EMPLOYMENT TRIBUNALS

BETWEEN

CLAIMANT	**V**	**RESPONDENT**
Dr U Prasad		**Epsom and St Helier University Hospital NHS Trust**

Heard at: London South Employment Tribunal **On:** 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16 & 17 November 2021
In chambers on 19 and 22 November 2021

Before: Employment Judge Hyams-Parish
Members: Mr C Mardner and Ms K Omer

Representation:
For the claimant: Mr M Jackson (Counsel)
For the respondent: Ms N Motraghi (Counsel)

RESERVED JUDGMENT

It is the **unanimous** Judgment of the Employment Tribunal that:

(a) The claim of whistleblowing detriment fails and is dismissed.

(b) The claim of direct sex discrimination fails and is dismissed.

(c) The claim of direct race discrimination fails and is dismissed.

(d) The claim of victimisation fails and is dismissed.

(e) The claim of sex related harassment fails and is dismissed.

(f) The equal pay claim is dismissed upon withdrawal by the claimant.

REASONS

A. CLAIMS AND ISSUES

1. The claims before this Tribunal arise out of two claim forms presented to the Employment Tribunal on 24 August 2018 ("the second claim") and 20 December 2019 ("the third claim") respectively.

2. The claimant's first claim was heard by Employment Judge Andrews, sitting with non-legal members ("the Andrews Tribunal"), over a period of 6 days in September 2017. The parties were sent a reserved decision in November 2017. All claims failed and were dismissed. The claimant appealed to the Employment Appeal Tribunal, as a result of which one small matter was remitted to the Andrews Tribunal. At the remittal hearing, this claim also failed and was dismissed.

3. This Tribunal was told that further claims had been brought and are currently in the system. Those claims relate specifically to the claimant's dismissal and were not before this Tribunal.

4. The following claims were the subject matter of the hearing before this Tribunal:

   (a) Whistleblowing detriment (s.47B Employment Rights Act 1996 ("ERA")).

   (b) Direct sex discrimination (s.13 Equality Act 2010 ("EQA")).

   (c) Direct race discrimination (s.13 EQA).

   (d) Victimisation (s.27 EQA).

   (e) Sex related harassment (s.26 EQA).

   (f) Equal pay (s.66 EQA).

5. This case has a long history to it and reaching agreement to a final list of issues appears to have been a long and drawn out process, concluding only weeks before this hearing.

6. The claims and issues were first identified and discussed at a case management hearing before Employment Judge Nash on 19 March 2019. Both parties were represented by Counsel and there is a case management order in which the legal issues are set out. There was a further case management hearing before Employment Judge Tsamados when those

issues were amended. The respondent was ordered to draft a revised list of issues following that hearing. By September 2021, only weeks before this hearing, the parties were still unable to reach agreement on a list of issues. A case management hearing was therefore listed before Employment Judge Dyal. That hearing lasted four hours and resulted in the production of the final list of issues used at this hearing, which were agreed by the parties. Those issues can be found in the Schedule to this Judgment.

7. On the second day of the hearing, the claimant withdrew her equal pay claim, which was therefore dismissed by the Tribunal. During the hearing the claimant also withdrew the allegation identified at paragraph 17(x)(v)(i) of the list of issues in so far as it was alleged as an act of direct sex discrimination and harassment. However, Mr Jackson made clear during his closing submissions that the claim of victimisation relating to this allegation had not been withdrawn. Whilst Ms Motraghi had understood other claims to have been withdrawn by the claimant during her evidence, this was disputed by Mr Jackson during his closing submissions. Accordingly, the Tribunal thought it safer to reach conclusions on all remaining claims.

B. THE HEARING

8. This hearing was originally listed as an in person hearing. The first six days of the hearing were indeed in person, but for reasons it is not necessary to repeat here, the parties agreed to convert the remainder of the hearing to a remote hearing using CVP. No difficulties were experienced during the remote hearing, which proceeded as normal.

9. Due to the parties being unable to agree one consolidated bundle for the hearing, the Tribunal was presented with one bundle prepared by the respondent, consisting of 3591 pages. In addition, the claimant had produced two bundles of her own, containing 691 pages and 446 pages respectively.

10. The Tribunal received witness statements from the following individuals as part of the respondent's case:

- Dr Arun Perikala (Specialty Cardiology Doctor)
- Mr James Allan (Services Manager for Cardiology)
- Dr James Marsh (Joint Medical Director)
- Dr Peter Andrews (Consultant Nephrologist and Clinical Director)
- Dr Richard Bogle (Director for Medical Education, former Clinical Lead for Cardiology)
- Dr Simon Winn (Clinical Director for Medicine)
- Dr Stephen Hyer (Responsible Officer, formerly Director of Research and Development and Co-Clinical Director for Medicine)
- Dr Yousef Daryani (Clinical Lead for Cardiology)
- Ms Patricia Baskerville (Non-Executive Director)

11. All of the above witnesses gave evidence at the hearing apart from Dr Perikala. He attended the hearing and began to give evidence but was clearly so unwell he could not continue. Due to ill health, he was unable to return to complete his evidence and therefore the respondent informed the Tribunal that it would not be relying on his evidence.

12. During the hearing, the respondent was permitted to rely on a supplemental witness statement for Dr Hyer. The Tribunal also allowed an application by the respondent to rely on a new witness, Ms Baskerville, whose witness statement was served during the hearing.

13. The claimant also relied on a number of witnesses. These were as follows:

- Dr David Ward (former Consultant Cardiologist at St George's)
- Dr Sanjay Mutgi (Consultant Physician, Acute Medicine, St Helier)
- Dr Shanthi Paramothayan (former Consultant Physician in Respiratory and General Medicine for the respondent)
- Mr Mark Briggs (BMA representative)
- Dr Ranjit Shail (Consultant Physician)
- Dr Veronica Varney (Respiratory Consultant, St Helier)
- Dr Sola Odemuyiwa (former Consultant Cardiologist)

14. Mr Briggs was not available to give evidence at the hearing and therefore the Tribunal was invited to give the evidence contained in his witness statement such weight as it considered appropriate in the circumstances, given that he was not available to be cross-examined.

15. Ms Motraghi confirmed that she did not have any questions for the claimant's witnesses (apart from Dr Odemuyiwa) and therefore the evidence in their witness statements was accepted as though they had attended the hearing to give their evidence in person. Dr Odemuyiwa's evidence was interposed during the claimant's evidence on day 5.

16. The Tribunal also allowed an application by the claimant to rely on a supplemental witness statement from Dr Shail. This supplemental witness statement was provided to the respondent and the Tribunal during the hearing.

17. The Tribunal spent the first two days of the hearing reading witness statements and relevant documents contained in the above mentioned three document bundles.

18. Both Counsel provided detailed written submissions which were read by the Tribunal on the morning of the final day of the hearing. The afternoon was spent hearing oral submissions.

19. The Tribunal found the submissions very helpful and considered them carefully before reaching its decision. If any part of those submissions is not referred to below, including any case law, that should not be interpreted as the Tribunal having not considered the points raised.

C. FINDINGS OF FACT

20. Subject to what is said at paragraph 21 below, this Tribunal decided all of the findings of fact below on the balance of probabilities, having considered all of the written and oral evidence given by witnesses during the hearing, together with documents referred to by them. Any failure to mention any specific part of the evidence, or refer to a particular document, should not be taken as an indication that the Tribunal failed to consider it. The Tribunal has only made those findings of fact necessary for it to determine claims brought by the claimant. It has not been necessary to determine every fact in dispute where it is not relevant to the issues between the parties.

Findings of fact made by the Andrews Tribunal

21. Whilst it is not necessary to do so, certain findings made by the Andrews Tribunal are repeated here as they provide important factual context, particularly as much of the evidence given by the claimant also covered the same period as that dealt with by the Andrews Tribunal. This Tribunal was careful not to make findings on the same matters as those covered by the Andrews Tribunal, not least because this Tribunal is bound by those findings.

22. The respondent is a large NHS Trust operating across a number of sites. The claimant commenced employment as a consultant cardiologist with the respondent on 3 May 2010. She was appointed to that position following a competitive selection process. Dr Bogle sat on the panel that appointed the claimant. The other candidate for the role was a male cardiologist who had been working in the department as a locum.

23. The claimant worked mainly at St Helier, but also had one session per week at St George's. From 2014, the claimant worked at the community clinic in Wallington (which replaced previous sessions at Epsom).

24. The claimant's line manager, until October 2016, was Dr Hyer, but the day to day strategic direction of the cardiology department was provided by Dr Bogle (also based at St Helier). For this reason, the claimant had extensive dealings with him. As a consultant, the claimant had a high degree of autonomy in her role, notwithstanding she worked as part of a team.

25. Cardiology is a male dominated specialism and the claimant was the only female consultant in the department. There are female consultants in other disciplines within the respondent. There would on occasion be overlap so all

cardiologists would from time to time work with those other female consultants.

26. There were four other permanent consultants within the cardiology department, all of them male:

- Dr Foran, based mainly at St Helier, appointed in August 2002.
- Dr Daryani, based mainly at Epsom, appointed in March 2012.
- Dr Bajpaj, based mainly at Epsom, appointed May 2015.
- Dr Malik, based mainly at Epsom, appointed June 2017 to replace Dr Odemuyiwa upon his retirement.

27. Cardiologists covered all areas of the specialism but tended to focus on either interventional or non-interventional work. Dr Bogle focussed on the former, and the claimant on the latter.

28. In addition to consultants, there were registrars (those training to become consultants) or other junior doctors (variously described as staff, career or mid-grades). Dr Perikala was one such staff grade doctor. He trained in India and worked for the respondent since 2008.

29. The Andrews Tribunal concluded that, certainly during the period 2012/2013, relationships between Dr Perikala, the claimant and Dr Bogle were "problematic".

30. In early 2012, Dr Perikala started to raise concerns about the claimant with Dr Bogle. Concerns were initially raised orally, but then an email was sent by Dr Perikala to Dr Bogle on 8 May 2012 complaining about the allocation of patients and the general management of the Tuesday clinic at Epsom by the claimant. Dr Bogle replied, saying he would speak to the claimant, which he did and it seemed that an arrangement to resolve the issue was agreed. Dr Perikala again emailed Dr Bogle on 15 May 2012, complaining about the claimant's attitude towards him at the Tuesday clinic.

31. Dr Perikala again emailed Dr Bogle on 10 July 2012 setting out his dissatisfaction with the way clinics were being run by the claimant. He said he could not continue to do the clinics as they were making him mentally ill. On 11 July 2012, Dr Bogle emailed Dr Perikala saying that he had spent a long time discussing the issue of the Epsom clinic with the claimant and a trial period had been agreed whereby Dr Perikala would work from his own list only on Tuesdays, with a possible way forward for him to return to St Helier. It is not completely clear how long the trial lasted and if it was at all successful. In any event the claimant and Dr Perikala continued to work with each other in the Epsom clinic until 2013.

32. The Andrews Tribunal said, by that stage, the respondent had effectively failed to manage the situation and had allowed it to escalate out of control. The Andrews Tribunal found that this failure was not related to, or because of, the claimant's sex, but rather a consequence of trying to run a busy cardiology service with limited resources. There was the added complication of managing interpersonal relationships between professionals who perhaps could have taken more responsibility for their own behaviours in an attempt to resolve the situation.

33. On 13 February 2013, an anonymous letter was sent to the Chief Executive of the respondent making serious allegations about the claimant and her alleged failings. Dr Perikala was later identified as the author of that letter. It led to an investigation by Dr Male, commissioned by Dr Stockwell (the then Responsible Officer) after discussion with the Medical Workforce Group ("MWG").

34. The claimant raised a grievance with the respondent on 12 July 2013, as she believed management had breached its duties towards her and her health and safety. In particular, she referred to the anonymous letter and alleged that she had been subjected to harassment contrary to the EQA. No reply was ever received by the claimant to this grievance, which clearly should have been properly acknowledged and dealt with.

35. Dr Stockwell reviewed Dr Male's report in August 2013 and concluded that there was insufficient evidence against the claimant to proceed to a formal hearing but that the allegations were not completely unfounded and had not been raised maliciously. Dr Stockwell met with the claimant and her union representative on 21 August 2013 and informed them of the outcome and asked the claimant to reflect on her own behaviours. He also said that he would not investigate who the author of the letter was, as whistleblowers were entitled to protection. He had already sought advice from HR in this regard. The position was confirmed in writing on the same day. This letter made no reference to the claimant's grievance raised in July.

36. The Andrews Tribunal found that in all those circumstances it was easy to see why the claimant was very upset by the anonymous letter and the respondent's failure to properly respond to the grievance. The Andrews Tribunal said that there was no evidence before it, other than the claimant's opinion, to suggest that Dr Stockell's decisions were influenced in any way by the claimant's sex

37. The claimant raised another grievance on 16 September 2013. This was sent to the same individuals as the previous grievance, plus the BMA. This grievance covered similar ground as the previous grievance but also other areas in some detail and again specifically referred to allegations of breaches under the EQA and ERA. Again, there was apparently no reply from the

respondent, but the claimant in a later letter to HR dated 30 September 2015, confirmed that she did not pursue that complaint "*in a spirit of conciliation*".

38. The respondent had been carrying out an increased number of Transoesophageal Echocardiograms (TOEs) since 2007 and in January 2013, Dr Bogle (assisted by Dr Perikala) decided to carry out an audit of TOEs across the service. The Andrews Tribunal found that it was not inappropriate to use Dr Perikala to assist with the audit as it was a neutral process and not directed at any individual. The audit showed a higher failure rate by the claimant's intubation, at around 25% compared to the departmental average of around 3%.

39. Dr Bogle emailed the claimant on 20 May 2013 informing her of the audit and the outcome asking her to check whether certain assumptions were correct. In summary, the claimant was very unhappy with the audit and did not accept its findings. She believed it was inaccurate and incomplete. She and Dr Bogle continued to email each other regarding this, both in June and September 2013.

40. In early 2015, the respondent acquired a mobile catheter laboratory and Dr Bogle had the task of drawing up a timetable for it to be staffed by the consultants, including the claimant. He issued a first draft timetable which the consultants were very unhappy with. The claimant's particular concern was that it required her to work in the mobile laboratory fortnightly on a Thursday, thereby having to give up one weekly session at St George's per fortnight. The significance of this is that St George's is a tertiary centre which she was very keen to continue attending weekly as it gave her access to wider professional benefits. Dr Bogle's explanation was that he was asking everyone to compromise to some degree, including himself, as he would also have to give up a session at St George's. The claimant said that the difference between her and Dr Bogle was that he was giving up only one of several sessions he had there and therefore kept the benefit of weekly attendance. The draft timetable also scheduled Dr Daryani to reduce his sessions at St George's to one per fortnight. An extremely bad-tempered meeting was held between the relevant consultants on 15 July 2015. It is very clear from the transcript that all the consultants (all male except the claimant) were very angry with Dr Bogle and in turn he became angry with them.

41. On 30 July 2015, a second anonymous letter was written. This complained about the claimant's treatment of a specific patient. It was copied to the respondent's Chief Executive, the GMC, the CQC, the Secretary of State for Health and the patient concerned. Dr Perikala told Dr Bogle shortly afterwards that he was the author of the letter. Dr Bogle was dismayed and believed it to be an extremely unhelpful thing to have done. Dr Perikala had not personally been involved in the patient's treatment. He had only heard from colleagues about it. The Tribunal found that sending the letter to the Secretary of State went beyond his professional duties, and was done to

humiliate the claimant. However, the Andrews Tribunal concluded that such conduct that was not related to the claimant's sex.

42. Dr Stockwell met with the claimant on 17 August 2015 and showed her the anonymous letter. At that stage he did not know the identity of the author. He told her that the matter had already been raised in any event and was being investigated as a serious incident. She told Dr Stockwell that she regarded the letter as an act of harassment and victimisation. Dr Stockwell emailed the claimant the same day, copying HR, so that appropriate policies could be copied to her, together with her options for complaining about harassment and victimisation.

