Case No: 2302369/2016

THE EMPLOYMENT TRIBUNAL

SITTING AT:	**LONDON SOUTH**
BEFORE:	**EMPLOYMENT JUDGE K ANDREWS**
MEMBERS:	**Ms H Bharadia** **Mr S Anslow**

BETWEEN:

Dr U Prasad

Claimant

and

Epsom & St Helier University Hospitals NHS Trust

Respondent

ON:	**21 – 28 (10-11am) September 2017** **28 & 29 September 2017 in chambers**

Appearances:
For the Claimant: **Mr A Aarmodt, Counsel**
For the Respondent: **Mr B Cooper, Queen's Counsel**

JUDGMENT

1. The claimant was not directly discriminated against because of her sex nor was she harassed or victimised.

2. The claimant was not subjected to a detriment because she had made a protected disclosure.

3. Accordingly all claims fail and are dismissed.

REASONS

1. In this matter the claimant complains that she has been unlawfully discriminated against because of her sex (both direct and harassment), that she has been victimised and subjected to detriments because she made protected disclosures.

2. A list of issues was agreed between the parties. Part way through the cross examination of the respondent's witnesses, the claimant withdrew various of her allegations. A revised list was prepared and that is attached to this Judgment at Appendix A.

Evidence

3. We heard evidence for the claimant from herself and Dr D Shah, Clinical Lead for the Acute Medical Unit, and Dr S Odemuyiwa, former Consultant Cardiologist. For the respondent we heard from Dr R Bogle, Consultant Cardiologist and Clinical Lead for Cardiology, Dr A Perikala, Staff Grade Doctor in Cardiology, Dr J Marsh, Joint Medical Director, and Dr M Stockwell, Associate Medical Director.

4. We also had an agreed bundle of documents (comprising three full lever arch files).

5. Both Counsel made helpful submissions which were fully considered.

Relevant Law

6. Direct discrimination Section 13 of the Equality Act 2010 (the 2010 Act) provides that a person discriminates against another if, because of a protected characteristic, he treats that person less favourably than he treats or would treat others. Sex is a protected characteristic.

7. To answer whether treatment was "because of" the protected characteristic requires the Tribunal to consider the reason why the claimant was treated as he/she was. The Equality and Human Rights Commission Code of Practice states that whilst the protected characteristic needs to be a cause of the less favourable treatment it does not need to be the only or even the main cause.

8. It is a matter for the Tribunal to determine what amounts to less favourable treatment to be interpreted in a common sense way and based on what a reasonable person might find to be detrimental.

9. Section 23 of the 2010 Act refers to comparators and says that there must be no material difference between the circumstances relating to each case. The relevant "circumstances" are those factors which the employer has taken into account when treating the claimant as it did with the exception of the protected characteristic (Shamoon v Chief Constable RUC 2003 IRLR 285).

10. Harassment Section 26 of the 2010 Act provides that A harasses B if A engages in unwanted conduct related to a relevant protected characteristic and that conduct has the purpose or effect of violating B's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for B. When deciding whether conduct has had that effect subsection 4 requires the Tribunal to take into account the perception of B, the other circumstances of the case and whether it is reasonable for the conduct to have that effect.

11. Two authorities give helpful guidance in applying these provisions: Richmond Pharmacology Ltd v Dhaliwal (2009 IRLR 336) and Land Registry v Grant (2011 IRLR 748) where Elias LJ said:

> "Where harassment results from the effect of the conduct, that effect must actually be achieved. However, the question whether conduct has had that adverse effect is an objective one – it must reasonably be considered to have that effect – although the victim's perception of the effect is a relevant factor for the tribunal to consider. In that regard, when assessing the effect of a remark, the context in which it is given is always highly material.
>
> Moreover, tribunals must not cheapen the significance of the words "intimidating, hostile, degrading, humiliating or offensive environment". They are an important control to prevent trivial acts causing minor upsets being caught by the concept of harassment."

12. As to whether the treatment was "related to" the protected characteristic, it will be sufficient if there is an associative connection (R (EOC) v S of S for Trade & Industry [2007] ICR 1234) though in practice it can often amount to the same test as for direct discrimination.

13. Victimisation Section 27(1) of the 2010 Act says that a person (A) victimises another person (B) if A subjects B to a detriment because B does a protected act. A protected act includes making an allegation (whether or not express) that A or another person has contravened the Act. The protected act need not be the sole reason for the detriment in question; it is sufficient if it was a significant influence on A's decision (Nagarajan v London Regional Transport [1999] ICR 877 HL). There is no need for the Claimant to rely upon a comparator to make out a claim of victimisation. Something will amount to a detriment where a reasonable person would or might take the view that the act or omission in question gives rise to some disadvantage.

14. Burden of proof The position on this in discrimination claims is at section 136 of the 2010 Act. Guidance on applying this has been provided in Igen v Wong and others ([2005] IRLR 258) confirmed by the Court of Appeal in Madarassy v Nomura International plc ([2007] IRLR 246).

