimant	Mr Michael Poullis
MS	Mr Mike Shackloth, Thoracic Surgeon / Clinical Lead for Thoracic Surgery (2015-2016)
NM	Mr Neeraj Mediratta, Cardiothoracic Surgeon
NS	Dr Nigel Scawn, Associate Medical Director – Clinical Services then Deputy Medical Director (from April 2021)
OL	Dr Oliver Lord (MDU)
RAP	Dr Raphael Perry, Medical Director (from June 2015)
RDP	Mr Richard Page, Thoracic Surgeon / Clinical Lead for Thoracic Surgery (up to 2014, then Jan 2017-March 2018)
SW	Mr Steve Woolley, Thoracic Surgeon
VW	Ms Vicki Wilson, Head of HR
RM	HR Adviser

EA	Eva Allen
JT	Jo Twist, Director of HR
LL	Proposed disciplinary panel member to provide HR support Lynn Lowe,
NB	Proposed disciplinary panel member, a non-executive director of the respondent Dr Nick Brookes.
AR	Disciplinary panel member Medical Director at St Helens Trust, Professor Andrew Rowland
CO	Proposed disciplinary panel member Claire Ormond
JD	Disciplinary panel member Janet Doran
MJ	Appeal panel member Mr Mark Jones (MJ) non executive director from 2014 and chair of the appeal panel,
JMu	Jane Mullin External HR Support on the appeal panel
PMa	Dr Paul Mansour (PM) external medical representative on the appeal panel.

Patient A	The hospital patient numbers and extracts from records for the patients were visible to the Tribunal but need not be included here
B	for the judgment to be understood. By consent, the patient numbers
C	were converted to letters, for use in the judgment, and the Tribunal has removed reference to the date of the patient interventions so as
D	to further reduce risk of patient identification.
E	

The Facts

26. The claimant started working for the respondent in 1999. He was a cardio-thoracic surgeon. He worked from Liverpool Heart and Chest Hospital (LHCH) (the respondent) and from Aintree hospital (AH) in his thoracic practice.

27. The claimant had a theatre list at LHCH on Monday mornings. His patients would be admitted on Sunday and he would routinely visit them, discuss their procedure with them and complete, amongst other things, a site verification procedure form (SVP) for each patient.

28. The claimant got married. After his marriage and from about 2015 onwards, for his own domestic reasons, he no longer regularly attended hospital on Sundays to meet the patients who had been admitted for his Monday theatre lists. He began completing the SVP forms for his Monday lists on Friday, before seeing the patients.

29. The SVP forms were one of a layer of safeguards in place in thoracic surgery to minimize the risk of wrong side surgery, operating on the wrong lung, which the respondent classified as a "never event". The claimant had been instrumental in their introduction to LHCH in around 2007.

30. The SVP form required an electronic signature on the Electric Patient Record (EPR) database. When signed and dated electronically the form meant that the doctor was signing to confirm that:

a. The patient had been admitted to hospital for his surgery.

b. The doctor had met with the patient.

c. The doctor had discussed the procedure with the patient, and

d. confirmed understanding of the site of intended procedure, and

e. marked the site of the procedure on the patient's chest with indelible marker.

31. Relationships with the claimant and the thoracic surgery team were strained. In around August 2016 Professor Oo (AO) chaired a meeting of the thoracic surgery team about problems within the team in communications, trust within the team and clinical practice. At that meeting it was agreed to let go of the past and move forward together as a team.

32. On XX March 2017 the claimant filled out a SVP form for Patient B when Patient B was not in the hospital.

33. It is an agreed fact that on 98 occasions, including for Patient B above and Patient A below, between April 2015 and April 2017 the claimant completed SVP forms for patients on a date prior to the day of admission of the patient to hospital and therefore prior to seeing and marking the patient.

April 2017: an SVF issue comes to Dr Page's(RDP) attention

34. On Friday XX April 2017 the claimant completed an SVP form for Patient A. He added his electronic signature to the form at 07.38. The patient had not been admitted, the claimant had not met with him/her, the claimant had not marked the site of the intended procedure on the patient on Friday XX April 2017 when he added his electronic signature to the SVP form to say that he had.

35. Patient A was admitted on the following Sunday XX April 2017. The next day, Monday XX April 2017 the claimant cancelled Patient A's surgery. Patient A had lung cancer and was expecting to have surgery on the Monday. The claimant did not make an entry on EPR about his decision to cancel or the reason for it. (he later said that it was because he could not find his handwritten notes). He did not record what had been communicated to the patient on EPR. The claimant later offered to perform the surgery, so that it fell within a target number of days for surgery in cases of that kind, at his next opportunity which was as part of a waiting list initiative theatre list, meaning that he would be paid for it.

36. The following day Tuesday XX April 2017 RDP sent an email to Mr Scawn (NS) and Hayley Kendall (HK) and Manoj Kuduvali (MK) and AO in which he expressed concern about the claimant's decision to cancel surgery for Patient A and the SVP form having been completed which he said is "*wrong on a number of counts and could have lead to an error*". RDP said "*Rather bizarrely Mike filled in a pre-op side verification note on EPR at 07.37 on Friday XX/4/17 though the patient wasn't in hospital at the time…Mike is continually finding reasons to resist the process and the latest incident is another example of his dysfunctional behaviour with a major impact on patient care."* RDP did the patient's surgery himself within an NHS theatre list.

37. On XX July 2017 the claimant cancelled surgery for Patient B. The patient had needed to have tests performed before surgery. The claimant had not ordered those tests to take place prior to the day of surgery. The patient was admitted for surgery at LHCH and due to have tests done on the day of surgery on the direction of the claimant but the machine for performing the tests was broken that day.

38. On XX July 2017 the claimant completed two separate consent forms for Patient C. Patient C was also a lung cancer patient whose surgery was cancelled. The claimant said it was due to the absence of PFT's. They had been done 10 days earlier and sent to the respondent 3 hours before the operation was cancelled but the claimant had made no effort to find out if the PFT results were available. (He later said at investigatory interview that none of the notes or radiology was available).

39. In August 2017 the claimant made a statement in his application for a clinical Excellence Award to the effect that he goes into the hospital on Sundays to see and mark his patients and that this is an example of his excellence in practice.

40. In August 2017 there was correspondence between the claimant and RDP about changes to the provision of a Registrar for the claimant's Aintree clinic and about other changes in service at the respondent. The claimant's response was an email on 30 August 2017. It was copied to RDP. It had no salutation and is reproduced here in full because it is indicative of the relationship between the claimant and RDP at that time;

> "With no capacity to see ANY new THORACIC patients – enforced on me, my Monday NHS THORACIC operating list may end up being empty.
>
> Luckily, I am away for one week – OTHERWISE I WOULD HAVE NOTHING THAT WEEK TO OPERATE ON.
>
> You seem determined to not back down, you can't see what is going on.
>
> Why should I work for free, no other consultants do in the trust – I am sure {SW} was paid for an extra clinic this week.
>
> HOW CAN A SURGEON WORK WHO SEES NO NEW PATIENTS?
>
> I HAVE COPIED THE MEDICAL DIRECTOR IN AS I FEEL I AM BEING FORCED OUT OF THE THORACIC SURGERY DEPARTMENT BY MAKING MY WORKING CONDITIONS INTOLERABLE.
>
> Mike"

41. HK replied on 31 August 2017 explaining how new and follow up patients could be seen, including making provision at Aintree and splitting the claimant's Thursday afternoon clinic at the respondent to include new thoracic patients. It also reminded the claimant that if he was short of thoracic surgery the department had agreed that it would share other consultant's patients to populate theatre lists. Hayley Kendall added *"….capital letters could be taken as shouting...email etiquette forms part of our professional working relationships…..please can you check that the emails aren't all in capitals before sending….the division is just requesting that you work flexibly within your thoracic practice as per the other thoracic consultants*." She indicated that she would add the issues to the agenda for a meeting the following week.

The eight concerns letter

42. On 7 September 2017 RDP wrote to HK and MK. RDP said "*Here are my thoughts regarding Mike P's inability to continue with his thoracic practice*". There were then 8 numbered paragraphs headed; out-patients, in-patient care, theatre work, on-call work, team working, other admin tasks, and attitude to management team, which were each prefaced by his view that the claimant was unable to work at the level of competence expected of a thoracic surgeon and the 8th paragraph, sub-headed general behaviour, expressed the view that the claimant was unable to work at the level of professionalism expected of a thoracic surgeon.

43. At a thoracic surgical team meeting on 19 September 2017 the team were trying to arrange dates to get together for a mediation meeting. RDP was concerned that the claimant lacked teamwork and behavioural skills. RDP felt that the team had become dysfunctional. The claimant said that he would not meet with his colleagues until any allegations made against him by his colleagues had been put in writing to him. The claimant said words to the effect that the consultants should think carefully about what they were alleging about him as he might have allegations to make about them.

44. Following that meeting his thoracic surgeon colleagues reported, through RDP, to HK that they could not work with the claimant. A meeting was arranged for the complainant thoracic surgeons with management on 21 September 2017.

The claimant stands down from thoracic surgery

45. On 20 September 2017 the claimant wrote to Dr Perry (RAP), MK and HK asking that he become a full-time cardiac surgeon. HK saw no reason why this could not be arranged and wrote to the claimant to confirm the position. RDP's email response to this news was "Hallelujah!"

The thoracic surgeons meeting

46. On 21 September 2017 the thoracic surgeons, MK, SW, RDP, JAS and MS met with HK and told her, in response to the news that the claimant was to work solely as a cardiac surgeon, that the issues with the claimant were not limited to thoracic surgery. The team view, expressed in the notes of the meeting, which came to be a group complaint, was that the claimant was someone who did not look after patients properly, would look for mistakes in clinical practice to point out to others and would threaten to refer colleagues to the GMC and or the police. The surgeons perceived the claimant to be someone who made open disparaging remarks about them and the Trust generally at both internal and external events.

47. The surgeons outlined some of the issues as follows: divergence tactics (that meant finding a reason to send a difficult case to another consultant), poor handover in patient care, poor communications with patients, refusal to do consent forms, refusal to see patients on other wards during ward rounds, issues with cancellations including cancellation on core lists but the claimant working extra lists and their lack of trust in him as on-call surgeon.

48. Notes of the meeting were distributed on 28 September 2017. On 17 October 2017 the minutes were agreed.

49. At this time there was another investigation into the claimant under the respondent's disciplinary procedure underway, not related to the allegations in this case. It was about a website.

The disciplinary investigation

50. The 21 September 2017 meeting led to an investigation into the claimant under the respondent's "Handling Concerns about the Conduct, Performance and Health of Medical Staff" Policy and Procedure (HCP). It covers action to be taken when a concern about a doctor first arises. It states that its provisions are in accordance with the national framework Maintaining High Professional Standards in the Modern NHS (MHPS).

51. HCP provides at 3.1.4 that when a concern arises the Chief Executive will notify the Chairman who will appoint a non-executive director (the Designated Member) to oversee the case during the investigation process and ensure momentum is maintained.

52. HCP provides at 1.7 the role of a case manager which includes, as follows:-

- To identify the nature of the problem or concern, assess the seriousness based on information available and consider the likelihood of the matter being resolved without the resort to formal disciplinary procedures.

- to refer the matter to the General Medical Council when there is a clear judgment that the practitioner is considered to be a serious potential danger to patients or staff.

- to appoint a Case Investigator, following consultation with the Medical Director, Chief Executive and Director of Workforce Development, taking into account the grade of the practitioner involved. An external investigator may be appointed where deemed appropriate.

- To determine, on receipt of the investigation report, the appropriate course of action as identified in 1.15

- To refer to NCAS for advice when he/she considers an exclusion needs to be extended over a prolonged period outside his/her control

53. On XX October 2017 the claimant had not completed adequate documentation for patient E.

54. On 19 December 2017 RAP asked Profesor Wright (JW) to act as the case manager in relation to an investigation into the claimant.

55. RAP said that Dr Justin Ratnasingham (JR) was to be the investigating officer. JW was reluctant to take on this work for personal reasons unrelated to the claimant. In January 2018 he agreed to do so at RAP's request. He was provided with the notes from the thoracic surgeons meeting/ group complaint on 21 September 2017 and the HCP policy.

Exclusion

56. JW immediately considered whether this might be a case that required exclusion and decided it was not.

57. JR was also considering his role as investigator and what it entailed.

58. HCP provides at 1.8 the role of a case investigator which includes, as follows:

- To ascertain the facts in an unbiased manner

- To involve a senior member of the medical staff if a question of clinical judgment is raised during the investigation process

- To safeguard the confidentiality throughout the investigation as far as possible

- To ensure that sufficient information is gathered

- To complete the investigation within 4 weeks of appointment and submit a report to the case manager within a further 5 days (or read extended period)

- To obtain appropriate professional advice in cases involving issues of professional conduct, following consultation with the chair of the LNC

59. JW met with JR and a colleague from HR, RM, on 5 January 2018 to discuss and agree draft terms of reference for the investigation. He based the terms of reference on the content of the group complaint, which he knew to be vague and wide-ranging at that time. He instructed JR to concentrate on obtaining objectively verifiable data in his investigation and to begin by interviewing the thoracic surgeons. JW supported by RM drafted terms of reference following that meeting dated 18 January 2018.

Case manager meets the claimant

60. On 18 January 2018 JW met with the claimant and shared with him the Terms of Reference (ToR1) and HCP. ToR1 stated that the purpose of the investigation was to provide an in-depth independent report into concerns raised by the thoracic surgeons on 21 September 2017. The terms of reference were:

> To investigate Mr Poullis' alleged conduct, behavourial and clinical practice, in particular considering the following:
>
> a) Poor communication and unprofessional behaviour, including intimidation and threats of reports to the Police and GMC;
>
> b) Threatening comments to colleagues in a meeting on 19 September 2017;
>
> c) Lack of Trust and confidence from the Thoracic Surgeons in Mr Poullis;
>
> d) Inappropriate criticism of the Trust externally, which could bring the Trust into disrepute;
>
> e) Inappropriate clinical practice, to include:-
>
> - Evidence of delayed care
>
> - Poor documentation e.g. lack of discharge letters and no clear care plans documented
>
> - Patients not appropriately consented for treatment
>
> - Lung functions {PFT} no being carried out in line with BTS guidelines

f) Is Mr Poullis' conduct/behaviour to the standard expected of a Consultant Surgeon and in accordance with Trust Values and Behaviours?

g) If not, has trust and confidence in Mr Poullis and the Trust broken down to such an extent that the relationship is irreparable?

61. It was agreed that the thoracic surgeons would be interviewed before the claimant and that copies of all interview notes would be included as appendices to the investigation report. The claimant was to be kept informed, advised who would be interviewed and was to be allowed to propose others for interview and submit documents himself. It was envisaged by HCP that an initial report would be ready within 4 weeks of 18 January 2018.

62. On 22 January 2018 JW wrote to the claimant confirming that the thoracic surgeons would be interviewed, then, as had been agreed at the 18 January meeting, the claimant would be interviewed and that there were to be no restrictions on the claimant during the investigation.

63. On Friday XX February 2018 the claimant cancelled surgery for Patient D saying that he "needs a CTScan aorta". Three days later on Monday XX February 2018 the claimant reinstated Patient D to the theatre list but with no intention of performing the surgery that day.

Investigation

64. JR interviewed all of the thoracic surgeons to understand their concerns before interviewing the claimant. During February 2018 he interviewed: JAS, SW, MS, RP, MK and he interviewed NM and manager HK.

65. JAS said that he had a trust issue with the claimant as he did not believe that the claimant's primary concern was the patient. He said the claimant had an inordinate amount of cancellations due to the claimant and not the patient. He said if you fail to prepare the patient there will be cancellations. JAS said that he had heard that the claimant keeps a dossier on each consultant, that the claimant threatens to report his colleagues to the police and GMC, and asked had anyone considered the effect of that on the patients.

66. SW said there were issues with the claimant's data completion particularly post operative data. He said there was a lack of trust between the team and the claimant because of his lack of communication. He said handovers were sketchy and described the extra work he had had to do when he had taken over the claimant's Aintree clinic because there were no discharge summaries for patients. SW said this meant he had had no information on the procedure that had been performed and that the GP would not have been given information so that would have affected future treatment and pathways for the patient. SW said that a named anaesthetist had told him he had to do hours of extra work to prepare for surgery with the claimant as the information he needed as anaesthetist was not readily available from the patient records. SW said you would only consent a patient on the day before surgery or day of surgery in an emergency and that it ought to have been done in advance in clinic and recorded.

67. MS said that the claimant had cancellations more often than others and expressed his view that not having pulmonary function test (PFT's) results available should not cause a cancellation on the day.

68. RDP gave a statement as to his concerns about the claimant. They included poor engagement with the administration of his practice such as making sure all investigations were available when listing a patient for surgery, providing appropriate and legible information on patients in the notes, taking responsibility for entry of information on his patients in the EPR database and dictating discharge letters. RDP said that the claimant tended to blame others for his deficiencies. RDP said that the claimant had a very low threshold for cancelling patients, with willful neglect of their needs and the workings of the rest of the hospital. He said that the thoracic service was much more functional since the claimant's departure from it and the Aintree Clinic ran easily.

69. MK said that the claimant had not functioned well in the thoracic unit. He said the claimant had worked dysfunctionally and in a way that was substandard in relation to management of pathways, handover of patients and systems not being followed in urgent cases which could have caused patient harm. MK said that there was a lack of documentation from the claimant and that his notes from clinics amounted to a scrawl on the back of a form. MK expressed concern about the claimant's cancellations and in particular cancellations for Patient D and Patient E.

70. JR interviewed HK. HK said that the claimant had cancelled a patient and put the patient back on the list knowing that he was not going to operate on that patient saying that his reason for having done so was "*management would tell me off if I cancelled so I put him back on my list".* This was Patient D.

71. JR also interviewed NM who was not critical of the claimant save that he said that not having PFT's should not cause a cancellation on the day of surgery as he would expect a patient to have been "worked up", that is to say prepared, and any relevant information transferred (from Aintree or handwritten notes) or available for the day of surgery.

Other disciplinary hearing scheduled for March

72. The claimant was invited to a disciplinary hearing to take place on 15 March 2018 in the other investigation. It was subsequently postponed to May and again postponed. The claimant lodged a grievance, which was heard and succeeded in part (he said that the person presenting the case against him had made remarks to the panel which were highly prejudicial to him) and then in August 2018 the claimant offered to accept a written warning in relation to that other matter.

Claimant kept informed

73. JW had an office two doors away from the claimant. They each came to work early in the morning and often had a chat over coffee or in passing. JW kept the claimant informally informed of the development stages, but not specific detail, in the investigation.

74. The surgeons took time reviewing the notes of their interviews and approving them. It took until July to get all of the notes approved and back from the surgeons. JR was also looking at medical records to investigate the allegations.

75. JW also kept the executive team informed of progress in the investigation. That included reporting verbally at meetings to RAP, and to Director of HR Jo Twist. From February to summer 2018 JR produced various drafts of an investigation report. The timescale of preparing the report within one month of January 2018 had been missed. JW saw some of the drafts and gave feedback about both content; the need for specificity and data, and form; he wanted a narrative report with data in appendices.

76. From time to time JW also updated RAP as to progress in the investigation. There was discussion between them about a conduct / capability point. They were both of the view that the matters under investigation were conduct related matters. JW also discussed this with JR who also agreed, these were conduct issues, but they were both clear that if a capability issue arose during the ongoing investigation they would address it as such. JW continued to work with the claimant and remained of the view that he was a consistently very capable surgeon.

77. In May 2018 the claimant emailed JW asking that detail of a previous complaint about him made by RDP be included. JW replied promptly in terms that he would be sticking to ToR1 and was very concerned that he might be put in a position of bias if he were given information outside of the terms of reference. The claimant understood and did not pursue the point.

Invitation to investigatory interview

78. On 17 August 2018 JW spoke to the claimant and explained the slow progress in the investigation to date and the reasons for it. He said that JR would interview him soon. The claimant told JW he was happy to proceed in that way. An email was sent to the claimant inviting him to an investigatory interview on 5 September 2018.

Practitioner Performance Advice, formerly NCAS, (PPA)

79. JW contacted PPA by telephone on 23 August 2018 and received a letter following the conversation, from Mr Preece at PPA. The letter recorded what JW had said; that the claimant had been informed of the investigation, accepted the reasons for delay, including his other disciplinary process that was running, and knew that he was to be interviewed in September.

Postponements at claimant's request

80. The claimant was represented by Ms Eva Allen (EA) of the BMA. She was not available for the 5 September meeting and requested a postponement. The respondent rearranged the hearing for 21 September 2018.

81. On 14 September 2018 Oliver Lord (OL) from the MDU also representing the claimant, contacted the respondent requesting;

- Clarification of the terms of reference (more specificity as to incidents, patients, dates relied on)
- Claimant access to clinical records
- Copies of correspondence with PPA
- Other documents relied on to be shared
- Confirmation of the identity of the person providing specialty specific advice to the investigation

82. JW agreed that ToR1 could be revised/updated to include the specificity OL wanted and that process began. JR knew that it was underway on 20 September 2018. JW was working on revised terms of reference with VW from HR supporting him.

Revised Terms of Reference (ToR2)

83. ToR2 continued to address poor communication, poor documentation and cancellation issues. Many issues that had formed part of the group complaint were dropped for lack of evidence, including the allegation that the claimant had criticized the respondent externally and the allegation that some two years earlier in September 2016 the claimant had left a clinic at Aintree with no plan for 18 patients.