43. An exchange of texts between the claimant and Dr Bogle on 18 August 2015, in general terms, showed Dr Bogle being very supportive of the claimant in connection with the letter and offering his assistance.

44. The claimant raised a grievance on 30 September 2015 in which she requested that an urgent investigation be started into the harassment and victimisation that she had experienced. In summary, she referred to a restriction on her work at St George's, the two anonymous letters with a specific request that the authorship of those letters should be investigated and that she felt she was being harassed by Dr Perikala "*and likely some other member(s) from the cardiology team*". She did not make any express reference to her sex being a reason for that harassment.

45. In response to that grievance, a meeting was held on 5 October 2015 between the claimant, her BMA representative, Ms O'Brien (General Manager), Ms Tripp (HR) and Dr Hyer. In a letter dated 12 October 2015, Dr Hyer confirmed the outcome of that meeting, namely that there was an ongoing investigation into the issues relating to Dr Perikala and that the respondent's policy did not allow for information regarding an investigation, or any documents included as part of that investigation, to be shared with anyone other than the staff member being investigated. She was told that she would be informed when the matter had been dealt with.

46. It was also confirmed that Dr Marsh would be contacting the claimant to arrange a meeting to discuss onward actions. At a meeting between the claimant and Dr Marsh on 20 November 2015, the claimant repeated her request that an investigation into the alleged bullying commence as a matter of urgency.

47. In November 2015, Dr Marsh asked Dr Bogle to provide him with a general update on the situation within the service. Dr Bogle sought the views of five senior colleagues (four replied) and he collated those views in a lengthy email

dated 25 November 2015[1]. The terms of the email were balanced but he did state his belief that they raised significant concern and required the respondent to investigate.

48. On 26 November 2015, the claimant emailed Dr Marsh, Dr Hyer and Dr Shah, with the subject line "*Home visits by Dr Perikala*". She reported that she had been told by a patient, W, that Dr Perikala had visited him at his home, had suggested to patient W that he had been mistreated and had with him a large folder with details of other patients. She said that she believed this was yet another example of a malicious act by Dr Perikala towards her causing further harassment and she repeated her request that an urgent investigation into the patient W matter and Dr Perikala's behaviour/conduct be started. Dr Perikala's evidence during the Tribunal hearing for the first claim was that he did visit this patient at home sometime in 2013 and the he did so to ensure that he received his proper medication promptly and that whilst there he did make a comment about the (mis)treatment the patient had received. The written comments from the patient obtained in November 2015 and September 2017 were not wholly consistent with that account.

49. Dr Marsh replied on the same day thanking the claimant for bringing the issue to his attention, informing her that he would have a discussion with Mr Croft (Director of People and Transformation) about how to proceed, and asking her to continue to focus on delivering the best patient care.

50. On 30 November 2015, the claimant sent an email to three of her colleagues (not within the cardiology department) forwarding a copy of her email to Dr Marsh (with the same subject line) and asked if it was usual practice/acceptable behaviour for a junior doctor who had not passed MRCP to advise a patient with very complex cardiac problems. This prompted a reply to all from Dr Sinclaire commenting on the situation in some detail and offering his own opinions as to the appropriateness of the alleged behaviour. In response, Dr Marsh emailed all the recipients of the exchange saying that he was aware of the allegations, that they were being investigated and he would be grateful if there could be no more emails about the matter as it was not helpful to either party.

51. Also on 30 November 2015, the claimant met with a representative of the CQC in the course of a routine inspection of the respondent. The Andrews Tribunal accepted her evidence that during that meeting she advised them of her concerns about Dr Perikala, including issues of patient safety and breach of data protection and harassment. They further accepted that the claimant was told by the CQC that they would raise these issues with the respondent, but that Dr Stockwell, did not recall the CQC informing him of the allegations.

[1] Dr Marsh said in evidence during this hearing that the email was sent on 20 November 2015. As there is a finding of 25 November 2015 by the Andrews Tribunal we have not interfered with this. There are two copies of the email in the bundle, with each date on, but the content is the same in any event. We do not therefore believe the discrepancy is important.

52. Dr Marsh spoke to the claimant by telephone on 2 December 2015 regarding her harassment allegation, and assured her that it would be thoroughly investigated. They also discussed his concern that she had sent an email to other consultant colleagues in the terms set out at paragraph 50 above, and he asked her to refrain from further activities that might compromise any investigation or escalate the situation. She assured him she would not.

53. Dr Marsh and the claimant then met on 7 December 2015. He wrote to her on the same day noting that at that meeting he had explained that he was concerned about the email she had sent to her colleagues and issued her with an improvement notice as a result. The letter made it clear that should there be no improvement, and should further issues of that nature occur again, formal disciplinary action may be taken. The respondent's position was that this meeting was informal and the issue of an improvement notice was similar to an informal warning and not a disciplinary sanction. Accordingly, there was no need nor entitlement for the claimant to be represented at that meeting. The Andrews Tribunal accepted that Dr Marsh, whether he was right or wrong, genuinely believed that the claimant had no right to representation at the meeting and that is why she was not offered any. They further accepted that the reason Dr Marsh issued the improvement notice was for the reasons set out on its face.

54. During that meeting the claimant also raised concerns she had about Dr Perikala's clinical competency and it was agreed that she would set those out in writing which she did on the same day citing, inter alia, five specific patient issues. In response, on 28 January 2016, Dr Marsh wrote to Dr Bogle, as the clinical lead, asking him or one of his colleagues to review the examples given so that Dr Marsh could decide whether the concerns should be investigated formally. Dr Bogle carried out the review himself, completing a report on 30 January 2016. His conclusion was that four of the cases gave no significant concern and that although there were concerns in respect of the fifth, they had already been addressed.

55. The claimant told the Andrews Tribunal that it was inappropriate for Dr Bogle to carry out this review of Dr Perikala as he was not independent. The Andrews Tribunal did not accept that proposition and found that Dr Bogle was best placed, amongst those available internally, to do the exercise. The report that he produced indicated that the review was thorough.

56. In the meantime, an anonymous complaint was made to the GMC in respect of Dr Perikala and those same five patients. It was later confirmed that the claimant was the author. This led to a lengthy investigation which finally concluded that there was no evidence that Dr Perikala had fallen below the required standards.

57. In time, and following on from the claimant's complaint dated 26 November 2015, Dr Marsh met Dr Perikala on 14 December 2015. He confirmed the

outcome of that meeting in a letter to Dr Perikala on 23 December 2015 in which he notified him that he was commissioning an investigation under the Maintaining High Professional Standards policy ("MHPS")[2] to be handled by Dr Stephenson. The terms of reference for the investigation would look at the complaint from the claimant about Dr Perikala's visit to patient W and the two anonymous letters which the claimant alleged were written with malicious intent, as well as an allegation that referrals for TOEs were being diverted away from the claimant.

58. In October 2015, Ms Fiona Goulder (Lead Cardiac Physiologist in Echocardiography) raised concerns with Dr Bogle about an inappropriate referral by the claimant of a patient for a stress echo test. Dr Bogle said in an email dated 28 October 2015 that he would be approaching Dr Daryani to undertake a stress echo audit with a broader remit than just referrals by the claimant. The Andrews Tribunal found that this decision by Dr Bogle was entirely within his remit. There was no obligation on him to give the claimant prior notice, nor to seek her consent before doing this. Dr Daryani oversaw that audit (the data for which was collected by a registrar), which showed a higher rate of abnormalities in the claimant's cases than Dr Daryani's. In April 2016, the results of the audit were presented to a meeting at which the claimant was not present. Dr Bogle's evidence, which was not challenged, was that Dr Daryani circulated the results in advance of the meeting to all consultants.

59. Following that presentation, Dr Bogle expressed his concerns regarding the results and asked Dr Daryani if he thought they were concerning enough to suspend the service at St Helier. In effect this was the claimant's stress echo practice. In an email exchange with Dr Marsh, Dr Bogle said that his view was that the service should be suspended pending a complete review, but deferred to Dr Daryani as he was the imaging lead. Dr Bogle's evidence, which the Andrews Tribunal accepted, was that he did not know at this time that the claimant intended to use her stress echo practice as the basis for an application for a clinical excellence award.

60. In an email dated 5 May 2016 sent to Dr Marsh, copied to others, the claimant said that the audit results were incomplete and inaccurate. She sent an email on 20 June 2016 stating that a complete set of data was attached. There was no separate attachment though the email did set out various data sets. Dr Bogle's evidence, which the Andrews Tribunal accepted, was that this email did not provide a full set of data that could be used to test the audit results.

61. By early May 2016, Dr Marsh, having consulted with the MWG and having taken advice from the National Clinical Assessment Service, came to the view that an Invited Service Review ("ISR") on the claimant's practice was appropriate. An ISR is a consensual process without disciplinary implications

[2] MHPS is the equivalent of a disciplinary procedure for doctors and dentists

and an alternative to an MHPS process. The background to this decision was the concerns raised by Dr Bogle in his email dated 25 November 2015, together with further concerns that had been raised by Dr Naveed Dani (Staff Grade Cardiologist) in March and May 2016. It was Dr Marsh's hope that an ISR would generate recommendations that would assist the claimant and allow the respondent to support her and to improve the service. Efforts were made from early May 2016 to set up a meeting between the claimant and Dr Marsh to discuss this proposal.

62. Dr Stephenson's report following the investigation into the claimant's complaints regarding Dr Perikala was completed on 1 June 2016. He upheld the first allegation but not the second. This eventually led to disciplinary proceedings against Dr Perikala, chaired by Dr Ruth Charlton (Joint Medical Director), the outcome of which, in March 2017, was that an improvement notice was issued against him.

63. A meeting took place on 13 June 2016 between Dr Marsh and the claimant. Dr Bogle and Ms Neale were also present. At the outset the claimant said she was unhappy to attend as she was unable to secure representation from the BMA. It was agreed therefore that the meeting would be recorded so that she could later discuss it with them. In summary, the claimant was advised of the outcome of both Dr Bogle's review of the concerns she had raised about Dr Perikala and Dr Stephenson's conclusions. In relation to those later matters the claimant was told that the complaints had been dealt with and an MHPS investigation started, but the outcome could not be shared with her due to confidentiality. They also discussed the location of Dr Perikala at St Helier and that the claimant would not be required to work with him.

64. Dr Marsh informed the claimant of the proposal that an ISR be carried out due to concerns raised about the claimant's practice and the reasons why. She did not agree to this proposal and said that she would take advice and action. It was agreed that they would meet again.

65. That further meeting took place on 16 August 2016, after several attempts by Dr Marsh to hold it earlier. It was arranged at the last minute by text on the day when the claimant agreed to Dr Marsh coming to her office before she started her ward round. Dr Marsh confirmed in an email sent at 10.33 that day what had been discussed, namely, that he had asked her for her consent to the ISR being undertaken and that she had raised various concerns. Dr Marsh attached the draft terms of reference for the ISR and asked the claimant to confirm by 26 August 2016 if she was willing to participate in the investigation. The Andrews Tribunal concluded that there was nothing untoward in the way Dr Marsh contacted the claimant to set up this meeting, or in the conduct of the meeting itself. It was a reasonable approach, given that they were both busy professional people and previous attempts to meet had been made.

66. The claimant’s BMA representative, Farah Cheema, emailed Mr Croft on 25 August 2016 saying that the claimant believed she was being singled out and that the review would be more balanced if it included Dr Perikala and all her consultant colleagues. She also asked for the outcome of the harassment and bullying complaint she had made the previous year and until she received that, she could not respond to the suggestion of another review.

67. The Andrews Tribunal found that whilst the claimant had been singled out for the proposed ISR in September 2016, that being less favourable treatment, it was not because of the claimant's sex. It was because of the various concerns that had arisen as explained to the claimant at the time by Dr Marsh. Further, the decision was made having taken advice from external professional bodies.

68. Mr Croft replied on 6 September 2016 explaining why it was felt the proposed ISR was appropriate, why it would not include her colleagues and asking the claimant to reconsider her position so that a formal process would not be necessary. He also confirmed that the harassment and bullying complaint had concluded and one allegation had been upheld with appropriate action being taken.

Background findings of fact made by this Tribunal

69. In 2015, the claimant worked at St George’s under her contract with the respondent. Following concerns being raised about a particular case, St George’s commenced their own investigation which concluded on 19 October 2015. This found serious concerns with one case and a higher than expected rate of failure to complete a procedure without assistance from other consultant cardiologists. The outcome of the St George’s investigation was a recommendation that the claimant should be accompanied by a mentor for a period of time and for certain procedures and that the mentor should sign her off as an independent operator. The report also recommended that the claimant should not be training a Specialist Registrar.

70. This triggered Dr Marsh to write to Dr Bogle on 19 November 2015 in the following terms, which is the communication referred to at paragraph 47 above:

> ***As you know there were concerns raised about the performance of Dr Usha Prasad at St George’s Hospital.***
>
> ***There has been an investigation and meeting between the clinical director at St George’s cardiology service and Dr Prasad with an agreed supervision and remediation plan.***
>
> ***I would like assurance about the safety of the service at Epsom & St Helier NHS Trust. In particular, do you have any other concerns about the performance of Dr Prasad, and are you assured that her current practice does not impact on the service.***

71. On 12 September 2016, the claimant lodged a further grievance. This is the protected disclosure referred to at paragraph 12(v) of the list of issues. In it, the claimant complained about a number of matters, including treatment of her by Dr Bogle and Dr Perikala, which she referred to as sex discrimination and due to her being a whistleblower, as well as failures to investigate the anonymous letters. In her letter, the claimant summarised events going back to 2013 and said that there had been a campaign of harassment against her.

72. The grievance was initially acknowledged by Mr Croft on 27 September 2016.

73. By October 2016, following numerous communications back and forth over a period of time, Dr Marsh had received confirmation from the claimant (via her medical defence organisation representative) that she was not prepared to consent to an ISR on the terms proposed by the respondent.

74. In an email to the Head of ISRs, Dr Marsh said the following:

> ***Given the broad nature of concerns relating to her clinical practice and her relationships within the department, it is our intention to perform a MHPS investigation. The terms of reference are likely to change slightly given the specific focus on her (within the context of the service).***

75. On 10 November 2016, Dr Marsh again wrote to the claimant, apologising for the delay and confirming that her grievance would be investigated by Mr De Alyn.

76. On the same day, the claimant presented her first claim to the Employment Tribunal.

77. The claimant attended a meeting with Mr De Alyn to discuss her grievance on 23 November 2016. As part of the investigation, Mr De Alyn interviewed Dr Perikala on 10 January 2017, Dr Stockwell on 11 January 2017, Dr Bogle on 16 January 2017, Dr Marsh on 20 January 2017 and Ms Smart on 31 January 2017. The claimant was further interviewed by telephone on 13 January 2017.

78. On 26 January 2017, after having discussed his concerns with the Chief Executive, HR and Practitioner Performance Advice Service ("PPA"), Dr Marsh wrote to the claimant informing her that he intended to commission an investigation under the MHPS and that Dr Andrews would be appointed as the case investigator. Dr Marsh set out the terms of reference ("TOR") as follows:

> ***TOR1***
>
> ***Concerns relating to Dr Prasad within the cardiology service at St Helier with specific consideration of her multidisciplinary team working and***

> ***her professional relationships with colleagues, including cardiac technicians, trainees and specialty doctors and potential detrimental impact on patient care.***
>
> ***TOR 2***
>
> ***Concerns relating to Dr Prasad's clinical work within echocardiography and angiography service, including stress echocardiography, transoesophageal echocardiography and diagnostic angiography services.***
>
> ***TOR 3***
>
> ***Concerns relating to Dr Prasad's diagnostic and clinical work at St George's Hospital and her working arrangements within the hospital.***
>
> ***TOR 4***
>
> ***Concerns relating to Dr Prasad's clinical governance and response to learning and changing her practice in light of patient experience, complaints, audit and incident reports.***
>
> ***TOR 5***
>
> ***Concerns relating to clinical management of cardiac emergencies and achieving the best outcomes for patients.***

79. In his letter, Dr Marsh informed the claimant that he did not propose to place any restrictions on the claimant's ability to practice or to exclude her from work. The term 'exclusion' in the MHPS is used to describe a suspension from work.

