Case No: 1808465/2007
1808887/2008
1810815/2008

EMPLOYMENT TRIBUNALS

Claimant:	**Dr Eva Michalak**
First Respondent:	**Mid Yorkshire Hospitals NHS Trust**
Second Respondent:	**Mrs Susie Brain-England**
Third Respondent:	**Mrs Julia Squire**
Fourth Respondent:	**Mr Toby Lewis**
Fifth Respondent:	**Dr Nick Naftalin**
Sixth Respondent:	**Dr David Dawson**
Seventh Respondent:	**Dr Mahesh Nagar**
Eighth Respondent:	**Dr Collin White**
Ninth Respondent:	**Dr Sue Barnes**
Tenth Respondent:	**Dr Rob Lane**
Eleventh Respondent:	**Dr Richard Jenkins**
Twelfth Respondent:	**Mrs Dianne Nicholls**
Thirteenth Respondent:	**Dr Deborah McInerny**
Fourteenth Respondent:	**Dr Patrick Neligan**
Fifteenth Respondent:	**Professor William Burr**

Heard at:	**Leeds**	**On:**	**1 September 2009 – 12 February 2010**

Before: **Employment Judge Burton**

Members: **Mr G Hopwood**
Mrs A Steele

Representation

Claimant:	Dr Julian DeHavilland, Husband
First to Thirteenth Respondents:	Mr Frank Sutcliffe, Solicitor
Fourteenth and Fifteenth Respondents:	Mr Richard Mumford, Counsel

RESERVED JUDGMENT

1. The Claimant was unfairly dismissed.

2. There should be no reduction from any award by reason of any contributory fault or by reason of any assertion that if fair and proper procedures had been followed the Claimant may have been fairly dismissed.

3. That dismissal was not an automatically unfair dismissal pursuant to s 98A Employment Rights Act 1996.

4. The Claimant was subjected to a detriment by reason of having made a qualifying protected disclosure.

5. The Complaint of Sex Discrimination is well founded in relation to the First Respondent (The Mid Yorkshire Hospitals NHS Trust), the Sixth Respondent (Dr David Dawson), the eighth Respondent (Dr Collin White) and the twelfth Respondent (Mrs Dianne Nicholls)

6. The Complaint of Race Discrimination is well founded in relation to the First Respondent (The Mid Yorkshire NHS Trust), the sixth Respondent (Dr David Dawson), the eighth Respondent (Dr Collin White) and the twelfth Respondent (Mrs Dianne Nicholls)

7. The Complaints brought against the Second, Third, Fourth, Fifth, Seventh, Ninth, Tenth, Eleventh, Thirteenth, Fourteenth and Fifteenth Respondents are dismissed.

REASONS

1. This is a claim brought by Dr Eva Michalak against fifteen named Respondents. Dr Michalak has been represented throughout these proceedings by Dr Julian DeHavilland, her husband, Respondents 1 - 13 have been represented by Mr Frank Sutcliffe, solicitor. The Fourteenth and Fifteenth Respondents have been represented by Mr Richard Mumford of Counsel.

2. These proceedings were initially listed to be heard over a period of fourteen days, between 1 September and 28 September 2009. The original time estimate proved wholly inadequate and so the Hearing was adjourned part-heard to 19 November 2009. The matter was referred for Judicial Mediation in between those two Hearing dates. The matter then continued to be heard on those dates that had been identified as being mutually convenient, the evidence finally being concluded on 12 February 2010. We spent a total of 36 days hearing evidence. Directions were then made for written submissions to be exchanged and lodged and the Tribunal met in chambers

on 8 April 2010 to commence our deliberations. The Tribunal spent the 15th – 19th April deliberating and arriving at our findings of fact. Those were then produced in draft form to be used as a basis for our final deliberations which were conducted on the 26th and 27th May 2010

3. It was agreed between the parties in advance of the start of this Hearing, that the issues relating to the Fourteenth and Fifteenth Respondents were sufficiently discrete that the Tribunal could hear the Claimant's evidence in relation to those issues and then hear from those witnesses to be called on behalf of the Fourteenth and Fifteenth Respondents, before we began to deal with the proceedings against the remaining Respondents. In that way Mr Mumford was not required to attend throughout the hearing.

4. It was also agreed by all the representatives that the Tribunal should read witness statements in advance of that witness giving evidence and that their statements could then be taken as read. That agreed approach has saved considerable amounts of time, it took the Tribunal the best part of two working days to read the Claimant's witness statement, it would have taken her far longer to have read it out aloud, and by and large the other witness statements were read in the Tribunal's own time, rather than during the normal sitting hours.

5. We would like to say something about the representatives. Mr Mumford and Mr Sutcliffe, of course, dealt with this matter with their customary courtesy and efficiency. We are particularly indebted to Mr Sutcliffe upon whom the majority of the burden no doubt fell to manage the voluminous documents which were involved in this case, we had some sixteen files of documents in all, many of which being lever arch files with documents photocopied on both sides. We are also very appreciative of the fact that when the case was originally adjourned part-heard, Dr DeHavilland and Mr Sutcliffe reached an agreement as to the number of days that were required to complete the evidence, the days when each of the witnesses would be called and the length of time that Dr DeHavilland would need to cross-examine each of those witnesses. Fortunately each of the witnesses was able to attend on the agreed dates and Dr DeHavilland ensured that his cross-examination was completed within the time that had been allocated to him. In that way we were able to progress this case to conclusion, conscious of the fact that on occasions Dr DeHavilland may well have wanted to ask many more questions than time sometimes permitted.

6. We would particular wish to pay tribute to the contribution that Dr DeHavilland has made to these proceedings. As he has repeatedly told the Tribunal, he has no legal expertise or training. He is, we understand, a Research Scientist by profession. It seems to us that he has used his talents to the maximum effect in getting to grips not only with the facts of this case but achieving an understanding of the employment law that applies and to the procedures that the Tribunal use in determining disputes of this sort. He has clearly gone to very considerable efforts to prepare his wife's witness statement in a way that, although lengthy, could be easily read and absorbed by the Tribunal, he has prepared a number of diagrammatic or schematic documents designed to assist the Tribunal in readily

understanding aspects of the Claimant's case and he has prepared a lengthy but equally cogent written submission for the Tribunal to consider. His cross-examination of the witnesses would put many professional advocates to shame. He clearly put considerable effort into preparing his cross-examination which was always structured and rarely repetitive. Unsurprisingly, in a case as complex as this, there were many occasions when the Tribunal sought to intervene to provide guidance or assistance where, for example, it was thought that the wrong questions may be being asked of the wrong witness. Invariably that guidance was met with a courteous response and was accepted by Dr DeHavilland. We would like to give Dr Michalak our assurance that, in our view, it is highly unlikely that she could have been better served by a professional representative.