84. The respondent provided ToR2 to the claimant on 20 September 2018. They were as follows, (save that the Tribunal has not reproduced allegations that were not pursued to disciplinary hearing):

The Terms of reference to be investigated, that MPP has demonstrated inappropriate and unprofessional conduct in relation to the management of patients specifically

1. Inappropriate cancellation/delay care of patients

    1.1 *This allegation was not pursued.*

    1.2 On Friday, XX April 2017 a patient with lung cancer cancelled on the day of surgery because MPP could not find his handwritten notes Patient A.

2. Completing site verification forms without patient being in hospital

    2.1 Patient had a preoperative side/site verification form filled out on XX March 2017 when they were not within the hospital Patient B.

    2.2 Patient had a preoperative side/site verification form filled out on XX September 2017 when they were not within the hospital Patient A.

2.3 Patient had a preoperative side/site verification form completed 2 days before the patient was even admitted to hospital in April 2017 Patient A.

3. Patient not appropriately consented for treatment

This allegation was not pursued

4. Failure to adequately document care

4.1 On XX October 2017 the patient had no surgical documentation preoperatively within EPR Patient E.

4.2 On XX February 2018 surgery cancelled as MPP emails dating patient needed CT aorta prior to surgery however this was not documented on EPR Patient D.

4.3 Cancellation of surgery on XX July 2017 following full spirometry not being performed was not documented Patient C.

4.4 Surgery cancelled on XX July 2017 apparently because testing machine for transfer factor was not working however there is no note on EPR from MPP regarding decision to cancel surgery or any further plans Patient B.

5. Lung functions (PFT) not being carried out in line with BTS guidelines

This allegation was not pursued

Conduct or Capability?

85. On 20 September 2018 the BMA acting for the claimant wrote to say that they thought the investigation should be split into two separate investigations, one for conduct, the other for capability. The BMA felt that they should represent the claimant for conduct issues but that the MDU would be needed for any capability issues.

86. JW considered the conduct and capability distinction and the allegations made about the claimant. RAP was consulted as Medical Director. He felt that the majority was conduct and that it could depend on the way the questions were put. JR was consulted on this point in his role as investigating officer. He had done the interviews with the surgeons and knew that they had said that the claimant had good technical skill but the problems were in his communications with his colleagues and his behavioural approach to patient care. JW decided that the allegations did not relate to technical skill and so were matters of conduct.

87. JW wrote to EA from the BMA on the 20 September 2018 to say *"the interview tomorrow will only focus on behaviour and not clinical competence….if any clinical competency needs to be evaluated it will require separate TOR and full MDU input on a separate day*"

88. On 21 September 2018 the claimant requested a copy of the respondent's Medical Note Keeping Policy. A member of the HR team replied on 24 September directing the claimant to access the appropriate policy through the respondent's intranet.

Investigatory interview with claimant

89. On 21 September 2018 JR interviewed the claimant. EA of the BMA accompanied the claimant. The claimant said (i) he hadn't had time to consider ToR2. They had only been provided to him the night before the interview. (2) He was not wanting to be obstructive but was declining to answer questions on the advice of the BMA because (3) the matters were clinical issues and therefore should be classified as capability rather than conduct.

90. The respondent's HCP provides

> 3.4.1 all issues regarding the misconduct of practitioners will be dealt with in accordance with the Trusts Disciplinary Procedure, which sets out acceptable standards of conduct and behaviour expected of all employees.
>
> …
>
> 3.4.3 breaches of rules which are regarded as misconduct will generally fall into one of the following categories
>
> an infringement of disciplinary rules, including conduct which contravenes the standard of professional behaviour required by doctors by the General Medical Council.
>
> …
>
> wilfull, careless, inappropriate or unethical behaviour likely to compromise standards of care and patient safety or create serious dysfunction to the effective running of the service.
>
> 3.4.4 …
>
> 3.4.5 Failure to fulfil contractual obligations may also constitute misconduct e.g. regular non-attendance at clinics or ward rounds, or not taking part in clinical governance activities….
>
> 3.4.6 As a general rule no practitioner will be dismissed for a first offence, unless it is one of gross misconduct. If a practitioner considers that the case has been wrongly classified as misconduct he is entitled to use the Grievance Procedure. Alternatively, or in addition, representations can be made to the Designated Board Member.

91. The respondent's Disciplinary Procedure included a Disciplinary Toolkit which gave examples of minor, serious and gross misconduct.

> Conduct which may lead to summary dismissal/gross misconduct

> The following are examples of offences, which may be regarded by the Trust as gross/serious misconduct thus warranting dismissal or downgrading without previous warning. This list is to be regarded as neither exclusive nor exhaustive.
>
> Serious or repeated failure to act in line with the Trust's values and behaviours
>
> Ill-treatment or wilful neglect of patients
>
> Serious breaches of policies - serious offences, breach of any of the Trust agreed policies, procedures or recognised national legislation
>
> Any deliberate falsification of records.
>
> Any serious breach of professional conduct

Interview rearranged

92. The investigatory interview was suspended and rearranged for 12 October 2018. EA had written on 5 October 2018 to say that the view of both the MDU and BMA was that the allegations related to clinical practice and decision making and as such she was not able to advise the claimant.

93. The claimant attended the investigatory on 12 October 2018, accompanied by OL of the MDU. At the meeting the claimant was asked and answered questions about each of the allegations in ToR2 by JR.

94. In relation to Patient A and cancellation, the claimant was asked did you cancel because the handwritten notes were not available and the claimant replied *Yes.* He said, when asked could he have talked to the patient to reconstitute missing information, "*there is always time to do stuff but is it appropriate….I could have but it is not safe medicine, he was an elective patient and I had seen him, there was a number of errors, all Radiology and other bits missing."*

95. The claimant was asked about site verification procedures and explained "*you check patient info, clinical list, operating details and theatre and then mark the patient*". He described it as "vital" to follow the process. The claimant said "*I used to come in on a Sunday, it was not paid, and go through the site markings and forms which resulted in there being no critical incidents on the Monday. I tried not to come in on Sunday and do this and did it on Friday for the Monday patients. It was right and I checked everything. I know the operating list is correct as I checked this and corrected errors on the Friday. This is not me being lazy and I did not tell the registrar to mark the patient. I consented the patient, reviewed the operating list, clinical notes and x-rays which you can check with IT, they were all done in my office on the Friday. Patient was safe as they cannot leave the wards without markings.*"

96. He also said, *"I know what I did was not right, it was incorrect and misleading, I apologise for this it was not my intention, I did the form, list and marking and I will do appropriate tests and pre-op. I should not have managed like*

this but it is quite common for people to sign the things that they did not do….I did this for the best"

97. It was put to the claimant that he was signing to say he had marked a patient which was impossible if the patient was not in the hospital. The claimant accepted he had done that. He said he didn't do all of the "bits" (that is to say the component parts in the correct order) and that he made an error which was a stupid oversight. He said, "*I admit that if I sign to say the patient had been marked and I had not seen them I would be in more trouble".*

98. JR asked questions about each of the patient cases cited in the ToR2.The claimant answered. Contemporaneous notes were made. They were sent to the claimant for him to check their accuracy.

Claimant request for PFT data

99. The claimant wrote on 30 November 2018 to say that he wanted to make some changes. He requested *"the number of full pulmonary functions that I have ordered on EPR, as this will give a denominator to the two cases where problems arose…allowing the frequency…in my practice to be put in perspective".*

100. On 3 December 2018 JR replied attaching the notes in word format so that the claimant could amend them. He included information that the claimant had requested and attached root cause analysis documents that the claimant had requested save that he did not send the PFT data but confirmed that the claimant could access the records himself.

101. The claimant then requested a delay whilst he checked the notes and made some enquiries. The claimant wrote on 19 December 2018 to JR to say that he hadn't yet finished his amendments to the interview notes, that the root cause analysis (RCA) timeline provided for one of the cases was inaccurate, that he was awaiting responses to his own enquiries re PFT tests, that he hadn't begun to check the notes of the 21 September interview yet and that it would not be possible for him to do all of those things by the deadline the respondent had set of 19 December 2018. In effect, he was asking for more time. He wanted to do all of those things and have time for BMA / MDU advice on them. He was granted more time.

102. The claimant returned the notes on 18 January 2019. They had been altered to include points that the claimant had not made at interview and to insert extracts from documents into the transcript of the notes. JR allowed those additions and it was this version of the notes, transcript plus additional comment and documentation, that was used in the investigation report. It was then a year since the investigation had begun.

Investigation Report and Recommendation

103. JW and JR met to discuss the case during the week of 21 January 2019. There had been a number of drafts of JR's report as the investigation progressed. JR presented a final report to JW as case manager, and to RAP on 8 February 2019. The report included a copy of a paper from The Annals of Surgery Journal from 2007. It stated that in the study "*of the 188 wrong site errors that got past the*

*original preoperative screening process….44% were never corrected". T*he report included an extract from The Clinical Records Keeping Policy which said

> *Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.*
>
> *You must keep records that contain personal information about patients colleagues or the trust securely, and in line with any data protection law requirements.*
>
> *Clinical records should include:*
>
> *A relevant clinical findings*
>
> *B the decisions made and actions agreed, and who is making the decisions and agreeing the actions*
>
> *C the information given to patients*
>
> *D any drugs prescribed or other investigational treatments*
> *E who is making the record and when*

104. The 8 February 2019 report, referred to during the tribunal hearing as JR2, had 50 appendices. They included

- At appendices 1-7 the notes of interviews with the surgeons and HK and NM
- At appendix 16 the RCA root cause analysis document for patient E
- At appendix 17 the RCA for Patient D
- (both of which JR had had prepared by a management colleague not otherwise involved in the case)
- At appendix 18 the amended and agreed interview notes from the claimant's investigatory interview on 12 October 2018
- At appendix 19 ToR2
- At appendix 20 the consent form for Patient E
- At appendix 21 the consent form for Patient C
- At appendix 22 the consent form for Patient D
- At appendix 25 the two page, 100 entries list of patients with SVP forms allegedly completed by the claimant or his registrar (98 by the claimant and two by his registrar) prior to hospital admission. They were seen at pages 6367 and 6368 in the Tribunal's bundle.

105. The appendices also included the relevant policies and procedures including HCP. They included for each of the patients A-E, EPR documents, a timeline summary (RCA) for the case and letters and patient investigation reports. The report itself had a summary of the investigation into each of the allegations and a conclusion section.

106. JW decided there was a disciplinary case to answer in respect of three of the five allegations. They were:

i. Falsification of records:

ii. Inappropriate cancellation:

iii. Inadequate documentation of care:

107. On 7 February the claimant wrote to JR commenting on the RCA that had been used for Patient D at the investigatory interview. The claimant wanted the RCA changed to his version based on his recollection. JR decided to retain the RCA that had been prepared independently and used at interview but agreed to also include the claimant's own version of an RCA for Patient D.

108. JR prepared a revised report dated 15 February 2019 which included the claimant's version of the RCA for Patient D at appendix 51. This report was referred to as JR2+ during the tribunal hearing.

Decision to proceed to disciplinary proceedings: case to answer letter

109. JW wrote to the claimant informing him that there was a disciplinary case to answer on 25 March 2019. The letter set out the three allegations and said:

1. Falsification of hospital records (site verification forms)

This is documented in the Investigation Report and referred to in section 2 of the ToR2. I have concluded that there is a case to answer in sections 2.1 and 2.2 of the summary of findings and conclusions respectively and 2.3 of the conclusions. Trust data is provided in appendix 25. Examples of patient records are provided for patient B and patient A.

2. Inappropriate cancellation / delayed care of patients

This is documented in the Investigation Report and referred to in section 1 of the TOR2. I have concluded that there is a case to answer in sections 1.2, 1.3 and 1.4 of the summary of findings and conclusions respectively. Trust data is provided in appendix 24 pages 1 and 2. Examples of patient records are provided for Patients A, C and B. I have also concluded that patient D should be included as an example.

3. Inadequate documentation of care

This is documented in the Investigation Report and referred to in section 4 of the ToR2. I have concluded that there is a case to answer in sections

> 4.1, 4.2, 4.3 and 4.4 of the summary of findings and conclusions respectively. Trust data is provided in appendix 24 pages 1 and 2. Examples of patient records are provided for patient A, patient C, patient B, patient E and, patient D. I have also concluded that patient A should be included as an example.

110. The case to answer letter went on to say that if proven any of the alleged misconduct may be considered a breach of the Trust Disciplinary Rules specifically gross misconduct in the form of

- fraud/falsification of patient records
- serious or repeated failure to act in line with the trust values and behaviours
- gross or wilful neglect of duties
- a serious breach of trust and confidence

111. The claimant was informed that a disciplinary hearing would be arranged and a copy of the Trust's Disciplinary Policy was attached. The claimant was informed of his right to attend the hearing with a representative from a professional body of his choice. The letter went on to say

> *"Whilst I have taken the decision not to exclude you from work pending the outcome of the disciplinary hearing, I must emphasise that this does not detract from the seriousness of the issues to be determined which must be kept confidential. You should be aware that the allegations against you are of a serious nature, and that, if substantiated, a possible outcome of the hearing could be your dismissal without notice."*

112. The letter attached a copy of the investigation report JR 2+ and its 51 appendices, though appendix 51 itself (the claimant's RCA for Patient D) was omitted in error. The letter invited the claimant to exchange a statement of case with the respondent attaching any documents he wished the disciplinary panel to see by 4pm on 12 April 2019. The letter proposed a disciplinary hearing date 24 May 2019.

Updating PPA

113. On 18 April 2019 RAP met with Mr Preece from PPA to update him in relation to the claimant's case. Mr Preece wrote a letter confirming the content of that meeting. He noted that the respondent had taken specific legal advice and had discussed the constitution of a panel to hear allegations of misconduct relating to matters of a professional nature. He reminded the respondent that if the panel were to find any of the allegations before them proven then they should take into account previous relevant employment history when determining any sanctions to be imposed.

114. OL was not available for 24 May 2019 and thought that the exchange of statements of case date of 12 April 2019 date was too soon. Both the document

exchange and hearing dates were put back at the claimant's representative's request.

EA has concerns

115. On 23 April 2019 EA, from the BMA, wrote to RDP. She said that (i) the investigation report was factually incorrect throughout (2) that the case was really about clinical practice and therefore JR should have sought the professional opinion of an independent external thoracic surgeon and (3) the classification of the allegations of gross misconduct was procedurally incorrect, flawed and unfair because it relates to clinical practice and not conduct and (4) JR's investigation is incomplete as the claimant had not had an opportunity to share his list of witnesses with JR. The letter alleged that the investigation report is therefore *"unbalanced, biased and cannot be considered as being sufficiently fair and impartial to be put before any type of panel-conduct or capability*". EA called for the claimant to have the opportunity to highlight factual inaccuracies and omissions in the report, further investigation if necessary, or an external thoracic surgeon to be appointed to review the matter, and for the matter to be re-categorised as capability. EA said that if the Trust would not agree to correctly classify the matter as capability the claimant would be left with no alternative but to pursue a grievance.

JW responds to EA's concerns

116. JW responded to EA's letter on 2 May 2019. He said he was satisfied that the issues identified by the investigation were conduct issues. He pointed out that the claimant had had opportunities to provide witness details but had not done so and went on to say that the claimant could, of course, bring witnesses to the disciplinary hearing. He confirmed that the claimant could highlight factual inaccuracies and omissions at the disciplinary hearing. He reiterated that an external thoracic surgeon is not required in the case because the allegations against the claimant were conduct based and related to falsification of documents, inappropriate cancellation and alleged failures to document care. He reiterated that the respondent did not believe any of the issues related to capability and therefore the capability policy was not relevant.

117. JW went on to say that any grievance which related to issues which were inextricably linked with the issues in the disciplinary case was unlikely to be heard separately as those concerns could be raised with and considered by the disciplinary panel.

New hearing date

118. On 16 May 2019 HR Business Partner FR wrote to the claimant again inviting him to attend a disciplinary hearing and setting out the allegations, their classification as gross misconduct, the potential for them to result in dismissal, his right to be represented and setting a new date of 11 June 2019 for a disciplinary hearing. The letter informed the claimant of the constitution of the panel. It was envisaged at that time that it would be chaired by Dr John Morris (JM). The panel would also comprise an independent external HR support Lynn Lowe (LL), and a non-executive director of the respondent Dr Nick Brookes (NB).

119. The respondent's HCP provided for the composition of a misconduct panel as follows:

> "3.4.2 Where the alleged misconduct relates to matters of a professional nature or where the investigation identifies issues of professional conduct, the Case Investigator will obtain appropriate internal or external independent professional advice. If the case proceeds to a hearing the panel will include a member who is medically qualified and not in the employment of the Trust"

120. EA wrote that day stating her disappointment at JW's response and the claimant's right to pursue a grievance. The relevant right was at 3.4.6 of HCP.

121. On 20 May 2019 claimant submitted a grievance to HR Business Partner FR. The complaints in his grievance letter were:

a. The classification of the allegations as conduct not capability and as a consequence of that classification the claimant being denied the protections of 3.7 and 3.8 of HCP which dealt with capability proceedings.

The claimant was referring to the provisions of the HCP at (i) 3.8.1 which related to the claimant being given an opportunity to check factual accuracy of the investigation report before it goes to a panel and (ii) 3.8.5 as to the composition of the panel and the claimant having an external independent medical practitioner on the panel and (iii) 3.8.6 which provided for the panel to have advice from a senior clinician from the same or similar clinical specialty as the claimant but from another NHS employer.

b. That the claimant should be allowed to correct factual inaccuracies in the investigation report *before* it goes to a panel and not as part of his statement of case to the panel.

c. That the tone and language of the investigation report was prejudicial, so that JR overstepped his role as case investigator. (This was the point the claimant had made in his grievance in the other case, and had succeeded on that point).

d. That he had been bullied by another Trust employee and that all but one of the current allegations are testament to ongoing bullying.

e. That the process is retaliation for the claimant having raised concerns about high death rates in the past.

f. That he was being treated differently than others who had cancelled cases, documented inaccurately in EPR, failed to document in EPR and signed and dated actions and conversations which had not taken place.

122. The claimant raised these issues as "detriments" and requested an adjournment of the hearing date set for 11 June 2019 until the grievance had been resolved.

Director of HR responds

123. On 28 May 2019 JT responded to the claimants' grievance letter. She confirmed that the classification of the allegations was a matter for the case manager and that she was satisfied that the case manager had sufficient information to make the decision. However, to give the claimant some further reassurance she had arranged to replace the non executive director on the panel NB, with an external medically qualified person. She proposed contacting a Medical Director at St Helens Trust, Professor Andrew Rowland. JT said that the claimant could make any comments he wanted about the investigation report at the disciplinary hearing and raise any concerns he had at that time. She said that wider issues of bullying or harassment could be raised under the Trust's formal policies in those areas and need not delay the disciplinary hearing.

Hearing postponed at claimant's request

124. The June hearing was postponed at the claimant's request and another allegation letter was sent, in the same terms as the previous two but setting a new date for a disciplinary hearing to take place on 20 August 2019. PPA was kept informed.

125. OL wrote on 1 August to ask could the August hearing be vacated on the basis that JR had expressed personal opinions in his investigation report. OL also said that the claimant wanted JR to be present to be questioned at the hearing.

126. FR wrote, in response to OL's letter, to the claimant direct. She said that the hearing had already been delayed from 24 May 2019 due to the claimant's representatives being unavailable. She said:

> *"You have had the opportunity to review the investigation in its entirety and also submit your own statement of case which is an opportunity for you to detail where you feel the investigating officer, as stated by Dr Lord, has offered a number of personal opinions in his report and chosen not to reference key information provided by yourself. If you have not detailed this information in your statement, we are happy for you to provide a supplementary statement by 12 August 2019, the same date we have agreed for the additional EPR information, and the panel will consider this at the hearing.*
>
> *Please also be advised that whilst it is intended that the panel will go ahead without the investigating officer being available as your witness, if they believe the evidence of the investigating officer is significant and prohibitive to their ability to reach an outcome, they will consider adjourning the hearing for another date and the investigating officer is available in order for that evidence to be taken into consideration."*

127. The claimant was informed on 2 August 2019 that the panel would comprise JM, AR and Claire Ormond (CO) who was an external HR support panel member.

128. The claimant submitted a Statement of Case Document (August SoC) with 8 appendices in readiness for a disciplinary hearing.

129. On 14 August 2019 EA wrote to RAP protesting that the hearing should not go ahead in the absence of JR. Her letter said:

> *"the absence of a key witness and the trust's refusal to adjourn the hearing as a consequence is a ground of appeal in and of itself and would most likely bolster any subsequent employment tribunal claim, if the outcome gave rise to one"*

EA requested that the hearing be adjourned and relisted for 2 days. RAP agreed to a further postponement and said that he hoped that the hearing could be relisted before the end of September. The claimant was then not available in September and the matter was relisted for 10 and 11 October 2019.

130. The claimant was given a day of special professional leave so that he could meet with the MDU in London to take advice prior to the disciplinary hearing.

Deferred revalidation

131. On 12 September 2019 RAP informed the claimant that he had been advised by the GMC to defer the claimant's professional revalidation until after the rearranged disciplinary hearing.