80. Dr Marsh gave his rationale for starting an investigation as follows [sic]:

> ***At this time, I was still having conversations with Dr Bogle about the index concerns that were raised in November 2015; in particular, Dr Prasad was not accepting the results of the stress echo audit that had been undertaken, and when I discussed these with her, I was left with a view that she was not willing to accept the findings of the audit. I was also left with the perception of a person who was not reflecting when criticisms raised about their practice. Reflection is an important part of a doctor's practice. My view was that the concerns from November 2015 were still live due to the ongoing discussion with Dr Bogle and other colleagues in the department that reiterated the concerns. It was not easy to see how we could provide resolution without formal intervention given Dr Prasad's stance. I had sought to undertake an invited service review ("ISR"), which is an assessment carried out by the Royal College of Physicians with regards to Dr Prasad's work within the context of the broader cardiology service; I had hoped that the review would generate recommendations that would assist Dr Prasad and allow the Trust to support her and to improve and support the cardiology service. ISRs have been used across the Trust to great effect and productive outcomes, including when the clinical practice of male clinicians is in question; however Dr Prasad refused to agree to the terms of reference in the review, so this could not proceed.***

81. Dr Andrews was trained in carrying out investigations under MHPS and had also received diversity training. The Tribunal accepted that Dr Andrews had little knowledge of the claimant before being asked to conduct the investigation. He was unaware of the claimant's Employment Tribunal claim and was unaware of internal proceedings which had completed, or were on-going. He had a good working relationship with Dr Bogle and Dr Foran, but did not know Dr Beeton (Consultant Cardiologist at Ashford and St Peter's Hospitals NHS Trust). Dr Marsh knew Dr Beeton professionally and had worked with him before.

82. On 21 February 2017, a report was produced into the grievance the claimant had raised in September 2016. This was a detailed, comprehensive and considered report prepared by the investigating manager. Whilst the report criticised the fact that a previous grievance had not being dealt with in a timely manner, and commented that the claimant could have been better informed, Mr De Alyn concluded that there was "*no evidence of any significant failure by the Trust or 'omission to act' or to prevent any detriments to Dr Prasad*". The report concluded that it was for the commissioning manager to review the findings and make a final determination on the merits. The Tribunal concluded that this meant that there would need to be a hearing before a panel who would then reach a conclusion on the grievance.

83. On 15 March 2017, Dr Perikala was given an improvement notice by Dr Charlton for attending patient W at home when it was not necessary to do so, and failing to document the meeting.

84. Dr Andrews was formally appointed to conduct the investigation (referred to at paragraph 78 above) on 12 April 2017 and he was provided with a copy of the TOR. The claimant was informed by letter that Dr Andrews had been appointed, and once again she was told what the TOR were.

85. As Dr Andrews was not a cardiologist, Dr Beeton was engaged to provide clinical expertise. He initially did a review of the clinical cases of concern which had been referred for investigation. He attended the respondent's offices and reviewed relevant patient files and notes, before reviewing the case summaries he was provided with, and his focus was on assessing whether the claimant's actions demonstrated an acceptable level of patient care. Of the 43 cases reviewed, Dr Beeton concluded that 18 demonstrated a moderate or severe departure from acceptable levels of care, while a further 12 were found to be 'not provable' which meant that other senior practitioners were involved in the decision-making or procedures, or where any error identified was attributable to unavoidable causes. Dr Beeton concluded that there were four additional cases where the error was 'mild' and six where there was no misconduct. Three cases were being investigated elsewhere (the GMC and St George's Hospital) and so were not considered in detail by

Dr Beeton. Dr Beeton provided his findings on these clinical cases to Dr Andrews on 12 July 2017.

86. On 22 May 2017, the claimant was informed by letter that her grievance (paragraph 82 above) would be heard by Daniel Elkeles (Chief Executive) and, to this end, was invited to a grievance meeting on Friday 16 June 2017.

87. On 17 July 2017, the claimant was informed by letter that her grievance meeting had been rescheduled, at her request, to be held on 9 August 2017.

88. Dr Andrews began his interviews of witnesses on 31 May 2017. As part of his investigation, he wrote to the claimant asking her to attend a meeting with him. One such letter was sent on 1 August 2017, which suggested two dates to meet. By email dated 4 August 2017, the claimant's medical defence union representative responded to the above letter saying that neither date was convenient. The email further stated that the matters set out in the TOR had already been investigated and that the investigation amounted to bullying and harassment. The respondent put to the claimant during her cross examination that the above email was evidence that she refused to attend a meeting with Dr Andrews. Whether or not that is correct, the evidence confirms that there was certainly a reluctance on the part of the claimant to engage, and that she only eventually met with Dr Andrews when she really had no choice.

89. Clearly hoping that the claimant would engage with the process, Dr Marsh wrote to the claimant's representative on 7 August 2017 asking why the proposed dates were inconvenient and asking for alternative dates to be proposed. He wrote again to the claimant on 7 September 2017 referring to the claimant not wanting to attend a meeting with Dr Andrews, responding to concerns about the process and stating that she was required to attend the meeting. The claimant responded to this letter via her representative on 19 September 2017 suggesting dates to meet Dr Andrews at the end of October 2017.

90. On 20 September 2017, the claimant wrote to Dr Andrews giving the names of 20 persons she wanted interviewed as part of his investigation.

91. On 6 October 2017, the claimant attended a grievance hearing chaired by Mr Croft.

92. During the months of October and November 2017 the claimant was unable to attend a meeting with Dr Andrews due to her having been signed off work by her GP for stress. In light of this, the claimant's representative wrote to Dr Marsh suggesting that they arrange a date for the claimant to meet Dr Andrews in the new year.

93. On 25 November 2017 the parties were sent the judgment and written reasons in respect of the first claim.

94. In January 2018, following a conversation between Dr Andrews and the claimant's representative, Dr Andrews agreed to send the claimant some questions aimed at seeking the claimant's input to those matters under investigation. He did this on 10 January 2018, making clear that any responses needed to be sent to him by 16 January 2018.

95. In the absence of receiving any response from the claimant, and concerned about how long the investigation had been on-going, Dr Andrews decided to prepare an interim report based on 10 interviews he had conducted up to that point. For reasons already stated, this report was prepared without any input from the claimant. Dr Andrews concluded that TOR 2, 3, 4 and 5 were upheld, while TOR 1 was partially upheld.

96. On 12 February 2018, Dr Marsh met with the claimant and her representative. The content of this meeting was recorded in a letter sent by Dr Marsh to the claimant dated 13 February 2018. The outcome of the investigation was discussed at the meeting, as set out in Dr Andrews' interim report, and Dr Marsh informed the claimant that he proposed to proceed to a formal hearing to consider the concerns raised about her clinical practice. He also offered the claimant a further opportunity to meet with Dr Andrews so that her responses could be incorporated into a final report before proceeding any further. On the back of this interim report, Dr Marsh decided that the claimant's clinical practice should be restricted.

97. The claimant eventually met with Dr Andrews on the afternoon of 23 February 2018, when she was accompanied by her representative. By this stage, the claimant had also provided a written response to each of the questions sent by Dr Andrews to the claimant in January 2018. During this meeting, each of the TOR/allegations was discussed and the claimant gave her response to each. The meeting lasted just under two hours.

98. Prior to her meeting with Dr Andrews, on the morning of 23 February 2018, the claimant and her representative also met with Dr Marsh. At this meeting, the claimant sought to persuade Dr Marsh that her clinical practice should not be restricted and that many of the allegations had no merit. Dr Marsh advised the claimant that until he had the necessary assurances regarding those matters that had been raised as part of the investigation, the restriction would remain. He said to the claimant that there had been a number of opportunities to meet with Dr Andrews and urged the claimant to attend the meeting with Dr Andrews that was scheduled that afternoon.

99. On 27 March 2018, the claimant submitted her responses to Dr Beeton's findings (paragraph 88). As a result of these further representations, Dr Beeton produced a revised report.

100. On 11 July 2018, there was a meeting with Dr Beeton, the claimant and Dr Andrews. As a result of this meeting, Dr Beeton reviewed his findings again, and confirmed that a number of his criticisms had been addressed. However, he was of the view that there had still been serious errors in management in seven cases, moderate errors in four cases and mild errors in two cases.

101. Dr Andrews interviewed 10 of the 20 witnesses suggested by the claimant. He did not interview the remainder because the investigation had already been going on for a year, and he concluded that the additional individuals would not be able to offer material assistance to the investigation.

102. On 25 July 2018, the claimant received a letter confirming the outcome to her grievance. The panel acknowledged that the investigation into her grievance raised in 2015 took too long. The panel agreed that relationships in the cardiology department had broken down and that it was important that this was addressed. The panel recommended that mediation be provided for the whole department to restore working relationships and identify a way forward for the team to work effectively together again.

103. On 21 August 2018, Dr Andrews produced a final report having at that point received the claimant's representations and Dr Beeton's revised report, as well as having interviewed the claimant's witnesses. In relation to the concerns he had investigated, Dr Andrews concluded:

> ***TOR 1: Partially upheld.***
>
> ***This investigation has indicated significant concerns re the working relationships within the Cardiology unit, at both Consultant and Junior Doctor levels. On the balance of probabilities, these difficulties have impacted adversely upon the standard of patient care. Multiple issues have been raised, and the behaviour of at least one Junior Doctor may have been unprofessional. However, the common factor in many of these concerns appears to be Dr Prasad.***
>
> ***The investigation has identified no significant evidence to support a suggestion of sexual, religious or racial discrimination within the Cardiology service.***
>
> ***TOR 2: Upheld.***
>
> ***On the balance of probabilities, this investigation has indicated significant concerns re aspects of the clinical care provided by Dr Prasad. Concerns relate to her technical proficiency, her decision-making, and her ability to recognise and learn from serious errors of judgement. No evidence has been produced, however, to suggest inappropriate behaviour towards patients or that UP is not popular with her patients.***
>
> ***There were significant concerns with the claimant's clinical care, in particular with decision making, technical proficiency, and ability to recognise and learn from serious errors of judgement. There was no***

evidence to suggest that Dr Prasad was unpopular with patients, or had behaved inappropriately towards patients.

TOR 3: Upheld.

On the balance of probabilities, this investigation has identified significant concerns re aspects of the clinical care provided by Dr Prasad at St George's Hospital, London. Concerns relate to her technical proficiency, her decision making, and her organisational and administrative skills.

TOR 4: Partially upheld

On the balance of probabilities, this investigation has identified significant concerns re aspects of Dr Prasad's clinical governance, approach to audit, and response to and learning from adverse events. A particular concern is that Dr Prasad appears to lack insight into the concerns levelled against her, and that her participation in audit and incident investigation has been poor. It is not possible to say with confidence that she operates at the standard expected of an independent Consultant Cardiologist.

TOR 5: Upheld

On the balance of probabilities, this investigation has identified significant concerns re aspects of Dr Prasad's approach to, confidence in, and ability to manage cardiac emergencies.

104. Overall, Dr Andrews concluded that the investigation showed that there were significant issues in the way the claimant interacted with other members of the Cardiology team, at all levels of seniority. The evidence that Dr Andrews obtained during the investigation demonstrated that the working relationships within the department were dysfunctional and that this was impacting on patient care. Dr Andrews did not believe that this animosity was limited to the relationship between the claimant and Dr Perikala; she seemed to have difficult relationships with others in the department too, including Dr Bogle, Ms Goulder, Ms Thompson, Dr Dani, Professor Brecker, Ms Sloane and Ms Smart.

105. Dr Andrews concluded, with assistance from the review undertaken by Dr Beeton, that there were significant concerns in relation to the claimant’s technical proficiency and decision-making, and that she demonstrated a lack of insight and failure to reflect and learn from previous errors of judgment. There were also documented concerns about her clinical governance, approach to audit and her ability to manage cardiac emergencies.

106. Dr Andrews made three recommendations:

- That the respondent explore options to improve the working relationships, working practices and leadership within the cardiology department to ensure there was no ongoing compromise to patient care;

- That the respondent consider whether the claimant was operating at the standard expected of a consultant cardiologist; and

- That the claimant's pattern of non-engagement and limited insight into complaints against her be taken into consideration when assessing the likelihood of her returning to effective clinical practice within the respondent. This arose out of serious concerns about the claimant's initial refusal to participate in the investigation, particularly in the context of previous non-engagement with the respondent, St George's and other clinical/non-clinical colleagues when her professional relationships or performance had been questioned.

107. In reaching his conclusions, the Tribunal accepted that Dr Andrews had considered the very many testimonials provided by the claimant but that he did not attach significant weight to them as they came from people who had trained with her a long time ago, who had met her on an ad-hoc basis at meetings, did not work at the respondent, and/or had no knowledge of the events and allegations that Dr Andrews had to investigate. Therefore, while they were able to provide useful information as to the claimant's wider reputation, Dr Andrews said that they did not assist him in determining whether the clinical or conduct allegations were made out.

108. Dr Marsh met with the claimant on 24 August 2018 to discuss the report prepared by Dr Andrews. At that meeting Dr Marsh informed the claimant that a disciplinary hearing under MHPS would be convened.

109. By letter dated 27 September 2018, Dr Marsh wrote to the claimant stating that he was considering whether the report, produced by Dr Andrews, raised capability and/or conduct concerns upon which formal action needed to be taken. He invited the claimant to provide her views on the report by 12 October 2018. Dr Marsh said he would then decide what further action should be taken. Those comments were provided by the claimant's representative, on her behalf, by letter dated 9 November 2018. In essence, the claimant's representatives argued that the matters raised in the report by Dr Andrews related to differences of clinical opinion rather than conduct/capability issues. They argued that all of the matters needed to be reassessed in the light of further responses provided on behalf of the claimant, and that all clinical restrictions should be lifted.

110. On 10 December 2018, Dr Marsh wrote to the claimant further to the grievance outcome asking to discuss the recommendation for mediation with her.

111. On the same day, Dr Marsh wrote to the claimant informing her that he had decided to refer the disciplinary matters to the PPA. He had completed a referral form and invited the claimant to comment on it, giving her 10 days to

do so. At the same time, lawyers instructed by the claimant's medical defence union were writing to Dr Marsh about the respondent's lack of proper oversight of the restrictions, together with the respondent's failure to review and lift them. More importantly, the claimant's representatives argued that the claimant could not properly engage in the PPA process whilst restricted from clinical duties. Whilst the respondent's view was that the restrictions needed to stay in place, they indicated that they were open to exploring the possibility of a period of supervised practice, either at Epsom and St Helier, or at St Georges. This back and forth correspondence between the claimant's representatives and the respondent continued into 2019.

112. By letter dated 31 January 2019, the PPA wrote to the parties recommending a behavioural assessment and suggesting dates for an interview in March 2019. The PPA acknowledged that the restrictions placed on the claimant would pose a problem as far as any assessement of her was concerned. The letter stated:

> ***The Group acknowledged there were significant clinical concerns identified in the evidence submitted for consideration by the Trust; however, it was our understanding that Dr Prasad had not undertaken any clinical work in the past year. This is obviously a prohibitive restraint on an assessment as a practitioner would need a significant period of remediation in a suitable placement before an assessment was feasible. The Group also noted that there were no significant efforts to return Dr Prasad to work in the last twelve months.***
>
> ***However, the Group did feel that a behavioural assessment should be offered, noting there were also documented behavioural concerns, and both parties agreed the department in which Dr Prasad is employed is problematic in disposition. The behavioural assessment would be independent, objective and formative, and the Group felt it could offer Dr Prasad support in working to resolve any outstanding issues.***

113. The PPA suggested two dates for a proposed assessment to take place, namely on 12 or 13 March 2019.

114. On 6 February 2019, Dr Marsh met with the claimant and her representative to discuss mediation and the assessment. During that meeting, the claimant and her representative expressed some reservations about the assessment because it would be simply focussed on her. Dr Marsh said that the hope was that the assessment would enable her to return to full clinical practice. The claimant acknowledged that the process could be constructive but that she would need to consider the risks. Dr Marsh informed the claimant the he considered that a period of supervised practice within Epsom/St Helier could be difficult due to the relationship issues within the department and that he had begun to make enquiries of three acute trusts in Surrey about a possible secondment for the claimant.