15. In summary, the claimant must prove facts from which, in the absence of an adequate explanation from the respondent, the Tribunal could conclude that direct discrimination occurred. If he does so, then the burden shifts to the respondent to prove that no discrimination occurred. If the respondent cannot so prove then the Tribunal must find in the claimant's favour. The Tribunal may, if it is more appropriate to do so in the particular case,

consider the question of whether there was less favourable treatment because of the protected characteristic as a single question, rather than in distinct stages (Shamoon and Madarassy as above).

16. It is generally recognised however that it is unusual for there to be clear evidence of discrimination and that the Tribunal should expect to consider the position in accordance with the guidance but also to step back to consider all the relevant facts in the round in order to determine what inferences if any it is appropriate to draw (Qureshi v Victoria University of Manchester ([2001] ICR 863).

17. In Madarassy it was also confirmed that a simple difference in status (whether race or sex) and a difference in treatment is not enough in itself to shift the burden of proof; something more is needed. Further, in Glasgow City Council v Zafar [1998] ICR 120, it was confirmed that unreasonable treatment alone combined with a protected characteristic is not sufficient to shift the burden. It is important in assessing these matters that the totality of the evidence is considered.

18. Time limits – discrimination Any complaint of discrimination may not be brought after the end of the period of three months starting with the date of the act complained of or such other period as the Tribunal thinks just and equitable (section 123 of the Equality Act 2010). Where the alleged discriminatory act is one of the failure to act, section 123(4) provides that in the absence of evidence that failure is taken to occur when the alleged discriminator does something inconsistent with doing the act, or otherwise on expiry of the period in which they might reasonably have been expected to do it.

19. There is guidance from the Court of Appeal for Tribunals in exercising that discretion set out in the case of Robertson v Bexley Community Centre (2003 IRLR 434). The Tribunal has a very wide discretion in determining whether or not it is just and equitable to extend time. It is entitled to consider anything that it considers relevant subject however to the principle that time limits are exercised strictly in employment cases. When Tribunals consider their discretion to consider a claim out of time on just and equitable grounds there is no presumption that they should do so unless they can justify failure to exercise the discretion. On the contrary the Tribunal cannot hear a complaint unless the Claimant persuades it that it is just and equitable to extend time. The exercise of discretion is the exception, say the Court of Appeal, rather than the rule.

20. Conduct extending over a period is to be treated as done at the end of that period (section 123(3)(a)). (This is distinct from an act with continuing consequences where time runs from the date of the act as above.) Where an employer operates a discriminatory regime, rule, practice or principle then that will amount to an act extending over a period (Barclays Bank plc v Kapur (1991 ICR 208 HL). When deciding if there is such conduct, however, Hendricks v Commissioner of Police for the Metropolis [2002] EWCA Civ 1686 confirms that the correct focus is on the substance of the

complaint that the respondent is responsible for the state of affairs leading to the alleged discrimination rather than too literal approach in analysing whether a regime, rule, practice or principle exists on specific facts. This approach has been confirmed in the context of the 2010 Act in Rodrigues v Co-operative Group EAT July 12.

21. In O'Brien v Department for Constitutional Affairs [2009] IRLR 294 the Court of Appeal held that the burden of proof is on the claimant to convince the Tribunal that it is just and equitable to extend time. In most cases there are strong reasons for a strict approach to time limits.

22. When considering anything that it considers relevant a Tribunal will also look at the factors listed in section 33 of the Limitation Act 1980 which include a) length and reasons for delay, b) the likely effect of the delay on the evidence c) the promptness with which the claimant acted once they knew the facts d) their knowledge of the time limits and e) the steps they took to get professional advice (British Coal Corp v Keeble 1997 IRLR 336). This is however a useful checklist rather than a statutory requirement (Southwark London Borough Council v Afolabi 2003 IRLR 220).

23. Protected disclosures Protections are given to workers that make protected disclosures as defined in the Employment Rights Act 1996 (the 1996 Act).

24. Any disclosure of information (a mere allegation is not sufficient) which in the reasonable belief of the worker making the disclosure and, if made on or after 25 June 2013, is made in the public interest and tends to show one or more of the matters listed at section 43B(1) of the 1996 Act will be a qualifying disclosure. That list includes that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject and that the health and safety of any individual has been, is being or is likely to be endangered. The disclosure must identify, albeit not in strict legal language, the breach relied upon (Fincham v H M Prison Service EAT 0925 & 0991/01).

25. To be protected a qualifying disclosure has to be made in accordance with one of six methods of disclosure which include to the person's employer (section 43C(1)).

26. Whether a worker had a reasonable belief as required by section 43B will be judged by taking into account that worker's individual circumstances. Accordingly those with relevant professional knowledge will be held to a higher standard than laypersons in respect of what is reasonable for them to believe (Korashi v Abertawe Bro Morgannwg University Local Health Board 2012 IRLR 4). The information does not have to be true but to be reasonably believed to be true there must be some evidential basis for it. The worker must exercise some judgment on his or her own part consistent with the evidence and resources available (Darnton v University of Surrey 2003 ICR 615).

27. "Public interest" is not defined in the 1996 Act nor is there any statutory guidance as to its meaning but the worker must reasonably believe the disclosures to be in the public interest.