The Parties

7. Dr Eva Michalak was born on 1 September 1958. She was born and brought up in Poland, which is where she trained and qualified as a medical Doctor. Her qualifications were such that upon coming to live in the United Kingdom, she attained Consultant status and having worked in other hospitals within the UK, on 29 April 2002 she was employed by the Respondents as a Consultant Physician, with a specific interest in nephrology.

8. The Mid Yorkshire Hospitals NHS Trust manages three main hospitals at Pontefract, Wakefield and Dewsbury.

9. Mrs Susie Brain-England is a Non-Executive Director of the Respondent Trust and was a Chair of the disciplinary panel, which led to the Claimant's dismissal.

10. Mrs Julia Squire is the current Chief Executive of the Respondent Trust and a member of the disciplinary panel.

11. Mr Toby Lewis is the former Chief Operating Officer of the Trust and also a member of the disciplinary panel.

12. Dr Nick Naftalin was an "independent" medical member of the disciplinary panel, he is not employed by the Trust.

13. Dr David Dawson was the Trust's former Medical Director and Interim Chief Executive. He was the original case manager co-ordinating the investigation into the Claimant's alleged conduct.

14. Dr Mahesh Nagar is the Trust's Associate Medical Director and a Consultant Anaesthetist. He was a member of the CEA appeal panel which consider the Claimant's appeal in June 2007 and was the successor to Dr Dawson as case manager.

15. Dr Colin White is a Consultant Physician at the Trust and Dr Michalak's former head of department.

16. Dr Sue Barnes was the Clinical Director in General Medicine at the Trust.

17. Dr Rob Lane is a Consultant in Palliative Care and Medical Director at the Trust.

18. Dr Richard Jenkins is a Consultant Endocrinologist/Diabetologist at the Trust and was clinical lead for acute medicine since June 2005.

19. Mrs Dianne Nicholls is the Trust's Director of Human Resources.

20. Dr Deborah McInerny was the "independent" investigator commissioned by the Trust to carry an investigation into the allegations against the Claimant.

21. Dr Patrick Neligan was the Associate Dean of the Yorkshire Deanery.

22. Professor William Burr was the Post-Graduate Dean of the Yorkshire Deanery.

23. It may be helpful to explain the role of the Yorkshire Deanery. They are a part of the establishment of the Strategic Health Authority, they are responsible for commissioning and monitoring the training and education of Junior Doctors within this area.

24. We attach as a first appendix to this decision, a cast-list of all of those other people who feature within the history of this case for ease of reference.

The Issues

25. It is perceived wisdom that it is of importance for Employment Judges to ensure that the issues in any case, bar the most simplest, are precisely defined at an early stage through the case management process. It is correctly seen as vital that the Tribunal should, at an early stage, know precisely what the issues in a case are to enable the Employment Judge to effectively case manage proceedings and also to enable Respondents to know exactly what case they are being asked to meet. The definition of issues helps parties focus their minds upon that evidence which is of relevance and that evidence which may have no bearing upon the issues which a Tribunal are to be asked to resolve.

26. Having said that the task is often far from easy. Very frequently parties before us, particularly Claimants, are unrepresented. We are frequently faced with claims alleging discrimination, of all sorts, which consist of little more than a lengthy statement of events spanning, frequently, a number of years followed by a bare assertion of discrimination. The various concepts involved in discrimination are sufficiently complex to make it difficult, in our experience, for many professional advocates to comprehend . For many litigants in person the task is an impossible one. Employment Judges spend many hours in Case Management Discussions trying to explain those concepts to unrepresented Claimants and trying to distill from the mass of information put before them what the legal issues may be. Inevitably that process leads to a schedule of issues which is the Judge's own

interpretation of what the issues are likely to be which may or may not accord with the Claimant's understanding.

27. Such was the difficulty in this case. The complaints that this Tribunal were being asked to consider involved many events that occurred between the Claimant's appointment in April 2002 and her ultimate dismissal on 14 July 2008. This Employment Judge would once again express his appreciation for the efforts made by Dr DeHavilland when he sought to come to grips with the complicated legal issues involved and when he prepared various schedules setting out the acts of discrimination upon which he sought to rely. During the process of case management these allegations were incorporated into the agreed schedule of issues which is attached to this decision as appendix 2. It has to be acknowledged by this Employment Judge that his understanding of this case, when that schedule was formulated by him, was far less extensive than his understanding now is. Having, however, reviewed that schedule, whilst being far from perfect, it does, we think, adequately reflect the key component parts of the case being advanced on behalf of the Claimant. The one additional issue which is not reflected within the schedule but, as is clear from the submissions before us, is within the contemplation of the parties as being an issue for us to resolve, is whether the reason, or principal reason, for the Claimants dismissal was that she had made a qualifying protected disclosure or whether she had been subjected to a detriment by reason of having made a protected disclosure.

28. The core of the Claimant's case can, however, be distilled, we think, into the following parts:-

    (a) By reason of the fact that the Claimant became pregnant and took maternity leave shortly after her appointment, by reason of the fact that upon her return from maternity leave she raised issues about payment that had been made to her professional colleagues during her absence, and the Respondents' failure to make those payments to her and thereafter complained of sex discrimination, she became unpopular with senior clinicians and managers within this Trust. It is her contention that as a consequence a concerted campaign was mounted to bring her employment with the Trust to an end (this was referred to by Dr DeHavilland as a "get Eva campaign"). It is her contention that her ethnic origin had a part to play in the Respondents' actions. That concerted campaign led to a "bogus" disciplinary procedure being adopted, an unjustified, lengthy, suspension leading to her dismissal, for no good or justifiable reason.

    (b) The Claimant contends that she was, by the time of her dismissal, a disabled person, suffering from a psychiatric illness caused by the Respondents' actions, that the Respondents failed to make appropriate adjustments in the course of the disciplinary procedure to take account of the difficulties that that illness caused her and that they then dismissed her at a hearing which she could not attend because she was ill and a patient in St James' Hospital suffering

from suspected heart disorders.

(c) That, as a consequence, her dismissal was the conclusion of an extensive process of sex and race discrimination, was related to the fact that she had made a protected disclosure, amounted to disability discrimination, and was an unfair dismissal, both in terms of Section 98 and Section 98A of the Employment Rights Act 1996.

29. Shortly before the substantive Hearing was due to begin, an issue arose relating to the medical evidence obtained in support of the Claimant's contention that she was a disabled person. The Respondents were seeking to instruct their own medical expert and were not willing to concede disability on the basis of the report that had been obtained. To have given such leave would, inevitably, have led to the substantive Hearing having to be postponed, which everybody viewed as being undesirable. This Judge took the view that the medical evidence that had been obtained so far went not only to the issue of disability but potentially to the issue of remedy. It is the Claimants intention to pursue a claim for compensation for personal injuries allegedly sustained by reason of these alleged acts of discrimination. This Judge took the view that in the circumstances of the Claimant's case, as he understood it to be, the allegation of disability discrimination may not add a great deal, if anything, to the substance of her claim, depending upon the Tribunal's findings, and it was accordingly agreed that the issue of whether the Claimant was a disabled person would not be resolved at the substantive Hearing, but would be left to be resolved at a subsequent Hearing, if the parties believed that to be necessary in the light of the total findings of this Tribunal in relation to the other issues before it.