132. On 14 September 2019 OL wrote to the respondent requesting:

> *Clarification of terms of reference a, c, d and e in enough detail that Mr Poullis can prepare a response. Could I ask for the following:-*
>
> *a) the incident that is being referred to*
>
> *b) the patient numbers, and dates for the consultations that are to be reviewed*
>
> *c) the date, occasion and alleged comments made by Mr Poullis*
>
> *d) the patient numbers and dates for the consultations that are to be reviewed*

OL asked for clinical records to be available, for correspondence with PPA to be provided, for any other documents to be relied on to be shared and for the name of the person who would provide specialty specific advice to the panel.

133. The claimant asked for a copy of the record keeping policy in force in 2016/2017.

The "7 pieces of information" addendum to the claimant's statement of case

134. On 18 September 2019 the claimant wrote to JW attaching a letter and excel file. During the tribunal hearing this came to be referred to as the "7 pieces of information" addendum to the claimant's August SoC. Although this was received after the deadline that had been agreed for exchange of statements of case JW was happy to accept it and included it in the bundle of documents to be used at the disciplinary hearing. On 26 September 2019 the claimant again wrote to the

respondent requesting further information in advance of the disciplinary hearing. This letter resumed the numbering from his 7 pieces of information letter.

The 8+ addendum to the claimant's statement of case

135. JM saw the 8+ letter on 8 October 2019 and said that he thought it was too late be included for consideration by the disciplinary panel. JW as case manager disagreed and allowed the claimant's late submission, the "8+", to be considered, as an addendum with his "7 pieces" letter to the August SoC by the panel.

136. The claimant wanted data about the number of PFTs requested not just by him but by each of his thoracic colleagues so as to put in context any allegation about his failure to organize PFTs leading to cancellations. He also wanted, in relation to the SVP form issue, to find proof of others completing SVP forms prior to admission on the same day of admission. He requested for every Monday, for all thoracic patients, confirmation of the login to the system time for those patients, all radiology chest x-rays, CT scans, PET scans viewed prior to 8am on the same day of surgery broken down by consultant, confirmation of viewing of EPR, correspondence, letters prior to 8am on the same day of surgery, broken down by consultants and the total number of patients. He wanted the same data for each patient and each consultant for every day of the week for all thoracic patients in the database.

137. JW replied on 27 September 2019 stating that the data the claimant had requested was neither necessary nor appropriate for the disciplinary hearing. JW said "*you can make any points that you wish to with regard to the activities of wider colleagues and if the disciplinary panel consider they need to take this information into account when making a decision, no doubt they will undertake further investigations or obtain additional documentation as they see fit."*

Invitation to hearing

138. On 4 October 2019 FR again wrote to the claimant inviting him to attend a disciplinary hearing this time on 10 and 11 October 2019. The letter again set out the allegations the claimant was to face, their classification as potential gross misconduct, the potential outcome of dismissal, the composition of the disciplinary hearing panel and informed claimant of his right to be represented at the hearing.

139. The 4 October letter responded to OL's request on 14 September 2019 for clarity around the incidents by setting out again, as the previous invitation to hearing letters had done, the section of the investigating officer's report that addressed each point and the relevant patient numbers.

140. On 4 October 2019 the claimant asked the respondent to confirm that the following would be available as witnesses at the disciplinary hearing, MS, JAS, SW and NM and he asked if the respondent would be calling any witnesses.

141. On 9 October 2019 the respondent noticed the claimant did not appear to have been sent appendix 51 to JR 2+, JR's investigation report. FR looked into it and found that the appendix was the claimant's version of the RCA for Patient D, so that although it had not been sent to him prior to the disciplinary hearing in October 2019, it had previously been included in documentation sent to him and

was in any event a document that he had produced and submitted to the respondent. FR sent it again and also made sure that the claimant was again sent a copy of the respondent's Clinical Record Keeping Policy.

Filtering the data to ensure it captures pre date of admission data

142. Prior to the hearing JR went back to the data analyst colleague and obtained a print out of a spreadsheet of all the occasions on which a SVF form predated the date on the system for patient admission. At the tribunal hearing this document was referred to as page 3835.1. JR had asked the data analyst Mr Malik (AM) to filter this data so as to remove entries for same date admission and SVP form completion. He could not be sure for those entries that the doctor, whether the claimant or someone else, had not seen the patient before completing those SVP forms. He had also asked for the data to be filtered to remove an SVP form entry for procedures, such as bronchoscopy, where no SVP was required. Finally, he asked for errors to be removed where a wrong date of visit for the patient had been entered on the system. This took some time.

143. In this way JR could be confident that what he was presenting to JW and what was before the panel was a list of occasions on which an SVP had been completed before a patient was on site, for a procedure that needed an SVP form and where the visit date had been entered correctly. Having seen the document at 3835.1 in the tribunal bundle (but not shared it with the claimant in October 2019) prior to the disciplinary hearing JR was content that the document at appendix 25 (the two page list of 100 entries, the Tribunals pages 6367 and 6368) which had been sent to the claimant and the panel accurately alleged the (admitted) instances on which the claimant (or his registrar on two occasions) had completed an SVP form prior to patient admission and prior to having seen or marked the patient.

The disciplinary hearing

144. The hearing took place on 10 October 2019. The panel comprised JM, AR and not CO but Janet Doran (JD) for HR support. JM was the decision maker. The claimant was represented at the hearing by OL.

145. The panel heard JW present the management statement of case. In relation to allegation 1, the falsification of site verification procedure forms, the claimant admitted that he had completed SVP forms before marking the patient. JW took the panel to the claimant's arguments on this allegation and his mitigation. JW responded to the following points that the claimant had made in mitigation of his admission.

The first allegation: falsification of hospital records (site verification forms)

> 145.1The *claimant's contention that others had completed SVF before marking the patient too.* The claimant said there were 222 instances of this having occurred in total, not just the cases the respondent had alleged against him. JR told the panel that he had asked a data analyst to look at the data. They had excluded SVP form completion pre admission on the system on "same date" cases because the respondent could not rule out that the surgeon may have seen the patient, marked the patient and completed the SVF before the nurses could formally record the admission date on the

system. All same date cases had been excluded for all surgeons, including any for the claimant, as had wrong procedure and wrong date cases. That left 98 (admitted) cases of SVP form pre dating the admission date completed by the claimant and 2 cases completed by his registrar.

145.1 *The claimant's contention that other surgeons had made errors*. The claimant cited 7 examples of clinical and other errors made by his colleagues. JW submitted that they were not relevant as they were unrelated to the site of surgery.

145.2 *The claimant's contention that his secretary had made errors.* The claimant said that she had a long term illness and this had contributed to her making a high number of errors. He also referred to personal circumstances of one of her family members. This was about the claimant's handwritten notes making it back from Aintree clinic to LHCH. JW said that this was not relevant to the SVP form issue.

145.3 *the claimant's contention that no harm ensued.* The claimant said that his actions resulted in no deaths, near misses, critical incidents, complaints or legal action.

145.4 *the claimant's contention that he had not acted covertly or for personal gain.* JW accepted on behalf of the Trust that the claimant's actions had not been covert, not done for personal gain and that the claimant had admitted that what he had done was wrong.

146. There was then a short adjournment to allow the claimant and OL to prepare questions to put to JR. OL then questioned JR and JW about the specific detail for each allegation and there was detailed discussion about the cases of Patients A, D and B.

147. AR asked to be taken to the SVP form and was. The claimant said *"I marked the box, I am wrong in what I did, or the way I did it".*

148. OL put to the case manager and investigator that the claimant was being treated differently than other surgeons including RDP. OL put to JR that RDP had been interviewed in a way that was different from other witnesses.

149. There was discussion of the case of Patient C. OL challenged the use of the phrase "willful neglect" by JR in the investigation report.

150. The claimant then presented his case. He apologised in relation to the SVP form issues saying "*I am truly sorry for filling out the correct site form on a Friday. I was wrong, but I did it for good reasons*." He went on to say "*pre-documentation is common in the Trust"*. The claimant spoke in detail about each of the patients A-E.

The second allegation: inappropriate cancellation/ delayed care of patients

151. In relation to allegation 2 about inappropriate cancellations the claimant accepted that he had cancelled Patient's D's operation on a Friday for the following Monday because of absence of a scan. The claimant accepted that he then instructed his secretary to put Patient D back on his operating list "*because of pressure from HK*" and he accepted that it was "*a silly error*"

The third allegation; inadequate documentation of care

152. In relation to allegation 3 inadequate documentation the claimant accepted "*my documentation of many of these cases has made it difficult to fully explain my clinical actions and, hence, should have been much better"*

153. The claimant confirmed that the documentation he had submitted for consideration by the panel (including his August Statement of Case, his September 7 pieces of information and his October 8+ continuation document) had been included. He said *"I am happy that they have been included".*

154. AR questioned the claimant directly himself, reading the claimant's admission about the SVP form made at investigatory interview back to him and asking him did he accept that was an accurate statement and was his position at disciplinary hearing the same as at investigatory interview. The claimant confirmed it was still his position and said "*I did do the wrong thing, with good intentions*".

155. The hearing adjourned for lunch from 1.20pm until 2.05 pm. After lunch the panel focused on the cancellation allegation. JW referenced Patient's A,B,C and D and said that the claimant had been aware that these examples would be used. The panel then checked the allegation letters from 25 March 2019 through to the latest iteration of the letter on 4 October 2019 and everyone agreed that the allegations were the same and that the claimant had been made aware of them.

156. JM said that the panel was to decide if the cancellation was inappropriate not as a medical decision but considering the claimant's behaviour in the way in which it was cancelled. AR said that he needed to clarify if this was a matter of personal misconduct and related to no effort being made to obtain information prior to cancellation (as opposed to a clinical judgment as to whether to cancel or not). JW confirmed that to be the case. OL then said that as that was the case, it was a conduct issue, he could narrow down the witnesses needed to attend the disciplinary hearing. After a short adjournment OL said that he had only wanted to question witnesses on clinical decision making in cancellations.

157. JW asked what about allegations 1 and 3 ? He was prompting OL to question the witnesses on the claimant's argument that others had completed SVP forms prior to marking patients and prior to the day of admission and that others had documented care inadequately. OL said,

> *"MP has responded to those and has admitted this was the wrong thing to do, our argument is that we are not going to dispute those. Based on this we are happy not to call witnesses*".

158. Notwithstanding this JW called MS. JM was happy for MS to appear before the panel. MS joined the hearing and in response to questions said that if a patient was on the list and admitted for surgery and data was missing he would search for

it exhaustively and seek to clarify if the tests had been performed. He would not have added a patient's name back on to a list having cancelled the operation, as the claimant had done, when he had no intention of operating. He would always document his contact with patients in EPR, either directly onto EPR or if in clinic in handwritten notes that he would ensure were scanned on to EPR. He would never record a patient meeting on the back of a consent form. He would always give a reason for cancellation to the patient and document it on EPR and document a subsequent treatment plan. He confirmed that his secretary, shared with the claimant, made no more mistakes than others and that he had never had to change his practice because of her.

159. OL questioned MS. Neither the claimant nor OL asked MS had he ever completed and signed an SVP form without having first marked the patient. Nor did they question him about cancellations or adequate documentation.

160. The panel adjourned and reconvened for closing statements. OL said that the claimant accepts he was wrong in relation to SVF and described putting Patient D back on the list after having cancelled his operation as a "*stupid mistake*". OL's final submission was "*We would accept a finding of misconduct and ask the panel to allow MP to continue to be employed by the Trust".*

The decision making

161. JM was the sole decision maker but was advised by AR and JD.

Allegation 1

162. The panel had seen the 98 instances of alleged SVP form falsification by the claimant at appendix 25. The panel was aware of the claimant's admission. The panel had heard the claimant say at the disciplinary hearing

> *I am truly sorry for filling out the correct site form on a Friday. I was wrong, but I did it for good reasons, albeit flawed, and no deception, personal gain or cover up were involved. The electronic log will confirm that I checked EPR, radiology and operating list to make sure that everything was correct and had been done prior to filling out the correct site form. ……I know other people's poor practice does not excuse mine, I accept I have made mistakes and will not do this again".*

163. The panel had seen what the claimant had said at investigatory interview.

> "*you check patient info, clinical list, operating details and theatre and then mark the patient*". He described it as "vital" to follow the process. The claimant said "*I used to come in on a Sunday, it was not paid, and go through the site markings and forms which resulted in there being no critical incidents on the Monday. I tried not to come in on Sunday and do this and did it on Friday for the Monday patients. It was right and I checked everything. I know the operating list is correct as I checked this and corrected errors on the Friday. This is not me being lazy and I did not tell the registrar to mark the patient. I consented the patient, reviewed the operating list, clinical notes and x-rays which you can check with IT, they were all done in my office on the Friday. Patient was safe as they cannot*

leave the wards without markings." *"I know what I did was not right, it was incorrect and misleading, I apologise for this it was not my intention, I did the form, list and marking and I will do appropriate tests and pre-op. I should not have managed like this but it is quite common for people to sign the things that they did not do….I did this for the best".* It was put to the claimant that he was signing to say he had marked a patient which was impossible if the patient was not in the hospital. The claimant accepted he had done that. He said he didn't do all of the bits and that he made an error which was a stupid oversight. He said "*I admit that if I sign to say the patient had been marked and I had not seen them I would be in more trouble".*

164. The panel had seen what the claimant had said in his own statement of case document to the disciplinary hearing

"I have been a consultant for 11 years at LHC age. For the first 8 years I checked radiology and patient notes, marked patients and consented them on a Sunday afternoon, without payment. 3 years ago, I got married and my wife stop becoming into the hospital at the weekend, so I checked radiology, EPR, and operating this accuracy on the Friday. I did this due to the high number of errors that my secretary who it is alleged had alcohol and relationship issues created (which the trust was well aware of the time) and my observation that some patients and my colleagues had deaths, adverse events and in one case legal action-listed in my statement to Dr Ratnasingham, due to errors in the process of completing the site verification form- the site verification form is the last stage of preoperative surgical assessment prior to surgical incision-after reviewing medical notes, radiology and confirming operation list is correct. My system resulted in no errors, near misses, critical incidents or complaints with regard to surgical procedures performed due to missing relevant information. The patients were safe at all times, even though I ticked the box on the correct side form when it was still not in the hospital, I marked and consented admission-I never delegated, and always did the operations myself, so even if I fell ill, patients were still safe, the nurses would not be able to let them leave the ward to theatre as pre-op checker is not complete."

"I have reflected and consider the cases under documentation. What I did was inaccurate, and potentially misleading, this was not my intended wish. Should I have any correct site forms to do in future I will do them on admission after marking. As the form is labelled pre-op site/site verification I did not feel at the time this was a big issue, as long as the appropriate checks were completed pre-op-which I did, and not in theatre-which I never did. I do not try to mitigate my short fallings by saying others have done the same, but pre-documentation within the trust is common."

165. The panel had seen what the claimant had said in his 7 pieces of information addendum to his statement of case

222 correct site forms have been created prior to hospital admission. The investigation has identified 100 were created by me, potentially indicating that 122 were created by colleagues…..{The investigation} did not ask any of my colleagues if they have a completed this form prior to admission!"

166. The panel had observed MS being questioned by JW and was aware that the claimant had declined the opportunity to question MS on the SVP point. The panel had seen the statements from the surgeons and HK and NM as appendices to the management statement of case.

167. The panel had seen the claimant's assertion in appendix 1 to the claimant's statements of case document (August) that said, "I did not say that what I did circumnavigated the correct site process – I actually said the opposite. My *system was safer." "I did not admit it constituted a significant patient safety issue"*.

168. The panel had seen the report from the Annals of Surgery Journal that said 44% of cases of wrong site surgery that get past the preoperative checks do not get corrected that is to say they are not prevented from becoming a never event.

169. The panel unanimously agreed that the claimant had done what had been alleged, what had been admitted, and that it amounted to gross misconduct.

Allegation 2

170. In relation to allegation 2 inappropriate cancellation, the panel had heard the claimant's explanation of his actions in relation to Patient A. This was the lung cancer patient whose operation was cancelled on the Monday morning, day of surgery because notes were missing and the claimant had made no attempt to find the notes himself, discuss the information with the patient or consult a colleague. The panel noted that the claimant had said that he would not consult a colleague who had a higher mortality rate than him in surgery. The claimant had accepted at the hearing that it was unacceptable not to have tried to find the notes.

171. Patient C was also a lung cancer patient whose surgery was cancelled. The claimant said it was due to the absence of PFT's. They had been done 10 days earlier and sent to the respondent 3 hours before the operation was cancelled but the claimant had made no effort to find out if PFT results were available. Patient B also had lung cancer surgery cancelled because the claimant had left it until the day of surgery for tests to be done, the machine had broken on the day and they could not be done. The claimant argued that the reason for cancellation for Patient B was also because the patient was chesty but JM did not accept that failure to "work up" the patient and have him prepared for surgery was not part of the reason, as the EPR system showed lack of PFT's as reason for cancellation. Patient D had also had surgery cancelled and then the claimant had instructed his secretary to put the patient back on the list so that his list would look fuller than it was, even though he had no intention of carrying out Patient D's surgery on the Monday.

172. The panel unanimously agreed that the claimant had inappropriately cancelled surgery for patients and that this amounted to gross misconduct.

Allegation 3

173. In relation to allegation 3 inadequate documentation of care, the panel was concerned that Patient E did not have preoperative assessment or anything prior to his surgery documented on EPR. The panel did not accept that the claimant's practice of writing on the back of a consent form was an adequate response to this allegation. The claimant was aware that each contact with a patient should have

been documented on EPR. The claimant would have been aware that the consent form only gets uploaded to EPR after discharge and so any records on paper would be useless during the patient's hospital admission. For Patient D the claimant had cancelled the operation, requested a scan and did not document on EPR what his decision was, the reason for it, what had been explained to the patient nor any plan for treatment. This was the patient that the claimant had asked his secretary to put back on the list so as to keep out of trouble with management, even though the claimant had no intention of performing the surgery.

174. The panel was convinced that the claimant had little or no regard for the impact of what he did on the patient or the ward staff and that this inadequate documentation amounted to gross misconduct. The claimant had admitted *"my documentation has made it difficult to fully explain my clinical actions and hence should have been much better"*

Mitigation

175. The panel met immediately after the hearing to consider the case. Although JM was the sole decision maker, he consulted with the panel members about the allegations. They all agreed that the allegations amounted to gross misconduct. They were satisfied that the claimant had done the things he was alleged to have done and that each of them amounted to gross misconduct on its own. They all agreed that the range of sanctions included dismissal. Mr Morris was concerned about the consequences of a dismissal for the claimant's career and wanted to take time and give serious consideration to the possibility of a lesser sanction than dismissal. In each of the Patient Cases A-E and for each allegation, the panel had heard the claimant's explanation and had heard and read the claimant's mitigation.

176. JM was also immediately concerned, having decided that the allegations amounted to gross misconduct, and having heard the claimant's apologies and justifications, about the impact on patient care if the claimant were to be at work. He was concerned that there could be a repeat of the SVP form issues or inappropriate cancellation or failure to document care and that any one of those three matters if repeated could result in harm to a patient. JM contacted RAP and recommended that the claimant be given special leave for the day between the end of his leave period and the decision date, so that he would have no patient contact, pending the disciplinary decision. RAP agreed to do that and informed the claimant.

177. JM took a week to make his decision. He had sleepless nights during that week considering the sanction. The claimant had admitted two of the three allegations, and sought to apologise for them and give assurance that they would not happen again. The claimant had asked not to be dismissed and had offered to be subjected to a written warning. JM asked HR for support and for template letters addressing both dismissal and the imposition of a final written warning.

178. JM took into account the mitigation that the claimant had put forward in his statement of case and the submissions of OL. They included that the claimant was a consistently capable surgeon, of 11 years service and that his surgical outcomes, which had been included as an appendix to his statement of case, were excellent.

The apology as mitigation

179. He also considered the admissions made by the claimant. JM had heard the claimant apologise and say in relation to both the SVP form allegation and the inadequate documentation of care allegation that it would not happen again. JM was not convinced by this because at disciplinary hearing he knew that the Patient D case had happened after the investigation had begun and because the claimant was still contending that others had done what he had done. JM had seen no evidence to support that contention.

180. JM was also concerned that whilst the claimant was saying he was sorry, he was not truly accepting that what he had done had compromised patient safety. The claimant continued to say that his way had been safer, no risk to patient safety. JM was not confident that the claimant would change his behaviours because he listened to the claimant explaining his actions for Patients A, B, C, D and E and he felt the claimant was continuing to seek to justify or excuse what he had done.

Bullying in the thoracic team as mitigation

181. JM took seriously the claimant's assertions that he had been investigated and disciplined because of poor relationships in the thoracic team. JM had not been aware of the detail of the issues in the thoracic team. He had not seen RDP's letters of 25 April 2017 nor 7 September 2017. He had seen the minutes of the surgeons 21 September 2018 meeting and the witness statements from the surgeons as part of the investigation but he attached little if any weight to them in reaching the decision that the conduct was gross misconduct or in relation to sanction. He placed far greater weight on the claimant's own case in his documentation and on the claimant's responses at investigatory interview and disciplinary hearing. JM was clear that it was the claimant's own conduct, largely admitted, that was informing his decision making.