115. On 11 February 2019, the BMA wrote to the PPA on behalf of the claimant seeking a review of the recommendation for a behavioural assessment to be carried out on the claimant.

116. On 11 March 2019, Dr Marsh wrote to the claimant following up their discussion about mediation during the meeting on 6 February 2019. He commented that he had not heard further from the claimant regarding that matter.

117. On 12 March 2019, the claimant wrote a lengthy letter to Dr Marsh, which was copied to Ms Baskerville, Dr Hyer, Dr Winn and HR. In it, she complained about the restrictions placed on her, alleged breaches of various corporate governance policies, including MHPS, and complained generally about the way she had been treated. The claimant sought disclosure of further information and copies of correspondence.

118. Also on 12 March, Dr Marsh wrote to the claimant chasing up her permission to share further details with other trusts so that he could secure a secondment and the claimant could undertake a period of supervised practice. This letter had obviously crossed with the claimant's letter of the same date and on 15 March 2019, the claimant wrote to Dr Marsh in response to his 12 March 2019 letter referring him to her letter of the same date.

119. On 28 March 2019, the claimant wrote to the PPA taking issue with their recommendation for a behavioural assessment, in particular that it should be focussed only on her.

120. As it became clear that the claimant would not agree to the PPA assessment, Dr Marsh decided that there was no other option but to invite the claimant to a disciplinary hearing. The hearing was originally arranged to be held in August 2019 but was rearranged at the claimant's request as her union representative was unavailable. In fact it appears that there were a number of requests to postpone the hearing in the weeks leading up to the hearing by the claimant, for reasons which included objection to the management case being presented by a barrister, objections to the bundle to be used at the hearing, and an objection to the hearing going ahead before various grievances had been dealt with.

121. The hearing was rescheduled and the claimant was informed that the hearing would be held on 15 and 16 October 2019. On 15 October 2019, the claimant did not attend; the panel was told that she was too unwell to do so. The claimant's companions attended; they were Mr Briggs (BMA Representative), Dr Philip Howard (a consultant for the respondent), Dr Odemuyiwa and the claimant's brother. The panel comprised of Ms Charlton, Debbie Eyitayo (Director of People) and Dr Fluck (an external panel member and cardiologist). Also in attendance were Dr Marsh and Eloho Orukele (Head of MWG).

122. The claimant had not provided her documentation for the hearing until the day before, when she submitted numerous emails and a large number of documents.

123. The claimant contacted Ms Orukele at 12.04 stating that she had been asking for an appointment with occupational health ("OH") but had been unable to get one. The respondent therefore arranged for an emergency appointment with OH later that day. However the claimant did not attend this appointment stating that it was too short notice.

124. The hearing went ahead on 27 and 28 January 2020. Prior to that, it had been postponed because the claimant wanted to be represented by Dr Howard. It had to be postponed again due to concerns about the claimant's health. As there was insufficient time to complete the hearing on 27 and 28 January, it was completed on 25 March 2020.

125. By letter from the respondent to the claimant dated 9 June 2020, the claimant was dismissed.

D. LEGAL PRINCIPLES

Whistleblowing detriment

126. The term "protected disclosure" is defined in section 43 of the ERA as follows:

> ***43A. Meaning of "protected disclosure"***
>
> ***In this Act a "protected disclosure" means a qualifying disclosure (as defined by section 43B) which is made by a worker in accordance with any of sections 43C to 43H.***
>
> ***43B. Disclosures qualifying for protection***
>
> ***(1) In this Part a "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show one or more of the following—***
>
> ***(a) that a criminal offence has been committed, is being committed or is likely to be committed,***
>
> ***(b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,***
>
> ***(c) that a miscarriage of justice has occurred, is occurring or is likely to occur,***
>
> ***(d) that the health or safety of any individual has been, is being or is likely to be endangered,***

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

(f) that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed.

127. A disclosure of information must be one that conveys facts rather than simply makes an "*allegation*" or "*mere assertion*". That said, it is important not to draw a rigid distinction between them as they are not mutually exclusive concepts. Importantly, the disclosure of information has to have a sufficient factual content and specificity such as is capable of tending to show one of the matters listed in s.43(B)(1).

128. Section 43(B)(1) ERA requires that the disclosure of information must "*in the reasonable belief of the worker……tend to show*" one of those matters at s.43(B)(1)(a)-(f). The worker is not required to show that the information disclosed led him or her to believe that the relevant failure was established, and that the belief was reasonable — rather, the worker must establish only reasonable belief that the information tended to show the relevant failure. It is a subtle but important distinction.

129. A worker does not therefore have to prove that the facts or allegations disclosed are true, or that they are capable in law of amounting to one of the categories of wrongdoing listed in the legislation. The wording of S.43B(1) ERA indicates that some account is to be taken of the worker's individual circumstances when deciding whether his or her belief was reasonable. Thus, the focus is on what the worker in question believed rather than on what a hypothetical reasonable worker might have believed in the same circumstances. This introduces a requirement that there should be some objective basis for the worker's belief. As long as the worker subjectively believes that the relevant failure has occurred or is likely to occur and their belief is, in the Tribunal's view, objectively reasonable, it does not matter that the belief subsequently turns out to be wrong, or that the facts alleged would not amount in law to the relevant failure.

130. In determining public interest, a Tribunal has to determine (a) whether the worker subjectively believed at the time that the disclosure was in the public interest and (b) if so, whether that belief was objectively reasonable. There might be more than one reasonable view as to whether a particular disclosure was in the public interest, and the Tribunal should not substitute its own view. The reasons why a worker believes disclosure is in the public interest are not of the essence, although the lack of any credible reason might cast doubt on whether the belief was genuine. However, since reasonableness is judged objectively, it is open to a Tribunal to find that a worker's belief was reasonable on grounds which the worker did not have in mind at the time.

131. Section 47(B) ERA states the following:

> ***(1) A worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure.***
>
> ***(1A) A worker ("W") has the right not to be subjected to any detriment by any act, or any deliberate failure to act, done—***
>
> ***(a) by another worker of W's employer in the course of that other worker's employment, or***
>
> ***(b) by an agent of W's employer with the employer's authority, on the ground that W has made a protected disclosure.***

132. Section 48 ERA states the following:

> ***(2) On a complaint under subsection (1), (1ZA), (1A) or (1B) it is for the employer to show the ground on which any act, or deliberate failure to act, was done.***

133. In ***London Borough of Harrow v Knight 2003 IRLR 140*, EAT**, the Appeal Tribunal set out the requirements for a successful claim under S.47B(1):

- the claimant must have made a protected disclosure
- he or she must have suffered some identifiable detriment
- the employer, worker or agent must have subjected the claimant to that detriment by some act, or deliberate failure to act
- the act or deliberate failure to act must have been done on the ground that the claimant made a protected disclosure

134. As is clear from the above extract from the ERA, with a whistleblowing detriment claim, it is for the employer to show the ground on which any act, or deliberate failure to act, was done (s.48(2) ERA). It does not mean that, once the claimant asserts that he or she has been subjected to a detriment, the respondent must disprove the claim. Rather, it means that once all the other necessary elements of a claim have been proved on the balance of probabilities by the claimant — i.e., that there was a protected disclosure, there was a detriment, and the respondent subjected the claimant to that detriment — the burden will shift to the respondent to prove that the worker was not subjected to the detriment on the ground that he or she had made the protected disclosure.

135. As to causation and whether a whistleblower was subject to a detriment because s/he made a protected disclosure, the law was clearly stated by Elias LJ in ***Fecitt and ors v NHS Manchester (Public Concern at Work intervening) 2012 ICR 372 CA*** where he said a Tribunal's task is to decide

whether the protected disclosure *materially influenced* the employer's treatment of the whistleblower, in the sense of more than trivially.

Direct discrimination

136. Section 13 EQA provides the following which prohibits direct discrimination:

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

137. Essentially s.13 requires a comparison to be made with either an actual or hypothetical comparator who does not share the claimant's protected characteristic. Whether the comparator is actual or hypothetical, the comparison must help to shed light on the reason for the treatment. However, the comparator test — i.e. asking whether someone without the claimant's protected characteristic would have been treated in the same way as the claimant — will only help the Tribunal in determining whether there was direct discrimination if the situation of the claimant resembles that of the comparator in material respects. For this purpose, s.23(1) EQA stipulates that there must be "*no material difference between the circumstances relating to each case*" when determining whether the claimant has been treated less favourably than a comparator. In other words, in order for the comparison to be valid, "*like must be compared with like*".

138. Of course the focus in direct discrimination cases must always be on the primary question "*why did the respondent treat the claimant in this way?"* Put another way, *"what was the respondent's conscious or subconscious reason for treating the claimant less favourably?"*

139. It is well established in case law that a respondent's motive is irrelevant when determining whether there has been direct discrimination and that the protected characteristic need not be the sole or even principal reason for the treatment as long as it is a *significant influence* or an *effective cause* of the treatment: ***R v Nagarajan v London Regional Transport [1999] IRLR 572***.

140. The burden of proof in discrimination cases is set out at s.136(2) and (3) of EQA which states:

> ***(2) If there are facts from which the court could decide, in the absence of any other explanation, that a person (A) contravened the provision concerned, the court must hold that the contravention occurred.***
>
> ***(3) But subsection (2) does not apply if A shows that A did not contravene the provision.***

141. What this means is that it is for the claimant to prove facts from which a Tribunal *could* conclude, in the absence of any evidence from the respondent,

that the respondent committed an act of discrimination. Only if that burden is discharged would it then be for the respondent to prove that the reason it dismissed the claimant was not because of a protected characteristic. Therefore, it is clear that the burden of proof shifts onto the respondent only if the claimant satisfies the Tribunal that there is a 'prima facie' case of discrimination. This will usually be based upon inferences of discrimination drawn from the primary facts and circumstances found by the Tribunal to have been proved on the balance of probabilities. Such inferences are crucial in discrimination cases given the unlikelihood of there being direct, overt and decisive evidence that a claimant has been treated less favourably because of a protected characteristic.

142. When looking at whether the burden shifts, something more than less favourable treatment than a comparator is required. The test is whether the Tribunal "*could conclude*", not whether it is "*possible to conclude*". In ***Madarassy v Nomura International plc 2007 ICR 867, CA*** it was said that the bare facts of a difference in treatment only indicates a possibility of discrimination. They are not, without more, sufficient material from which a Tribunal "*could conclude*" that, on the balance of probabilities, the respondent had committed an unlawful act of discrimination. However, the 'more' that is needed to create a claim requiring an answer need not be a great deal. In some instances, it can be furnished by non-responses, an evasive or untruthful answer to questions, failing to follow procedures etc. Importantly, it is also clear from case law that the fact that an employee may have been subjected to unreasonable treatment is not necessarily, of itself, sufficient as a basis for an inference of discrimination so as to cause the burden of proof to shift.

143. Notwithstanding what is said above, in ***Laing v Manchester City Council and anor 2006 ICR 1519, EAT***, the point was made that '*it might be sensible for a Tribunal to go straight to the second stage… where the employee is seeking to compare his treatment with a hypothetical employee. In such cases the question where there is such a comparator — whether there is a prima facie case — is in practice often inextricably linked to the issue of what is the explanation for the treatment*'.

Victimisation

144. Section 27 of EQA provides as follows:

> ***(1) A person (A) victimises another person (B) if A subjects B to a detriment because—***
>
> ***(a) B does a protected act, or***
>
> ***(b) A believes that B has done, or may do, a protected act.***
>
> ***(2) Each of the following is a protected act—***

> ***(a) bringing proceedings under this Act;***
>
> ***(b) giving evidence or information in connection with proceedings under this Act;***
>
> ***(c) doing any other thing for the purposes of or in connection with this Act;***
>
> ***(d) making an allegation (whether or not express) that A or another person has contravened this Act.***
>
> ***(3) Giving false evidence or information, or making a false allegation, is not a protected act if the evidence or information is given, or the allegation is made, in bad faith.***

145. The test to be applied here is threefold:

- Did the claimant do a protected act?
- Did the respondent subject the claimant to a detriment?
- If so, was the claimant subjected to that detriment because she had done a protected act, or because the employer believed that she had done, or might do, a protected act?

146. Here, once again, the most important decision to be made by the Tribunal is the "*reason why*" the respondent subjected the claimant to a detriment. Was it because of the complaint alleged to be a protected act – or was it something different? Even if the reason for the detriment is related to the protected act, it may still be quite separable from the complaint alleged to be a protected act.

147. A person claiming victimisation need not show that the detriment meted out was *solely* by reason of the protected act. As Lord Nicholls indicated in ***Nagarajan v London Regional Transport 1999 ICR 877, HL****,* if protected acts have a '*significant influence*' on the employer's decision making, discrimination will be made out. ***Nagarajan*** was considered by the Court of Appeal in ***Igen Ltd & ors v Wong and other cases 2005 ICR 931, CA,*** a sex discrimination case. In that case Lord Justice Peter Gibson clarified that for an influence to be 'significant' it does not have to be of great importance. A significant influence is rather "*an influence which is more than trivial. We find it hard to believe that the principle of equal treatment would be breached by the merely trivial. The crucial issue for the Tribunal to determine is the reason for the treatment — i.e. what motivated the employer to act as it did? But it is not necessary for the protected act to be the primary cause of a detriment, so long as it is a significant factor*".

148. Whilst the same burden of proof applies in such cases, namely that the claimant must prove sufficient facts from which the Tribunal could conclude, in the absence of hearing from the respondent, that the claimant has suffered an act of discrimination, it is also perfectly acceptable to go straight to the "*reason why*" because that is the central question that the Tribunal needs to answer.

Harassment

149. Section 26 EQA defines harassment as follows: -

> ***(1) A person (A) harasses another (B) if—***
>
> ***(a) A engages in unwanted conduct related to a relevant protected characteristic, and***
>
> ***(b) the conduct has the purpose or effect of—***
>
> ***(i) violating B's dignity, or***
>
> ***(ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.***
>
> ***(4) In deciding whether conduct has the effect referred to in subsection (1)(b), each of the following must be taken into account—***
>
> ***(a) the perception of B***
>
> ***(b) the other circumstances of the case***
>
> ***(c) whether it is reasonable for the conduct to have that effect.***

150. There are three essential elements of a harassment claim under s.26(1):

- unwanted conduct
- related to disability
- which had the *purpose* or *effect* of (i) violating the claimant's dignity, or (ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for the claimant (the "proscribed environment").