28. Section 47B gives a worker the right not to be subjected to any detriment by his employer "on the ground" that he or she has made a protected disclosure. This imports a causation test but the protected disclosure need not be the only/main reason for the act in question provided it had a material (i.e. more than trivial) influence (Fecitt v NHS Manchester 2012 ICR 372 CA).

29. It is for the claimant to prove that the act/omission complained of amounts to a detriment. It is for the employer to show the ground on which any act, or deliberate failure to act, was done (Section 48(2)).

30. Time limits – protected disclosures Complaints pursuant to these sections must be presented to the Tribunal 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 within such further period as the Tribunal considered reasonable in a case where it is satisfied that it was not reasonably practicable for the complaint to be presented within that three month period (section 48(3)).

31. Whether it was reasonably practicable for the Claimant to submit the claim in time is a question of fact for the Tribunal to decide having looked at all the surrounding circumstances and considered and evaluated the Claimant's reasons.

Findings of Fact

32. Having assessed all the evidence, both oral and written, we find on the balance of probabilities the following to be the facts.

33. 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 was on the panel that appointed her. The other candidate for the role was a male cardiologist who had been working in the department as a locum.

34. The claimant remains in the employ of the respondent in that role. She works mainly at the St Helier site but also has one session per week at St George's and also, since 2014, works at the community clinic in Wallington (which replaced previous sessions at Epsom).

35. The claimant's formal line manager, until October 2016, was Mr S Hyer, Clinical Director for Specialty Medicine, but day to day strategic direction for the cardiology service is provided by Dr Bogle (also based mainly at St Helier) and consequently she has extensive dealings with him. As a

consultant however she has a high degree of autonomy subject of course to always being part of a team.

36. There are four other permanent consultants (all male) within the department:
    a. Dr J Foran, based mainly at St Helier, appointed August 2002;
    b. Dr Y Daryani, based mainly at Epsom, appointed March 2012;
    c. Dr A Bajpaj, based mainly at Epsom, appointed May 2015;
    d. Dr N Malik, based mainly at Epson, appointed June 2017 replacing Dr Odemuyiwa on his retirement.

37. All the witnesses agreed that cardiology is a male dominated specialism and it is not in itself surprising therefore that the claimant is the only female consultant in the team. 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.

38. In very broad summary, all cardiologists cover all areas of the specialism but tend to focus on either interventional or non-interventional work. Dr Bogle focussed on the former and the claimant on the latter (particularly imaging).

39. In addition to consultants in the department, there are also either registrars who are training to become consultants or other junior doctors (variously described as staff, career or mid grades). Dr Perikala is one such staff grade doctor. He trained in India and has worked for the respondent since 2008.

40. It is a feature of this case that Dr Bogle and Dr Perikala have, at times, expressed negative views about aspects of the claimant's abilities and practice. The claimant says that they are wrong in those views and that she is a very experienced and competent cardiologist who in her previous 20+ years of experience has worked with very many consultant colleagues and junior doctors with absolutely no issue. She also referred us to various letters of support and testimonials as well as broadly positive feedback in both appraisals and 360 degree feedback all suggesting that she was generally well regarded. It is that background that leads her, in part, to the conclusion that the issues that have arisen during her employment with the respondent are because of her sex rather than any genuine concerns about her abilities. Whilst it is central to our conclusions whether her sex was indeed relevant, we are not in any position to make any finding, and we make none, as to whether the criticisms expressed of the claimant were justified or not.

41. <u>2012/2013</u>

42. The claimant says that she first started experiencing difficulties in her working life in late 2012 in particular with Dr Bogle and Dr Perikala. Prior to that she said she had not been aware of any discriminatory attitudes

towards her although she says that the picture slowly began to emerge after she had made criticisms of Dr Perikala in 2011/2012.

43. The claimant initially made a series of specific allegations about the period 1 February 2013 to 16 September 2013 but then, as described above, the majority were withdrawn. The allegations that remain from 2013 are also very relevant background to the allegations regarding later events. In addition, having considered the evidence before the withdrawal of various allegations, we note that on at least two occasions within this period Dr Bogle responded to the claimant's concerns in a flexible way but she failed to engage with him constructively. First, on a timetabling issue in March 2013 and second later that year in relation to the TOE audit described below.

44. In any event we note that it was very apparent during this period that relationships between the claimant, Dr Perikala and Dr Bogle were problematic.

45. Dr Perikala started to raise concerns with Dr Bogle regarding the claimant in early 2012. This was initially orally but then a first email was sent on 8 May 2012 by Dr Perikala complaining about allocation of patients and general management of the Tuesday clinic at Epsom by the claimant. Dr Bogle replied and said he would speak to the claimant which he did and it seemed that an arrangement to resolve the issue was agreed. That arrangement however was not or could not be implemented quickly so they continued to work together. Dr Perikala again emailed Dr Bogle on 15 May complaining in detail about the claimant's attitude towards him at the Tuesday clinics. Dr Bogle's reply was:

> "Oh dear this doesn't sound very good at all. You should not have been expected to do the Ad hoc clinic - that this totally unfair and you should have refused. I had hoped things would improve after my conversation last week I will tackle this with her tomorrow."