30. The Claimant effectively alleges a conspiracy operating over a period of some four years. We have heard much detailed evidence involving many events that occurred during that period. By the very nature of the Claimant's case, she relies upon the Tribunal drawing inferences from many of those events to support the basic contention of a conspiracy. This is, effectively, a jigsaw consisting of many pieces of evidence, and in order to succeed in this case the Claimant's contends that it is only when all those pieces of evidence are put together that the picture becomes clear.

31. We are conscious that in our findings of fact there will be many issues of detail that have been canvassed at length before us, which we may have omitted to make reference to . It is, however, our belief that if we piece together sufficient parts of the jigsaw, we will be able to determine what the picture consists of to the appropriate level of proof required of us.

Findings of Fact

The Evidence

32. Before we deal with the history of this case, we would like to make some observations about the quality and the nature of the evidence that some of the key witnesses before us have given. We begin by commenting upon the

evidence of Dr Michalak. We recognise immediately that we have to approach her evidence with care. The Tribunal were presented with a beautifully prepared witness statement divided into seven different sections, colour-coded to co-ordinate with a detailed, but very helpful, pictorial representation of this claim. Dr DeHavilland makes no secret of the fact that this statement is of his creation. When giving her evidence before the Tribunal Dr Michalak confirmed that the contents of that statement were true. We have absolutely no reason to believe that Dr Michalak did not give us that assurance in good faith. We have no reason to believe that she was not aware of the contents of the document.

33. The fact of the matter is that it was not a document of her making. That of course is not all that unusual, in that many witness statements presented to Employment Tribunals are the creation of the solicitors involved, albeit that the documents are created on the basis of instructions given. In this case there is a risk that this document was created on the basis of the recollection of Dr DeHavilland, rather than the recollection of Dr Michalak.

34. In the normal event, any problems arising in that regard would become evident during the course of cross-examination. Unfortunately, in this case, Mr Sutcliffe had the greatest of difficulty in cross-examining Dr Michalak. We make no findings as to her actual state of mental health, because this is an issue that might be the subject of debate in the future. All we would say is that it was abundantly apparent that throughout the course of her evidence Dr Michalak was close to tears, and on occasions we had to break to enable her to compose herself.

35. Mr Sutcliffe endeavoured to cross-examine her by asking simple straightforward questions that would normally attract simple and straightforward answers. Unfortunately Dr Michalak was not able to respond in such a way. We have no doubt that she and her husband have lived and breathed the circumstances surrounding this case over a number of years. She saw this Hearing as her main and perhaps last opportunity to give a full and detailed account of all the events that led, as she perceived it, to the end of her career. She was obviously desperate to ensure that nothing at all was left out.

36. Almost every question asked of her resulted in Dr Michalak explaining that the issue about which she was being asked was very important and that in order to answer the question it was necessary for her to go back through the history of events in order that the Tribunal could fully understand the context within which her answer was being given. Efforts made by the Tribunal and, in fairness, by Dr DeHavilland, to persuade Dr Michalak to give shorter more concise replies proved fruitless. Whenever she was pressed to do so she became increasingly distressed leading to breaks having to be taken.

37. Despite using his very best endeavours as the first day or two of cross-examination went by Mr Sutcliffe was making next to no progress in covering the issues in this case. It was apparent to him, and to the Tribunal, that we could spend many days dealing with Dr Michalak's evidence in that way, which could lead to this Hearing being prolonged almost indefinitely.

38. With a view to helping the Tribunal Mr Sutcliffe reconsidered his approach and endeavoured to deal with cross-examination on the basis that he would put the Respondents' case to the Claimant, indicating that he anticipated that she would not agree with it, but asking her simply to confirm whether or not she did accept the Respondents' position. In that way he believed he was fulfilling his responsibility as an advocate to put his case to the witness.

39. Unfortunately that approach was still unsuccessful. If anything the Claimant's ability to respond became even worse. Instead of being faced with one specific issue to respond to, she was being faced with much broader propositions which visibly overwhelmed her and lead to her trying to summons up a detailed response to everything that was being put to her. Having tried his hardest, Mr Sutcliffe quite rightly abandoned his cross-examination of the Claimant.

40. In assessing the evidence of this case, therefore, we have to approach the Claimant's evidence with care, by reason of the fact that the Respondents were deprived of that opportunity to effectively challenge it in cross-examination.

41. We then wish to comment upon the evidence of some of the principal witnesses for the Respondents. We start with the obvious example of Dr Dawson. He was the Medical Director of the Respondent Trust; the most senior Doctor within the organisation. As we will recount in the course of our findings, he told deliberate lies to colleagues and to supervising professional bodies relating to the scoring process that led to the Clinical Excellence Awards being granted and the Claimant being excluded from that award. He instructed Mandy Williamson, the Trust's Medical Staffing Manager, a senior Personnel position, to write to the Claimant in terms which she knew to be untrue both in relation to that scoring process and in relation to the fact that she had provided the panel dealing with the Clinical Excellence Awards with her appraisal records.

42. The explanation given by Dr Dawson for that disreputable conduct was that he was seeking to protect the reputation of Mr Parkes, the Chief Executive of the Trust, and Mr Waite, their Financial Director. That explanation was shown to be bogus when he repeated the lie in a response given to a questionnaire served upon him by the Claimant at a time when Mr Parkes was no longer the Chief Executive and was no longer in need of that protection. Dr Dawson therefore has to be regarded by us as a self acknowledged liar and his evidence has to be treated with caution accordingly.

43. We then turn to Mrs Nicholls, the Trust's Human Resources Director. She of course played a key role in co-ordinating the disciplinary action that was taken against the Claimant. As our findings of fact will recount the Claimant was suspended in total for some 2 ½ years. Supported by the BMA, she pursued a claim in the High Court seeking an injunction to require the Respondents to permit her to return to work, albeit perhaps on a restricted basis. Mrs Nicholls prepared a witness statement in opposition to that

application; her witness statement being dated 18 October 2007.

44. That witness statement contains a number of deliberate falsehoods. The original allegations made against the Claimant, as this Judgment will recount, related to her bullying Junior Doctors. Very early on into the Respondents' investigation Dr McInerny established that there was little or no evidence to support that proposition. She interviewed the Junior Doctors involved. The closest that she got to any suggestion of bullying was that Dr Polack suggested that the Claimant had called Dr Raju, to her face, "stupid". When Dr McInerny interviewed Dr Raju, however, she said that that had not happened.