151. When considering "effect", the Tribunal must consider the claimant's perception; the circumstances of the case; and whether it is reasonable for the conduct to have that effect: s.26(4). Establishing reasonableness is essential: ***Pemberton v Inwood [2018] EWCA Civ 564.***

Time limits

152. Section 123 of EQA deals with time limits for bringing discrimination claims in the Employment Tribunal and says as follows:

> ***(1) [Subject to [sections 140A and 140B] on a complaint within section 120 may not be brought after the end of—***
>
> ***(a) the period of 3 months starting with the date of the act to which the complaint relates, or***
>
> ***(b) such other period as the Employment Tribunal thinks just and equitable.***
>
> ***…………***
>
> ***(3) For the purposes of this section—***
>
> ***(a) conduct extending over a period is to be treated as done at the end of the period;***
>
> ***(b) failure to do something is to be treated as occurring when the person in question decided on it.***

153. The EAT in ***British Coal Corporation v Keeble [1997] IRLR 336*** held that the Tribunal's discretion in these circumstances is as wide as that of the civil courts under s.33 of the Limitation Act 1980. This requires courts to consider factors relevant to the prejudice that each party would suffer if an extension were refused. These include:

- The length of, and reasons for, the delay
- The extent to which the cogency of the evidence is likely to be affected by the delay
- The extent to which the party sued had co-operated with any requests for information
- The promptness with which the claimant acted once they knew of the possibility of taking action
- The steps taken by the claimant to obtain appropriate professional advice once they knew of the possibility of taking action

154. Sections 48(3) and (4) state as follows

> ***(3) An Employment Tribunal shall not consider a complaint under this section unless it is presented—***
>
> ***(a) before the end of the period of three months beginning with the date of the act or failure to act to which the complaint relates or, where that***

> ***act or failure is part of a series of similar acts or failures, the last of them, or***
>
> ***(b) within such further period as the Tribunal considers reasonable in a case where it is satisfied that it was not reasonably practicable for the complaint to be presented before the end of that period of three months.***
>
> ***(4) For the purposes of subsection (3)—***
>
> ***(a) where an act extends over a period, the "date of the act" means the last day of that period, and***
>
> ***(b) a deliberate failure to act shall be treated as done when it was decided on;***

155. In ***Arthur v London Eastern Railway [2006] EWCA Civ 1358, [2007] IRLR 58*** the Court of Appeal went back to the statutory wording that they must be part of a 'series' and acts which are 'similar' to one another. It held that a Tribunal should hear evidence to determine whether acts or omissions form part of such a series and not rely on submissions alone. Potentially relevant considerations were described by the Court of Appeal as follows:

- it is necessary to look at all the circumstances surrounding the acts
- were they all committed by fellow employees?
- if not, what connection, if any, was there between the alleged perpetrators?
- were their actions organised or concerted in some way?
- why did they do what is alleged?

E. ANALYSIS, CONCLUSIONS AND ASSOCIATED FINDINGS OF FACT

156. The Tribunal turned to each of the claims, applying the legal principles to the facts in order to reach a decision on each allegation. Numbers in squared brackets below are references to the agreed list of issues in the Schedule to this judgment.

157. Surprisingly in a case of this length, there were relatively few disputed facts, or certainly those that needed to be determined in order for the Tribunal to reach its conclusions. Much of the Tribunal's focus was therefore on whether the claimant had established sufficient facts to establish a claim, and then on why the respondent did what it did. Essentially what the Tribunal needed to examine was whether the respondent did what it did because the claimant made protected disclosures, made complaints of discrimination, was because of the claimant's sex or race, or whether, with the claims of harassment, such actions were related to the claimant's sex.

158. The Tribunal accepted that the claimant felt genuinely aggrieved about the way she had been treated. There is no doubt that the claimant vehemently denied the allegations relating to her capability or conduct; she believed the issues were more about clinical judgment and she should not have been subject to a MHPS process.

159. The Tribunal considered a very large number of allegations by the claimant, many of which the Tribunal concluded were not very well thought through and, in some cases, were completely misconceived. The Tribunal doubted whether the claimant really believed some of the claims she was making. Examples included allegations relating to breaches of MHPS where the claimant could not identify the breaches; race discrimination allegations where the comparator was the same race; sex discrimination allegations where the comparator was the same sex. The tribunal concluded that the factual premise of many allegations was simply wrong.

160. The Tribunal also concluded that the whistleblowing allegations which flowed from concerns raised by the claimant to the respondent about health and safety were not very persuasive. The Tribunal accepted that as a consultant, the claimant was expected, like any other consultant or clinician, to raise concerns about health and safety; indeed it was their duty. The Tribunal heard that other consultants were raising concerns about such matters as levels of radiation and the state of x-ray machines, alongside the claimant. The Tribunal was not satisfied that the claimant was being targetted for raising these concerns. Neither was it satisfied that the underlying reason for the treatment of her was the fact that the claimant had brought previous Employment Tribunal claims or had raised complaints of mistreatment and discrimination.

161. Ms Motraghi described the claimant's approach as "*scattergun*". Whether or not that is right, there is no doubt that the claimant's evidence was difficult to understand in places, her witness statement did not provide sufficient, or any, evidence to support some of her claims. She also to failed identify or produce documents to support many of the claims she was making.

162. The Tribunal considered the actions of the respondent, and studied their evidence, very carefully. The Tribunal concluded that the witnesses gave their evidence honestly and to the best of their ability bearing in mind they were often being asked to recall matters that had occurred some years earlier. They gave credible evidence, with reasons for their decisions and actions. The Tribunal examined with care whether what they said was true, or whether there was something more sinister and they were influenced by disclosures and complaints the claimant had made, or they did what they did because of the claimant's sex or race. For the reasons set out below, the Tribunal concluded, having looked at all of the evidence, that they were not

influenced by protected disclosures, complaints of discrimination or because of the claimant's sex or race.

Did the claimant make a protected disclosure? [12-16]

163. It is accepted by the respondent that the claimant made the following protected disclosures:

163.1. The first claim.

163.2. The second claim.

163.3. The discussion with JA on 21 and 29 November 2017 during which she raised concerns about work patterns in the cardiology department and patient safety.

163.4. The discussion with SW on 6 December 2017 during which she reiterated concerns about work patterns and patient safety.

163.5. The emails which she sent to Nicola Tripp (HR Advisor) on 22 and 23 January 2018 in which she set out her concerns about the quality of patient care in a document headed “Issues for Discussion”.

163.6. The written grievance that the claimant submitted in September 2016 and which concluded in April 2018.

163.7. In the context of a root cause analysis into a patient death in September 2018:

- To the quality manager on 28 February 2019.
- To the clinical lead on 8 March 2019.
- To Dr Marsh on 8 May 2019.
- To Dr Marsh on 14 June 2019.
- To the freedom to speak up guardian on 14 June 2019.

164. In light of those concessions, the Tribunal accepted that they were indeed protected disclosures within the meaning of the ERA.

165. The respondent did not, however, concede that the following protected disclosures were made:

165.1. An email to HR on 21 December 2017 enquiring about the dosage of radiation received whilst working at Epsom

165.2. An email to HR, Director of People and PB in connection with the root cause analysis.

166. The Tribunal was not taken to these emails or provided with sufficient evidence to conclude that the disclosures at paragraphs 164.1 and 164.2 were made.

Did the claimant do a protected act? [19]

167. It is not disputed by the respondent that the claimant did a protected act within the meaning of s.27 EQA. Those protected acts are the first and second claims (paragraph 19 of the list of issues).

Whistleblowing, direct sex discrimination, and victimisation claims [17][18]

168. Whilst out of necessity the Tribunal has made specific findings and reached conclusions in relation to each and every detriment in the list of issues, the Tribunal agreed with Mr Jackson when he suggested that the Tribunal should also step back and look at the situation in the round and consider the pattern of behaviour which the claimant said that she suffered at the hands of the respondent. Whilst the Tribunal has therefore addressed each of the detriments separately, that should not be interpreted as the Tribunal having looked at each of the detriments in isolation without looking at all allegations in the round.

169. Mr Jackson also suggested that the Tribunal was not restricted to looking at those matters which pre-dated the second claim when determining those claims which had arisen and which formed part of the second and third claims. The Tribunal agreed with that in principle. Of course the Tribunal was careful not to stray into areas that would be the subject of any subsequent claims but where it had a bearing on those matters before this Tribunal, then of course the Tribunal agreed that it should be considered. One such matter that the Tribunal was invited to consider was the outcome of the claimant's hearing before the GMC. The GMC began an investigation into the claimant which concluded in March 2021 with no further action to be taken. The claimant continued to state throughout this hearing that she had been exhonerated by the GMC, suggesting that their conclusion must cast doubt on the actions and motivations of the respondent. However, the Tribunal found it difficult to draw any such conclusions from the GMC outcome. The Tribunal was not shown the content of the GMC referral or the case examiner’s report. Whilst the GMC and the respondent were looking at the same cases, their remits were likely to be quite different. In any event, the Tribunal was not shown sufficient evidence to decide either way.

170. References to “*unlawful reasons*” at paragraphs 172 to 227 below means where the reasons for the acts or omissions alleged against the respondent were either because the claimant made one or more protected disclosures, did one or more protected acts, or was *because* of her sex.

171. Turning now to the detriments, the Tribunal's conclusion on each of them is set out below. Claims have been grouped together where they are similar or where there is an overlap.

Being informed on 7 February 2018 that the claimant could not carry out any clinical work [17(i)]

Being suspended from clinical duties on the pretext of competency concerns on 12 February 2018. [17(ii)]

172. Paragraphs 4 and 5 of Part 2 of the MHPS deal with restricting a doctor’s practice, and exclusion (which is another word for suspension). Those paragraphs state as follows:

> ***4. When serious concerns are raised about a practitioner, the employer must urgently consider whether it is necessary to place temporary restrictions on their practice. This might be to amend or restrict their clinical duties, obtain undertakings or provide for the exclusion of the practitioner from the workplace. Where there are concerns about a doctor or dentist in training, the postgraduate dean should be involved as soon as possible.***
>
> ***5. Exclusion of clinical staff from the workplace is a temporary expedient. Under this framework, exclusion is a precautionary measure and not a disciplinary sanction. Exclusion from work ("suspension") should be reserved for only the most exceptional circumstances.***

173. The claimant sought to persuade the Tribunal that she had been ‘excluded’ rather than restricted. The Tribunal rejected that suggestion. The Tribunal found as fact that exclusion is the same as suspension, which means that an employee is prevented from attending the workplace. The claimant was restricted, which meant that she could attend the workplace but was restricted as to the duties that she could perform. In the claimant’s case, she was restricted from performing clinical duties.

174. The Tribunal accepted Dr Marsh’s evidence that the decision to restrict the claimant's clinical practice was based solely because of the concerns raised in Dr Andrews’ report. On the back of that report, Dr Marsh said he was “*concerned about Dr Prasad’s clinical practice and working relationships to the extent that I considered there was a real risk to patient safety and care*”. The Tribunal could see no reason to disbelieve Dr Marsh and accepted that his belief was genuinely held. The report revealed concerns about the claimant that came from no less than 12 individuals, including Dr Foran (the

then longest serving cardiologist) Ms Goulder, Ms Sloane, Ms Thompson and Dr Dani.

175. While the Claimant did not accept the criticisms of her, she did accept in her oral evidence that if the matters described by her colleagues were true, they would be "*serious cause for concern*".

176. Given the above findings, the Tribunal concluded that the reasons given by Dr Marsh for imposing the restrictions had nothing to do with the unlawful reasons.

Instigating an investigation into the claimant's professional practice without any reasonable or proper cause to do so [17(iii)]

177. There is no doubt that there was a difference of opinion between the claimant and Dr Marsh (and indeed others within the respondent, and outside, including those that were supporters of the claimant) as to whether there was proper cause to start an investigation into the claimant's clinical practice and allegations relating to her conduct/capability. That was essentially what this whole case was about. However, this Tribunal's role was not to consider the detail of the concerns raised about the claimant and decide whether they were well founded; its role was to decide whether the instigation of the investigation into the claimant was because of, or materially influenced by, any of the unlawful reasons.

178. On the basis of the information known to Dr Marsh at the time, whether or not the claimant agreed with it, the Tribunal accepted that he had proper cause to start an investigation. His motives in doing so had nothing to do with the unlawful reasons. The Tribunal concluded that at each stage of this long and drawn out process, attempts were made by Dr Marsh to explore alternatives to formal action under the MHPS framework, such as the ISR. It was partly because of these attempts to pursue an alternative approach and avoid a formal route that the process took so long.

Failing to follow the procedural requirements of the MHPS Policy when conducting the investigation into her professional practice [17(iv)]

179. Despite many attempts by the Tribunal to clarify precisely the procedural requirements that the claimant said were not followed, or breached, the claimant could not identify anything that amounted to a breach. The factual premise of this allegation was incorrect.

Failing to particularise the exact issues which led to her exclusion from clinical duties on 7th and 12th February 2018. The snippets of case information provided by Dr Bogle were inaccurate, misleading and incomplete. Nor did it seek the claimants input prior to suspending her from all clinical duties [17(v)]

180. For the above reasons, the Tribunal did not accept the claimant's suggestion that she had been excluded. The MHPS framework document says at paragraph 13 that "*as soon as it has been decided that an investigation is to be undertaken.....[the practitioner] must be made aware of the specific allegations or concerns that have been raised*". This happened in the claimant's case as she was informed of the terms of reference in January 2017. It is right that they were headings and did not go into detail at that stage. Importantly, however, there was no requirement, whether set out in the MHPS, or at all, to particularise the details of cases at the point of restricting the claimant. Again, there was a disagreement between the claimant and the respondent about precisely what information ought to have been given. Regardless of that, the Tribunal was satisfied that decisions about what information should be provided, were not motivated by, or because of, any of the unlawful reasons.

Denying her the opportunity to propose an alternative to suspension on 12th February 2018 [17(vi)]

181. The Tribunal concluded that the decision to restrict the claimant's practice was for the respondent to take. There was no right, whether in the MHPS framework or otherwise, for a doctor to propose alternatives. The MHPS framework does not require an employer to agree a suspension or restrictions with a doctor. For this reason the Tribunal did not believe that the claimant had suffered any detriment. Even if she had, it was not because of any of the unlawful reasons.

Failing to give the claimant copies of all relevant documents despite several requests 12th February 2018 and via several emails in February 2018 [17(vii)]

182. The claimant failed to particularise this allegation in her evidence and therefore the Tribunal did not hear sufficient evidence about such requests to enable it to conclude that the claimant had suffered any detriment.

Failing to inform the claimant of the right to appeal the way the MHPS procedure had been conducted on 16th Feb 2018 despite requests at a meeting with Nicola Tripp on 23 February 2018 and a written and verbal request to PB (Non-executive director overseeing MHPS process) on 16th Feb 2018 and during a meeting on 20th Feb 2018 [17(viii)]

183. There was no right to appeal and the Claimant was unable to identify where such a right existed. The Tribunal could therefore identify no detriment suffered by the claimant. Even if there was, there was no evidence from which the Tribunal could possibly conclude that this was because of any of the unlawful reasons.

Failing to promptly interview the list of witnesses provided by the claimant in September 2017 resulting in an unfair investigation [17(ix)]

184. Dr Andrews had a wide discretion to decide how he conducted the investigation. It was well within his discretion to decide to wait until he had interviewed the claimant before interviewing her witnesses. That delay, the Tribunal concluded, was due to the reluctance on the part of the claimant to meet Dr Andrews, itself causing a significant delay to the whole process. The Tribunal was satisfied that Dr Andrews wanted to get on and conclude the investigation as quickly as he could, whilst ensuring that the investigation was thorough and fair. The Tribunal was not satisfied that any delay resulted in an unfair investigation. The Tribunal concluded that the timing of Dr Andrews interviewing the witnesses, if it could be said that there was a delay, did not cause the claimant to suffer a detriment. Even if a detriment was suffered, the Tribunal accepted Dr Andrews' reasons for the timing of interviewing witnesses. It had nothing to do with any of the unlawful reasons.

185. As to Dr Andrews decision to interview 10 of the 20 individuals whose names were given to him by the claimant, again it was within his discretion who to interview. The Tribunal accepted that Dr Andrews gave thought to that issue and decided, the reasons for which the Tribunal found perfectly acceptable, to limit his investigation to interviewing 10 people only. Dr Andrews believed it was disproportionate to interview everyone, particularly as those he did not interview had very little information to provide in connection with the matters he was tasked with investigating. The Tribunal was satisfied that the decision who to interview of the claimant's witnesses had nothing to do with any of the unlawful reasons.

Dr Marsh delaying the submission of the claimant's response to the allegations against her to Dr Beeton by well over a month [17(x)]

186. The claimant appeared to allege that Dr Marsh had deliberately delayed the submission of her responses to Dr Beeton's report to him. There was indeed a five week period between the claimant providing her responses and Dr Marsh passing these to Dr Beeton. The Tribunal did not believe this was deliberate. There appeared to be no good reason why Dr Marsh would deliberately delay the submission of the claimant's responses. The relatively short delay was unfortunate but the Tribunal accepted that Dr James was an extremely busy professional and that the delay was unintentional. It was certainly not, in the Tribunal's view, done for any of the unlawful reasons.