Not been suspended, so can't be serious, as mitigation

182. JM was not concerned that the respondent had allowed the claimant to continue to practice after discovery of the SVP form issue in April 2017 and the investigation and interview in 2018. JM knew that the claimant had resigned his thoracic surgery role. He also felt that the claimant, being aware of being under investigation and the nature of the allegations from ToR1, would have been on his best behaviour. However, JM balanced against that the fact that one of the cases, Patient D, occurred after the claimant had resigned from thoracic surgery and whilst the claimant knew he was under investigation.

Inconsistent treatment as mitigation

183. Although the claimant persisted in both apologizing and contending that others had done what he had done in relation to the SVP forms, and that what he had done had not put any patient in harm's way, JM saw no evidence of any other surgeon having done what the claimant had done in relation to SVP forms and that was to systematically falsify patient documentation. JM had seen that the claimant had had the opportunity to put the issue to MS and had not done so. JM had heard the management statement of case about potential harm to patients in never events of wrong side surgery.

184. JM was aware from the 26 September 8+ letter that the claimant had asked the respondent for data which the claimant thought might show that others had completed SVP forms prior to seeing the patient. JM was clear that the claimant's request was for information not to clear himself but to seek to incriminate others. JM noticed that the claimant had sought to blame his wife for the SVP form issue (in not wanting him to go into hospital on Sundays) his secretary for the missing notes, management for putting pressure on him to have more than one patient on his list hence him putting Patient D back on the list (not intending to operate) after cancelling the surgery.

185. JM was satisfied in relation to the SVP form issue that JR had been thorough and accurate in obtaining filtered data from the data analysts (AM and GH) and that that data showed a systematic and deliberate falsification by the claimant and did not show that for anyone else. In relation to allegation 1 JM was satisfied that the investigators report and statement of case had provided clear examples that the claimant had been able to respond to.

186. On the cancellation allegation JM considered the mitigation point about others cancelling and noted that the claimant had had opportunity to point to others who had inappropriately cancelled surgery but had not done so. The 8+ letter also asked for PFT data to put the claimant's failures in context. Mr Morris did not feel he needed that. What mattered was not how many tests the claimant had ordered or not ordered compared to others but that the claimant was prepared to cancel a surgery because test results were not available *without having searched for them.*

187. The case of Patient D troubled JM as it showed that the claimant had cancelled a surgery due for Monday on a Friday on the basis that he wanted a scan, not ordered the scan till after hours knowing it would not be done at the weekend, then on Monday put the patient back on the list so as to make his list look fuller and, the claimant said, not get in trouble with management. JM was deeply troubled at the lack of regard the claimant had for the impact of this decision making on the patient and the claimant's colleagues on the wards, in theatres and in management. There was no evidence before JM that anyone else had done this and MS had been asked about this at the disciplinary hearing and said that he would never do such a thing.

188. In relation to mitigation for allegation 3, JM was aware that the respondent had had EPR for four years and he was aware that there had been extensive training. The claimant had admitted that he continued to use paper records for in patients knowing that they wouldn't be uploaded to EPR until the patient was discharged. The paper records would therefore be useless to colleagues on site or remotely in caring for the patient during his hospital stay. The claimant had also accepted that there was a backlog in his discharge letters. He had said that this was due to delay by his more junior doctors and that he had chased them up. JM again felt that this showed a lack of regard for the impact of his behaviour on others treating the patient and on the patient himself. The claimant had raised that anaesthetists use paper records and that working his Aintree clinic used paper records. JM did not consider this to mitigate against the claimant's (admitted) failures to adequately document care on EPR at LHCH.

The decision to dismiss

189. Having considered mitigation, JM decided the appropriate sanction was dismissal because he thought there was a significant risk that the claimant would act in a similar way in future. He thought that if the claimant did, in relation to any of the three allegations, the consequences for a patient could be devastating. He also thought about how that would look for the respondent if it had known the claimant had done these things, that they amounted to gross misconduct and yet had allowed him to continue.

190. JM amended the template that had been sent to him by HR on the evening of 16 October to insert his reasoning for the decision but, in error, left the heading to read Final Written Warning. He sent it to HR who also missed the erroneous heading.

191. The decision to dismiss was given face to face at a meeting on 17 October 2019. The claimant was accompanied by Mr Parry from MDU. The claimant asked that JM review the allegations he had made against his colleagues.

192. A letter was sent to the claimant confirming the disciplinary outcome which had been given to him face to face. It contained the error in the heading which read – final written warning. It was three pages long and gave the reason for dismissal and informed the claimant of his right to appeal.

193. JM spoke to RAP about the claimant's allegations that there were other examples of SVP forms being completed prior to seeing the patient. RAP assured JM that none was systematic or deliberate as had been the claimant's.

The appeal grounds

194. The claimant wrote in October 2019 (letter wrongly dated 3 July 2019) appealing against his dismissal and setting out 13 grounds of appeal and attaching a 117 page document detailing his grounds and including appendices.

195. The respondent appointed Mr Mark Jones (MJ) to be the chair of the appeal panel, Jane Mullin to be the External HR Support on the panel (JM) and Dr Paul Mansour (PM) to be the external medical representative on the panel. JM prepared and submitted a statement of case. The hearing date was set for 7 May but was rescheduled to 20 July 2020 and the claimant was represented by OL.

The appeal hearing

196. The hearing in July 2020 took place during the coronavirus pandemic. It was conducted remotely on Teams. At the outset of the hearing the claimant confirmed he had seen all of the respondent's documents and had copies of HCP and Disciplinary Policies in use at the hearing. He adduced an extra document, The 2009 WHO surgical safety checklist, which was shared.

197. The claimant said he hadn't seen an email sent to Aintree to get him the PFT data he wanted. He hadn't had the EPR data he had wanted on SVP forms on same day admissions and he alleged that the respondent had not provided as part of the disciplinary pack his attachment on a corrected RCA sent on 3 May 2019 and had not included evidence he had submitted on 3 May 2018 in the disciplinary pack.

198. The claimant argued his "others had done the same" position in relation to the SVP forms and inadequate documentation allegations.

199. MJ confirmed that the panel had before it;

- the claimant's letter of appeal dated 25 October 2019
- the disciplinary hearing outcome letter dated 17 October 2019
- the notes of disciplinary hearing from 10 October 2019
- the management statement of case for appeal
- the claimant's statement of case for appeal
- the management statement of case including all appendices used at disciplinary hearing, including the claimant's RCA timeline for Patient D
- the claimant's statement of case used at disciplinary hearing including his 7 pieces of information letter and his 8+ additional submission.
- Investigation report JR2+ and its 51 appendices
- correspondences between the parties dated 18, 26, 27 September 2019 and 4 October 2019.
- A bundle described as "core" correspondence including the letters of invitation to the investigatory and disciplinary meeting, correspondences with PPA, the correspondences with the BMA and MDU in relation to the classification of the disciplinary matter as conduct or capability, and copies of correspondence as relating to subject access requests and an Information Commissioner's Office complaint made by the claimant.

200. After the hearing they deliberated for an hour. MJ did not declare his own views at that time but drew out the opinions of his panel members. The members were satisfied that JM had believed the claimant to be the only surgeon who had systematically completed site verification forms over a period of years before marking the patient.

201. The panel were convinced that JM had had reasonable grounds for believing that the claimant falsification of SVP forms amounted to gross misconduct. In relation to cancellations they were persuaded that JM had believed that the claimant was not going the extra mile to find data that seemed to JM to have been reasonably available before cancelling operations. They were persuaded that JM had reasonably believed that the claimant had inadequately documented care. The appeal panel agreed that JM had reasonably concluded that each of those matters independently amounted to gross misconduct.

202. The appeal panel noted that the disciplinary panel had formed the view that the claimant made criticisms of others to seek to excuse his own actions.

203. The appeal panel accepted JM's position that whilst the claimant had admitted and apologised for allegations one and three, the claimant might have propensity to do the falsification or inappropriate cancellation again in future. The appeal panel was convinced by JM's view that the claimant had been going out of his way to avoid doing anything wrong whilst under spotlight of process but would go back to his old ways as he believed them to be better than Trust processes and had said so at the disciplinary stage. The appeal panel noted that JM had taken into account that one of the patient examples at disciplinary hearing was a cardiac patient who was treated by the claimant after the claimant was aware of the allegations, even when the claimant was under the spotlight, so the fact that the claimant was not in thoracic surgery would not mean that the risk of harm to a patient was eliminated.

204. The appeal panel reviewed the disciplinary outcome and was satisfied that each of the allegations was sufficient on its own to amount to gross misconduct. The appeal panel felt that the falsification of the SVP forms was the most serious of the allegations. MJ was satisfied that the claimant had regularly and deliberately falsified safety critical documents and that the claimant did not demonstrate adequate insight at the disciplinary hearing into the severity of what he had done. The appeal panel felt that the claimant had sought to diminish its importance as part of patient safety yet they noted that he had been instrumental in introducing SVP forms in 2007 to avoid a never event. The appeal panel saw no sign of any reflection as to what cancellation might mean for a patient from the claimant at the disciplinary stage. They accepted that this had been a relevant factor for JM to take into account when considering sanction.

205. The appeal panel felt that not putting information on EPR is denying other doctors important care information and that again, at disciplinary stage the claimant had not acknowledged the impact of his failure to adequately document care on others. The appeal panel felt, in their discussion that what they were concerned with was that it was "*all about the patients"* for them, that the disciplinary panel had had regard to the impact on patient safety and patient care when considering the classification of the allegations as gross misconduct and when considering sanction, whereas for the claimant it was all about apologizing whilst still seeking to argue that it was not as risky as the respondent thought it was and whilst still arguing that others had done it.

206. During the appeal hearing the claimant alleged that JR, who was present, was not doing SVP forms properly himself. JR said that it was national practice not to use SVP forms for thoracoabdominal surgery on the aorta, as there is only one aorta so a wrong side issue does not arise.

207. The claimant alleged that JR had "pre documented" patients himself. JR said that he sometimes makes notes prior to seeing a patient so as to inform a full discussion but when this happens he marks the notes as having been made prior to meeting with patient. The claimant made an allegation that JR had done something on 31 July 2019 that was comparable to the claimant's conduct in delaying or cancelling patient care inappropriately. JR's recollection was that he was doing an anaesthetic list that morning and ITU follow up clinic in the afternoon.

There was a similar allegation made by the claimant about JR failing to document care. JR accepted that in the case cited by the claimant the documentation prior to surgery was incomplete because this was an urgent transfer to theatre. The records were subsequently completed and all present on EPR. The appeal panel accepted that was not comparable conduct to that of the claimant.

208. The claimant described his documentation practice as "idiosyncratic" and sought to defend his failure to document on EPR by saying that his paper records were available. He argued that other examples of inadequate documentation by others ought to exonerate him, whilst seeking to maintain that he had apologised for his inadequate documentation of care and that it was the sanction of dismissal that he objected to. He described the surgery pro forma as "not fit for purpose" and criticized his colleagues saying

> "*Dr Ratnasingham, Dr Wright and Dr Morris were operating outside their area of expertise, or should they argue it was within their area of general medical expertise, they clearly do not examine patients regularly, as it (the pro forma) has nowhere to document medical examination on it. Can the trust demonstrate to me where patient examination is documented… no examination (on the pro forma), so either done, but not documented or not done perhaps this is how so many patients have had valve lesions missed or old thoracotomy scars missed, some of whom have died. A comparison between operating list and the operation of the cardiac surgery database will confirm the magnitude of the former issue".*

209. The appeal panel noted the claimant's arguments that sought to implicate others, even where they were new arguments not put at disciplinary stage but found that they were not evidence of the dismissing officer having made a decision about the claimant's misconduct that was different from the respondent's response to comparable conduct from another doctor.

210. The appeal panel sat until after 7pm on the day of the hearing, allowing the claimant as much time as he needed to put his case. Then it sat after the hearing for an hour and had some discussion. It reconvened on Teams for further discussion later that week.

Claimant attempts to include more documents post hearing

211. On 22 July the claimant wrote to MJ. He said that the Trust had not allowed him to adduce new evidence at appeal but had allowed JR to say that he was allowed to use paper records in anaesthesia. He also raised an issue about JR writing to Professor Field and about production of a palliative care document by JR. The claimant made a fresh allegation that he had seen JW starting surgical incision prior to the completion of the WHO checklist on a number of occasions and called for the appeal panel to interview witnesses to this some of whom he named and others referred to by job title. He said:

> *This is of importance as the trust/Dr Wright are claiming it to be gross professional misconduct for me to have deviated from the WHO checklist, but it would appear he has himself*

The claimant attached a further document of 133 pages.

The appeal outcome

212. On 30 July 2020 the panel reconvened to consider their decision and the claimant's letter of 22 July 2020. They decided not to consider the 133 page document in detail as it would not be fair to do so because (i) the documents to be considered at appeal had been shared prior to the appeal hearing and agreed to be the relevant documentation, (ii) the claimant had confirmed at the hearing, subject to him adducing two new documents that day, that the panel had seen all that he wished them to see and (iii) that if they were to look at the 133 page document post hearing it would not be fair to the management side who had not had a chance to see it or challenge it. However, the panel noted that, at first glance, many of the 133 pages had already been considered at pages 40 – 117 of the claimant's appeal statement of case.

213. On 5 August 2020 MJ wrote on behalf of the panel setting out the appeal decision to the claimant. His letter took each of the 13 grounds of appeal in turn and responded to them.

1. Biased in the investigation

2. Conflict of interest

3. Predetermination of decision

4. Finding of gross misconduct being disproportionate

5. Failure to give due weight to evidence presented

6. Relying heavily on limited witness testimony

7. Missing evidence

8. The decision to summarily dismiss being unduly harsh and unfair decision

9. Procedural errors

10. The investigation arose due to the claimant raising concerns over mortalities and behaviour at the trust as a whistleblower

11. Issues with the transcript

12. Hindrance by restriction of data to defend myself

13. Different treatment compared to consultant colleagues

214. *Biased in the investigation*. The appeal panel found this ground was not made out. The claimant had relied on terms used in JR's report including "gross negligence" as evidence of JR's bias. The panel noted that this term had not been used in the disciplinary hearing itself, from having read the transcript. Further, the appeal panel said that it was "extremely concerned about [his] potential for putting patients at risk" and that patients under his care suffered needlessly due to the

manner of his cancellations and that they were cancer patients who were very sick people. The appeal panel felt that there was no bias from JR. It found that the claimant's actions in putting Patient D back on the list, with no intention of operating, raised a significant probity issue.

215. *Conflict of interest*. The claimant had said that there was a conflict of interest because JM, or JW and JR had been on a cycling holiday with MS, who had appeared as a witness. The appeal panel said there was no evidence that the disciplinary panel had been misled. The claimant had been given the opportunity to question MS, and any of the other surgeons, but had chosen not to. The ground was not upheld.

216. *Predetermination of decision.* The panel found that the error on the dismissal letter was not evidence of predetermination. The respondent taking legal advice was not evidence of this and the SAR and ICO issues, which the claimant had raised, were not evidence of this. The decision not to re-validate the claimant prior to disciplinary hearing was advanced as evidence of predetermination. The appeal panel took advice from AM on that point and he confirmed that a deferral of revalidation was consistent with practice in other trusts in the circumstances and was within GMC guidance. The appeal panel decided that the recommendation to defer revalidation was not evidence of predetermination of the outcome.

217. The panel rejected an argument by the claimant that by *not excluding* the claimant the respondent had in some way shown predetermination to dismiss. The panel also rejected the argument that the special leave between hearing and decision showed predetermination; it was satisfied by JM's account that this was done on grounds of patient safety post decision that the conduct amounted to gross misconduct and prior to determination of sanction. Further, Dr Al-Rawi's comment (he had expressed his view to the claimant that the investigatory process might lead to dismissal) was not evidence of predetermination.

218. *Gross-misconduct disproportionate.* The appeal panel accepted JM's position that the claimant was the only surgeon to have undertaken SVP forms on a day prior to the date of admission. It accepted JM's view of the impact of cancellation on patients in cases with "little or no effort being made by yourself in finding the missing clinical documentation or test results". It also accepted JM's decision that the inadequate documentation was a serious breach that failed to put patients first.

219. *Failure to give due weight to evidence.* The appeal panel accepted that the disciplinary panel had found that the claimant was the only surgeon to consistently and deliberately fail to accurately complete the SVP forms. This was not a question of weight of evidence, the documentation was clear and the claimant had admitted the SVP issue. The ground of appeal was not upheld.

220. *Limited witness testimonial.* The claimant had said that JW, JR and MS had provided information that misled the disciplinary hearing. The appeal panel rejected this assertion. MS was available to be questioned at the disciplinary hearing and it was not put to him by the claimant that he was misleading the panel. JW and JR were questioned by the claimant at the disciplinary hearing. The appeal panel found nothing untoward in the changes to RDP's statement from the

transcription of the investigatory interview notes to the narrative statement he had subsequently prepared.

221. *Missing evidence.* The claimant had said that the respondent had not tried to obtain data about his requests for PFTs from Aintree. The appeal panel accepted JR's explanation that he had asked Aintree for details of the claimant's requests for PFTs but not received any. The claimant had been informed prior to the disciplinary hearing that the respondent did not consider it necessary to have all of the PFT requests for all of the surgeons.

222. *Decision to dismiss unduly harsh and unfair.* The appeal panel accepted that JM had considered a range of sanctions and felt this was corroborated by the error on the dismissal letter heading. The claimant had argued that he was being dismissed because he had previously raised concerns about patient deaths. The appeal panel rejected this argument, accepting in full that JM had not known that the claimant had raised concerns when he decided to dismiss. JM had set out clearly his reasoning for the dismissal in his face to face communication of the decision to dismiss and in the dismissal letter.

223. *Procedural errors.* The claimant alleged that there was delay, that he was denied documentation re his requests for PFTs from Aintree, that he had raised three grievances, that witness statements were not signed and that there was no external thoracic specialist on the panel. The appeal panel found, having heard from JM, that the delay was not inappropriate and largely as a result of requests for delay from the claimant's representatives, that efforts had been made to get PFT requests but none had been forthcoming, that the issues raised in the grievances had been before the disciplinary panel and that whilst there were unsigned statements and there was no (external independent) thoracic specialist on the panel this would not have made any difference to the decision to dismiss because of the seriousness of the claimant's actions and his admissions in relation to two of the allegations.

224. *The claimant was investigated (and disciplined) because he was a whistleblower.* At the time of the appeal the claimant anticipated his tribunal claim relating to public interest disclosure detriment and dismissal. The appeal panel accepted the evidence of JM that he had not known the claimant was a whistleblower. There was no evidence of anyone else orchestrating disciplinary proceedings because the claimant was a whistleblower. The appeal panel noted that the claimant had not said he had suffered any detriment post whistleblowing but prior to the disciplinary investigation in this case.

225. *Issues with transcript.* The claimant said that he did not agree the accuracy of the transcript of the disciplinary hearing. Management agreed to make the corrections the claimant requested and the appeal panel was satisfied that none of them affected its decision.

226. *Hindrance by restriction of data to defend myself.* The claimant again referred to his requests for Subject Access and his Freedom of Information request. The appeal panel was satisfied that these were attempts to obtain data about wrongdoing by others to put the claimant's own wrongdoing in perspective and upon which to found his argument that he was being dismissed for things others had done and not been dismissed for. The appeal panel rejected that

argument because, it said, the disciplinary decision to dismiss had been made on the basis of the seriousness of the admitted allegations. The appeal panel said "you yourself accepted that the actions or behaviours of others do not mitigate your own behaviours".

227. *Different treatment compared to consultant colleagues.* At appeal hearing the claimant made new and wide ranging allegations relating to other surgeons. The appeal panel listened to those allegations but did not feel it necessary to investigate or accept or reject those allegations because it was not presented with a scenario that was the same as the claimant's. The appeal panel was satisfied that the claimant had "regularly and deliberately falsified safety critical documents" He had not shown the disciplinary panel, nor appeal panel a case of any other surgeon doing that.

228. The appeal panel had listened to the allegations made by the claimant about others and had listened to him say both that he admitted and apologised for wrongdoing and that he did not think any patients had been put at risk by his actions. MJ concluded his appeal outcome letter saying that the claimant did not demonstrate the adequate insight regarding the severity of his actions. For the appeal panel the SVP issue was the most serious. His appeal was denied.

229. Mr Jones shared the allegations that the claimant had made against his surgical colleagues with the chairman of the respondent Trust Board.

230. The claimant went to ACAS and commenced proceedings.

Relevant Law

231. Section 94 Employment Rights Act 1996 (ERA) provides that an employee has the right not to be unfairly dismissed by his employer.

232. Section 98 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;**
>
> **c) Is that the employee was redundant; or**

d) Is that the employee could not continue to work in the position which he held without contravention (either on his part or on that of his employer) of a duty or restriction imposed by or under an enactment.

b. **In subsection (2)(a) -**

a) 'Capability', in relation to an employee, means his capability assessed by reference to skill, aptitude, health or any other physical or mental quality; and

b) 'Qualifications', in relation to an employee, means any degree, diploma or other academic, technical or professional qualification relevant to the position which he held."