45. Those facts were fully known to Mrs Nicholls by February 2006. Notwithstanding that, in October 2007 Mrs Nicholls signed a witness statement, against a statement of truth, in which she stated (at Paragraph 86)

> "*the majority of witnesses have supported the original allegations*"

and, at Paragraph 90:-

> "*Dr McInerny's report found that many, but not all, of the Junior Doctors she interviewed felt bullied and harassed by her behaviour*".

Mrs Nicholls explains that falsehood by saying that the witness statement had to be prepared in a hurry. We do not accept that explanation. It takes no longer to tell the truth than it does to tell a lie. We therefore conclude that Mrs Nicholls' evidence as a whole must be approached with caution because she was prepared to tell an obvious untruth to the High Court with a view to persuading that Court to maintain the Claimant's suspension.

46. We then turned to the evidence of Mr Parkes. He was the Chief Executive of this Trust. An issue arose during the course of the Clinical Excellence Award process whereby, as it is now acknowledged by the First Respondent, for the year 2004-2005, when Mr Parkes purported to have marked all the applicants, he had, in fact, done nothing of the sort. It is accepted that he simply asked that his scores should be shown as the average of all the other scores given and that was the fact that Dr Dawson was so anxious to cover up.

47. His witness statement to this Tribunal, however, expressly states that when he scored applications the year before, he did mark all the applicants. He specifically states that he remembers spending a whole weekend doing that. When cross-examined he repeated that assertion and stated that he had no doubt that that is what he had done.

48. His attention was, however, then drawn to the documentary evidence. It was shown that his scores were identical to the scores given by a Mrs Snaith, who was a lay-person external to the Trust. Not only did he give each of the applicants an identical score to those given by Mrs Snaith, but each of those scores was broken down into four parts, and once again Mr

Parkes' scores replicated exactly those of Mrs Snaith.

49. He accepted that the process of scoring for a Clinical Excellence Award was a highly subjective process, and he accepted that statistically it was impossible that two scorers should give each applicant identical scores. He accepted that the only logical conclusion that could be reached was either that he had copied her scores or she had copied his. His attention was then drawn to Mrs Snaith's score-sheet which contained a number of handwritten comments against some of the applicants' names, which made it abundantly obvious that she had scored each of those applications herself. He was invited, therefore, to accept the inevitable conclusion that he had copied her scores.

50. In the face of that overwhelming evidence, Mr Parkes still maintained that he had scored those applications himself. That simply could not be true and Mr Parkes was, therefore, telling us a deliberate lie. His evidence, accordingly, must be approached with caution.

51. We then turn to the evidence of Dr White. He was Dr Michalak's line manager. He is a Consultant Physician. If we were to accept the Claimant's primary case it is probable that we would have to conclude that Dr White was an integral part in a process that involved making unfounded allegations against Dr Michalak with a view to bullying her out of this Trust. That is a grave allegation to make against a senior professional man and one which would normally have to be approached with scepticism.

52. However we know that in 2001 Dr White was involved in an issue relating to another Consultant Physician, Dr Michael Tobin. After a complaint made to the General Medical Council, in June 2005 they delivered a finding that Dr White had acted outside his area of speciality and clinical experience in carrying out an audit/investigation, that he ignored warnings from colleagues, prior to that audit being completed, that it was not appropriate for him to be carrying out that investigation and that he knew, or should have known, that it would be difficult for him to appear impartial in conducting the audit, because of issues of professional disagreement between himself and Dr Tobin in the past.

53. As a consequence they concluded that Dr White allowed an audit/investigation to be published, which was fatally flawed and that, as a consequence, he had made unfounded criticisms of Dr Tobin and had failed to treat him fairly. That was found to be a breach of the General Medical Council's guidance and he was found to be guilty of serious professional misconduct. The Council reprimanded Dr White for that conduct.

54. We note that notwithstanding that finding, in 2005, the Trust took no disciplinary action against Dr White, although he did stand down voluntarily from a management position. Dr DeHavilland draws our attention to the discrepancy between the way in which Dr White was treated and the way that his wife was treated. The point, however, that we wish to make at this stage of our Judgment is that if Dr White is a man capable of an act of bullying of Dr Tobin, in that way, we could only conclude that he was capable

of behaving in the same way to Dr Michalak.

55. We then turn to the evidence of Mandy Williamson. She held the position of Trust Medical Staffing Manager, a senior HR position. She is a Fellow of the Chartered Institute of Personnel and Development and subject to a Professional Code of Conduct. This requires her to exercise integrity, honesty, diligence and appropriate behaviour in their activities and not to act in collusion with others to engage in unlawful conduct. Notwithstanding those principles, on her own admission she colluded with Dr Dawson to deliberately mislead the Claimant and other supervisory bodies. To her credit, on the other hand, she was perfectly frank in accepting that she had behaved in that way when challenged by Dr DeHavilland in cross examination.

56. Another recurring feature in the evidence that we heard in this case relates to the issue of diversity. We are told that approximately 50% of the consultant body within this Trust comes from non-White/British or Irish ethnic origins. It is accepted that, therefore, the composition of any of the management, disciplinary or supervisory panels or committees that exist within this Trust should, in general terms, reflect that diversity, acknowledging that a "quota system" would not be desirable. It is a striking fact that, as we considered the evidence in this case, such bodies that had dealings with the Claimant were composed entirely or predominantly of White/British people.

57. The final point that we wish to raise at this stage is perhaps one of the most astonishing features of this case. As an Employment Tribunal we are, of course, very used to dealing with complaints of unfair dismissal. Whatever findings we make in such cases we rarely have difficulty in finding out why the person who made the decision to dismiss arrived at that decision. Employers are, in our experience, always able to explain why they decided to dismiss the employee involved because, when all is said and done, that it what they have come to the Tribunal to do.

58. This Tribunal heard evidence from three of the four members of the disciplinary panel who decided to dismiss the Claimant; Mrs Squire, Dr Naftalin and Mrs Brain-England. They had all agreed the terms of the letter of dismissal that was sent to Dr Michalak. When, however, each of them was asked, in cross-examination, to explain what events they had found to have taken place to justify the findings recorded in that letter of dismissal, they all had the greatest of difficulty or were unable to do so. When pushed, sometimes they would guess. When they were then taken to the relevant facts they had to accept that there was no basis for such a finding. It was, to us, astonishing that three professional and eminent people had arrived at a decision to dismiss a senior member of the clinical staff without having any apparent understanding as to why they were doing that.

59. Of course there had been a significant passage of time between those events and these witnesses being called to give evidence. That however does not explain this lack of understanding. They had all the documents available to them with which they could have refreshed their memories.

Witness statements were taken from them much closer to this Hearing and they must have known that this was a matter that they were going to be asked about.