46. The claimant says that this reply shows there was partiality on the part of Dr Bogle and that he immediately seemed to take Dr Perikala's side. We understand why the claimant has that view and Dr Bogle perhaps used inadvisable language when talking to a junior doctor about his consultant colleague. However in the context of the earlier efforts made by Dr Bogle to address this with the claimant, and his undoubted exasperation that the situation was not being resolved, we do not find that this showed him automatically taking Dr Perikala's side. We also do not find that this reply was in any way related to the claimant's sex.

47. The situation continued, however, and on the evening of 10 July 2012 Dr Perikala again emailed Dr Bogle and also Dr Foran giving details of his dissatisfaction with the way the clinics were run and saying he could not continue to do them and that they were making him mentally sick. Dr Bogle emailed the claimant informing her of Dr Perikala's email and concerns setting out some options to consider and asking to speak about the matter the following day. 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 had been agreed where Dr Perikala would work from his own list only on Tuesdays and a possible way forward of him returning 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 October 2013.

48. It seems that there was by this stage a failure by the respondent, whether through Dr Bogle or otherwise, to effectively manage the situation which allowed it later to escalate out of control. We find that this failure was not related to or because of the claimant's sex, however, but was a consequence of trying to run a busy cardiology service with limited resources and the added complication of managing interpersonal relationships between professionals who perhaps could have taken more responsibility for their own behaviours and resolving the situation.

49. In the meantime, an anonymous letter was sent to the Chief Executive of the respondent on 13 February 2013 making serious allegations regarding the claimant and her alleged failings. Dr Perikala was later identified as the author of that letter. This led to an investigation by Dr Male, commissioned by Dr Stockwell after discussion with the Medical Workforce Group. This was an appropriate response in all the circumstances.

50. The claimant lodged a grievance with the respondent, on 12 July 2013, as she believed that 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 2010 Act and breaches of her rights under the 1996 Act in respect of her workplace. This letter was addressed to HR and copied to Drs Foran and Stockwell as well as the then Chief Executive. No reply was ever received by the claimant to this grievance which clearly should have been properly acknowledged and dealt with.

51. Dr Stockwell reviewed Dr Male's report in August 2013 and concluded that there was insufficient evidence to proceed to a formal hearing but the allegations were not completely unfounded and had not been raised maliciously. He met 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 be investigating who the author of the letter was as whistle blowers 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.

52. In all these circumstances it is easy to see why the claimant at this stage was very upset by the anonymous letter and the respondent's failure to properly respond to a grievance. There is no evidence however, other than the claimant's opinion, before us to suggest that Dr Stockwell's decisions in this regard were influenced in anyway by the claimant's sex.

53. The claimant raised another lengthy grievance on 16 September 2013. Again this was sent to each of and was copied to the same individuals plus the BMA. This letter covered similar ground but also other areas in some detail and again specifically referred to allegations of breaches under the 2010 and 1996 Acts. 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".

54. The respondent had been carrying out an increased number of Transoesophageal Echocardiograms (TOEs) since 2007 and in January 2013 Dr Bogle decided to carry out an audit, assisted by Dr Perikala, across the service. This procedure was carried out across the service by him, the claimant and Dr Daryani and accordingly data on all three was collated and considered.

55. The claimant says that it was inappropriate to use Dr Perikala to assist on this audit as by that time Dr Bogle knew that he was the author of the anonymous letter in February 2013 and therefore that he had a problem with the claimant. The respondent says that it was not inappropriate as an audit is a neutral process that is designed to identify whether a service is meeting appropriate quality standards, is not directed at any individual and is an integral part of clinical governance. We accept the respondent's position on this.

56. In any event the results of the audit showed a higher failure rate by the claimant's intubation at around 25% compared to the departmental average of around 3%. 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. On 11 June Dr Bogle sent her a dataset and asked her to check it for accuracy and let him know of any missing cases or incorrect coding. He also asked her to suggest an appropriate phrase describing various outcomes to the procedure that she had mentioned in her correspondence. He chased her for a reply on 4 September and proposed an action plan. She replied on 23 September saying she had not had a chance to go through the files but confirmed the audit was incomplete and inaccurate. In due course the audit report was completed and sent to the Clinical Director but in any event no further action was taken in that respect and the claimant remained free to undertake TOEs.

57. <u>2014</u>

58. The only matter before us dating from 2014 is the claimant's allegation that Drs Bogle and Perikala made fun of another female consultant in or around June to August 2014. This was denied by both of them. There was insufficient evidence before us to conclude that these comments were made (and similarly with regard to the allegation of other comments in

2015) and even if they were, that they were made because of the sex of the consultants concerned. The alleged comments were not sex specific.

59. Issues also arose for the claimant in 2014 at St George's with regard to her pacing work there which led, rightly or wrongly, to her being "buddied". The claimant was not employed by the respondent however when she did this work and it is not relevant to her claim.

60. 2015

61. 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 relevant 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 lab 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.

62. Dr Bogle's explanation of his approach to the timetable was that he was asking everyone to compromise to some degree including himself as he would also give up a session at St George's. The claimant says 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.

63. 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.