233. The burden of proof lies on the employer to show what the reason or principal reason was, and that it was a potentially fair reason under section 98(2). According to Cairns LJ in **Abernethy v Mott, Hay & Anderson [1974] ICR 323**:

> **"A reason for the dismissal of an employee is a set of facts known to the employer, or it may be of beliefs held by him, which cause him to dismiss the employee."**

This requires the Tribunal to consider the mental processes of the person who made the decision to dismiss. In **Linfood Cash and Carry v Thomson**

> **"The Tribunal must not substitute their own view for the view of the employer, and thus they should be putting to themselves the question -could this employer, acting reasonably and fairly in these circumstances properly accept the facts and opinions which it did? The evidence is that given during the disciplinary procedures and not that which is given before the Tribunal".**

234. **Jhuti** in the Court of Appeal cited Arnold J in the EAT in **Burchell v British Home Stores [1978] IRLR 379** which set out the standards for determining whether dismissal for (mis)conduct is fair:

> **"First of all there must be established by the employer the fact of that belief; that the employer did believe it. Secondly, that the employer had in his mind reasonable grounds on which to sustain that belief. And thirdly, we think that the employer, at the stage at which he formed that belief on those grounds...had carried out as much investigation into the matter as was reasonable in all the circumstances of the case."**

235. Where the employee has admitted his misconduct the employer will be acting reasonably in believing that the misconduct has been committed so the requirement for investigation will be reduced **Royal Society for the Protection of Birds v Croucher [1984] IRLR 425**

236. Where the employer does show a potentially fair reason for dismissing the claimant the question of fairness is determined by section 98(4).

> **"(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."**

237. In **Iceland Frozen Foods Limited v Jones [1982] IRLR 439,** Browne-Wilkinson J formulated the correct test in the following terms

> **"…the correct approach for the Industrial Tribunal to adopt in answering the question posed by Section 98(4) Employment Rights Act 1996 is as follows:**
>
> **(1) The starting point should always be the words of Section 98 (4) themselves;**
>
> **(2) In applying the section the Industrial Tribunal must consider the reasonableness of the employer's conduct, not simply whether they (the members of the Industrial Tribunal) consider the dismissal to be fair;**
>
> **(3) In judging the reasonableness of the employer's conduct an Industrial Tribunal must not substitute its decision as to what the right course to adopt for that of the employer;**
>
> **(4) In many (though not all) cases there is a band of reasonable responses to the employee's conduct within which one employer might reasonably take the one view, another quite reasonably take another;**
>
> **(5) The function of the Industrial Tribunal, as an industrial jury, is to determine whether in the particular circumstances of each case 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."**

238. If the three parts of the **Burchell** test are met, the Employment Tribunal must then go on to decide whether the decision to dismiss the employee (instead of imposing a lesser sanction) was within the band of reasonable responses, or whether that band fell short of encompassing termination of employment. In a case where an employer purports to dismiss for a first offence because it is gross misconduct, the Tribunal must decide whether the employer had reasonable grounds for treating the misconduct as gross misconduct: see paragraphs 29 and 30 of **Burdett v Aviva Employment Services Ltd UKEAT/0439/13.**

239. Generally gross misconduct will require either deliberate wrongdoing or gross negligence. Even then the Tribunal must consider whether the employer acted reasonably in going on to decide that dismissal was the appropriate punishment. An assumption that gross misconduct must always mean dismissal is not appropriate as there may be mitigating factors: **Britobabapulle v Ealing Hospital NHS Trust [2013] IRLR 854** (paragraph 38). The Tribunal must determine whether dismissal was a response that no reasonable employer could have adopted in the circumstances.

240. The Court of Appeal in **Salford Royal Northern Foundation Trust v Roldan 2010 IRLR 721** determined that more will be expected of a reasonable employer where the allegation is one of misconduct and the consequences to the

employee if they are proven, are particularly serious. Elias LJ, at paragraph 13, quoting his own judgment from A v B [2003] IRLR 405 said

> **"*the relevant circumstances {in Section 98(4)} include the gravity of the charge and their potential effect upon the employee. So it is particularly important that employers take seriously their responsibilities to conduct a fair investigation where, as on the facts of that case, the employee's reputation or ability to work in his or her chosen field of employment is potentially apposite. In A v B the EAT said this:***
>
> ***"a careful and conscientious investigation of the facts is necessary and the investigator charged with carrying out the inquiries should focus no less on any potential evidence that may exculpate or at least point towards the innocence of the employee as he should on the evidence directed towards proving the charges against him"***

241. In **London Ambulance Service NHS Trust v Small 2009 EWCA Civ 220** Mummery LJ reminded tribunals that it is all too easy to slip into a substitution mindset. A tribunal must avoid conducting its own fact-finding forensic analysis. The real question is whether the employer acts fairly and reasonably in all the circumstances at the time of the dismissal.

242. When applying Section 98(4) the Tribunal must take into account the size and administrative resources of the respondent, any relevant Code of Practice and the Human Rights Act 1998. The ACAS Code on Disciplinary and Grievance Procedures provides at paragraph 4:

- Employers and employees should raise and deal with issues promptly and should not unreasonably delay meetings, decisions or confirmation of those decisions.
- Employers and employees should act consistently.
- Employers should carry out any necessary investigations, to establish the facts of the case.
- Employers should inform employees of the basis of the problem and give them an opportunity to put their case in response before any decisions are made.
- Employers should allow employees to be accompanied at any formal disciplinary or grievance meeting.
- Employers should allow an employee to appeal against any formal decision made.'

243. The band of reasonable responses test applies to all aspects of the dismissal process including the procedure adopted and whether the investigation was fair and appropriate: **Sainsburys Supermarkets Ltd v Hitt [2003] IRLR 23.** The focus must be on the fairness of the investigation, dismissal and appeal, and not on whether the employee has suffered an injustice.

244. The circumstances relevant to assessing whether an employer acted reasonably in its investigations include the gravity of the allegations, and the potential effect on the employee: **A v B [2003] IRLR 405**. In **W Weddel & Co Ltd v Tepper [1980] IRLR 96** per Stephenson LJ

> ***"Employers do not have regard to equity or the substantial merits of the case if they jump to conclusions which it would have been reasonable to postpone in all the***

> ***circumstances until they had…"gathered further evidence" ……if they form their belief hastily and act hastily upon it, without making appropriate inquiries or giving the employee a fair opportunity to explain himself, their belief is not based on reasonable grounds and they are certainly not acting reasonably".***

245. The ACAS Code at paragraphs 5 -7 addresses the elements of an investigation

> **"5. It is important to carry out necessary investigations of potential disciplinary matters without unreasonable delay to establish the facts of the case. In some cases this will require the holding of an investigatory meeting with the employee before proceeding to any disciplinary hearing. In others, the investigatory stage will be the collation of evidence by the employer for use at any disciplinary hearing.**
>
> **6. In misconduct cases, where practicable, different people should carry out the investigation and disciplinary hearing.**
>
> **7. If there is an investigatory meeting this should not by itself result in any disciplinary action. Although there is no statutory right for an employee to be accompanied at a formal investigatory meeting, such a right may be allowed under an employer's own procedure."**

246. The Tribunal should consider procedural fairness together with the reason for dismissal **Taylor v OCS Group Ltd [2006] EWCA Civ 702.** The tribunal must decide whether in all the circumstances of the case the employer acted reasonably in treating the reason they have found for the dismissal as a sufficient reason to dismiss.

247. There is no obligation for an employer to investigate wholly speculative matters advanced as possible mitigation. Where an employer has previously treated another employee guilty of similar misconduct more leniently a dismissal may be considered unfair because it would not be equitable within the meaning in Section 98(4). Brandon LJ in **Post Office v Fennell [1981] IRLR 221** said:

> ***"The expression equity as there used comprehends the concept that employees who misbehave in much the same way should have meted out to them much the same punishment"***

248. However, allegedly similar situations must be truly similar **Hadjioannou v Coral Casinos Limited [1981] IRLR 352**, the employer must have been aware of the similar conduct **Wilcox v Humphreys and Glasgow Limited [1975] IRLR 211,** an employer may distinguish between two cases where there is a rational basis for the distinction made, though not that there were different decision making managers, and consistency may have to give way to flexibility. The appeal is to be treated as part and parcel of the dismissal process: **Taylor v OCS Group Ltd [2006] IRLR 613**

249. In **Idu v East Suffolk and North Essex NHS Foundation Trust [2019] EWCA Civ 1649** the Court of Appeal held that the determination of the correct classification of a surgeon's misconduct or capability under MHPS was a matter for the Court. The claimant had argued that the case against her involved professional conduct and that she was therefore entitled, under MHPS, to have an independent medically qualified person on the panel.

250. **Polkey v AE Dayton Services Limited [1987] IRLR 50 HL** established that where a claimant is successful a reduction may be made to an award on the basis that if the employer had acted fairly the claimant would have been dismissed in any event at or around the same time. This may take the form of a percentage reduction, or it may take the form of a tribunal making a finding that the individual would have been dismissed fairly after a further period of employment (for example a period in which a fair procedure would have been completed). The question for the tribunal is whether the *particular employer* (as opposed to a hypothetical reasonable employer) would have dismissed the claimant in any event had the unfairness not occurred.

251. The Employment Rights Act 1996 at section 122 and section 123 provides for a reduction in compensation because of contributory fault by the claimant.

Wrongful dismissal

252. The right to summarily dismiss an employee arises when the employee commits a repudiatory breach of contract. An employer can then waive the breach or treat the contract as discharged.

253. In **Mbubaegbu v Homerton University Hospital NHS Foundation Trust UKEAT/0218/17 (18 May 2018, unreported) cited in Harvey,** Choudhury J quoted a passage from **Neary v Dean of Westminster [1999] IRLR 288** which relied on a breach of the term of mutual trust and confidence. In that case the conduct in question "must so undermine the trust and confidence which is inherent in the particular contract of employment that the master should no longer be required to retain the servant in his employment. More recently, the test was set out by Collins Rice J in **Palmeri v Chares Stanley & Co Ltd [2021] IRLR 563**

> **"The test I am required to apply for that is variously formulated in the authorities. It includes considering whether, objectively and from the perspective of a reasonable person in the position of Charles Stanley, Mr Palmeri had "*clearly shown an intention to abandon and altogether refuse to perform the contract*" by repudiating the relationship of trust and confidence towards Charles Stanley (*Eminence Property Developments v Heaney [2011] 2 All ER (Comm) 223*). In a case like this "*the focus is on the damage to the relationship between the parties*" (*Adesokan v Sainsbury's Supermarkets Limited [2017] ICR 590* per Elias LJ paragraph 23). There is relevant analogy with the formulations in the employment cases: "*the question must be — if summary dismissal is claimed to be justifiable— whether the conduct complained of is such as to show the servant to have disregarded the essential conditions of the contract of service*." (*Laws v London Chronicle [1959] 1 WLR 698*, pages 700-701) It must be of a "*grave and weighty character*" and "*seriously inconsistent – incompatible – with his duty as the manager in the business in which he was engaged*" (*Neary v Dean of Westminster [1999] IRLR 288*, paragraph 20), or "*of such a grave and weighty character as to amount to a breach of the confidential relationship between employer and employee, such as would render the employee unfit for continuance in the employer's employment*" (*Ardron v Sussex Partnership NHS Foundation Trust [2019] IRLR 233* at paragraph 78)."

254. A repudiatory breach might be said to be conduct the effect of which is to render the continued relationship unsustainable. Conduct that is wilfull, a deliberate flouting of essential contractual conditions will cross a repudiatory line.

The Tribunal therefore has a fact finding function in wrongful dismissal, to establish what the employee has actually done and not just, as in unfair dismissal, what the employer reasonably believes him to be guilty of **British Heart Foundation v Roy UKEAT/0049/15.**

Application of the Law to the facts

255. The following application of the law follows the questions in the List of Issues provided by the parties, though not in the order presented in the appendix to the list. The questions are addressed thematically under the following subheadings derived from section 98 and the relevant law.

The reason for dismissal

1.What was the reason for the Claimant's dismissal or if more than one the principal reason? In particular was it conduct, a potentially fair reason (see appendix below)?

256. The Tribunal accepted the oral evidence of Dr Morris that the reason for dismissal was conduct. Dr Morris was satisfied that the claimant had falsified patient documentation, cancelled surgery inappropriately and failed to adequately document care. Conduct is a potentially fair reason for dismissal within section 98(2) ERA.

257. The claimant had argued that the outcome of the disciplinary process was predetermined and that this was not the real reason for his dismissal. He had argued that RDP was a puppet- master controlling the process and people involved in it to dismiss the claimant. Whilst this was not fully pursued at the Tribunal hearing it remained a sub-text in the claimant's evidence. The Tribunal found the allegations that RDP was a puppet-master to be unsubstantiated.

258. RDP had written a letter and expressed strong views about the claimant's practice (his *eight concerns* letter above), but there was no evidence that he had interfered with the decision making on dismissal or information provided to decision makers in the disciplinary process. Whilst there had been tension between the claimant and RDP and the broader thoracic surgery team it did not affect the decision making of Dr Morris. Dr Morris did not know about RDP's *eight concerns* letter. The Tribunal accepted the oral evidence of Dr Morris and Mr Jones that they had each made their own decision, without interference from RDP or anyone else.

259. Applying **Aslef v Brady** it is nothing to the point that the thoracic surgeons had refused to work with the claimant, or that RDP had written his letter. The Tribunal accepted the oral evidence of Dr Morris that the statements of the surgeons had carried little weight in his assessment of the evidence against the claimant at the disciplinary hearing. What had carried weight for Dr Morris was the claimant's admissions about the SVP forms and the patient scenarios for Patients A-E.

260. The claimant also suggested that the other investigation and disciplinary process had been an attempt to dismiss him but had been abandoned in favour of the process in this case because he had successfully argued that the panel in the

other case had been biased against him. This submission was wholly unsubstantiated. The claimant had accepted a sanction in the other case. Its factual circumstances were unrelated to the allegations in this case. It was about a website. If, as alleged, the respondent had been motivated to dismiss him then its decision to allow him to submit to a lesser sanction than dismissal in the other case and not to suspend him in this case would suggest otherwise.

Genuine belief

2.Did the Respondent have a genuine belief in the Claimant's guilt in respect of the matters it relied upon for dismissing the Claimant (see appendix below)?

261. The claimant admitted allegations 1 and 3 and at disciplinary hearing apologised for them and asked if he could remain employed subject to a written warning. Dr Morris relied on both the claimant's admissions and the evidence he saw and heard in the management statement of case in forming his genuine belief. In particular, he saw in relation to allegation 1, the SVP form issue, pages 6367 and 6368 citing 98 occasions on which the hospital records showed the claimant had completed SVP forms on dates prior to the dates of admission of the patients.

262. As part of the management statement of case the respondent gave 3 example cases for allegation 2, and 5 example cases for allegation 3. The cases related to specific patients. Dr Morris knew the following details:

> In the case of Patient A, a lung cancer patient, the claimant had completed an SVP form on XX April 2017 at 07.38. That was a Friday morning and the claimant was due to operate on the patient on Monday morning. The claimant did not want to have to come to hospital on the Sunday (unpaid) to meet and mark the patient and do the SVP form so he completed it in advance. On Monday morning he cancelled the surgery. He did not make an entry onto EPR to say why he had cancelled or what he had said to the patient. He told the disciplinary hearing the reason for cancellation was because his hand written notes had not been brought over or scanned up from Aintree. He did not make sufficient effort to get those notes before cancelling and he did not look to see if the information he needed could be reconstructed from radiology or other data available on EPR before cancelling.
>
> In the case of Patient B the claimant cancelled his surgery on XX March 2017. The reason the claimant gave was that the testing machine at LHCH was not working on the morning of surgery. The claimant had filled out an SVP form for Patient B before he was admitted to hospital. There was no other note on EPR to say why surgery had been cancelled or to state any further treatment plans for Patient B.
>
> In the case of Patient C the claimant had cancelled surgery because he said there were no notes available for the patient and no test results but they had been done 10 days earlier and sent to LHCH three hours before the claimant had cancelled the patient's surgery. The claimant had not made sufficient effort to find or reconstruct information in the notes from other sources before cancelling surgery.

In the case of Patient D which was in XX February 2018 when the claimant knew he was under investigation and was no longer performing thoracic surgery, he cancelled the patient's surgery scheduled for his Monday morning list at 17.11 on a Friday saying "needs CTScan aorta", knowing that the scan could not be carried out over the weekend. On the Monday morning XX February 2018 he reinstated the patient to the list, causing confusion for ward and theatre manager colleagues, and having no intention of performing the surgery. The claimant said he had done this because of management pressure.

In the case of Patient E in October 2017 there was no surgical documentation on EPR for the patient.

263. Having seen the ToR2, heard the evidence at hearing, read the management statement of case and appendices and the claimant's documentation Dr Morris genuinely believed that the claimant had falsified patient data, inappropriately cancelled care and failed to adequately document care.

On reasonable grounds
3.Was that belief formed on reasonable grounds (see appendix below)?

264. Dr Morris had reasonable grounds for believing that the claimant had done those things because of

264.1 The claimant's admission in relation to SVP forms and inadequate documentation at disciplinary hearing, including:

a) in relation to allegation 1 *I admit what I did was wrong,*

b) in relation to allegation 2 and Patient A *I spoke to the patient and he was completely cool….I had no notes to discuss…I took the decision on the day to relist…I accept I should have documented the reason for cancellation..I accept I could have done more and I am sorry.*

c) In relation to allegation 3 *I accept that my documentation of many of these cases has made it difficult to fully explain my clinical actions, and hence should have been much better.*

264.2 The admitted list of SVP form completions at 6367 and 6368

264.3 The RCA analyses for patients D and E as appendices to the investigation report and the timeline summary documents for patients A, B C, D and E and the claimant's own version of an RCA for patient D.

264.4 The claimant's concluding statement at disciplinary hearing set out above.

The reasonableness of the investigation

4.Had the Respondent carried out a reasonable investigation in forming such a belief? In particular, did the Respondent's investigation fall within the range of reasonable responses of a reasonable employer (see appendix below)?

265 The respondent carried out such investigation as was reasonable in all the circumstances within the Burchell case. It appointed JR as investigator and JW as case manager within the terms of the HCP. JW wrote and shared with the claimant the first set of terms of reference ToR1. JR interviewed the surgeons, the complaint having arisen out of concerns they raised at a meeting on 19 September 2017

266 JR set about gathering data about the allegations including commissioning individuals not otherwise involved in the process to prepare Root Cause Analysis documents for 5 exemplar patient cases.

267 The terms of reference evolved so that ToR2 was shared with the claimant prior to his own investigatory interview. Following interview the case manager received a written report from JR and decided to proceed to disciplinary hearing.

268 JR with help from AM and GH filtered the data on SVP forms completed prior to admission to produce a documents, pages 6367 and 6368 showing the 98 occasions on which the claimant completed SVP forms prior to patient admission. Dr Morris saw that data, the claimant had seen that data and admitted that he signed off those forms prior to patient admission.

269 The Tribunal rejects Mr Boyd's "nuanced admission" point; that this was an admission of prior completion of paperwork but done with the full intention of compliance, the cart before the horse point, and therefore not an admission of wrongdoing overall. The claimant admitted that on 98 occasions he had added his electronic signature to an SVP form confirming that he had marked a patient for surgery when he had not. That is an admission. The respondent did not need to set about proving all 98 cases.

270 However, JR obtained broader data which the Tribunal saw at p3835.1 showing 222 instances of SVP form completion prior to admission. The claimant did not have that broader data prior to the disciplinary hearing and during the tribunal hearing sought to pursue this point so as to undermine the respondent's investigation, suggesting that the respondent ought to have investigated all 222 and shared information with the claimant about all 222. The claimant's position was that if this had been done, disparity of treatment between him and his colleagues would have been exposed. In answer to question 4 on the List of Issues, the failure to provide the broader data the tribunal saw at 3835.1 to the claimant prior to the disciplinary hearing made no difference because (i) there were 98 occasions which he admitted, the respondent could rely on that admission and its investigation into the disciplinary allegations against *him* was reasonable in all the circumstances of the case and (ii), if the Tribunal is wrong about that, then he did see it and have full opportunity to comment on it, and make accusations in relation to others as a result of it, at appeal, so that any defect in process was cured on appeal.

271 The claimant argued that there were 222 cases in all and that it struck at the heart of natural justice that the claimant had not been provided with all 222. The Tribunal rejects that submission. It was explained to the claimant how the

data had been filtered to remove same day cases. The claimant knew the case against him. It was not for the respondent to build a case for him against others so that at sanction stage, the claimant might have something to cling to. It was for the claimant to point to someone who had behaved in much the same way as he had and had not been dismissed. The claimant did not do this.

The changing terms of reference

A1 Changing the terms of reference from the version accompanying the letter on 22.1.18 to the version on 20.9.18? Did this impact on the fairness of the process and ultimately the decision to dismiss?

272. The change in terms of reference had no impact on the fairness of the process. ToR2 was a reduced and refined version of ToR1. Some allegations were not proceeded with in ToR2. The Tribunal accepted the evidence of JW that in his experience terms of reference drafted from a group meeting can be wide ranging and lack detail. He was always conscious that after interviewing the surgeons and beginning to collect information in the investigation the terms of reference would need to be reviewed. The Tribunal was satisfied that the essence of the allegations which led to the decision to dismiss; falsification of SVP forms, inappropriate cancellations and inadequate documentation were there in ToR1, which included:-

- Evidence of delayed care (this related to what became allegation 2; the inappropriate cancellations)

- Poor documentation e.g. lack of discharge letters and no clear care plans documented (this related to what became allegation 3 inadequate documentation and allegation 1 in relation to SVP form falsification)

- Patients not appropriately consented for treatment (this and enquiry into it and the poor documentation allegation above, related to what became allegation 1)

ToR2 provided more specificity as to the allegations, using subheadings and gave examples by date and patient so that the claimant could see in detail what it was that he was alleged to have done. The content of ToR2 is set out above.