60. Accordingly when we now proceed to look at the history of events leading to this Tribunal Hearing we have to keep in our mind that three of the most senior members of management, the Chief Executive, the Medical Director and the Head of Human Resources, are prepared to say things which are clearly untrue, that Dr White is a man with a record for making unfounded criticisms against a professional colleague and that, at the end of the day, those who decided to dismiss the Claimant could give no cogent evidence as to why they had arrived at that decision. We have to wonder why the managers and senior clinicians who played a part in the ending of the Claimants career were so unrepresentative of the Cultural Diversity within this Trust.

Background

61. The Claimant, as we have already recorded, was born in Poland. She was trained in the faculty of medicine in Lodz, where she received a Diploma with Distinction and the accolade of being "the best student". In 1990 she completed a Post-Graduate study, whereby she was awarded a Diploma of Specialist in General (Internal) Medicine, and received a PHD for a thesis on "Studies on Properties of Platelets in Chronic Renal Failure". Between 1991 and 2000 she enjoyed various positions at various hospitals in Great Britain. Those positions demonstrated her specific interest in nephrology, some of those positions involved fixed-term contracts.

62. In the year 2000 she was granted an entry on the Specialist Register in General (Internal) Medicine, which entitled her then to apply for Consultant posts. By reason of the fact that her training had been mixed both within and without the UK, for technical reasons, she could not apply for the position of Consultant Nephrologist, even though the Joint Committee on Higher Medical Training accepted that she was well trained and would be able to hold down such a Consultant position.

63. The Respondents had opened a Medical Admissions Units within their hospitals, including the Pontefract General Infirmary ("PGI"). It may be helpful, at this stage of our decision, to explain the purpose of a Medical Admissions Unit ("MAU"). Patients are admitted into a hospital from two sources. Many are admitted through the Accident and Emergency Department; some are admitted by direct referral from a General Practitioner. Before the advent of MAU's such patients would often find themselves waiting for lengthy periods of times whilst they were assessed and either treated appropriately or admitted onto an appropriate ward. This led to all the stories that this Tribunal recalls of people waiting for many hours on trolleys in Accident and Emergency Departments or in corridors waiting to be allocated to an appropriate ward, made difficult because of a bed shortage.

64. In order to improve patient care and, we understand, to assist the

Respondent Trust in meeting Government targets as to the length of time that patients remained within an Accident and Emergency Department, the MAU was created. Initially, in Pontefract, this was a seventeen bed ward, to which patients would be admitted either when referred by the GP or would be transferred to from the Accident and Emergency Department once they had been assessed. The purpose of the admission onto the MAU was, firstly to carry out a more detailed assessment of the patient, and then to decide whether they could be treated and discharged to the care of their General Practitioner or should be admitted onto a specialist ward. Under the guidelines that applied, patients should not remain within the MAU for more than 24 hours.

65. Prior to the Claimant's appointment, the MAU was staffed principally by Junior Doctors, but the Consultant Physicians would make a twice daily ward round in order to make the final decisions to enable the patients either to be treated and discharged, or to be transferred to an appropriate ward. It is common ground that doing a ward round on the MAU is hard work. As we understand the position where a Consultant does a ward round on, for example, a general medical ward, he may have seen a number of the patients on that ward already. He will be well aware of their condition and a treatment plan will already have been determined and will be in course of operation. There will of course always be some new patients who require a more detailed assessment.

66. On the MAU, however, practically every patient seen on a ward round would be a new patient. Their condition may be obviously acute or apparently less serious. Quick decisions have to be made. The success of the MAU depended upon the Consultant doing the ward round making a rapid and accurate assessment and moving the patient out of that ward as quickly as possible, preferably, if appropriate, by discharging home.

67. The Respondents decided that there would be a more efficient use of the MAU if Consultants were appointed who had specific responsibility for that ward. The Claimant applied for that position and was appointed on 29 April 2002. Appointed with her, was her colleague, Dr Abbasi. The Claimant was interviewed and appointed by Dr White. Her special interest in nephrology was noted. Pontefract did not have a Renal Unit and referred their renal patients to St James' Hospital. Dr White was happy to encourage the Claimant's special interest with the hope that, in due course, a Renal Unit could be developed within the Respondent Trust.

68. Consultants work according to what is known as a "job plan". They are required to perform, and they are paid for, a certain number of "professional activities" ("PA's") per week. Complex negotiations sometimes have to take place before the job plan can be agreed. In the Claimant's case her initial job plan involved doing three ward rounds per week on the MAU, these dovetailed in with the ward rounds carried out by Dr Abbasi, she would do a number of outpatient clinics, she would have an on-call requirement, she was permitted time to attend at St James' Hospital to do clinics in their Renal Department and she was permitted time to perform administrative functions and personal study.

69. Junior Doctors working within a hospital can be divided into two types. There are Training Grade Doctors who, essentially, have been found a place in the hospital through an organisation like the Yorkshire Deanery, they are employed by the hospital but the purpose of that employment is to enhance their training, so that they can move up through the various grades of junior Doctor through becoming a Registrar and then ultimately, hopefully, achieving the status of Consultant.

70. There are then Staff Grade Doctors. These Doctors are not, essentially, predetermined to promotion, although of course promotion opportunities are available to them. It is not assumed that a Staff Grade Doctor will aspire to become a Consultant, although again that is possible.

71. As far as the MAU was concerned within the terms of their agreed Job Plan Dr Michalak and Dr Abbasi were responsible for operating the Unit during the day, assisted by two SHO's who worked within the Unit, on rotation, on a full time basis. At night the Unit was managed by a Registrar, with the assistance of other Junior Doctors who were again assigned to the Unit on rotation but often for a much shorter period. One of the nine Consultant Physicians,(including Dr Michalak and Dr Abbasi) would be on call during the night to render assistance to the Registrar, if necessary.

72. There was a hand over period when either Dr Abbasi or Dr Michalak arrived in the morning. The Registrar would normally have left the ward by that time. They would receive a report from the Junior Doctors who had been on duty all night as to the status of each of the patients, and it was expected that the Junior Doctors would then accompany the Consultant whilst they carried out a ward round. During the ward round instructions would be given to the Junior Doctors working during the day to arrange for the necessary tests to be carried out, treatment to be given or a bed to be found in an appropriate ward.

73. Thus Dr Michalak's actual contact with Junior Doctors fell into two parts. She had plenty of contact with those who worked during the day on rotation, but minimal contact with those who worked overnight, save for that brief handover period. One of the sources of contention that arose within the MAU involved this handover process. From Dr Michalak's perspective, it was important for the Junior Doctors to accompany her whilst she saw those patients that had been admitted overnight so that, firstly the Junior Doctors could provide her with a detailed history, and secondly so that Dr Michalak could fulfil the obligation that every Consultant has towards Junior Doctors, which is to provide a training experience to them.

Criticism of Training Style

74. The Junior Doctors, of course, had been at work all night. They were anxious to get home to their beds. There were occasions when they were due to start leave the following day and when, improperly, they would have left the ward before Dr Michalak arrived to start her working day. As a consequence of these problems, on 24 July 2002, both Dr Michalak and Dr

Abbasi wrote to Dr Harvey, the Director of Medical Education at the PGI, pointing out that many of the Junior Doctors were missing the morning ward round and bringing some specific examples to his attention.