Failing to ensure the claimant's continued professional development (CPD) by reviewing the restrictions on her practice after 17 out of 43 allegations against her had been dismissed as "no misconduct" when she made specific requests on 9 May and 15 June 2018 [17(xi)]

187. The Tribunal was satisfied that the claimant's restrictions were kept under review. However, Dr Marsh felt that he could not simply lift the restrictions, even though the number of concerns had reduced, until the matter had been resolved whether via a formal process, or an alternative. His decisions had nothing to do with any of the unlawful reasons and everything to do with protecting the public, faced with the concerns raised by Dr Andrews' investigation.

Failing to appoint the claimant to the role of Clinical Lead on/around 14 June 2018 despite her being the most experienced person for the role [17(xii)]

188. The Tribunal accepted the respondent's case that Dr Daryani was the stronger candidate. There was a complete absence of evidence to suggest that the decision was because of any of the unlawful reasons, and nothing from which the Tribunal could infer that was the case. The claimant was not at Dr Daryani's interview and had no way of knowing whether or not he had performed better than she had. Dr Winn gave very credible evidence on this issue which the Tribunal had little difficulty accepting. Dr Winn gave the claimant feedback and was able to pin point clearly the reasons why she had not been successful. The claimant did not challenge this decision at the time.

Failing to share the contents of the provisional MHPS report in June/July 2018 and therefore prolonging the claimant's exclusion [17(xiii)]

189. There was no obligation on Dr Andrews to share the interim report. There was also no evidence to demonstrate that the premise of the claimant's allegation was correct, namely that disclosure of the interim report would have resulted in an earlier lifting of the restrictions. The Tribunal was not satisfied that this caused the claimant to suffer a detriment. Even if it did, such failure was not because of any of the unlawful reasons.

Dr Perikala excluding her from an e-mail on 3 July 2018 [17(xiv)]

190. A copy of this email was never shown to the Tribunal, which could not be satisfied, on the evidence, that the factual premise of this allegation was indeed correct. The Tribunal was therefore not satisfied that the claimant had suffered a detriment.

Dr Bogle excluding the claimant from a WhatsApp group named St Helier Cardiology Team prior to 6 July 2018 [17(xv)]

191. The Tribunal accepted that this group was set up by Dr Bogle for junior members of the cardiology team, together with some nurses and physiologists. It was set up for educational purposes, to aid learning and development, and to enable the sharing of insights from journals or papers.

The Tribunal rejected any suggestion that the claimant had suffered any detriment. Even if she had, it was certainly not because of any of the unlawful reasons.

Failing to appoint the claimant to the role of Deputy Clinical Director on 23 July 2018 despite her being the most experienced person for the role [17(xvi)]

192. The Claimant applied for the above role and was interviewed on 23 July 2018. Dr Winn said in evidence that the claimant and Dr Kahr were both invited to interview. Both were asked the same six questions and the contemporaneous notes of Dr Winn and Mr Camp showed the responses of the candidates. The panel considered the performance of both candidates and determined that Dr Kahr was the better candidate, performing very well at interview and "*showing a clear understanding of the role of the department within the Trust*." Dr Winn compared and contrasted the answers of the claimant and Dr Kahr to show that Dr Kahr provided a broader vision of service needs of the director, giving examples of change management across a range of settings.

193. The claimant was given the news that she was not successful by telephone on the same day as the interview and sent an email from Dr Winn in which he provided her with constructive feedback, highlighting what she did well and what she could improve for the future.

194. In her evidence, the claimant conceded that she did not even know who had been the successful candidate or that the successful candidate was a woman. When she was asked how or why she would make an allegation that she had been subjected to sex discrimination when she did not even know whether the person appointed was male or female, the Claimant said that this was a 'mistake' and the Tribunal should consider it as a whistleblowing detriment.

195. The Tribunal had little difficulty accepting the respondent's evidence that there had been a proper and fair process and that the decision not to appoint the claimant was because the successful candidate had performed better than the claimant and had nothing to do with any of the unlawful reasons.

Excluding the claimant from a WhatsApp teaching group on/around August 2018 [17(xvii)]

196. Dr Bogle set up a WhatsApp group in October 2017 to coordinate the teaching of medical students. He did not add any consultants to the group when he set it up. Some time later, in May 2018 and August 2020, locum consultant Dr Osman and Dr Foran were added respectively, because they both requested to join. No other consultants were part of the group. The factual premise of this allegation was incorrect as the Tribunal did not believe the claimant was 'excluded' as alleged, or at all. The claimant did not suffer

any detriment and neither was the Tribunal satisfied that the reason the claimant was not invited to the group was because of any of the unlawful reasons.

Paying the claimant less than her male colleagues [17(xviii)]

197. The Tribunal was not satisfied that the claimant was treated less favourably than her male colleagues. The persons she compared herself with were not appropriate comparators because they were entitled to be paid a higher sum than the claimant to reflect the greater programmed activities (PAs) they had agreed with the respondent to carry out. At all material times since 2011, the Claimant had been working a 10 PA job plan. This was in accordance with her contract of employment. The claimant undertook private practice on Wednesday mornings (i.e. she was not working for the respondent at this time). She also worked a nine day fortnight and she did no 'on call' work. The claimant's comparators were male cardiology consultants who the Tribunal concluded had also been paid in accordance with their job plans. However, their job plans were for more than 10 PAs. They worked on call and/or had clinical management responsibilities such as the clinical lead position. The Claimant could not identify any instance where a male comparator was paid more than they should have been, having regard to their agreed job plan. There was absolutely no evidence from which the Tribunal could conclude that decisions regarding what the claimant should be paid was because of any of the unlawful reasons.

Deciding on/around 24 August 2018 to proceed to a Disciplinary hearing in respect of her conduct [17(xix)]

The decision to hold a capability/conduct hearing in the MHPS investigation (which the claimant maintains to have been flawed and based on false allegations) [18(ii)]

Not following an alternative to inviting the claimant to a capability/conduct hearing [18(iii)]

198. Dr Marsh decided that there was a case to answer following receipt of Dr Andrew's report on 12 August 2018. He further concluded that the matter should go forward to an MHPS hearing after speaking with the responsible officer, Dr Martin Stockwell. The Tribunal concluded that Dr Marsh was perfectly entitled to rely on the report to make his decision. His decision to refer the matter to an MHPS Panel was in line with the MHPS policy and by doing so, a separate panel could reach its own decisions having heard from the claimant.

199. As it happened, the panel had the advantage of having an external cardiologist as a panellist. Notwithstanding Dr Marsh's decision to proceed with an MHPS hearing, he nevertheless continued to explore the option of a

behavioural assessment which was recommended by the PPA as an alternative to a formal MHPS process. He did not have to do this. The Tribunal concluded that the decision to proceed with a disciplinary hearing was taken as a last resort, and only after a great deal of consideration was given to it, taking into account the claimant's comments on the report, and also considering alternatives. The Tribunal did not believe that this decision had anything to do with any of the unlawful reasons.

Taking away the claimant’s Research projects and her role as a PI (Principal Investigator) for Cardiology Research Projects despite the lack of any adverse data related to research projects. The Research projects have national and international portfolio [17(xx)]

200. Dr Daryani gave evidence that within the trials there was ‘clinical involvement’ and therefore as the claimant was clinically restricted, the claimant's role in the research projects had to stop. The decision to remove the claimant from the PI role was Dr Marsh’s, on the advice of Dr Pauline Swift (Head of Research & Development). He explained in evidence that he had referred to Dr Swift for her view as to whether someone who was restricted could continue in that role. Her clear view was that the claimant could not continue in the role. Given the above, the Tribunal concluded that this decision was not in any way influenced by any of the unlawful reasons.

Prolonged MHPS process due to failure to review clinical restrictions (leading to a loss of private work) [17(xxi) and 18(xi)]

Continued failure to lift clinical restrictions [18(i)]

Not removing restrictions on the claimant’s practice following the raising of concerns by the claimant and her MPS advisor Dr Liliane Field in July 2019 [18(xix)]

201. As to the length of the process, the Tribunal accepted that the MHPS process was prolonged. However there were a number of different reasons for this. The Tribunal relies on its findings above, which sets out the chronology and details the various factors which led to the process becoming very protracted. The Tribunal concluded that the way the claimant and her advisers defended the allegations itself led to significant delays. Of course other delays were caused by the respondent's attempts, albeit unsuccessful, to explore alternatives to formal action. The length of the process, whilst very unfortunate, was not down to one individual and was not influenced by any of the unlawful reasons.

202. The Tribunal was satisfied that the restrictions were reviewed on a regular basis and there was clear evidence during the hearing that such reviews did take place. The restrictions could not be lifted until the respondent was satisfied that the concerns raised by Dr Andrews had been dealt with or

determined, whether via a formal process or some form of alternative. The Tribunal was satisfied that any failure or decision not to lift the restrictions at an earlier point was for the above reason and not for any of the unlawful reasons.

A prolonged grievance investigation which took over 2 years to conclude. Failure of respondent to uphold claimants grievance even when all information and evidence presented [17(xxii)]

203. The grievance process did take two years. It was a process that became very protracted and complicated and covered complaints which went back a number of years. When the Tribunal looked through the chronology of what had happened, it was clear that the individuals dealing with it were not motivated by any of the unlawful reasons and the unlawful reasons were not the cause of the delay.

Failing to investigate the claimant's grievance (submitted on 2nd July 2019 by her representative and on 29th July by the claimant) [18(iv)]

204. The Tribunal rejected the factual premise of this allegation. However, a decision was made to separate out the grievance issues relating to the MHPS process, that would be heard by the MHPS Panel, and other grievances which would be addressed through a separate grievance process. Dr Charlton wrote to the claimant by letter dated 15 August 2019 in which she wrote:

> ***Having looked at the content of the letter, it overlaps considerably with the MHPS process. In many cases it appears to be the basis of your response to the concerns raised and/or complaints about the process that was adopted. In my view, these matters are so intrinsically linked that they cannot be separated into two distinct processes and the most appropriate course of action is for the grievance to be considered by the panel who have also been convened to consider the concerns about capability and conduct. I consider that approach will enable us to deal with all the issues in the most timely way possible and ensure that everything relevant is fully considered in both processes. This is consistent with the Trust's Grievance Policy at paragraph 37.***

205. Dr Charlton informed the claimant that matters that would be dealt with in line with the grievance process included complaints about gender pay gap, job planning and concerns in the document "issue for discussion". The claimant was informed that Ms Orukele would liaise with her in order to take those issues forward.

206. The above matters were indeed addressed in the grievance investigation report dated 12 October 2019 by Cheryl Neale, Medical Workforce Case Investigation. It was through this process that the respondent identified that the claimant had been underpaid in the year 2010-2011 and it was

recommended that she should be paid for the additional PAs she carried out in that year.

207. A further investigation was carried out by Emma Wilson which addressed residual matters such as health and safety issues, breach of duty of care and a complaint that the claimant felt unsupported, isolated and excluded from the wider team on her return to work in February 2018.

208. In those circumstances, the Tribunal rejected the suggestion that the respondent failed to investigate the grievances. The premise of this allegation was not correct. There was no detriment and there was nothing which the respondent did that was because of the unlawful reasons.

In selecting an external panel member to sit on the panel who had worked closely with the case manager (Dr Marsh) and the external expert (Dr Beeton), despite the claimant's objections [18(v)]

209. The Tribunal did not accept the factual premise of this allegation. Dr Marsh did not work closely with Dr Fluck, as alleged by the claimant, or at all. Dr Marsh explained that he attended St Peter's to perform Renal Clinics and to attend in-patients with renal related problems. There were a small number of patients he saw in the renal clinic who also saw Dr Fluck in connection with cardiac issues. The interactions were entirely professional and almost entirely based on professional correspondence to the GP, copied to each other. Dr Marsh could not remember the last time that he had referred a patient to Dr Fluck, or received a referral from him. The Tribunal was satisfied that Dr Fluck had no prior knowledge of the case, he had signed a no conflict of interest statement and the MHPS Panel were satisfied that the level of working relationship did not compromise the MHPS Panel. This was also the view of the Appeal Panel. There was no evidence from which the Tribunal could conclude that Dr Fluck's appointment to the panel was for any of the unlawful reasons.

Being informed that the outcome of the hearing may include dismissal should the panel decide that it was appropriate [18(vi)]

210. The Tribunal concluded that this could not in any sense be described as a detriment. The respondent simply did what was best HR practice in circumstances where the panel would have to consider all options up to and including dismissal. Such a decision to inform the claimant of that possible outcome was not because of any of the unlawful reasons.

The Trust instructing a barrister to present its case during the internal hearing (which the claimant contends is contrary to the Trust's policies) [18(vii)]

The barrister attending the hearing on 15th and 16th October 2019 despite assurances and in the claimant's absence [18(viii)]

211. The Tribunal accepted the respondent's evidence that it was not uncommon for a barrister to be instructed to attend MHPS hearings. The claimant could point to nothing which suggested that it was contrary to the MHPS policy or any other policy of the respondent's. In any event the factual premise of this allegation is incorrect as the barrister did not present the respondent's case - Dr Marsh did. The barrister did not attend the hearing albeit he was at the same venue as the hearing for the purpose of providing the respondent with legal advice. The Tribunal concluded that the claimant was not in fact put to any detriment and that the reasons for having a barrister attend the hearing venue, albeit he was not present in the hearing, was not because of any unlawful reason.

Not providing minutes of all Medical Workforce meetings where the claimant's restrictions were reviewed, despite these being requested [18(ix)]

212. No minutes were provided to the claimant because none were prepared or existed. That might sound unusual, given what the MWG discussed at their meetings, but the Tribunal accepted that was their practice. The Tribunal did not believe such a decision or practice was in any way connected with any of the unlawful reasons.

Not providing all data, despite 'several requests and official submissions for subject access requests' [18(x)]

213. There was insufficient evidence from which the Tribunal could understand what this allegation was about. On that basis, the Tribunal could not be satisfied that the claimant had suffered any detriment.

Failure of Dr Marsh and Dr Andrews to take notice of positive testimonials, feedback and supporting letters from 150 individuals [18(xiii)]

214. The Tribunal did not accept the factual premise of this allegation. Dr Andrews took into account the positive testimonials provided by the claimant. He expressly said so in his report and the testimonials were appended to it. However he also commented that they did not assist him directly because they did not address the issues he had to consider within the TOR. The factual premise of this allegation is therefore wrong.

Failure to act upon the submission of Dr Howard of a summary document titled UP Grievance submission against the capability conduct hearing (dated 14th October 2019) [18(xiv)]

Failure to act upon the submission by Dr Odemuyiwa of a summary document dated 21st July 2019 about his concerns regarding the claimant's treatment [18(xv)]

Failure to act upon the issues raised in a document titled 'Issues for Discussion' which was submitted on 22/23rd January 2018 [18(xvi)]

215. The Tribunal concluded that the "failure to act" was a failure to accept what was said in those documents and to give the relief sought, namely the removal of clinical restrictions. As has already been said, Dr Marsh required assurance regarding the claimant's clinical practice before he was satisfied that she could return to clinical practice. While there remained a difference in view between the claimant and Dr Marsh, the only way the restrictions could be lifted was a MHPS process which concluded, at least to some extent, in the claimant's favour, or pursuing an alternative. The Tribunal refers to its above findings. Clearly, the restrictions could not simply be removed on the basis of advocacy or lobbying by the claimant, Dr Howard, Dr Odemuyiwa, or indeed anyone else. The respondent was not motivated by any of the unlawful reasons in respect of this allegation.

Withholding the results of an earlier investigation that had taken place into her practice by Dr Beeton, until it was provided in response to an SAR in August 2019 [18(vii)]

216. This was a reference to Dr Beeton's investigation into the management of patient JW and did not form part of the MHPS investigation. The Tribunal was not at all clear what detriment the claimant suffered as a result of this disclosure, or alleged withholding of the investigation. Even if it was a detriment, there was no evidence upon which the Tribunal could conclude it had anything to do with the unlawful reasons.