Late notice of ToR2

A4. The new terms of reference were provided to C on the evening of 20/9/18 prior to C's investigative meeting on 21/9/18 – did this give C insufficient time to prepare for that meeting and if so, did that impact on the fairness of the process and ultimately the decision to dismiss ?

273. The claimant saw ToR2 the day before his investigatory interview. The interview had been scheduled for 21 September 2018. That would have been insufficient time for the claimant to prepare for that meeting but the meeting was adjourned at the claimant's request to allow more time for him and his representative to respond to ToR2. The interview then took place on 12 October 2018. This was adequate time, 20 days, for the claimant and his representatives, having seen ToR2 to be ready for investigatory interview. The initial late provision

of ToR2 had no impact on the fairness of the process and decision to dismiss as it was cured by adjournment.

274. The investigation report led to a recommendation that disciplinary action be commenced. JW wrote to the claimant on 25 March 2019 setting out the allegations he was to face. The allegations were repeated in invitation to hearing letters over the months as the hearing was postponed. They were the same allegations that Dr Morris relied on in hearing the disciplinary case. They are reproduced here. The Tribunal finds that they arose out of ToR2, which arose out of ToR1, which arose out of the surgeons meeting on 19 September 2017.

> Falsification of hospital records (site verification forms)
> This is documented in the Investigation Report and referred to in section 2 of the ToR2. I have concluded that there is a case to answer in sections 2.1 and 2.2 of the summary of findings and conclusions respectively and 2.3 of the conclusions. Trust data is provided in appendix 25. Examples of patient records are provided for patient B and patient A.
>
> Inappropriate cancellation / delayed care of patients
> This is documented in the Investigation Report and referred to in section 1 of the TOR2. I have concluded that there is a case to answer in sections 1.2, 1.3 and 1.4 of the summary of findings and conclusions respectively. Trust data is provided in appendix 24 pages 1 and 2. Examples of patient records are provided for Patients A, C and B. I have also concluded that patient D should be included as an example.
>
> Inadequate documentation of care
> This is documented in the Investigation Report and referred to in section 4 of the ToR2. I have concluded that there is a case to answer in sections 4.1, 4.2, 4.3 and 4.4 of the summary of findings and conclusions respectively. Trust data is provided in appendix 24 pages 1 and 2. Examples of patient records are provided for patient A, patient C, patient B, patient E and, patient D. I have also concluded that patient A should be included as an example.

275. The Tribunal finds that the change in terms of reference was entirely appropriate as the investigation gathered focus and had no adverse impact on the fairness of the investigatory process or decision to dismiss.

Not reinterviewing the claimant about the RCA timeline for Patient D

A6. Did R act unreasonably or unfairly in not re-interviewing C after C had on 11/1/19 suggested that the timeline/root cause analysis for one of the disciplinary cases (patient D) was incomplete and inaccurate? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

276. The decision not to re-interview the claimant had no material impact on the fairness of the process or decision to dismiss. The claimant prepared his own RCA for Patient D and it was included in the claimant's SoC for use at disciplinary hearing. The Tribunal notes that an RCA should be prepared by someone independent. The claimant was not independent but nonetheless the respondent allowed him to adduce his alternate RCA for Patient D.

277. Dr Morris saw the claimant's alternate RCA timeline at Appendix 51 and it was taken into account in the decision to dismiss. There was detailed discussion of Patient D's case at the disciplinary hearing. The Tribunal saw the agreed notes of the disciplinary hearing which record JR taking the panel to the claimant's own statement where he dealt with Patient D. This was the cardiac case from February 2018 after the claimant had given up thoracic surgery and after the claimant was aware that he was being investigated. The claimant had looked at the xray on the Friday evening and called for a CTScan of the aorta and cancelled the surgery then at 8.11 on the Monday morning had emailed his secretary to put the patient back on the Monday list.

278. The claimant had full opportunity to say what he wanted to say and to challenge the respondent's statement of case at the disciplinary hearing. Dr Morris placed more weight on what was said at disciplinary hearing in front of him and the panel than on the content of the investigatory interview notes. At the hearing the claimant was able to refer the panel to his corrections, as he put it, to the RCA and to say that the patient had been passed to him by colleagues and suggested that he had spotted something that none of his colleagues had spotted. He said, when asked why he had emailed to put the patient back on the list "*it was because of pressure from Hayley Kendall…I was being asked why I only had one patient on my list so I asked for him to be put back on my list, it was a silly error".*

Conduct rather than capability- designation under MHPS

A9 Did R act unreasonably in treating the allegations as matters of conduct rather than capability?

279. The classification of the allegations was a matter for JW as case manager. The respondent acted reasonably in classifying them as conduct because:

> 265.1 JW had seen the minutes of the surgeons meeting from 19 September 2017 He knew the nature of the allegations. He had regard to HCP particularly at 3.4.1 and 3.4.3 and 3.4.5 (set out above).
>
> 265.2 He consulted with JR in January 2018. He consulted again later after JR had interviewed the surgeons and knew that they had said that the claimant had good technical skill but the problems were in his communications with his colleagues and his behavioural approach to patient care. JR agreed with the conduct classification. JW was a doctor himself and well placed to understand the difference between clinical and non clinical matters.
>
> 265.3 JW consulted with RAP in March 2018. RAP felt that the majority of concerns were conduct related but that it could depend on the way the questions were put.
>
> 265.4 JW remained open to the ongoing review of the classification of allegations and gave assurance in his letter to EA on 20 September 2018 when he said "*if any clinical competency needs to be evaluated it will require separate TOR and full MDU input on a separate day*"

280. The Tribunal found that in consulting others and remaining open to review and giving assurance that if clinical issues arose separate ToR could be prepared and MDU could be involved in a separate investigatory interview, JW acted reasonably in classifying the allegations before him as conduct.

281. Further, JW kept PPA informed and shared with them the fact that they were conduct allegations. He spoke with Mr Preece in August 2018 and met with him in April 2019. Mr Preece reminded JW that if a misconduct allegation were upheld the panel would need to take into account any mitigation. There was correspondence between the claimant's representatives EA and OL and JW and RAP on this point. The respondent told the representatives how it had classified the allegations and responded to their arguments that they were clinical issues.

282. The claimant put his arguments about the classification of the offences at investigatory interview, in his statement of case and at disciplinary hearing and appeal. The respondent did not act unreasonably in its classification of the allegations as conduct.

283. Applying **Idu**, and the HL in **Skidmore**, that the correct categorization of the conduct charged was a matter for the Court and not the Trust, the Tribunal finds that the respondent complied with MHPS / HCP in properly categorizing each of the three allegations against the claimant as a conduct issue. The first allegation was about falsification, the second about a lack of effort, the claimant being too ready to cancel and the third about a failure to document care. The Tribunal finds that they do not relate to professional conduct. They were not about behaviours arising from the exercise of his medical skills. The respondent, in any event, arranged for an independent medically qualified person to be part of the disciplinary and separately, the appeal panel.

Failure to refer ToR2 to external thoracic surgeon

A10 Did R fail to consider C's request to have the terms of reference reviewed by an external Thoracic Surgeon and/or was R obliged to seek such an opinion under MHPS? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

284. The respondent considered the request and replied. JW wrote to EA. He said that an external thoracic surgeon is not required in the case because the allegations against the claimant were conduct based. HCP has different provisions for conduct panels and capability panels. The respondent was not obliged under its HCP on a conduct issues to seek an opinion on the terms of reference from an external thoracic surgeon. The respondent did not fail to consider the request, the response letter is detailed. It considered the request and reasonably rejected it.

285. Much was made by the claimant of the respondent's failure to appoint a thoracic surgeon, both to review the investigation report and to be part of the decision making panels. He asserted in cross-examination that if there had been a thoracic surgeon on the panel his case would have been understood and he would not have been dismissed. His disciplinary panel included an external doctor Professor Andrew Rowland, a Medical Director and Dr Morris, both senior doctors. His appeal panel included Dr Paul Mansour, a Consultant Cellular Pathologist and Medical Director. Both decision makers had expert medical input yet the claimant

persisted in saying that only a thoracic surgeon should judge him. He had had the opportunity to question all the thoracic surgeons at LHCH at his disciplinary hearing and had chosen not to do so. The Tribunal, having heard the oral evidence of Dr Morris and Mr Jones finds that the presence of a consultant thoracic surgeon on the panel would have made no difference to the outcome. Their reasoning for their decisions related not to the intricacies of thoracic surgery, but to behavioural choices in patient care.

286. The Tribunal notes that JR spoke to JAS, an internal thoracic surgeon, about normal practice in thoracic surgery as part of his investigation but did not share that content with the claimant. The Tribunal finds that that conversation and the failure to share its content had no material impact on the fairness or outcome of the disciplinary and appeal processes because (i) as stated above the reasoning of Dr Morris and Mr Jones related not to the intricacies of thoracic surgery but to behavioural choices in patient care and because (ii) the claimant had admitted the SVP issue and (iii) the claimant had had the opportunity to question JAS at the disciplinary hearing but OL had decided not to. Both decision makers gave evidence that he would have been dismissed for that alone, in any event.

The claimant's requests for further information

A8. Did R fail unreasonably to respond to C's email of 26/9/19 to C's request for further information in respect of (i) PFT's and (ii) surgical site markings? This is not part of C's pleaded case and cannot therefore be advanced by C.

A5. Did R respond to C's request post his investigation meeting set out in his email of 30.11.18? If so, was that unreasonable or unfair and did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A7. Did C request missing information in emails of 3.12.18 and 19.12.18? If so, did R fail to respond to those requests? If so was that alleged failure unreasonable or unfair and did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A8a. In any event, did R fail to respond and was the alleged failure reasonable or not? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

287. The requests of November 2018 and December 2018 and September 2019 were for (i) PFT data (ii) The RCA timeline for Patient D to be corrected and (iii) Record Keeping Policy documentation from 2016 and 2017 and (iv) more time to amend the notes of the investigatory interview. On the PFT data point the Tribunal finds that the failure to provide documentation or tell the claimant the total number of PFT requests he had made on EPR compared to his colleagues did not materially impact on the fairness of the process nor the decision to dismiss. This is because it was not the respondent's case that the claimant was failing to order tests routinely. It wasn't a volume point. The issue was that he was cancelling too readily and without good reason, without checking to see if tests had been done and where the results were, that he had not prepared a patient properly so that leaving the tests to the day of the surgery at LHCH put the surgery at risk.

288. Dr Morris had heard the management statement of case about patients A-E and heard and seen the claimant's detailed responses, including his own RCA for Patient D, on each of those cases. The Tribunal finds that if Dr Morris had had "volume of PFT's ordered" or "comparison with peers ordering PFT's data", it would

have made no difference to the fairness of his decision to dismiss. Dr Morris was satisfied that the claimant had not made sufficient effort to find PFT data before cancelling and would have dismissed for that alone.

289. Further, the Tribunal accepts Dr Morris' evidence as set out in the letter of dismissal that the SVP form issue alone, as admitted, would have amounted to gross misconduct and for the reasons set out above relating to the claimant's failure to accept the risks to patient safety in his conduct, Dr Morris would have dismissed. Knowing that the claimant had ordered many, many PFT's and only had one or two not completed so that surgery could not go ahead, (even if other colleagues had also had surgery not go ahead for want of PFT's) would not have outweighed the claimant's lack of effort before cancelling surgery or the other (admitted) grounds for dismissing the claimant.

290. The Tribunal accepts the respondent's submission that the employer does not need to do a "deep dive" analysis in the case of an admission. On the SVP form point the data provided was sufficient. The claimant admitted the 98 occasions on which he had completed the SVP form before he had seen and marked the patient. On the inadequate documentation of care point the claimant admitted that he had not adequately documented care. The respondent submitted that an admission lowers the bar for reasonableness of investigation **Boys and Girls Welfare Society v McDonald 1997 ICR 693.** There was no factual contest in this case about the 98 cases nor the inadequate documentation of care. In **RSPB v Croucher** Waite J reversed a first instance finding on failure to carry out a reasonable investigation where the employee in question had admitted overclaiming expenses.

291. The claimant's submissions sought to undermine the reasonableness of the investigation into the SVP issue by referring to the 222 cases of SVP completion prior to date of admission on the EPR system, and suggesting that the incidence of 222 cases meant that the claimant was not the only surgeon falsifying forms. This is a potential disparity of treatment point for range of reasonable responses. In this case there was no need to test that suspicion or belief because the claimant had admitted 98 occasions of SVP completion and inadequate documentation of care. It does not render an investigation unfair or unreasonable, and thereby bring the dismissal into question, because an employer faced with an admission does not go and investigate all the other possible occasions on which other people may (or may not) have done the same thing. As reasoned above, it may be relevant as to sanction where a claimant can show someone who has done the same thing and is treated differently. That was not shown in this case.

292. On the RCA timeline point the claimant prepared his own timeline and the disciplinary panel saw his timeline alongside that of the respondent. There was some confusion as to whether or not it was included in the paperwork sent to the claimant prior to the disciplinary hearing (appendix 51). The Tribunal finds that the claimant and the disciplinary hearing had his RCA timeline before the disciplinary hearing. The respondent adopted a reasonable and fair approach in including the claimant's own version of the timeline. There was nothing in the RCA timeline point to render the investigation and the dismissal unfair.

293. On the Record Keeping Policy point the respondent's HR team had directed the claimant to the intranet to access those polices on 24 September 2018. The

Tribunal finds that the claimant had had opportunity to access the policy before his disciplinary hearing.

294. In relation to the time to amend the investigatory interview notes the respondent allowed the claimant the time he wanted and allowed him to go beyond agreeing or amending notes and actually allowed him to make additions to them. The claimant was permitted to augment what he had said at investigatory interview by including new content in the amended notes. He had a "second bite at the cherry" on investigatory interview contribution. The respondent was fair and reasonable in allowing both time and new content.

295. The investigation was fair and reasonable in all the circumstances of the case.

Sufficient to dismiss in all the circumstances

5.Did the Respondent act reasonably in treating that reason as sufficient to dismiss the Claimant in all the circumstances (including with reference to the size and administrative resources of the Respondent undertaking and the equity and substantial merits of the case) as per section 98(4) ERA 1996 (see appendix below)?

296. Dr Morris acted reasonably in treating each of the allegations on its own as a sufficient reason to dismiss.

Allegation 1. There was sufficient reason to dismiss because the claimant had admitted 98 occasions of SVP form falsification. He protested throughout, having apologised for doing this, that it was not a risk of harm to patients. Dr Morris acted reasonably in deciding that the falsification of SVP forms was a risk to patient safety and therefore that it was sufficient reason to dismiss.

Allegation 2. The Tribunal finds that the respondent acted reasonably as there was sufficient reason to dismiss on inappropriate cancellation of care on Patient D case alone. Dr Morris reasonably concluded that the claimant had cancelled surgery without making sufficient effort to find the notes. This had consequences for the patient, the ward staff, the theatre staff and management of theatre lists. Dr Morris took the other examples of inappropriate cancellation into account too.

Allegation 3. Dr Morris considered that the admitted failure to document care was sufficient reason to dismiss. Dr Morris had regard to the impact of that inadequate documentation on patient care and on the ability of other doctors and nurses to care for the patient. The claimant's notes were handwritten, illegibly, on the back of consent forms in a physical file in a trolley on a ward during the patient's stay in hospital and would only be scanned onto EPR when the claimant was discharged. The Trust had had its EPR system in place for over 4 years so that there was a central record that could be accessed by those involved in the care of the patient either from a ward, a clinic or remotely. By failing to adequately document care on EPR the claimant was in effect, denying other doctors access to the treatment plan for the patient. The claimant admitted that he had failed to adequately

document care. The respondent was reasonable to treat that as sufficient reason to dismiss.

297. The allegations taken together were sufficient reason to dismiss. Overall, having had regard to the size and administrative resources of the NHS Trust respondent and the equity and substantial merits of the case the Tribunal finds that the respondent acted reasonably in treating each of the allegations and all of them taken together as sufficient to justify dismissal for the claimant, notwithstanding his surgical ability.

Failing to consider the 222 instances of SVP forms pre admission

A15. Did R act unreasonably at the disciplinary hearing by failing properly to consider the EPR data provided by C which allegedly showed that 222 safe site forms had been created for patients prior to hospital admission and/or contrary to the Trust's procedure of which 122 were completed by individuals other than C? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

298. The panel properly considered the SVP form issue. JW and JR had obtained data from AM and GH to make sense of the 222 alleged instances and to filter that data to reflect the position for C.

A16.Did R act unreasonably at the disciplinary hearing by failing to properly respond to C's request to undertake a more forensic review of the safe site forms? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A17. Did R act unreasonably at the disciplinary hearing by failing to ask, as part of the investigative process and/or at the disciplinary hearing whether C's colleagues had completed site verification forms prior to admission and/or post-admission, but prior to marking the patient? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A18. Did R act unreasonably at the disciplinary hearing by omitting from the disciplinary process a consideration of system entries where the site verification document and admission dates were the same? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

299. A more forensic view was unnecessary. What the claimant wanted was for the respondent to find cases for him to implicate others. The respondent was not required as part of its response to the claimant's alleged conduct to do that. Prior to the disciplinary hearing JR went back to the data analyst colleague and obtained a print out of a spreadsheet of all the occasions on which a SVF form predated the date on the system for patient admission. At the tribunal hearing this document was referred to as page 3835.1. JR had asked the data analyst AM to filter this data so as to remove entries for same date admission and SVP form completion. He could not be sure for those entries that the doctor, whether the claimant or someone else, had not seen the patient before completing those SVP forms. He had also asked for the data to be filtered to remove an SVP form entry for procedures, such as bronchoscopy, where no SVP was required. Finally, he asked for errors to be removed where a wrong date of visit for the patient had been entered on the system. In this way JR could be confident that what he was presenting to JW and what was before the panel was a list of occasions on which an SVP had been completed before a patient was on site, for a procedure that needed an SVP form and where the visit date had been entered correctly. Having seen the document at 3835.1 in the tribunal bundle (but not shared it with the claimant in October 2019) prior to the disciplinary hearing JR was content that the document at appendix 25 (the two page list of 100 entries, the Tribunals pages 6367 and 6368) which had been sent to the claimant and the panel accurately

alleged the (admitted) instances on which the claimant (or his registrar on two occasions) had completed an SVP form prior to patient admission and prior to having seen or marked the patient.

300. As part of this process the respondent saw at disciplinary hearing, as did the claimant well in advance of the appeal hearing, all the instances of SVP pre admission for all doctors. At appeal hearing Mr Jones was clear that no other doctor had systematically and deliberately falsified SVP forms as the claimant had done. It was not incumbent on the respondent to investigate others but in this case the respondent did look at all instances and found no one else had acted as the claimant had acted. There was no comparable behaviour by another doctor within 3835.1 to sustain an inconsistency or disparity of treatment argument. It was within the range of reasonable responses for the respondent not to interview other thoracic surgeons on this point. What was curious was the claimant's decision not to put the point to the thoracic surgeons as witnesses but instead to stand them down. If falsification of SVP forms was as widespread as the claimant alleged then why didn't he put it to each of the thoracic surgeons as witnesses as the disciplinary hearing. The claimant was not credible when he said that it was to avoid incriminating them.

301. The respondent acted reasonably in properly filtering the data to remove cases of *apparent* SVP pre admission (the same date cases) where it could not be sure that there was not a delay in the patient being entered on the system. This was filtered for all doctors, not just the others, so that the claimant was not treated any differently than his peers in this regard. What the respondent arrived at was a position, for all doctors, in which it could confidently say that an SVP form had been completed when a patient was not in the hospital.

A19. Did R act unreasonably at the disciplinary hearing by failing to take account of C's contention that the Trust's internal site verification procedures were not part of LocSIPP and that the site verification issue was not strictly about 'never events' or patient safety? This is not part of C's pleaded case and cannot therefore be advanced by C.

A19a. In any event, did R to take account of C's contention that the Trust's internal site verification procedures were not part of LocSIPP and that the site verification issue was not strictly about 'never events' or patient safety? If so, was this unreasonable by R, and how did that impact on the fairness of the process and ultimately the decision to dismiss?

302. Whether part of LocSiPP or not, Dr Morris knew that the claimant admitted having completed 98 SVP forms, saying that he had marked the site of surgery on the patient, when he had not. Dr Morris knew that the claimant had been instrumental in introducing the SVP forms in 2007. The Tribunal accepts the oral evidence of Dr Morris who said that this was an issue as to the claimant's probity and the Tribunal finds it was disingenuous of the claimant at the disciplinary and appeal hearings and at Tribunal to seek to argue that falsifying an SVP form was not outwith proper practice at the Trust for surgery with laterality and not a patient safety issue. The respondent took into account the claimant's submissions at disciplinary hearing and appeal hearing about LocSiPP and reasonably focused not on whether or not there was a breach of procedure, or what the procedure ought to have been or what WHO said or what the claimant thought best practice was, but the falsification of the form, which was how the allegation had been put in ToR2. The claimant had added an electronic signature to say he had done something he had not done.

A20. Did R have grounds to believe and therefore to conclude at the disciplinary hearing that C was guilty of gross misconduct in relation to the completion of documentation relating to patients?