75. That letter received a constructive response from Dr Harvey, which raised some of the practical difficulties that had arisen as a result of the reorganisation of the MAU, the conflicts that the Junior Doctors felt in meeting their obligations to Dr Abbasi and Dr Michalak, whilst at the same time attending to other professional responsibilities that they had and it raised some concerns as to the teaching experience that the Junior Doctors reported. The letter says:-

> *"There was a strong sense from the whole PRHO Group* (that is Pre-Registration House Officers) *that they were sometimes humiliated in the ward round setting where contributions that they had made were openly criticised in front of patients, relatives and nursing colleagues. It is well recognised that learning is unlikely to occur in that context. Having responsibility for the quality of Junior Doctors' learning experience I would ask for a review of the teaching style on the MAU ward rounds and I would be happy to discuss this aspect with you further."*

76. Dr Harvey then went on to make some useful suggestions as to the way in which some of the practical difficulties could be resolved. That letter was copied to Dr White, as Clinical Director.

77. On 4 September 2002 Dr White received another letter from Dr Munroe, the Junior Medical Doctors' Representative, complaining about other difficulties that the junior medical staff on the MAU were experiencing. This is related to the fact that junior staff arriving at 5:00pm discovered that patients who had been admitted had not yet been reviewed by a Consultant, and that the daytime ward rounds were felt to be unnecessarily long. There was a concern that MAU Consultants were using Clinical Incident Forms as a means of raising complaints against Junior Doctors.

78. The Trust have a process whereby if any member of staff observes circumstances which, in their view, may give rise to a clinical risk to patients, they are entitled to complete a Clinical Incident Form which then has to be reviewed and investigated. The Trust's procedures are such that this is not meant to be a blame process but a means whereby the Trust can identify areas of risk to patients and take appropriate steps to ameliorate those risks.

79. Dr Munroe complained about the fact that Junior Doctors were being expected to provide cover in the Accident and Emergency Department, that, as had been agreed, the MAU Consultants were not taking responsibility for patients who had been transferred to the High Dependency Unit and there were concerns expressed about the nature of duties that had been allocated to Staff Grade Doctors.

80. It has to be said that none of these areas of concern expressed by Dr Harvey or Dr Munroe makes specific reference to Dr Michalak and their

comments may equally refer to Dr Abbasi. It is also clearly the case that some of these concerns simply arise from structural difficulties within the Trust as a whole.

81. On 11 and 12 September 2002 the PGI was visited by an external assessment team from the Royal College of Physicians. In their subsequent report they raised particular concerns in relation to the MAU at Pontefract. The report states:-

> *"There are major concerns about the experience of the SHOs on the Medical Admissions Unit at Pontefract."*
>
> "*The routine and culture established on MAU at Pontefract however militates against good experiential learning."*
>
> *"All who had worked on MAU at Pontefract recently had reservations about their time."*

When speaking about the two full-time Junior Doctors within the MAU, the inspection report says as follows:-

> *"The team has serious concerns about these two posts, with duties on the MAU at Pontefract. There is an expectation that all the staff, which also includes Nurses, should accompany the MAU Consultant on duty on both the morning and afternoon weekday ward rounds. Programmed to start at 8:00am, the morning rounds may not begin until 9:00am and continue for two to three hours for a maximum of seventeen patients, not all of whom will be new or unduly complex. The overnight SHO leaves as contracted at 10:00am. However as the later round is at 3:30pm, it effectively compresses the working day to this limited window, patients build up un-clerked and discharges are delayed. The SHOs find this and the teaching style adopted extremely stressful. In addition, there is a culture of completing Incident Forms for even the most minor of infringements, such as failing to tick a box on a TTO Form and adverse comments to patients about SHOs which has become very threatening. There are major hazards for the experiential learning of the SHOs and presumably, because of the impact on the patient pathway through the hospital, serious implications for the admission, care and discharge processes for patients in medicine."*

It is clear that some of these concerns seem to relate to the changes which came about when Dr Abbasi and Dr Michalak were appointed. Prior to their appointment the morning ward round was done by the on-call Consultant who was available to begin his ward round at 8:00am. The Junior Doctors were due to leave work at 10:00am and accordingly they had time to accompany the on-call Consultant whilst completing his ward round within their normal working hours. Dr Abbasi and Dr Michalak were not, however, due to start work until 9:00am. That accordingly had a knock-on effect on the Junior Doctors and their working hours.

82. In due course the contents of this report were used by the Respondent as evidence of the Claimant's inappropriate conduct towards Junior Doctors. Whilst not being specifically made within the report, it was suggested that she was responsible for completing these Clinical Incident Forms inappropriately. These documents are of course stored by the Respondent, but at no time have any such documents been produced by them to show that Dr Michalak was responsible for behaving in this way.

83. Dr Michalak is also said to be responsible for providing Junior Doctors with a threatening and inappropriate learning experience. The handwritten notes of that inspection have however been provided in the process of discovery. These notes include what appear to be the interview of the two Junior Doctors who were allocated to the MAU during the day. These notes record the following comments:-

> *"Michalak starts late goes on three hours."*
>
> *"Too detailed style of teaching not conducive to learning. Too exposed in front of others."*
>
> *"Filling in Incident Forms on minor events. Do not feel comfortable."*
>
> *"Starts 8:30 finish 12:30."*

84. Those notes also make reference to other accepted concerns that the Junior Doctors had, namely that PGI did not have access to an Intensive Care Unit and that there was a shortage of Nurses.

85. We heard much evidence in relation to the length of Dr Michalak's ward round. It was suggested that her ward rounds took three to four hours each, which were thought to be far too long. There would be on average seventeen patients to be seen on each ward round. We were taken to the Royal College of Physicians' guidelines which suggested that a Consultant should take about fifteen minutes with each patient on a ward round. Those guidelines were described by Dr White as being "aspirational". It was however conceded that if a Consultant were to take fifteen minutes with each of seventeen patients, they would be taking up to four hours to complete a ward round.

86. Some of these concerns were discussed at a Consultants' meeting that took place on 12 September 2002 at Dr White's home. The Consultants, collectively, agreed that when two additional Staff Grade Doctors were appointed to the MAU (which in the event did not occur) their job plan should incorporate a late start and finish to enable them to review patients into the evening. It was agreed that if the MAU Consultant was not able to do a ward round on a Monday morning (which at this point in time was the responsibility of the on-call Physician) then that ward round should be done by one of the MAU Staff Grade Doctors, thus relieving the on-call Physician from that responsibility. It was also agreed that patients admitted into the HDU were no longer the responsibility of the MAU Consultant, but would be the responsibility of the on-call Consultant.