64. 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. Whether Dr Perikala's concerns were well founded or not, which we do not know, we find that they were genuinely held. Therefore sending the letter to the Chief Executive, the GMC and the CQC was not an unreasonable thing for him to do and in line with what he saw as his professional duties. Sending it to the Secretary of State for Health and the patient, however, was not reasonable and not in line with those duties.

65. Dr Stockwell met 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 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 in complaining about harassment and victimisation.

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

67. The claimant submitted a grievance on 30 September 2015 in which she requested that an urgent investigation into the harassment that she was experiencing be started. 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 cardiology team". She did not make any express reference to her sex being a reason for that harassment or connected to it.

68. 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 but that she would be informed when the matter had been dealt with.

69. 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.

70. 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. The terms of the email were balanced but he did state his belief that they raised significant concern and required the respondent to investigate.

71. On 26 November 2015 the claimant emailed Dr Marsh, Dr Hyer and Dr Shah, with the subject line "Home visits by Dr Perikala". This is the first alleged protected disclosure. She reported that she had been told by a patient, Mr W, that Dr Perikala had visited him at his home some time before, had told him 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 herself causing further harassment and repeated her request for an urgent investigation into this and his behaviour and conduct. (Dr Perikala's

evidence 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.)

72. 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 about how to proceed and asking her to continue to focus on delivering best patient care.

73. 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 problem. This is the second alleged protected disclosure. It 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.

74. Also on 30 November 2015 the claimant met with a representative of the CQC in the course of a routine inspection of the respondent. We accept her evidence that during that meeting she advised them of her concerns about Dr Perikala including issues of patient safety, breach of data protection and harassment (the third alleged protected disclosure). We also accept that the claimant was told by the CQC that they would raise these issues with the respondent. We accept the evidence of Dr Stockwell that to the best of his recollection the CQC did not inform him of these allegations. The CQC report was not before us nor any other evidence as to what the CQC did or did not do in respect of the claimant's concerns.

75. Dr Marsh spoke to the claimant on the 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 and he asked her to refrain from further activities that might compromise any investigation or escalate the situation. She assured him she would not.

76. 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 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 further issues of that nature occurred again, formal disciplinary action may be taken. The respondent's position is that this meeting was informal and the issue of an improvement notice is similar to an informal warning and therefore is not a disciplinary sanction

but rather advice. Accordingly there was no need nor entitlement for the claimant to be represented at that meeting. We were not referred to any written policy that deals with the status of and process surrounding improvement notices. We accept 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. We also accept that the reason Dr Marsh issued the improvement notice was for the reasons set out on its face.

77. 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 concerns and that although there were concerns in respect of the fifth, they had already been addressed.

78. The claimant says that it was inappropriate for Dr Bogle to carry out this review of Dr Perikala as he was not independent. We do not accept this proposition. Dr Bogle was the best placed, amongst those available internally, to do the exercise. The report that he produced indicates that the review was thorough.

79. 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.

80. 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 document (MHPS) to be handled by Dr Stephenson. The terms of reference for the investigation would be in relation to the complaint from the claimant that he had visited one of her patients at home and told the patient he had been mistreated and an allegation that he had behaved inappropriately towards the claimant. Those terms of reference were later refined to make the second allegation more specific namely that the two anonymous letters were written with malicious intent and that referrals for TOEs were being diverted away from the claimant.

81. <u>2016</u>

82. In October 2015 Fiona Goulder, senior chief endocardiographer, had raised concerns with Dr Bogle about an inappropriate referral by the claimant of a patient for a stress echo test. Dr Bogle confirmed her

concerns in an email on 28 October 2015 in which he said he would be approaching Dr Daryani to undertake a stress echo audit with a broader remit than just referrals by the claimant. This decision by Dr Bogle was entirely within his proper remit. There was no obligation on him to give the claimant prior notice nor to seek her consent. 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.

83. 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.

84. 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 on that as he was the imaging lead. Dr Bogle's evidence, which we accept, is 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.

85. In her email dated 5 May 2016 to Dr Marsh, copied to others, the claimant said that the audit results were incomplete and inaccurate. She then 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 we accept, was that this email did not provide a full set of data that could be used to test the audit results. It does not appear however that that was put to the claimant at the time.

86. By early May 2016 Dr Marsh, having consulted with the Medical Workforce Group and 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 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 Dani 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.

87. 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 Charlton, Joint Medical Director, the outcome of which, in March 2017, was that an improvement notice was issued against him.

88. 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 taped so that she could later discuss it with them. Accordingly a lengthy transcript of the meeting was available to us. 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 instigated but the outcome could not be shared with her due to confidentiality - in line with the letter sent to her in October 2015. They also discussed the location of Dr Perikala at St Helier and that the claimant would not be required to work with him.

89. 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 to meet again.

90. 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 asked her for her consent to the ISR being undertaken and that she 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. We find 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 are both busy professional people and previous attempts to meet had been made.

91. The claimant's BMA representative, Ms 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 made the previous year and until she received that, she could not respond to the suggestion of another review.

92. 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.

93. Ms Cheema replied on 13 September 2016 stating that the claimant would be raising a grievance, that she had contacted ACAS and had put in a legal claim.