303. The respondent had reasonable grounds for concluding that the claimant had committed gross misconduct in relation to the SVP issue alone. It was not necessary for the Tribunal to reason through the fairness of the dismissal in relation to the other allegations; the SVP issue alone was enough for this to have been a fair dismissal.

Cancellation of Patients Allegation

A21.Did R act unreasonably at the disciplinary hearing by failing to undertake any or any reasonable assessment of the reasons for C's cancellation of patients? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A22. Did R act unreasonably at the disciplinary hearing by confining the analysis as to cancellation of patients to the year of the investigation only? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A23. Did R act unreasonably at the disciplinary hearing by failing to take reasonable account of elective reasons put forward by C for the cancellation of patients which were outwith C's control? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A24. Did R have reasonable grounds to believe and therefore to conclude at the disciplinary hearing that C was guilty of gross misconduct in relation to the cancellation of patients charge?

304. Dr Morris and the panel were taken through the exemplar cases for patients A-E at the disciplinary hearing and they had regard to the claimant's position both verbally at the hearing and in his documentation on cancellation. Dr Morris did not decide based on an alleged higher incidence of cancellation by the claimant than his colleagues, nor on cancellation in any particular year though there was data was before him, his decision was based on the detail of the exemplar cases. It was about the effort the claimant had failed to make before cancelling, his propensity to cancel too readily. For Dr Morris and his panel, the failings were in the lack of effort, the readiness to cancel and they had regard to the impact of cancellation on the patient.

305. Similarly, at appeal Mr Jones was concerned not with the volume or cancellations compared to colleagues nor at the incidence of cancellation in any one year but at the effect of the cancellations on the exemplar patients. Mr Jones took into account the explanations that the claimant gave as to why the decisions to cancel were outwith his control, for example the non availability of PFT tests at LHCH on the day of surgery in the Patient B case. It was not the clinical decision as to whether to cancel or not that concerned Mr Jones, it was not a capability issue, it was about the readiness with which the claimant cancelled. Mr Jones accepted that the claimant did not make sufficient efforts to find test results which had existed so that surgery was cancelled unnecessarily.

306. The respondent acted reasonably in treating the claimant's inappropriate cancellation of care, across the exemplar patients, (neither Dr Morris nor Mr Jones relied solely on any one case) as sufficient reason to dismiss.

Documentation of care

A25.Did R act unreasonably at the disciplinary hearing by failing to take reasonable account of C's explanations as to the charge that he failed to adequately document care? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A26. Did R have reasonable grounds to believe and therefore to conclude at the disciplinary hearing that C was guilty of gross misconduct in relation to the failure to adequately document care charge?

307. The disciplinary hearing took account of the claimant's explanations given orally and in his documentation. It heard the claimant admit and apologise for the failure to adequately document care and request that he keep his job subject to a warning. Dr Morris found that the admitted failure to document care was sufficient reason to dismiss. The Tribunal considers that Dr Morris acted reasonably in deciding the inadequate documentation of care was sufficient reason to dismiss because Dr Morris had regard to the impact of that inadequate documentation on patient care and on the ability of other doctors and nurses to care for the patient. The claimant's notes were handwritten, illegibly, on the back of consent forms in a physical file in a trolley on a ward during the patient's stay in hospital and would only be scanned onto EPR when the claimant was discharged. The claimant knew this. The Trust had had its EPR system in place for over 4 years in 2017 so that there was a central record that could be accessed by those involved in the care of the patient either from a ward, a clinic or remotely. By failing to adequately document care on EPR the claimant was in effect, denying other doctors access to the treatment plan for the patient.

A27. Did R have reasonable grounds to believe and therefore to conclude at the disciplinary hearing that C was guilty of gross misconduct in relation to all 3 matters that formed the basis of the charges that C faced before the panel?

308. Taken together the three allegations, two admitted, one contested, were proven and the respondent had reasonable grounds, set out above, for concluding the claimant was guilty of gross misconduct in relation to the three.

Other alleged failings

A28. Did R fail to consider (properly or at all) as part of the disciplinary hearing C's addendum to his original statement of case? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A29. Did R fail to consider (meaningfully or at all) at the disciplinary hearing C's written responses to all of the disciplinary allegations? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

309. The respondent properly considered the claimant's documentation. Dr Morris and his panel saw the August SoC the, additional 7 pieces of information letter, the 8+ letter and the respondent's management statement of case with its 52 appendices; including the claimant's amended investigatory interview notes, to which he had been allowed to add new content, and his RCA timeline for Patient D. The Tribunal heard the oral evidence of Dr Morris and considers that the consideration of documentation in this case was thorough. The disciplinary panel also heard the claimant's oral submissions, and it had offered MS and the other thoracic surgeons to the claimant as a witness but the claimant had chosen not to question them. The Tribunal accepts Dr Morris' evidence that he attached most weight to the claimant's own responses both written and oral at disciplinary hearing.

Sanction

A30. Did R decide that the appropriate sanction for C was a final written warning, but in fact dismiss C?

310. No. Dr Morris was clear and utterly convincing on this point. The Tribunal accepts his evidence that he was considering a range of sanctions and that he took a week to decide on sanction and lost sleep over it. The heading on the letter was an error. Dr Morris explained how this had come about. He had asked HR for template letters and then typed his content into them. The headings had not been changed. Further, Dr Morris had told the claimant face to face what the outcome was. The subsequent letter confirming the outcome had the error just in its heading and no one reading beyond the heading, who had been at a meeting and been told face to face he was being dismissed, could have been in any doubt about the reason and reasoning behind the dismissal.

6.Did the Respondent's decision to dismiss fall within the range of reasonable responses of a reasonable employer (see appendix below)?

311. The decision to dismiss could not be said to be a decision no reasonable employer could reach. The claimant had been warned in the various iterations of the letters convening disciplinary hearings that dismissal was a possible outcome. The claimant had attempted throughout and through his representatives to have the allegations reclassified as capability, the upshot of which would have been to avoid dismissal as a possible sanction and to look at remediation training. The efforts at reclassification were *because* dismissal was a sanction within the range of reasonable responses. The claimant and OL further showed this to be the case when they made submissions asking that the claimant's employment be preserved and offering to accept a written warning.

312. Dr Morris considered mitigation and the claimant's apologies but Dr Morris reasonably concluded that they were not sincere because of the claimants ongoing attempts to incriminate and blame others; including his wife, his secretary, NM and other doctors whom he alleged to have done the same as him though never put this to them, and because of the Patient D case in February 2019 when the claimant was no longer in thoracic surgery and knew he was under investigation.

313. The allegations themselves, individually were serious. Falsifying patient records, cancelling care inappropriately and failing to document care were each matters that went to the heart of the trust that the employer was entitled to have in its employee. Dr Morris' decision to dismiss fell within the range of reasonable responses.

314. At appeal Mr Jones considered sanction. The Tribunal accepts his oral evidence that he and his panel felt that it was all about the patients and that the claimant had had little or no regard for the impact of his actions (in terms of risk to patient safety on allegations 1 and 3, and in terms of distress at cancellation, in allegation 2) on the patients. At appeal the claimant had asked for a final written warning. The appeal outcome of upholding dismissal fell within the range of reasonable responses.

7.Did the Respondent follow a fair procedure including with reference to the ACAS Code?

Delay

315. The Tribunal expressed concern about delay at the outset of the case, having had sight of the chronology and when considering the list of issues. The respondent cross examined the claimant as to each of the stages in the process. The respondent took 13 months following the thoracic surgeons meeting in September 2017 before it conducted an investigatory interview with the claimant. The primary period of delay in autumn 2017 was in waiting for notes of the meeting to be approved and then in appointing an investigating officer and case manager. Once they were in place in January 2018 the claimant was then kept informed and consulted about timescales and agreed that he should not be interviewed until after the thoracic surgeons had been interviewed. Those interviews took place in February 2018 and the notes were not approved and returned by all surgeons until July. There was no reason advanced by the respondent as to why it took five months to get the notes back from the surgeons.

316. These periods of delay were well outside the time scales envisaged in HCP. However, the claimant was kept informed by JW and was content with the process. In September 2018 there was then delay at the request of the claimant to give him time to be fully prepared for the investigatory interview, the ToR2 having only been given to him the night before the scheduled interview date of 21 September 2018. The respondent was right to suspend that investigatory interview to afford the claimant time to properly consider ToR2. The claimant then requested more time to amend the notes of the investigatory interview and was allowed that time, from October through to the end of January 2019. It took a year, from investigatory interview, through various iterations of the management statement of case, to get to disciplinary hearing in October 2019. The respondent gave no satisfactory explanation as to why it should take a full year to get from investigatory interview to disciplinary hearing.

317. Some of the delay was as a result of the requests of the claimant and his representatives for more time but it was for the respondent to have driven the process more quickly than this. The delay in this case, whilst far from ideal, did not prejudice the claimant in any way, he remained in employment, working in cardiac surgery, was kept fully informed and happy with the timescales. Delay had no impact on the overall fairness of the decision to dismiss.

Conduct not capability

318. The representations made about classification of the allegations as conduct not capability were fully considered and reasons given by the respondent for its classification, arising from consultation and a shared view of RAP, JW, JR and Jo Twist Director of HR, to the representations made by MBA and MDU. Further, the Tribunal, above, found the allegations were properly classified as conduct within HCP and MHPS.

The claimant knew the case against him

319. The claimant knew the case against him in sufficient detail at each stage of the process to be able to respond. He was afforded the courtesy of being allowed not only to comment on minutes of meetings and agree them, but to amend and add new content to them. He was also afforded the courtesy of external medical

panel members at both disciplinary and appeal hearings. He was represented by, alternately and sometimes concurrently, the MDU and BMA. EA from the BMA chose to write not to JW but to RAP which caused a little further delay as letters were shared and JW responded.

320. The claimant was provided with the management statement of case in sufficient time to be able to respond to it. The claimant was given 6367 and 6368 which showed the case against him in allegation 1 and he was given details in the appendices to the management statement of case JR2+ of the exemplar cases sufficient for him to be able to respond to them. He was told he could access medical records for the purposes of responding to those exemplar cases and he was directed to the intranet for access to policies and was provided with a copy of HCP and the Keeping Medical Records Policy.

Grievance handled concurrently with disciplinary hearing

A12. When C raised his grievance with regard to this matter (conduct not capability) did R act unreasonably by failing to give proper consideration to C's grievance and /or failing to hold a proper grievance hearing ? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss ?

321. When the claimant's representatives first indicated a grievance they were given reasons why it was to be considered within the decision making of the disciplinary panel. Later, JT in her letter set out the respondent's rationale for hearing the grievance and disciplinary allegations together. The respondent knew that the claimant had raised a grievance in similar terms in the other case against him, relating to bias by the investigating officer or case manager. The respondent acted reasonably and within the ACAS Code in considering that the grievance and disciplinary matters were interrelated in this case and could be heard together. Further reasoning in response to question A12 is set out below.

A13. The decision to appoint Dr. John Morris as and/or Dr. John Morris holding the role of Chair of the Disciplinary Panel in light of a previous matter where C had been requested to provide an opinion regarding one of Dr. Morris' patients which C believes had a negative impact on their relationship. This is not pleaded by C and C is invited to indicate where he raised this issue with R. In any event, did R act unreasonably or unfairly in appointing Dr. John Morris to the role and did that materially impact on the fairness of the process and ultimately the decision to dismiss?

322. JW took care to keep the panel independent and free from bias in dissuading the claimant from raising matters outside of the ToR relating to a historic matter which the claimant thought relevant to the role of Dr Morris. Dr Morris consulted with his panel members. AR, at the hearing, questioned the claimant directly himself. Dr Morris made the decision to dismiss based on the claimant's own responses, written and oral, at disciplinary hearing. The Tribunal considered Dr Morris' role as evidenced in the transcript notes of disciplinary hearing and the reasoning for the dismissal set out in the letter of dismissal and in Dr Morris's evidence at Tribunal. It found nothing to suggest bias by Dr Morris and notes the candour with which Dr Morris described his decision making process; focusing on the responses of the claimant, attaching more weight to the claimant's responses to the exemplar cases than the statements of the other thoracic surgeons and taking a week to consider mitigation and sanction.

A14. Did the Case Investigator present the disciplinary case in a partisan manner, using terms such as "gross negligence" where there was no harm to patients? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

323. The Tribunal found nothing in the language used in JR1, JR2 or JR2+, or at the disciplinary hearing including the use of the phrase "gross negligence" and "willful neglect" to render the process or decision to dismiss unfair. JR was investigator and JW case manager. Their role was partisan, they were presenting the management statement of case. The claimant was represented by OL of MDU, he was partisan, he was representing the claimant. Dr Morris and his panel were not partisan. They looked at each side's documentation and considered what was said at the hearing. The Tribunal accepts the evidence of Dr Morris that the use of the words gross negligence and willful neglect in JR2 and JR2+ had little if any bearing on the decision of Dr Morris who based his decision making not in JR or JW's opinion of the claimant, or advocacy for management, but in the claimant's admissions and the evidence from the case examples and the claimant's responses to them at disciplinary hearing.

A11.When did C raise a grievance with regard to the matter proceeding as a conduct and not capability set of issues? R submits this was only raised 20/5/19

324. The claimant raised a grievance on 20 May 2019. The previous correspondences from the claimant and EA did not raise a grievance, they intimated that a grievance may follow if the claimant's demands were not met.

A12. When C raised his grievance with regard to this matter, did R act unreasonably by failing to give proper consideration to C's grievance and/or failing to hold a proper grievance hearing? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

325. The respondent properly considered how to address the claimant's grievance and gave reasons for its decisions when JT wrote to the claimant. The respondent properly considered that the content of that grievance was interrelated with the content of the disciplinary and ought therefore to be heard within the disciplinary hearing. Each of his grievance points at paragraph 121 above a) to f) was considered by the panel at the disciplinary hearing so that he did have a "proper" grievance hearing. Though not stand alone, all of his grievance points were properly considered at the disciplinary hearing.

326. a) *the conduct point.* Dr Morris heard argument and agreed that the matters had been properly classified as conduct. See the reasoning on A9 and A10 above. b) *On the point about the claimant being permitted to correct matters in the management statement of case* before JR2+ went to the panel, this was something to which the claimant would have been entitled in a capability process under HCP but not a conduct process. The claimant was, in any event, entitled to point out everything he disagreed with and he submitted lengthy documentation of his own to each panel. c) *the tone and language of the JR reports* point was considered at the disciplinary hearing. The Tribunal heard from Dr Morris that he relied on the claimant's admissions and evidence at the hearing rather than any descriptors, opinion or advocacy, used by JR or JW. d) *the bullying allegation* Dr Morris' panel were aware of this allegation and considered it. They found no evidence of the claimant having been bullied. The claimant had been told by JT he could use Trust procedures to bring bullying allegations if he wished to. He did not do that. In any event, the claimant had not said that he had been bullied into admitting the SVP form cases and the inadequate documentation admissions so that he would still have been dismissed for those points even if he had brought a complaint of bullying and it had been upheld elsewhere. e) *the retaliation point* Dr Morris' panel

considered this and their decision making was rooted in the claimant's admissions regarding the three allegations and his responses to the patient exemplar cases so that even if someone had been trying to get back at the claimant in some way (and the Tribunal does not accept that to be the case, it saw JW's letter and the efforts made to keep the panel free from any bias) he would still have been dismissed by the panel for the things that he had admitted he had done. Further, if it was Dr Morris who was alleged to be biased against him, and the claimant had not specified who was motivated against him, just that it was because he had complained about high death rates, then Mr Jones' panel would still have upheld the dismissal of the claimant, even if that bias had existed, for the things he admitted he had done because they were focused on the impact of his actions on the patients. Appeal would have been curative of any bias deficiency in process though the Tribunal found no evidence of bias f) *the inconsistent treatment point.* This was fully considered by the dismissal panel and appeal panel. The Tribunal accepts the evidence of Dr Morris and Mr Jones that the claimant did not have a comparable case to put before them. What he did was make allegations that others *must have* done the same as him. Dr Morris was clear, there was no other case of 98 admitted instances of SVP form falsification, and that alone was enough to dismiss.

327. On the disparity of treatment point the claimant persisted in cross-examination in saying that the respondent had failed to investigate who else had done as he had done. He was asked then, by Mr Gorton, who he says the respondent should have interviewed as to their practice in completing SVP forms. The claimant responded that all the actors in each of the cases, that is the patient scenarios for patients A,B,C, D and E. In re-examination Mr Boyd wished to ask the claimant to provide more specificity as to who the respondent should have interviewed. Mr Boyd was not arguing that a specific list had been provided by the claimant at investigatory stage, before disciplinary hearing or appeal. It was agreed that Mr Boyd would not re-examine so as to obtain a list of "actors" who ought to have been interviewed but could ask who else was a key player in the point about Patient A. The claimant said that that was Mr Al-Rawi though, out of an abundance of caution, EPR would need to be checked to verify that he was the anaesthetist in question for that patient. This was a curious response. Mr Gorton's question had been about SVP form completion. The claimant's response, in effect ask all the doctors involved in cases A-E, was not solely about SVP form completion and his further clarified response, ask Mr Al-Rawi, was even more curious as Mr Al-Rawi was an anaesthetist, not a thoracic surgeon required to complete an SVP form. The Tribunal finds that this response perpetuated the claimant's ongoing and generic assertion that other consultants must have been doing the same things as him. Mr Al-Rawi, an anaesthetist, would have used paper records, the claimant had made this assertion elsewhere to seek to justify his use of written notes on consent forms rather than on EPR, so the comparison was not appropriate and showed the Tribunal the claimant's propensity to seek to counter his own admissions with generic assertions that *others must have* done the same. He did not and could not say who, what or when.

328. The respondent did not act unreasonably in deciding not to have a separate grievance hearing because of i) the interrelated nature of the grievance and disciplinary content and ii) the opportunities given for the grievance points to be addressed in JT's letter of 28 May 2019 and the disciplinary hearing as reasoned above and because there had been a long delay already by May 2019 when JT

was considering the point and a grievance in the other case had led to the claimant's disciplinary process being abandoned. The Tribunal considers that for those reasons hearing the grievance and disciplinary together in this case was appropriate within ACAS guidance and reasonable in the timescales in this case.

329. The grievances were, therefore, heard at the disciplinary hearing and to the extent if any, in the alternative, they were not addressed, it would have made no material difference to the outcome as the claimant was dismissed for things he admitted he had done. In the alternative, even if there had been grievance issues that rendered the disciplinary hearing unfair in any way, Mr Jones reviewed all of the claimant's written submissions (save the additional 133 pages below) and heard from the claimant orally and heard the mitigation arguments and submission that the claimant would accept a final written warning to avoid dismissal. Mr Jones' evidence was clear that the claimant's admissions in relation to SVP forms alone would have warranted dismissal. The Tribunal finds that none of the grievance points, even if they had gone the claimant's way, would have outweighed his admission in relation to 98 cases of SVP form falsification, so that dismissal would still have ensued.

LOI8. If the Respondent did not follow a fair procedure, to what extent, if any does the principle in *Polkey* apply?

330. The procedure followed was fair in all the circumstances of the case. The principle in Polkey does not apply. If it had applied, if for example there was some procedural failing that required more time to have been taken, that would not have affected when the claimant would have been dismissed. For example, if a procedural failing had been established in relation to the decision not to hear the grievance separately (none was established) then there was scope within the timescales in this case for there to have been a grievance hearing in summer 2019 with a disciplinary hearing shortly thereafter, even if put back by a grievance appeal, so that the claimant would still have been dismissed on 10 October 2019. Secondly, on Polkey, if it had applied, on what the claimant admitted in relation to the 98 SVP forms alone, JM would have concluded that this was gross misconduct, and in relation to that, having heard the claimant's mitigation and being concerned that the claimant was not sincere in his apology and might do it again, JM would still have dismissed the claimant. A fair process would still have resulted in the claimant's dismissal for his SVP admissions alone. Accordingly, any Polkey deduction would be 100%.

LOI9. To what extent, if at all, did the Claimant contribute to his dismissal?

331. If the claimant had succeeded on any of his procedural points (he did not) then the Tribunal would have made findings as to contributory fault. Applying Section 122(2) the basic award would have been reduced because the Tribunal '*considers that any conduct of the complainant before the dismissal was such as it would be just and equitable to reduce or reduce further the amount of the award to any extent...*'. It would have been just and equitable to reduce any basic award by 100% because of the claimant's conduct. The relevant conduct is the falsification of SVP forms in 98 cases, the inappropriate cancellation of care particularly in the case of Patient D who was taken off and put back on the list with the claimant having no intention of carrying out the surgery, and the admitted inadequate documentation of care.

332. In respect of other awards, section 123(6) '*where the tribunal finds that the act was to any extent caused or contributed to by any action of the complainant, the Tribunal shall reduce the amount of the compensatory award by such proportion as it considers just and equitable...*'. Such conduct must cause or contribute to the claimant's dismissal, rather than its fairness or unfairness. There were no procedural failings here but if there had been the Tribunal would have found that the claimant's actions in allegations 1,2 and 3 were culpable and would have reduced the award by 100%.

LOA10.What compensation should the Claimant be awarded in the event that it is held that his dismissal was unfair?

333. The dismissal was fair so no compensation is due to the claimant. In the event that Polkey or contributory conduct reductions or deductions had applied the Tribunal would have identified the relevant conduct as the claimant's conduct at allegations 1,2 and 3 and would have found that taken together that conduct caused the claimant's dismissal. The Tribunal would have found in the circumstances that it would be just and equitable to wholly reduce any award due to the claimant to nil.