87. The Respondents took the complaints relating to the Claimant's alleged training style seriously and shortly after this inspection a meeting took place between Dr Michalak, Dr White and Mr Neil Woodhall, the manager of the Pontefract General Infirmary. It is clear that Dr Michalak constructively discussed these issues and agreed to attend regular meetings with the Junior Doctors, on a monthly basis, in order that any concerns that they may have could be raised and dealt with. This process would be overseen by the Medical Director, Dr Harvey, and it was acknowledged that some of the problems related to the introduction of the two MAU posts and the necessary bedding in period.

88. It is acknowledged that the Claimant fully participated in these monthly meetings, and by 22 November 2002, Dr Harvey wrote to a Dr Anderson, part of the inspection team, saying:-

> *"Taking soundings from the SHOs indicates that they are much happier with the ward round style on the MAU and the major issues that came up in the first meeting were around sustaining continuity of patient contact in order to facilitate learning from experience."*

Complaints begin

On 17 September 2002 a complaint was received by the Respondents from the wife of a patient admitted onto the MAU alleging that Dr Michalak had behaved in a highhanded and an offensive manner towards her. The Claimant gave a detailed response to this complaint, as did other people who were on the ward and observed the incident in question. It should be noted that her colleagues supported Dr Michalak's version of events, as a consequence of which no action was taken against Dr Michalak.

89. Rather curiously, on 22 November 2002, Mr Woodhall, the Hospital Manager, wrote to Val Baron, the General Manager in Medicine at the Pontefract General Infirmary, drawing her attention to, what was perceived to be, a high number of Dr Michalak's outpatient clinics having being cancelled. Mr Woodhall could not explain to us how these concerns had been brought to his attention, nor indeed what the outcome of Mrs Baron's subsequent investigations were. On closer scrutiny, in cross-examination, it would appear that some of the allegedly cancelled clinics were not in fact clinics that the Claimant was due to conduct and that others were cancelled for perfectly legitimate reasons, for example that the Claimant was taking annual leave or study leave.

90. On 10 December 2002 Dr Hussain, a Consultant Physician with a special interest in the elderly, wrote a letter of complaint to Dr White. Although not specifically naming her, this complaint appears to relate to Dr Michalak and related to the treatment given to a seriously ill patient admitted on the MAU. Subsequently Dr White investigated that matter, expressed the view that Dr Michalak's treatment of the patient was entirely appropriate, that Dr Hussain's treatment was unnecessarily and pointlessly heroic and suggested that Dr Hussain was exhibiting "prejudice" to Dr Michalak.

91. On 28 January 2003 a meeting took place between Dr Michalak, Dr White and Val Baron. It was agreed that Dr Michalak would begin work at 8:30am to enable the ward round to start sooner. There was discussion about Dr Michalak's special interest in nephrology, her attendance at St James' Hospital each Wednesday was referred to and she was told that at that point in time the Pontefract General Infirmary could not provide a clinic room for her to enable her to carry out a Renal Clinic at Pontefract. In a letter confirming that meeting of 18 February, Val Baron made reference to the fact that:-

> *"You found it difficult to acknowledge that there are occasions when colleagues find your behaviour towards them less than conducive to creating an effective working environment. However you did accept that this is their perception and agreed to make every effort to address this. This behaviour is particularly difficult for junior medical staff and nursing staff to deal with and we agreed that, as the Consultant, it is up to you to ensure a harmonious working environment is created."*

92. We note that at this stage there had been few, if any, specific matters of complaint that have been held to be justified in relation to Dr Michalak. In those circumstances it is rather surprising that the letter goes on to say:-

> *"If there is no evidence of any change at that time, then unfortunately we may be in a position where we have no alternative but to take this to a formal stage."*

It is not clear to us on what basis possible disciplinary action was being threatened at that stage.

93. On 2 March 2003 a Junior Doctor, Dr Myers, wrote a letter of complaint to Dr White. In his letter he seemed to be complaining that senior clinical staff would ask him to treat patients in a way that he disagreed with, that senior advice was not always available. As a consequence he felt exposed and was seeking to restrict his time in the MAU to three months, rather than six. He then complains about being blamed for a clinical incident which had nothing at all to do with him. The Respondents suggest that this complaint may, in some way, relate to Dr Michalak, but it is unclear why that should be the case and at any event we are unaware that any action was taken in relation to this complaint.

94. In the meantime, the Claimant had discovered that she was pregnant. She was due to commence her maternity leave in May 2003. It appears that her pregnancy was not straightforward and towards the end of her pregnancy she would sometimes carry out her ward rounds in a wheelchair. Rather surprisingly although Dr White was aware that this had happened he did not perceive it to be a problem.

The First "Secret" Meeting

95. On 19 March 2003 a meeting took place between Colin White, Val Baron and Emma Lavery. Ms Lavery was the Corporate HR Manager. Ms Lavery took and kept notes of that meeting. All these people are White/ British people. Dr DeHavilland speaks of this meeting as being a "secret" meeting, in that the Claimant was not at the time made aware that the meeting had taken place and only discovered that it had, much later on when discovery of documents was being provided to her.

96. The notes begin, clearly, by explaining the purpose of the meeting in the following terms:-

> *"CW and VB raised concerns re EM performance/conduct.*
>
> *Her approach, attitude, demeanour, clinical competence, relationship with Consultant colleagues poor.*
> *Complaints from Consultants and juniors.*
>
> *Un-co-operative.*
>
> *Unhelpful.*
>
> *Difficult.*
>
> *Not flexible.*
>
> *Not fulfilling job plan/duties.*
>
> *Agreed contract leaves one fixed session per week without consulting with CW or VB.*"

97. Dr White told us that he and Val Baron had initiated that meeting. They knew that at that time the Claimant was 7 ½ months' pregnant, but denied that that had any relevance to the reason for this meeting.

98. We do not understand what matters relating to her performance/conduct had been raised or had given cause for concern. We have not been told what issues of clinical competence were being questioned. We do not know which Consultant colleagues, except for Dr Hussain, it was alleged the Claimant had a poor relationship with. Dr White of course concluded that Dr Hussain's complaint about Dr Michalak was groundless. Complaints relating to Junior Doctors had been made, these had been addressed by Dr Michalak and significant improvements had been noted by the Respondents. We do not understand on what basis it was being said she was un-co-operative, unhelpful and difficult and, in cross-examination, neither Dr White nor Ms Baron were able to provide examples. It is not known how it is alleged that the Claimant was not fulfilling her job plan, and it clearly was the case that Dr White knew that the Claimant was carrying out one fixed session per week at Leeds, this was done with his full support and knowledge.