94. Further on 23 September 2016, Dr Hartley from Medical Protection wrote to Dr Marsh expressly confirming that the claimant did not agree to the ISR as proposed, appreciated that an MHPS would now be opened but expected her grievance to be resolved first.

95. On 10 November 2016 the claimant's claim form was received by the Tribunal.

Conclusions

96. Victimisation The claimant relies upon her grievance dated 30 September 2015 as a protected act. That grievance made multiple references to allegations of harassment but contained no express reference to her sex. Further, none of the many complaints made by the claimant about her treatment by that time included any allegation that her treatment was due to her sex. Therefore we conclude that the grievance of 30 September 2015 cannot be read, even implicitly, as an allegation of sexual harassment. It was not therefore a protected act and the claim of victimisation fails.

97. Even if we are wrong and that grievance was a protected act, we find that there was no causal link between it and either of the alleged detriments.

98. Detriment - whistleblowing The first question to be answered is whether the claimant made any protected disclosures. Three are alleged.

99. We find that the claimant's email dated 26 November 2015 and her conversation with the CQC on 30 November 2015 were both protected disclosures to prescribed persons. On both occasions she raised matters that amounted to a disclosure of information that was in the public interest and she reasonably believed tended to show at least one of the required relevant matters.

100. The claimant's email dated 30 November 2015, however, we conclude was not a protected disclosure. It did contain information about Dr Perikala "who has not passed mrcp, advising a patient" but it was sent to colleagues seeking their views rather than to her employer as a disclosure. The claimant cannot have reasonably believed that her colleagues were prescribed persons.

101. As to whether the claimant was subjected to the alleged detriments at paragraph 6.5 of the list of issues because she had made the two protected disclosures, we conclude that she was not as follows:

    6.5.1 we have found that the claimant was not offered representation at this meeting because Dr Marsh believed that to be the respondent's policy;

6.5.2 we have found that the improvement notice was issued because of Dr Marsh's concerns regarding the email the claimant sent to her colleagues. That email was not a protected disclosure;

6.5.3 we have found that the failure to disclose the investigation report was quite properly to preserve the confidentiality of Dr Perikala as had been indicated to her in October 2015 (before the protected disclosures had been made);

6.5.4 we note first the significant time lapse between the protected disclosures in November 2015 and the remaining alleged detriments in August 2016. Further, we have found that there was nothing untoward, and therefore no detriment, in respect of Dr Marsh's conduct on 16 August 2015;

6.5.5 the investigation of the claimant's grievance was conducted by Dr Stephenson who upheld one of the allegations. There was no evidence to suggest that he was aware of the protected disclosures. Further his thorough report, concluded on 1 June 2016, gives cogent reasons for his conclusions;

6.5.6 there was no such failure. An explanation was given at the meeting on 13 June 2016 and thereafter in correspondence between Mr Croft and Ms Cheema and between Dr Marsh and Dr Hartley;

6.5.7 the claimant was given sufficient time to accept the proposal. She was sent the draft terms of reference on 16 August 2016 and asked to reply by 26 August 2016. There was therefore no detriment and no causal link between the protected disclosures and that deadline.

102. Accordingly none of the section 47B detriment claims succeed on their merits. In any event, 6.5.1 and 6.5.2 are out of time as they took place before 13 June 2016 in circumstances where it was reasonably practicable for the claimant to put any claim in on time. At that time she had support from her union representatives and had some access to legal advice (see below). Further, these alleged detriments were not part of a series of later similar acts of failures that are in time.

103. Direct discrimination & harassment

104. We deal first with whether these claims were brought in time. The parties agree that prima facie any allegations of acts before 13 June 2016 are out of time.

105. In respect of the claims arising out of allegations in 2013 we conclude that they were not submitted in time and it is not just and equitable to extend that time limit. The claimant's grievance dated 16 September 2013 specifically complained about both the anonymous letter and the TOE audit which form the basis of her complaints before us from this period. Given her statement two years later that she had decided not to pursue that complaint in the spirit of conciliation, we conclude that these

allegations cannot be linked to and therefore form part of any continuing act thereafter. We note that the next allegation is not until the summer of 2014 and then the next not until summer 2015. In these circumstances it is not just and equitable to extend time to allow her nonetheless to pursue those claims now. We accept that the claimant was trying to resolve matter internally but also note that she had advice from the BMA from 2013. Further the terms of the grievances she wrote in 2013 clearly indicate that she had researched, if not been advised on, the legal position regarding such claims.

106. Turning to the later time period, we do conclude that the claims founded on alleged acts from June 2015 (the proposal that she give up sessions at St George's) through to 13 June 2016 (when she was told in a meeting by Dr Marsh that she could not have a copy of the investigation report into her complaint about Dr Perikala) are in time. The substance of the claimant's complaint is that the respondent was responsible for the state of affairs over this period that led to the alleged discrimination as specifically identified in the list of issues. It is perhaps quite a coincidence that that period ends on the very first day of the prima facie time limit thus bringing that sequence of events in time, but there it is.

107. For completeness, we do not find that there is any link between those allegations and the decision by Dr Marsh to seek to instigate the ISR and the related allegations in September 2016 and therefore do not find that there was conduct extending from June 2015 through to September 2016. However, the claimant does not need there to be. Both sets of allegations are in time.