Wrongful dismissal

LOI11. Was the Claimant guilty of an act or acts of gross misconduct entitling the Respondent to terminate his employment summarily?

A2. If the disciplinary allegations were serious enough to ultimately justify dismissal, taking no action at the time they were discovered in April 2017 – this is not part of C's pleaded case and cannot therefore be advanced by C.

A3. If the disciplinary matters were serious enough to ultimately justify dismissal, not suspending or placing restrictions on C's practice. This is not part of C's pleaded case and cannot therefore be advanced by C. In any event, did the failure to suspend or place restrictions on C's practice impact on the fairness of the process and ultimately the decision to dismiss?

334. When JW was appointed as case manager he had looked at the nature of the allegations against the claimant as contained in the minutes of the 21 September 2017 meeting almost all of which he thought were conduct, as opposed to capability related issues. He took into account (i) his own experience of the claimant and his confidence in the claimant's surgical ability and (ii) his own prior experience of group complaint issues, that is to say his view that the allegations from such a forum could often be vague and wide-ranging, and might when discussed one-to-one change considerably. JW decided without recourse to anyone else that this was not a matter that required exclusion or any constraint or restriction on the claimant's practice at that time.

335. Failure to suspend or restrict did not undermine the seriousness of what the claimant had done. The Tribunal accepted the evidence of Dr Morris that the claimant was a capable surgeon and that it was only at disciplinary hearing when Dr Morris had cause for concern that the claimant was not sincere and that he had, since leaving thoracic surgery inappropriately cancelled care, that the claimant's continuing practice issue arose. Earlier failure to suspend did not undermine the Tribunal's assessment of the following acts as, applying **Palmeri**, conduct which crossed the repudiatory line:

335.1 completing SVP forms on a Friday and adding an electronic signature to say that the patient had been marked when he had not in 98 cases.

335.2 inappropriate cancellation of care for Patient D and then putting him back on the list when the claimant had no intention of operating on him that day.

335.3 failing to make adequate entries on EPR in Patient Cases A,B,C, D and E.

336. The Tribunal finds as a fact the claimant did these things, that they amounted to a repudiatory breach of contract and that it follows that taken together they cross the repudiatory line.

Appeal process and hearing

A31. Did R decide prior to the appeal hearing not to consider any new evidence? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

337. Mr Jones decided post appeal hearing not to look at a supplementary 133 pages submitted by the claimant because the respondent had not seen it and not had opportunity to challenge it. Mr Jones read the content himself and noted much of it to be repeated submissions and information already before the panel. The decision not to share the additional content with the full panel and not to read it in detail had no impact on the fairness of the process because the claimant had had a full and fair appeal hearing that had lasted a full day. It would not have been fair or proportionate to allow more content submitted by one side to be considered by the panel after the hearing. That would not have had the parties on an equal footing. The claimant accepted in cross-examination that the 133 pages did not contain anything that had not already been considered. The decision therefore had no material impact on fairness.

A32. Did R as part of the appeal process fail to respond to C's historic requests for further information? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

338. The respondent did not fail to respond to the claimant's requests. It had responded but the claimant did not always get the responses he wanted. The tribunal accepts that it was unnecessary and would have been wholly disproportionate for the respondent to produce all PFT request data for all consultants. The further information the claimant wanted was to seek to establish that others had requested PFT tests on the day of surgery at LHCH. The respondent was not obliged to investigate others so as to seek to build the claimant's case for him that it was acting inconsistently. Even if other surgeons had left PFT testing to the day of surgery and it had not been available so that surgery would have to be cancelled, as with Patient B for the claimant, this would not have exonerated the claimant from the broader allegation of inappropriate cancellation of care on multiple occasions. The Patient D example of inappropriate cancellation, taken off the list and put back on, was sufficient on its own for the employer to have treated as a sufficient reason to justify dismissal. None of the claimant's requests for further information and the respondent's rejection of them materially impacted on the decision to dismiss. Again, because of the admissions in his own case, dismissal would have ensued in any event.

339. The information the claimant wanted also related to SVP forms. Again, even if others had been shown to complete SVP forms prior to admission, this would not have exonerated the claimant who had admitted doing this on 98 occasions. The claimant did not suggest that anyone else had done what he had done on the scale he had done it. He could have put that allegation to each of the surgeons at disciplinary hearing but he and OL chose not to. They stood the witnesses down. He could have put it to MS who was called at the disciplinary hearing but he chose not to. The reason the claimant gave for not having put this to MS was that he had been told by his representative OL not to incriminate others. It was not plausible that the reason the claimant didn't ask MS had he done SVP's pre admission was a desire not to incriminate a colleague. The claimant had incriminated colleagues prior to the investigatory processes; part of the RDP *eight concerns* letter and the subsequent concerns expressed by the surgeons at their September meeting were because the claimant was someone who (rightly or wrongly) his colleagues perceived to be someone who incriminated his colleagues, with reports to the police and the coroner. This case had been a whistleblowing case. The claimant was not someone who was unable to incriminate others where he felt it was right to do so. During the disciplinary process he incriminated others; he suggested his secretary was to blame for notes not reaching him at LHCH and therefore a cancellation being made. He incriminated NM, saying he had done pre admission SVP's but did not call him as a witness to this. Under oath at Tribunal the claimant continued to incriminate others, generically, saying that he was doing his best in a system that was broken and suggesting that falsification of patient records was widespread and that the system would not work without it. This evidence was rejected. It was not credible that if this practice was widespread, he or OL would not have put it to the other surgeons at disciplinary hearing. It is not plausible that evidence existed of his being treated worse than others who had done the same as him and the reason he failed to adduce it was a magnanimous desire not to incriminate others.

340. The absence of documentary evidence provided by the respondent of others doing same as him did not materially impact on fairness of process and decision to dismiss because he had admitted 98 occasions of SVP form falsification. It was enough for the respondent to dismiss for that alone. The claimant did not show anyone else who had systematically falsified SVP forms on the scale he had.

A33. Did the appeal panel gear itself towards seeking inculpatory evidence as opposed to anything inculpatory and exculpatory? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

341. The appeal panel listened to the claimant and his representative. It had looked at the management statements of case and the claimant's statements. What affected Mr Jones most was the claimant's lack of awareness of the impact of his actions on patients and staff. Mr Jones felt it was sufficient to dismiss the claimant for the scenario of patient D whose surgery was cancelled and whom the claimant then put back on list. The Tribunal accepted the oral evidence of Mr Jones that the appeal panel attached a lot of weight to the admission in relation to Patient D. There was no evidence to substantiate the argument that the appeal panel had sought only inculpatory evidence. Even if there had been an imbalance in the information put before the appeal panel, its decision was rooted in the claimant's own admission, not the respondent's efforts to incriminate him. This

was not a panel that was in thrall to the persuasive talents of the respondent. It acted on the direct testimony, written and oral, and admissions of the claimant, including his request that he be allowed to submit to a final written warning and keep his job.

A34. Did R act unreasonably in adding Dr. Mansour onto the appeal panel when he was not a surgeon and did not specialise in cardiothoracic surgery? This is not part of C's pleaded case and cannot therefore be advanced by C. If it was, what was the effect of this that Dr Mansour's understanding of C's appeal grounds would be limited? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

342. The claimant was not entitled under HCP to have a thoracic specialist as these were conduct issues. It was JW's decision as to the composition of the panel, to determine it and keep it under review. His decision to include Dr Mansour was not unreasonable. Dr Mansour was Medical Director at St Helens Trust. In the event the appeal panel comprised Mr Jones a non executive director from the respondent Trust, Dr Mansour and an HR Professional. The Tribunal rejects the suggestion that Dr Mansour's understanding of the appeal grounds would be limited. The appeal grounds were set out in writing in detail. The documentation was voluminous extending over several lever arch files. There was a full days hearing at which the claimant was represented. The claimant adduced no evidence to support a contention that Dr Mansour did not understand or was not capable of reaching a view and influencing a decision on the claimant's appeal. In any event, Mr Jones was the sole decision maker. The composition of the panel did not undermine the fairness of the process or decision to dismiss.

A35. Did the appeal panel fail to properly take into account the evidence that had been missing before the disciplinary panel? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A36. Did the appeal panel fail to properly consider the additional documentation provided by C? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

343. The appeal panel, as set out above, took into account the documentation provided by the claimant. It did not see the additional documentation he wanted to submit after the event, the 133 pages, for the good reason that it would not have been fair to the respondent to do so as the parties would not then have been on an equal footing. The hearing had been concluded and the claimant had had ample opportunity to put his case at appeal. The decisions to consider what was before it and not to consider the additional 133 pages, did not adversely affect the fairness of the appeal process and outcome. Mr Jones was most influenced by the claimant's written and oral representations at hearing and by the impact of what the claimant had admitted doing on the patients and staff.

Consideration of the SVP form issue at appeal hearing

A37. Did the appeal panel act unreasonably at the hearing by failing properly to consider the EPR data provided by C which allegedly showed that 222 safe site forms had been created for patients prior to hospital admission and/or contrary to the Trust's procedure of which 122 were completed by individuals other than C? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

344. The appeal panel did properly consider the data at pages 6367 and 6368. It was the 98 admitted instances of SVP falsification. The additional data, which

the Tribunal saw as pages 3835.1 did not (i) change the fact that the claimant admitted 98 falsifications nor (ii) provide evidence that anyone else had done what the claimant had done nor (iii) mean that failing to investigate the other alleged instances would render the process or outcome of the claimant's disciplinary or appeal hearings unfair.

A38. Did the appeal panel act unreasonably at the hearing by failing to properly respond to C's request to undertake a more forensic review of the site forms? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

345. The appeal panel did not act unreasonably. There was no need for the respondent at appeal to do a deep dive or more forensic review of that data because this was an admissions case; the claimant had admitted 98 occasions when he had filled in the SVP form and signed it to say he had marked the patient when he hadn't. That was the admission that Dr Morris had relied on and it was that data that the appeal panel scrutinized.

A39. Did the appeal panel act unreasonably at the hearing by failing to ask, as part of the hearing whether C's colleagues had completed site verification forms prior to admission and/or post-admission, but prior to marking the patient? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

A40. Did the appeal panel act unreasonably at the hearing by omitting from their hearing consideration of system entries where the site verification document and admission dates were the same? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

346. The appeal panel did not act unreasonably. It was not incumbent on them to build the claimant's case on incriminating others for him. The data revealed 98 cases that the claimant admitted. Mr Jones read the disciplinary hearing notes and knew that the claimant had had the chance to put the point to the other surgeons and had chosen not to do so. MS had been questioned by the respondent but OL for the claimant had chosen not to put this point to him. Mr Jones reported back to the respondent that the claimant was saying that there were other cases and he was assured that there was no other case of systematic falsification like the claimant's. The claimant did not point to such a case.

347. The disciplinary panel, the claimant and his representative and the appeal panel knew that the SVP form data had been filtered at request of JR by AM and GH to eliminate cases where there could be any doubt about SVP pre dating admission. This had been done for cases that might involve the claimant or other surgeons. Any omissions therefore potentially helped or hindered the claimant to the same extent that they would help or hinder anyone else. The panel were reasonable in accepting JR and JW's filtering of the data so as to rule out the possibility of falsely accusing the claimant of having filled in an SVP form prior to marking the patient, when he had in fact marked the patient but the patient had not yet been admitted onto the hospital database, so the system wrongly showed the SVP pre dating admission.

A41. Did the appeal panel act unreasonably at the hearing by failing to take account of C's contention that the Trust's internal site verification procedures were not part of LocSIPP and that the site verification issue was not strictly about 'never events' or patient safety?

A41a. In any event as a matter of fact did R not take this into account and was it unreasonable for R not to take this into account ? If so did that materially impact on the fairness of the process and ultimately the decision to dismiss.

348. The appeal panel did not act unreasonably in declining to engage in a broader debate about the rationale or procedural basis for SVP form procedure. The allegation was clear and the claimant had been fully able to respond to it at disciplinary and appeal hearings. The claimant had admitted he had put his electronic signature to say he had marked the patient when he had not.

349. The claimant tried to argue that his falsification had not resulted in patient harm (the Tribunal cannot say whether that is the case or not) and never would or could because of other procedures in place. This was disingenuous of him. He had been instrumental in setting up the SVP form process. His arguments about WHO guidelines and other safety standards being in place so that harm could never result, for example the patient would not be allowed to leave the ward without markings, and his arguments as to whether or not the SVP form procedure was part of LocSipp were a disingenuous attempt to seek to backtrack on his admission. He tried to reduce the impact of his falsification by saying it was a *cart before the* horse situation. In effect he was saying, look I may have made a mistake doing the forms in advance, and by the way the forms aren't *technically* part of LocSipp so you can't have me for breach of procedure, but no harm came from it nor ever could. The appeal panel saw the allegation. It related to falsification of a form. Whether the requirement to fill in the form was part of LocSiPP or not was immaterial. The issue was that the claimant had signed to say he had done something he had not done. The Tribunal accepts the evidence of Mr Jones that the claimant's apparent failure to grasp the consequences of a surgeon signing to say he had done something he had not done raised issues of his probity; integrity and uprightness and honesty.

350. The appeal panel's failure to decide whether the claimant's admitted conduct was a breach of LoCSiPP or not was immaterial to the determination of the allegations and had no material affect on the fairness of the process or decision to uphold dismissal.

Consideration of inappropriate cancellation at appeal hearing

A42. Did the appeal panel act unreasonably at the hearing by failing to undertake any or any reasonable assessment of the reasons for C's cancellation of patients? If so, how that materially impact on the fairness of the process and ultimately the decision to dismiss?

351. The claimant's reasons for cancellation were considered fully at both disciplinary and appeal stages. The appeal panel saw, and Mr Jones read in some detail over some time at home during lockdown before the appeal hearing, the notes of the investigatory interview and the disciplinary hearing at which the claimant had responded to each of the patient scenarios. At appeal Mr Jones also read Mr Morris's decision letter. The appeal panel themselves heard from the claimant. The appeal panel took into account the reasons the claimant had given for cancellation of care. The Tribunal accepts Mr Jones' evidence that they were struck by the effect on the patient of the claimant's cancellations and his apparent inability to grasp the impact his cancellations would have had on the patient and his nurse and doctor colleagues. The appeal panel thought about the emotional distress to the patients who had lung cancer, and for whom there might be a

perception that delay was life altering, and about the uncertainty on wards amongst nursing and other staff as to whether a patient was going to theatre or not.

352. At appeal this allegation was contested as it had been at disciplinary hearing. The claimant said he did not inappropriately cancel care. The appeal panel concluded for itself, particularly in relation to Patient D, who had been taken off and put back on the list, that the claimant had inappropriately cancelled care.

A43. Did the appeal panel act unreasonably at the hearing by failing to take reasonable account of elective reasons for the cancellation of patients which were outwith C's control? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

353. The appeal panel did take into account what the claimant had said about the reasons for cancellation in each of the cases. In relation to the Patient B case of tests not being available on the day at LHCH, the appeal panel had some empathy with the claimant but had regard to MS's evidence at disciplinary hearing that the patient should not have been left to have his tests done last minute in this way but ought to have been "worked up" so that all information was ready. The appeal panel did not accept that it was outwith his control to have patients ready for surgery on the day of surgery. The appeal panel thought that the claimant could have had tests done at Aintree, or got patient to attend LHCH prior to day of surgery. The claimant explained in cross-examination that he had not called all patients to LHCH as it would put them to travel cost and inconvenience. The appeal panel concluded that the issue was not this one case, Patient B and same day tests, but cancellations without efforts to have had tests undertaken in advance and have results available. The claimant was not dismissed for the Patient B case alone. It was the lack of effort to avoid the cancellations in the exemplar cases taken together, and individually in the Patient D case, that made the cancellations inappropriate for the appeal panel. The appeal panel's consideration of the factors outwith the claimant's control did not render the decision to uphold the dismissal unfair. It was a reasonable view that the appeal panel took, over the exemplar cases, that the claimant was therefore guilty of the conduct allegation that his cancellations had been inappropriate.

Consideration of failure to document care at appeal

A44. Did the appeal panel act unreasonably at the hearing by confining C's explanations in respect of failing to document care? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

354. The claimant's explanations were not confined. There was a long appeal hearing, it sat till 7pm, at which the claimant was represented and was free to say what he wanted and to adduce evidence as he wanted. The documentation that the appeal panel saw was voluminous running, as Mr Jones recalled to several lever arch files.

A45. Did the appeal panel act unreasonably at the hearing by failing to take account of C's explanations in respect of failing to document care? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

355. The panel took into account his explanations set out in writing and made orally. For example, the claimant argued that his use of paper notes was

"idiosyncratic" but the appeal panel rejected that idea. Mr Jones was of the view that the claimant knew the requirement to document care on EPR and had chosen not to do that. The claimant argued that anaesthetists use paper notes and the claimant ought to be able to. Mr Jones rejected that argument in relation to LHCH practice. The claimant was not an anaesthetist and knew that patient interaction needed recording on EPR.

356. The claimant had argued that putting paper notes on the back of consent forms was adequate as they would later be scanned onto EPR. Mr Jones rejected this as an argument that the claimant was thereby complying with requirements to document care. The Tribunal accepted the evidence of Mr Jones that all staff including the board members had been trained about the importance of documenting care in a central EPR system, the impact of that on patient care and had been shown how EPR worked. Mr Jones knew that EPR had been around for some years. Mr Jones knew that the claimant would know that handwritten paper notes on the back of a consent form stored in a trolley which may or may not be accessible on the ward and would not be scanned onto EPR until the patient had been discharged was not compliance with adequate documentation of care on EPR. Mr Jones and his panel were again influenced by their assessment of the impact of the claimant's practice on patients and colleagues

357. The claimant sought to explain non compliance by saying that Aintree was still paper based. Mr Jones felt this was a partial explanation but did not explain why the claimant did not ensure that notes from Aintree were scanned across or brought to LHCH and scanned onto EPR rapidly. The claimant sought to blame his secretary for the failure to get his paper notes from Aintree onto EPR. The panel rejected this as an adequate explanation. Mr Jones was also aware that the claimant was behind with his discharge letters, to patients and their GPs and again thought about the impact of that on patient care. The appeal panel took into account the claimant's explanations and found them inadequate.

46. Did the appeal panel unreasonably fail to take account of C's written responses to the disciplinary allegations? If so, did that materially impact on the fairness of the process and ultimately the decision to dismiss?

358. The appeal panel had several lever arch files of documents in the case. Mr Jones' oral evidence was that he had more time than he would usually have had and therefore spent more time reading this case than others because this was lockdown. He was at home. Documents were delivered to him in advance of the hearing and he took a lot of time to go through the documents several times, he told the Tribunal, before the hearing. The panel were taken to documents during the appeal hearing by both Mr Morris for management and OL for the claimant. The panel did not fail to take account of the claimant's written responses.

47. Did the appeal panel have reasonable grounds to believe and therefore to conclude at the hearing that C was guilty of gross misconduct in relation to the cancellation of patients charge?

359. Yes. As reasoned above, Mr Morris had reasonable grounds to believe that the claimant had inappropriately cancelled care having regard to the exemplar cases taken together and individually in relation to Patient D; the panel felt that this "gaming" of the list was sufficient to justify dismissal. Mr Jones was a compelling

witness at Tribunal that the panel had been appalled at the claimant's apparent lack of regard for the impact of the cancellation, reinstatement and cancellation on the patients.

48. Did the appeal panel have reasonable grounds to believe and therefore to conclude at the hearing that C was guilty of gross misconduct in relation to the failure to adequately document care charge?

360. Yes, the appeal panel had reasonable grounds for believing it had happened because the claimant had admitted that his documentation was lacking and the panel had considered his explanations in relation to the exemplar cases. As reasoned above it found his explanations lacking. The panel reasonably concluded that this was gross misconduct because Mr Jones and his panel considered the impact of that inadequate documentation on patients and colleagues and reasonably concluded that the claimant was guilty of gross misconduct. The Tribunal accepted the evidence of Mr Jones on this point that at the start of deliberations Mr Jones had not indicated his own position on the documentation charge but had asked his panel members their view and they had each felt it amounted to gross misconduct. Mr Jones agreed.

49.Did the appeal panel act unreasonably by rejecting C's appeal?

361. For all of the above reasons the appeal panel acted reasonably in rejecting the appeal. Mr Jones was a compelling witness when he said that he accepted and his panel shared Mr Morris' view that the claimant could not be trusted not to do those things again (at allegations 1,2 and 3). This was borne out by evidence that the Patient C case "the CTscan aorta" being ordered when the claimant knew it would not happen over the weekend and so cancelling the surgery, had happened in cardiac surgery when the claimant knew he was being investigated. This had persuaded Mr Morris and also persuaded Mr Jones that the claimant, although he had apologised, was not sincere in that apology and had not recognized that he needed to change. Mr Jones believed that without that recognition of the need for change in his behaviours there were risks to patient safety in the claimant remaining employed by the Trust.

Conclusion

362. For the reasons set out above the claimant's dismissal was fair and his complaints of unfair and wrongful dismissal fail.

Employment Judge Aspinall

Date: 30 November 2022

RESERVED JUDGMENT & REASONS SENT TO THE PARTIES ON

1 December 2022

FOR EMPLOYMENT TRIBUNALS