Failure to take action in response to the claimant's concerns about Dr Dr Perikala. (Dr Perikala instead being promoted to Associate Specialist)[18(xviii)]

217. The factual premise of this allegation is incorrect as Dr Perikala was formally sanctioned as a result of a MHPS process. He was given an improvement notice. Whilst the claimant might argue that the sanction was too lenient, in her view, that sanction was considered appropriate by the respondent. In any event, the Tribunal concluded that the claimant had not suffered any detriment as a result of the outcome of a process directed at Dr Perikala.

Failure to follow internal guidelines and policy, MHPS, or the ACAS code of conduct (as set out in the letters dated 2nd July 2019, 8 May 2019 and 29th July 2019) [18(xx)]

218. The claimant was unable to pin point for the Tribunal where the failures were that she relied on. The Tribunal was therefore unable to conclude that there were such failures. The factual premise of this allegation is incorrect.

Collaboration and collusion in the management of the internal MHPS investigation (as set out in the submission by Dr Howard of 14th October 2019) [18(xxi)]

219. This allegation was not understood by the Tribunal. In any event, the Tribunal was not satisfied that there was any collusion in the management of the MHPS process.

Failure to recommend the claimant for revalidation in September 2019 despite successful appraisal in August 2019 [18(xxii)]

220. The Respondent sought advice on this issue from the GMC. Their advice was clear, that in line with GMC guidance it was not possible to put a doctor forward for revalidation, and that deferral was the only option, deferral being a neutral act. In these circumstances, the Tribunal was completely satisfied that the reason for not recommending the claimant for revalidation was solely because of that advice and not for any of the unlawful reasons.

Failure to follow the recommendations of Baroness Harding, which were sent to NHS Trusts in July 2019 by NHS Improvement and NHS England (n.b the respondent does not accept that the recommendations at c to g accurately state Baroness Harding's recommendations, and are the claimant's restatement) [[18(xxiii)]

221. In her oral evidence, the claimant was unable to provide any information whatsoever in support of her contention that the respondent had breached, or failed to follow, any of the Harding recommendations. What the claimant referred to were not breaches at all. This claim had no merit whatsoever. The Tribunal could see no basis for concluding that the claimant had suffered a detriment.

On 8th January 2018, the claimant submitted a sick note to Mr James Allan citing symptoms of stress due to prolonged harassment and chest infection. Despite this, the respondent continued with the investigation against her, failing to take proper consideration of the impact it was having on her [18(xxiv)(a)]

222. This claim had no merit. The fact that the respondent continued with its investigation was not in any way connected with any of the unlawful reasons.

Whilst the claimant was on sick leave, Dr Marsh, Dr Andrews and HR personnel continued to send her numerous emails and papers through emails giving huge documents with multiple questions relating to the

investigation to answer giving the claimant very tight deadlines to respond 18(xxiv)(b)]

223. The claimant gave no indication that she was unhappy with communication from the respondent. The Tribunal was not satisfied that the claimant suffered a detriment. Even if she did, the Tribunal concluded that it was not because of any of the unlawful reasons.

The claimant wrote to her line manager via email on 8th August 2019 about the prolonged unnecessary and disproportionate ongoing clinical restrictions was causing her significant amount of stress and she felt very upset. Despite this the investigation continued [18(xxiv)(c)]

The claimant wrote to James Marsh on 29th July 2019 requesting to be allowed to continue to do clinical work as the isolation was causing her distress. This request was refused [18(xxiv)(d)]

224. Allegations regarding the on-going restrictions have been dealt with above.

On 14th October 2019, she was signed as unfit for work until 28 October 2019. Despite her sick note and subsequently detailed submissions by Dr Howard and Mark Briggs from the BMA the respondent continued with the capability hearing. The respondent also wished to force the claimant to attend OH the following day when she had already attended a consultation with her GP and was suffering from high levels of stress [18(xxiv)(e)]

225. The Claimant requested via her representatives, Dr Howard and Mr Briggs that the hearing be postponed. The MHPS Panel considered those representations and postponed the hearing. Being signed off sick for work does not, without more, mean lack of fitness to attend a hearing/ meeting. This allegation was completely without merit. The respondent's actions were not in any way connected with the unlawful reasons.

Investigation continued despite letter from the President of BAPIO (British Association of Physicians of Indian Origin) dated 13th October 2019 [18(xxiv)(f)]

Investigation continued despite effects of prolonged investigation and unnecessary clinical restrictions on claimant's health and wellbeing entered into the formal appraisal in 2018 and 2019 [18(xxiv)(g)]

226. The reasons why the investigation continued have already been dealt with above. Its continuation was not in any way connected with any of the unlawful reasons.

Failing to provide the minutes of meetings the claimant had with Dr Hakim despite requesting this from the HR Director in May 2019 and then again in June 2019, July 2019, August 2019 and September 2019 [18(xxv)]

227. The Tribunal accepted Dr Marsh's evidence that no minutes were produced or existed. The claimant therefore suffered no detriment. Any failure to produce minutes was not because of any of the unlawful reasons.

Claims of direct sex discrimination only

Dr Marsh writing to the claimant on 11th July 2019 to informally warn her about her alleged disrespectful and disruptive conduct at a Cardiology business meeting (in reliance on the account of others, Dr Marsh not being present) [22(i)]

Dr Marsh writing to claimant following a meeting with HR regarding job planning/pay on 4th July 2019 to informally warn her for being disrespectful (when Dr Marsh was not present) [22(ii)]

228. Dr Marsh wrote to the claimant by letter dated 22 July 2019 expressing his concerns about her conduct at a meeting on 11 July 2019 and the tone of her correspondence, which Dr Marsh considered aggressive and unprofessional. The letter was not part of a disciplinary process; it was not even an improvement notice. There was absolutely no evidence from which the Tribunal could conclude that a male colleague would not have been treated in exactly the same way in those circumstances.

229. Dr Marsh said in evidence that he could not recall a meeting other than the one on 11 July 2019 when he had concerns about the claimant's behaviour. In the absence of evidence from the claimant on this issue, the Tribunal accepted this evidence.

The claimant being micromanaged, having every matter escalated to the MD, and his responses supporting them unfairly, in particular as set out in her FBPs [22(iii)]

230. The Claimant did not address this allegation in her witness statement or oral evidence. There was no evidence from which the Tribunal could conclude that the claimant had been treated less favourably than her male colleagues.

The claimant was invited to participate in the interview process by Dr Daryani for a new consultant interview process on 11 July 2018. She was subsequently excluded without any notification and not allowed to interview even thought she was the Lead for Heart Failure Consultant Cardiologist and the appointment was for a heart failure role [22(iii)(a)]

231. The Claimant did not address this allegation in her witness statement or oral evidence. Neither was Dr Daryani questioned about it. There was no evidence from which the Tribunal could conclude that the claimant had been treated less favourably than her male colleagues.

Communication during Cardiology business meetings (escalated to HR and MD) –This is a reference to Dr James Marsh's 2 pieces of correspondence on 4 July 2019 [22(iii)(b)]

Letter from Dr Marsh around 4th July 2019 issuing the claimant with an informal warning following a cardiology business meeting (at which Dr Marsh was not present) and without having any input from the claimant or discussing it with her before issuing [22(iii)(c)]

232. These allegations are addressed above.

Email from Dr Daryani on or around July 2019 about day to day matters about the claimant's request for some information about a Regional Consultants meeting. His reply was unnecessarily copied by the Medical Director, Dr Marsh and the Head of HR [22(iii)(d)]

233. There was no basis for the Tribunal to conclude that a male colleague would have been treated any differently.

Removing the claimant form the educational supervisors list of 11th July 2019 [22(iv)]

234. The Claimant was clinically restricted and therefore was unable to be an educational supervisor for a cardiology trainee. That was the reason for the claimant's removal, not because she was female. There was no evidence from which the Tribunal could conclude that a male colleague in the same circumstances would have been treated any differently.

Continued restriction of the claimant from clinical duties (from February 2018 onwards) [22(v)]

235. This allegation has already been dealt with. She was not restricted because of her sex.

On 13 June 2018, the claimant attended a conference in London where she overheard people discussing about the respondent. The claimant looked on the internet and was very upset to view the video clip to find that she was totally excluded even though she works full time and provides significant amount of cardiac imaging diagnostic services for the respondent [22(vi)]

On 13 June 2018, claimant was very upset to learn via the video clip the Dr Bogle mentioned Heart Failures services at the respondent but failed to reference the claimant, despite the fact she is the respondents only heart failure consultant at St Helier site [22(vii)]

236. The claimant referred to a video clip in October 2013. In an informal discussion with the broader community at the respondent's annual board meeting, Dr Bogle spoke about some of the work being done by the cardiology team and cross team working. He only mentioned those involved in the specialist work being highlighted and referred to Dr Parthipun (Consultant Nuclear Radiologist) and Dr Keane (Radiologist). He did not refer to her male colleagues, such as Dr Foran or Dr Odemuyiwa. There was no evidence from which the Tribunal could conclude that this was in any way connected with the claimant's sex.

On dates unknown, Dr Bogle gathered 43 clinical allegations against the claimant and provided only snippets of data [22(viii)]

237. Dr Bogle explained in his witness statement and oral evidence that 12 individuals provided him with cases about which they had some concerns He did not investigate these himself and so did not have all of the details regarding those individual cases. He maintained a list of the cases and ultimately provided these to Dr Andrews in his MHPS investigation interview. As the (then) Clinical Lead, one would expect concerns to be raised with Dr Bogle. The comparators are the Claimant's Consultant Colleagues who were male. (Dr Bogle, Dr Foran, Dr Daryani, Dr Malik, Dr Bajpal and Dr Dani) There was no evidence that any of the above individuals were in the same situation as the claimant, namely being in a position of having a number of concerns being raised about them by other colleagues. Accordingly, they were not in similar circumstances to the Claimant. There was no evidence from which the Tribunal could conclude that Dr Bogle treated the claimant less favourably than he would have treated male colleagues in the same circumstances.

Harassment (sex related)

238. The claimant alleged that all of the allegations under paragraphs 17, 18 and 22 of the list of issues were also acts of harassment related to sex. The Tribunal relied on its findings at paragraphs 172-227 above, and under Section C of this judgment, when concluding that none of the allegations could be said to have involved unwanted conduct *related to sex*; indeed the the Tribunal concluded that the respondent's actions had nothing whatsoever to do with the claimant's sex.

Claim of direct race discrimination only

239. It is worth noting at the outset that in support of her race and sex discrimination claims, the claimant referred the Tribunal to information provided as a result of a Freedom of Information request which showed that a disproportionate number of BAME employees had been subject to disciplinary action, compared to those falling outside this group. Dr Marsh acknowledged the statistics and suggested that work had started to address the problems highlighted. However, on their own, these provided little assistance to the Tribunal and were certainly not sufficient to persuade the Tribunal that the claimant had been the subject of race discrimination.

Asking the claimant to undertake a behavioural assessment [26(i)]

240. The claimant compared herself to Dr Foran or Dr Bogle. It was difficult to view these as appropriate comparators given that there was no good reason why they would need to undertake a behavioural assessment. Clinical concerns had not been raised about them, nor were they subject to clinical restrictions. There was no evidence from which the Tribunal could conclude that there was less favourable treatment or that Dr Bogle's above actions were because of the claimant's race.

Dr Marsh not investigating the claimant's complaints about her male colleagues [26(ii)]

The claimant's complaints about Dr Perikala's acts (made in letters dated around Nov/Dec 2015, 22 January 2018 and August 2018) were not investigated in the same manner as the claimant was vigorously pursued. He was not put through a prolonged MHPS process or dismissed [22(iii)]

241. It was not for Dr Marsh to personally investigate complaints the claimant had regarding her male colleagues. Regarding Dr Perikala, the Tribunal noted that the claimant had chosen a comparator of the same race. Notwithstanding this, the concerns about Dr Perikala were investigated and he went through a MHPS process where Dr Marsh presented the management case. The MHPS Panel reached their independent conclusion. The process for Dr Perikala was not as prolonged as it was with the claimant, but the circumstances were completely different. It is impossible to compare them. The claimant was not treated less favourably because of race.

A letter dated 22 January 2018 (title "issues within Cardiology Dept") from the claimant was sent to Dr Marsh. This described Dr Bogle's misconduct and unprofessionalism [26(iv)]

242. This is not an allegation. There is no detriment or anything from which the Tribunal was able to conclude that the claimant had suffered race discrimination.

The claimant contends she brought to the attention of Dr Marsh a RCA report dated May 2019 concerning RP and patient P and no appropriate action was taken [26(v)]

243. Dr Marsh was not involved with the preparation of the Root Cause Analysis report, nor the respondent's response with respect to the Serious Incident report. The claimant copied Dr Marsh into her correspondence with Mr Karim Bunting and Dr Winn, who were responsible for it. It was not appropriate for Dr Marsh to override other people's decisions and get involved. Dr Marsh deferred to Mr Bunting and Dr Winn who escalated matters as appropriate and in accordance with the respondent's processes. The Tribunal could not see that the claimant had suffered a detriment and there was no evidence from which the Tribunal could conclude that the claimant had been treated less favourably because of her race.

Dr Dani repeatedly bypassed the claimant when treating patients under her care and referred patients for invasive procedures (this is not said to be an act of race discrimination; the complaint relates to Dr Marsh's reaction that follows). This was raised repeatedly to [Dr Marsh] in Aug 2018 or Aug/Sept 2019 and Dr Marsh took no appropriate action [26(vi)]

244. The Tribunal concluded that the allegation was that Dr Marsh took "no appropriate action" in response to this complaint. The Tribunal rejected this assertion. Dr Marsh's evidence was that he contacted Dr Daryani who was tasked with investigating whether Dr Dani had acted appropriately or unprofessionally. Dr Daryani concluded that she had not. There was no policy about having to discuss with a consultant before referring on for angiography. There is no evidence at all from which the Tribunal could conclude that a colleague of a different race would have been treated any differently.

245. Given the above conclusions, the Tribunal did not consider it necessary to address the time limit issues.

246. For the reasons given, all of the claimant's claims fail and are dismissed.

……………………………………………
Employment Judge Hyams-Parish
4 February 2022

Public access to Employment Tribunal decisions
Judgments and reasons for the judgments are published, in full, online at www.gov.uk/employment-Tribunal-decisions shortly after a copy has been sent to the claimant(s) and respondent(s) in a case.

THE SCHEDULE
LIST OF ISSUES AGREED BY THE PARTIES

Overview of claims 2 and 3

1. By way of an ET1 lodged on 24 August 2018 (the 'Second Claim') the Claimant claimed the following:

a. PID Detriment under section 47B of the Employment Rights Act 1996 (‘ERA’);

b. Victimisation under section 27 of the Equality Act 2010 (‘EqA);

c. Harassment under section 26(1) of the EqA, relying on the protected characteristic of sex;

d. Direct Discrimination on the grounds of sex under section 13 of the EqA; and

e. Breach of an equality clause implied under section 66 of the EqA.

2. By way of a further ET1 lodged on 20 December 2019 (the ‘Third Claim’) the Claimant made claims under the same provisions as 1(a) to (d) and also of direct discrimination on the grounds of race under section 13 of the EqA.

Jurisdiction (Second Claim)

3. For the claims under the ERA:

3.1. To the extent that any of the complaints are out of time, was it reasonably practicable for the Claimant to present them before the end of the relevant period?

3.2. If not, did she present the complaints within such a further period as the Tribunal considers reasonable?

4. For the claims under the EqA:

4.1. To the extent that any of the complaints are out of time, do they amount to conduct extending over a period?

4.2. If not, would it be just and equitable for the Tribunal to extend time?

Jurisdiction (Third Claim)

5. The issues on time set out above in respect of the Second Claim are repeated in respect of the Third Claim.

6. To the extent that any matters set out in the Third Claim were or should have been included in the Second Claim (or the First Claim, 2302369/2016), is the Claimant estopped from bringing them?

CLAIMS

Breach of Sex Equality Clause implied under s.66 of the Equality Act

The period to which the claim relates is the 6 years leading to the presentation of the claim.

7. The Claimant relies on Dr Foran, Dr Bogle, Dr Daryani, Dr Bajpal and Dr Malik as comparators (who shall be anonymised at Trial).