108. Our conclusions in respect of each of those allegations set out at the following paragraphs in the list of issues are as follows:

    3.2 - this request was made by Dr Bogle's proposed timetable but it was also made to the other consultants in the cardiology service. Although the claimant says it had greater impact on her we note that both the claimant and Dr Daryani were asked to reduce to one session per fortnight. We find that there was no less favourable treatment but even if there was, it was not because of the claimant's sex. It was because of the needs of the service;

    3.3 - carrying out the audit without the claimant's knowledge or consent was not less favourable treatment. It was routine and proper management of the service. Further, the decision to conduct the audit was not because of the claimant's sex but because concerns had been raised by a (female) colleague. Those concerns had been about the claimant but the audit was extended to the wider team.

    The disagreement between the claimant and the respondent as to whether the audit results as distributed were incomplete is just that – a professional disagreement. There is no evidence to suggest that the presentation of the results in April 2016 – even if they amounted to less favourable treatment which we do not accept – was because of the claimant's sex.

Further, they had been circulated in advance to all consultants including the claimant and therefore she was not disadvantaged by being absent from the meeting.

We have found that Dr Bogle was not aware of the claimant's intention to use the stress echo service for a clinical excellence application and accordingly that part of her allegation must fail;

3.4 (first allegation) – the claimant was singled out for the proposed ISR in September 2016, which is less favourable treatment, but it was not because of her 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;

3.4 (second allegation) & 3.5 - the claimant was provided with a response to the grievance she raised in respect of Dr Perikala. The reason she was not given a copy of the resulting report was not because of her sex but for valid reasons of confidentiality. There were no unreasonable delays;

4.1.2 This letter written by Dr Perikala reflected his genuinely held concerns about the claimant and we have concluded that given those concerns it was not unreasonable for him to send the letter to the respondent's Chief Executive, the GMC and the CQC. In that respect the purpose of the letter was to discharge what Dr Perikala saw as his professional duties. Sending a copy however to the patient and Secretary of State went beyond what he could have believed to be his professional duties and we find that this was done with the purpose of humiliating the claimant. It certainly, and reasonably, had that effect on her. We do not find however that the letter was related to the claimant's sex. It was related to Dr Perikala's concerns about her treatment of a patient. It did not therefore amount to sexual harassment.

4.1.3 There is insufficient evidence before us to make any finding as to what was said at this visit in 2013 and whether files were removed etc. We do find however that the reason for any comment made or behaviour at the time was concerns genuinely held by Dr Perikala (whether rightly or wrongly) which were not related to the claimant's sex. They could not therefore amount to sexual harassment.

109. Accordingly the claims of direct discrimination and harassment also fail.

_____
Employment Judge K Andrews
Date: 17 November 2017

Appendix A - AMENDED LIST OF ISSUES

The Claimant's claims are:

(a) Direct Sex Discrimination pursuant to s.13 of the Equality Act 2010

(b) Harassment related to the protected characteristic of sex pursuant to s.26 of the Equality Act 2010

(c) Victimisation pursuant to s27(d) of the Equality Act 2010

(d) Detriment suffered as the result of having made a protected disclosure under ss.43B and 47B of the Employment Rights Act 1996

1. Jurisdiction (s.123 of the Employment Rights Act 2010)

1.1. The Respondent contends that all of the acts and failures to act occurring before 13th June 2016 are out of time and that the Employment Tribunal does not have jurisdiction to hear these claims.

1.1.1. Do the matters complained of amount to an act extending over a period of time which ended on or after the 13th June 2016?

1.1.2. To the extent that any of the Claimant's discrimination complaints are out of time, would it be just and equitable to extend the time limit in the circumstances?

2. Jurisdiction (s.48 of the Employment Rights Act 1996)

2.1. The Respondent contends that all acts and failures to act occurring on or before 13th June 2016 are out of time and the Tribunal does not have jurisdiction to hear these claims. To the extent that the Claimant relies on acts or failures to act of occurring on or before 13th June 2016, do those acts or failures to act constitute an act extending over a period of time which ended after that date?

2.2. If out of time -

2.2.1. Is the Tribunal satisfied that it was not reasonably practicable for the Claimant to present her complaints within the three-month period (as extended by the ACAS conciliation period)

2.2.2. Did the Claimant submit her complaints within a reasonable period?

3. Direct Sex Discrimination (s.13 of the Equality Act 2010)

3.1. 1st February 2013 – 16th September 2013 (*Dr Perikala, Dr Bogle, Dr Stockwell*)

3.1.1. Failure to provide an apology re. investigation into February 2013 letter;

3.1.2. Failure to investigate the false allegations contained in the February 2013 letter;

3.1.3. Audits carried out by other Clinicians of the Claimant's Transoesophageal Echocardiogram (TOE) activities without her knowledge;

3.1.4. Incomplete or incorrect results of those audits communicated to the team.

[Comparators: Dr Bogle, Dr Foran, Dr Odemuyiwa and Dr Daryani]

3.2. June 2015 (*Dr Bogle*) Claimant requested to give up invasive sessions at St George's Hospital

[Comparators; Doctor Bogle, Dr Foran, Dr Odemuyiwa and Dr Daryani]

3.3. 23rd April (*Dr Bogle*) –

3.3.1. Stress Echo Audit carried out on service set up by the Claimant in 2010 without the Claimant's knowledge or consent;

3.3.2. Incomplete results distributed to the Cardiac Team in the Claimant's absence;

3.3.3. Suggestion of discontinuing the service in the Claimant's absence despite awareness that the Claimant intended to use the Stress Echo Service as an example of establishing and running a new service for the Claimant's clinical excellence award application

[Comparator: Dr Daryani]

3.4. 6th September 2016 – being singled out for clinical review in relation to her practice and failure to provide a response to the Claimant's grievance

3.5. 16th August 2016 (*Dr Marsh and Dr Bogle*) – delays in the Claimant's harassment and bullying investigation and failure to provide a report

[Comparators: Dr Bogle, Dr Foran, Dr Odemuyiwa, Dr Daryani, Dr Bajapi, and Dr Malik]

4. Harassment pursuant to s.26 of the Equality Act 2010

4.1. Did the Respondent submit the Claimant to unwanted conduct as follows:

4.1.1. 1st February 2013 – 16th September 2013 – repeated attempts to undermine and discredit the Claimant's credibility by Dr Bogle and Dr Perikala;

4.1.1.1. Various verbal complaints from Dr Perikala to Dr Bogle re Dr Prasad;

4.1.1.2. Emails to Dr Bogle from Dr Perikala re Dr Prasad;

4.1.1.3. Letter 1 sent by Doctor Perikala;

4.1.1.4. Dr Bogle's role in causing the investigation to be greenlit;

4.1.1.5. Investigation into Dr Prasad as the result of Letter 1.

4.1.2. 30th July 2015 – the letter (Letter 2) written by Dr Perikala copying in high profile individuals;

4.1.3. [Dates unknown] Home visits by Dr Perikala to Claimant's patient and removal of patient's file without the Claimant's knowledge or consent. The Claimant became aware of the removal of the patient's files on 24th November 2015

4.2. If proven, did the above relate to sex?

4.3. Did the conduct have the purpose or effect of:

4.3.1. Violating the Claimant's dignity? Or

4.3.2. Creating an intimidating, hostile, degrading or humiliating or offensive for the Claimant?

5. Victimisation pursuant to s.27 of the Equality Act 2010

5.1. Did the Respondent submit the Claimant to detriment as follows:

5.1.1. 6th September 2016 – failure to respond to Claimant's grievance, and being singled out for clinical review.

5.1.2. If proven, was the conduct the result of a protected act?

5.1.3. The Claimant relies upon the grievance dated 30th September 2015 as the relevant protected act.

6. Detriment suffered pursuant to s.47B of the Employment Rights Act 1996

6.1. Has the Claimant made a protected disclosure? – Did the concerns raised by the Claimant orally to a CQC Inspector on 30th November 2015 and in writing to the respondent on 26th November 2015 and 30th November 2015 amount to a disclosure that falls under s.43B of the Employment Rights Act 1996?

6.2. Did the Claimant have a reasonable belief that the disclosure tends to show one or more if the following in s.43(b)(1)(a)–(f)

6.2.1. That a criminal offence has been committed, is being committed, or is likely to be committed;

6.2.2. That a person has failed, is failing or is likely to fail with a legal obligation to which he is subject;

6.2.3. That a miscarriage of justice has occurred, is occurring or is likely to occur

6.2.4. That the health or safety of any individual has been, is being or is likely to be endangered;

6.2.5. That the environment has been, is being or Is likely to be damaged; or

6.2.6. 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.

6.3. Has the Claimant made a protected disclosure?

6.4. Was the disclosure made in accordance with ss 43c to 43h of the Employment Rights Act 1996?

6.5. Has the Claimant been subjected to a detriment? The Claimant relies on the following acts and/or failures to act:

6.5.1. Denial of an independent representative at the disciplinary meeting with the Claimant on 7th December 2015;

6.5.2. Issue of improvement notice on 7th December 2015;

6.5.3. Failure to disclose an investigation report in September 2016 relating to Dr Perikala and dated 1st June 2016;

6.5.4. Conduct of Dr Marsh at meeting of 16th August 2016 including: less than ten minutes notice being given of meeting, via text message meeting scheduled on a day when the Claimant was the only Consultant in the hospital and had to undertake her usual activities of conducting ward rounds, reviewing all cardiac patients on acute wards, teaching medical students, performing cardiac emergency procedures and then reviewing approximately 18 – 20 patients at an out-patient clinic; failing to provide a sufficient amount of time for the Claimant to read to Terms of Reference for the Invited Review referral.

6.5.5. Failure to uphold the Claimant's grievance on 25th August 2016

6.5.6. Failure to provide an explanation for singling out the Claimant in the Invited Service Review referral on 25th August 2016;

6.5.7. Providing insufficient time for the Claimant to accept the proposal on 25th August

6.6. If the Claimant was subjected to any detriment(s), was this because she made a protected disclosure?

6.7. If the Claimant's claims are accepted, which remedy should the Claimant be awarded?