8. Was the Claimant's work 'equal' to that of any of her comparators for the purposes of s.65 EqA on the grounds that it was like work

9. If so was the following a term of the comparator's contract: the number of PAs each of the comparators were assigned in their respective contracts of employment. C says this ranges from 11 to 14.5 PAs

10. If so was this term absent from the Claimant's contract or was the corresponding term of the Claimant's contract less favourable?

11. If so was the difference attributable to a material factor (that was not itself directly discriminatory, or, if it were to put her at a particular disadvantage as a woman, was a proportionate means of achieving a legitimate aim).

PID Detriment under section 47B of the Employment Rights Act 1996

12. The Claimant relies on the following as qualifying disclosures in her Second Claim:

(i) The First Claim itself 2302369/2016

(ii) The discussions with James Allan (Cardiology Manager) on 21 and 29 November 2017 during which she raised concerns about work patterns in Cardiology department and patient safety.

(iii) The discussion with Dr Winn (Clinical Director) on 6 December 2017 during which she reiterated about work patterns and patient safety.

(iv) The e-mails which she sent to Nicola Tripp (HR Advisor) on 22 and 23 January 2018 setting out her concerns about the quality of patient care in a document titled "Issues for Discussion" and her own safety at work. Email sent to HR on 21st of December 2017 enquiring about the dosage of radiation received whilst working at Epsom theatre.

(v) The written grievance submitted in September 2016 which was concluded in April 2018.

13. The Claimant relies on the following as qualifying disclosures in the Third Claim:

(i) The First Claim itself 2302369/2016

(ii) The Second Claim;

(iii) In the context of a Root Cause Analysis into a patient death in September 2018:

a. To the Quality manager on 28th February 2019
b. To the Clinical Lead on 8th March 2019
c. To Dr Marsh (Medical Director) on 8th May 2019
d. To Dr Marsh on 14th June 2019
e. To the Freedom to Speak Up Guardian on 14th June 2019 by email
f. To HR, the Director of People and Mrs Patricia Baskerville (non-exec director) via email

14. In any or all of these, was information disclosed which, in the Claimant's reasonable belief, tended to show one of the following:

(i) A breach of any legal obligation, or

(ii) A danger to the health and safety of any individual?

15. If so, did the Claimant reasonably believe that the disclosure/s was/were made in the public interest?

16. If so, was/were the disclosure/s made to her employer?

17. If any of the protected disclosures in the Second Claim are proved, was the Claimant, on the ground of any such protected disclosure, subject to any of the following alleged detriments by the employer or another worker:

(i) Being informed on 7 February 2018 that she could not carry out any clinical work.

(ii) Her suspension from clinical duties on the pretext of competency concerns on 12 February 2018.

(iii) Instigating an investigation into the Claimant's professional practice without any reasonable or proper cause to do so.

(iv) Failing to follow the procedural requirements of the MHPS Policy when conducting the investigation into her professional practice.

(v) Failing to particularise the exact issues which led to her exclusion from clinical duties on 7th and 12th February 2018. The snippets of case information provided by Dr Bogle were inaccurate, misleading and incomplete. Nor did it seek the Claimants input prior to suspending her

from all clinical duties.

(vi) Denying her the opportunity to propose an alternative to suspension on 12th February 2018

(vii) Failing to give her copies of all relevant documents despite several requests 12th February 2018 and via several emails in February 2018.

(viii) Failing to inform her of the right to appeal the way the MHPS procedure had been conducted on 16th Feb 2018 despite requests at a meeting with Nicola Tripp on 23 February 2018 and a written and verbal request to Pat Baskerville (Non-executive director overseeing MHPS process) on 16th Feb 2018 and during a meeting on 20th Feb 2018.

(ix) Failing to promptly interview the list of witnesses provided by the Claimant in September 2017 resulting in an unfair investigation.

(x) Dr Marsh delaying the submission of the Claimant's response to the allegations against her to Dr Beeton by well over a month.

(xi) Failing to ensure her continued professional development (CPD) by reviewing the restrictions on her practice after 17 out of 43 allegations against her had been dismissed as "no misconduct" when she made specific requests on 9 May and 15 June 2018.

(xii) Failing to appoint her to the role of Clinical Lead on/around 14 June 2018 despite her being the most experienced person for the role.

(xiii) Failing to share the contents of the provisional MHPS report in June/July 2018 and therefore prolonging the Claimant's exclusion.

(xiv) Dr Perikala excluding her from an e-mail on 3 July 2018.

(xv) Dr Bogle excluding her from a WhatsApp group named St Helier Cardiology Team prior to 6 July 2018.

(xvi) Failing to appoint her to the role of Deputy Clinical Director on 23 July 2018 despite her being the most experienced person for the role.

(xvii) Excluding her from a WhatsApp teaching group on/around August 2018.

(xviii) Paying her less than her male colleagues.

(xix) Deciding on/around 24 August 2018 to proceed to a Disciplinary hearing in respect of her conduct.

(xx) Taking away the Claimants Research projects and her role as a PI (Principal Investigator) for Cardiology Research Projects despite the lack of any adverse data related to research projects. The Research projects have national and international portfolio.

(xxi) Prolonged MHPS process due to failure to review clinical restrictions (leading to a loss of private work)

(xxii) A prolonged grievance investigation which took over 2 years to conclude. Failure of Respondent to uphold Claimants grievance even when all information and evidence presented.

18. If any of the protected disclosures in the Third Claim are proved, was the Claimant, on the ground of any such protected disclosure, subject to any of the following alleged detriments by the employer or another worker:

(i) Continued failure to lift clinical restrictions.

(ii) The decision to hold a capability/conduct hearing in the MHPS investigation (which the Claimant maintains to have been flawed and based on false allegations).

(iii) Not following an alternative to inviting the Claimant to a capability/conduct hearing.

(iv) Failing to investigate the Claimant's grievance (submitted on 2nd July 2019 by her representative and on 29th July by the Claimant).

(v) In selecting an external panel member to sit on the panel who had worked closely with the case manager (Dr Marsh) and the external expert (Dr Beeton), despite the Claimant's objections.

(vi) Being informed that the outcome of the hearing may include dismissal should the panel decide that it was appropriate.

(vii) The Trust instructing a barrister to present its case during the internal hearing (which the Claimant contends is contrary to the Trust's policies).

(viii) The barrister attending the hearing on 15th and 16th October 2019 despite assurances and in the Claimant's absence.

(ix) Not providing minutes of all Medical Workforce meetings where the Claimant's restrictions were reviewed, despite these being requested.

(x) Not providing all data, despite 'several requests and official submissions for subject access requests'.

(xi) Prolonged MHPS process due to failure to review clinical restrictions (leading to a loss of private work)

(xii) [Allegation dismissed by EJ Dyal]

(xiii) Failure of Drs Marsh and Andrews to take notice of positive testimonials, feedback and supporting letters from 150 individuals.

(xiv) Failure to act upon the submission of Dr Howard of a summary document titled UP Grievance submission against the capability conduct hearing (dated 14th October 2019).

(xv) Failure to act upon the submission by Dr Odemuyiwa of a summary document dated 21st July 2019 about his concerns regarding the Claimant's treatment.

(xvi) Failure to act upon the issues raised in a document titled 'Issues for Discussion' which was submitted on 22/23rd January 2018.

(xvii) Withholding the results of an earlier investigation that had taken place into her practice by Dr Beeton, until it was provided in response to an SAR in August 2019.

(xviii) Failure to take action in response to the Claimant's concerns about Dr Dr Perikala. (Dr Perikala instead being promoted to Associate Specialist.)

(xix) Not removing restrictions on the Claimant's practice following the raising of concerns by the Claimant and her MPS advisor Dr Liliane Field in July 2019.

(xx) Failure to follow internal guidelines and policy, MHPS, or the ACAS code of conduct (as set out in the letters dated 2nd July 2019, 8 May 2019 and 29th July 2019).

(xxi) Collaboration and collusion in the management of the internal MHPS investigation (as set out in the submission by Dr Howard of 14th October 2019).

(xxii) Failure to recommend the Claimant for revalidation in September 2019 despite successful appraisal in August 2019.

(xxiii) Failure to follow the recommendations of Baroness Harding, which were sent to NHS Trusts in July 2019 by NHS Improvement and NHS England (n.b the Respondent does not accept that the recommendations at c to g accurately state Baroness Harding's recommendations, and are the Claimant's restatement). The Claimant

has particularised her claim in her FBPs as follows:

a. Failure to adhere to best practice guidance by suspending the Claimant for 20 months from direct clinical practice

b. Failing to consider informal measures [as an alternative to suspension]

c. Involvement of a third party in the internal processes, Capsticks, who have little or no knowledge of the Respondent, the working practices and processes.

d. Resources spent by the Respondent in relation to the disciplinary and Tribunal process in respect of the Claimant in comparison to the available resources of the Claimant.

e. Impact of suspension, de-skilling the Claimant and depriving patients of essential intervention and treatment.

f. The prolonged suspension of over two years.

g. No proper oversight at board level.

(xxiv) Handling of the Claimant's health issues. The Claimant has particularised her complaint as follows.

a. On 8th January 2018, the Claimant submitted a sick note to Mr James Allan citing symptoms of stress due to prolonged harassment and chest infection. Despite this, the Respondent continued with the investigation against her, failing to take proper consideration of the impact it was having on her.

b. Whilst the Claimant was on sick leave, Dr Marsh, Dr Andrews and HR personnel continued to send her numerous emails and papers through emails giving huge documents with multiple questions relating to the investigation to answer giving the Claimant very tight deadlines to respond.

c. The Claimant wrote to her line manager via email on 8th August 2019 about the prolonged unnecessary and disproportionate ongoing clinical restrictions was causing her significant amount of stress and she felt very upset. Despite this the investigation continued.

d. The Claimant wrote to James Marsh on 29th July 2019 requesting to be allowed to continue to do clinical work as the isolation was causing her distress. This request was refused.

e. On 14th October 2019, she was signed as unfit for work until 28 October 2019. Despite her sick note and subsequently detailed submissions by Dr Howard and Mark Briggs from the BMA the Respondent continued with the capability hearing. The Respondent also wished to force the Claimant to attend OH the following day when she had already attended a consultation with her GP and was suffering from high levels of stress.

f. Investigation continued despite letter from the President of BDr PerikalaIO dated 13th October 2019.

g. Investigation continued despite effects of prolonged investigation and unnecessary clinical restrictions on Claimant's health and wellbeing entered into the formal appraisal in 2018 and 2019.

(xxv) Failing to provide the minutes of meetings the Claimant had with Dr Hakim despite requesting this from the HR Director in May 2019 and then again in June 2019, July 2019, August 2019 and September 2019

Victimisation under section 27 of the Equality Act 2010

19. In her Second Claim the Claimant relies on the lodging of the First Claim against the Respondent on 10 November 2016 (claim 2302369/2016) as a protected act. In her Third Claim the Claimant relies on the lodging of the Second Claim against the Respondent. The Respondent accepts that these were each protected acts.

20. Was the Claimant subject to any of the alleged detriments under paragraph 17 because she brought the First Claim against the Respondent?

21. Was the Claimant subject to any of the alleged detriments under paragraph 18 because she brought the Second Claimant against the Respondent?

Direct Discrimination (Sex)

22. Did the Respondent subject the Claimant to any of the alleged treatment under paragraphs 17, 18 or as follows:

(i) Dr Marsh writing to the Claimant on 11th July 2019 to informally warn her about her alleged disrespectful and disruptive conduct at a Cardiology business meeting (in reliance on the account of others, Dr Marsh not being present).

(ii) Dr Marsh writing to Claimant following a meeting with HR regarding job planning/pay on 4th July 2019 to informally warn her for being

disrespectful (when Dr Marsh was not present).

(iii) The Claimant being micromanaged, having every matter escalated to the MD, and his responses supporting them unfairly, in particular as set out in her FBPs

a. The Claimant was invited to participate in the interview process by Dr Daryani for a new consultant interview process on 11 July 2018. She was subsequently excluded without any notification and not allowed to interview even thought she was the Lead for Heart Failure Consultant Cardiologist and the appointment was for a heart failure role.

b. Communication during Cardiology business meetings (escalated to HR and MD) –This is a reference to Dr James Marsh's 2 pieces of correspondence on 4 July 2019.

c. Letter from Dr Marsh around 4th July 2019 issuing the Claimant with an informal warning following a cardiology business meeting (at which Dr Marsh was not present) and without having any input from the Claimant or discussing it with her before issuing.

d. Email from Dr Daryani on or around July 2019 about day to day matters about the Claimant's request for some information about a Regional Consultants meeting. His reply was unnecessarily copied by the Medical Director, Dr Marsh and the Head of HR

(iv) Removing the Claimant form the educational supervisors list of 11th July 2019.

(v) Continued restriction of the Claimant from clinical duties (from February 2018 onwards).

(vi) On 13 June 2018, the Claimant attended a conference in London where she overheard people discussing about the Respondent. The Claimant looked on the internet and was very upset to view the video clip to find that she was totally excluded even though she works full time and provides significant amount of cardiac imaging diagnostic services for the Respondent.

(vii) On 13 June 2018, Claimant was very upset to learn via the video clip the Dr Bogle mentioned Heart Failures services at the Respondent but failed to reference the Claimant, despite the fact she is the Respondents only heart failure consultant at St Helier site.

(viii) On dates unknown, Dr Bogle gathered 43 clinical allegations against the Claimant and provided only snippets of data.

23. If so, did the Respondent treat the Claimant less favourably than it treated or would have treated her comparators? The Claimant relies upon the following comparators: Dr Bogle, Dr Foran, Dr Daryani, Dr Malik, Dr Bajpal and Dr Dani

24. If so, can the Claimant prove primary facts from which the Tribunal could properly and fairly conclude that the difference in treatment was because of the protected characteristic?

25. If so can the Respondent prove a non-discriminatory reason for any proven treatment?

Direct Discrimination (Race)

The Claimant identifies her race as British Asian/Indian

26. Did the Respondent subject the Claimant to the following treatment:

    (i) Asking her to undertake a behavioural assessment.

    (ii) Dr Marsh not investigating the Claimant's complaints about her male colleagues

    (iii) The Claimant's complaints about Dr Perikala's acts (made in letters dated around Nov/Dec 2015, 22 January 2018 and August 2018) were not investigated in the same manner as the Claimant was vigorously pursued. He was not put through a prolonged MHPS process or dismissed.

    (iv) A letter dated 22 January 2018 (title "issues within Cardiology Dept") from the Claimant was sent to Dr Marsh. This described Dr Bogle's misconduct and unprofessionalism.

    (v) The Claimant contends she brought to the attention of Dr Marsh a RCA report dated May 2019 concerning Dr Bogle and patient Mr P and no appropriate action was taken.

    (vi) Dr Dani repeatedly bypassed the Claimant when treating patients under her care and referred patients for invasive procedures (this is not said to be an act of race discrimination; the complaint relates to Dr Marsh's reaction that follows). This was raised repeatedly to [Dr Marsh] in Aug 2018 or Aug/Sept 2019 and Dr Marsh took no appropriate action.

27. If so, did the Respondent treat the Claimant less favourably than it treated or would have treated her comparators? The Claimant relies upon the following comparators: Dr Foran and Dr Bogle (male Caucasian colleagues)

28. If so, can the Claimant prove primary facts from which the Tribunal could properly and fairly conclude that the difference in treatment was because of the protected characteristic?

29. If so can the Respondent prove a non-discriminatory reason for any proven treatment?

Harassment under section 26(1) of the Equality Act 2010

30. Did the Respondent subject the Claimant to unwanted conduct related to her sex?

31. The Claimant relies on the acts/omissions set in paragraph 17, 18 and 22:

32. If so did the conduct have the purpose or effect of violating the Claimant's dignity, or creating an intimidating, hostile, degrading, humiliating or offensive environment for the Claimant?

33. If so, having regard to the Claimant's perception and the other circumstances of the case, was it reasonable for the conduct to have that effect?