99. The note goes on to read:-

> *"Appointed May 2002 from properly constituted AAC. No restrictions on duties/development plan identified at interview. References checked. Appointed wholly into post. Advised we need to therefore live with this decision and be seen to support and develop EM before take down any formal route."*

100. There is absolutely no doubt to this Tribunal what those words make reference to. Ms Lavery admitted that in advance of this meeting, at the request of Dr White and Ms Baron, she had retrieved the records relating to the Claimant's initial appointment. We have no doubt whatsoever that Dr White and Ms Baron were hoping that some irregularity could be found in Dr Michalak's initial appointment in order that the appointment could be brought to an end. When Ms Lavery reported that the decision to appoint Dr Michalak had been a regular and unimpeachable one, she advised Dr White and Val Baron that they would "*need to live with this decision*". Each of the Respondents who attended this meeting denied that that was the intention but could not give any meaningful alternative meaning to these words. We see no difficulty in giving the words their natural meaning.

101. The alternative strategy was then agreed upon, namely that management should be:-

> *"Seen to support and develop EM before she is taken down any formal route*."

102. The words "*seen to*" can only have one meaning despite the Respondents protestations to the contrary. That is that Dr White and Ms Baron had no real intention of supporting or developing Dr Michalak, but they had to behave in such a way as to give that appearance. The plan clearly was to find a "*formal route*" whereby the Claimant's employment could be brought to an end.

103. The note goes on to read:-

> "*Failings became apparent shortly after appointment. Colin and Val been meeting with EM regularly and documented their concerns to her. Feel no improvement is being made. EM does not accept any failings in herself. My impression was that EM was not coping in her role and reacting aggressively to cover this up. Behaviour damaging though as senior position and VB and CW felt some action had to be taken."*

104. We do not know, nor has anybody provided an adequate explanation as to the events that had occurred that were so serious to justify the holding of this meeting and those views being expressed about her.

105. The note goes on to read:-

> "*I suggested VB inform EM they felt she was not coping with role and strongly encourage her to meet with mentor CW to identify.*
>
> *Also to undertake appraisal where performance issues could picked up in a positive developmental way to allow EM opportunity to discuss how she feels is performing and what she expects in support from role. Need to exhaust these measures initially."*

These were clearly the means whereby the Respondents could be "*seen to*" provide support to the Claimant. The note then reads:-

> *"Polish origin. Prior to appointment worked as Consultant in London hospital*."

106. This was the first of a number of occasions when the Claimant's ethnic origin, or the fact that there may be "*cultural issues*", were matters discussed by members of senior management and senior clinicians within this Trust. Dr DeHavilland, understandably, places considerable emphasis upon these comments as providing a basis for the proposition that the Respondents' conduct towards the Claimant was influenced by her ethnic origin. Repeatedly the Respondents' witnesses have denied that to be the case.

107. The universal explanation provided to the Tribunal by a number of these managers is that they wondered whether the fact that the Claimant had trained in Poland would have had an impact on the way that she related to her colleagues, Junior Doctors and to patients. It was suggested that the culture within the medical profession in Poland may have been akin to that that had once upon a time existed within the National Health Service, whereby Medical Consultants were regarded as being all important and invulnerable to challenge by junior members of staff and patients alike. It was wondered whether these attitudes prevailed within Polish hospitals and, if so, whether that explained the Claimant's behaviour.

108. Dr Nagar, indeed, gave an example of his thinking in that regard. He told the Tribunal that he was born and brought up in India, moving to the UK to practice medicine. He described how, when two Indian people are having a conversation with each other, it is very common for one to point their finger at the other in order to provide emphasis to a point that they are seeking to make. When Dr Nagar came to the UK and began to practice medicine, he behaved in that way to colleagues and to patients. A colleague then had a quiet word with him to explain that in our culture pointing a finger in that way could be seen as an act of aggression. He took that advice on board and adjusted his behaviour accordingly.

109. The problem with using that as an example as to the alleged concerns that the Respondents had about Dr Michalak, is that it is accepted that nobody, at any time, had that "quiet word" with Dr Michalak. Nobody, at any stage, sought to investigate whether the culture within Polish hospitals was of that type. Nobody spoke to Dr Michalak about that.

110. Ms Lavery's notes conclude with the following words:-

> *"To pick up on EM's return from maternity leave. May then proceed to formal route. Is it personal or professional misconduct? What is seriousness of clinical incompetence? Risk?"*

This note can only have one meaning, namely that Dr White and Ms Baron were agreeing that after the Claimant returned from maternity leave they would begin a process that may amount to a formal route leading to the termination of her employment.

Maternity Leave and "Happy Pay"

111. The Claimant then went on maternity leave on 12th May 2003. This of course was just over a year after her appointment started. We do not lose sight of the fact that she was appointed in order to relieve the General Physicians of the need to carry out regular ward rounds on the MAU. Dr DeHavilland suggests that the predominantly male body of Physicians would have been less than happy about the prospect of having to resume these ward rounds in order to provide cover during Dr Michalak's absence. It would appear that Dr Michalak may have been the first Consultant within this Department to enjoy the benefits of maternity leave.

112. There appeared to be no need for them to do so. On 6 June 2003, at a "Key Players' Meeting" it was reported that the Trust had advertised for a Locum Consultant and, by 5 September 2003, the same "Key Players" noted that a Dr Sooltan had taken up post on Ward 11 with sessions on the MAU for a period of six months as a Locum. It was noted that Dr Michalak was expected back to work in mid-October/November.

113. Various of the Respondents' witnesses have suggested that although Dr Sooltan was appointed to provide cover during Dr Michalak's absence, that he did not, to any material respect, do so. Indeed one witness suggested that he was found to be insufficiently competent to be able to work on the MAU. Those propositions are simply without foundation. We received detailed evidence from Mr Sean Garside. He was the manager for the General Medicine Directorate and, at the relevant time, he was based at Pontefract. He was involved in the management of the MAU during Dr Michalak's maternity leave. In cross-examination he accepted that Dr Sooltan covered all of Dr Michalak's ward rounds on the MAU, and indeed continued to do those ward rounds after her return when Dr Abbasi then took extended leave.

114. Notwithstanding the fact that Dr Sooltan was providing that cover, the Consultant Physicians believed that they were entitled to additional payments because of some notional additional work that they may have to do. They persuaded Val Baron to authorise these additional payments and on 27 August 2003 she wrote to the Payroll Department in the following terms:-

> *"During the maternity leave of Dr Eva Michalak, we have been unable to secure Locum cover. In view of this, the Consultant*

Physicians participating in the Acute Medical Rota have agreed to undertake additional ward rounds on the Medical Assessment Unit."

115. Ms Baron was wholly unable to explain how she could have written a letter in those terms when Dr Sooltan had commenced working on the MAU on 11 August.

116. Ms Baron then goes on to request that an additional payment of one session per week be paid to eight named Doctors, namely Dr White, Dr Wong, Dr Bangad, Dr Brooksby, Dr Johnson, Dr Hussain, Dr Sahay and Dr Lewis. This notwithstanding the fact that Dr Brooksby and Dr Lewis were Cardiologists who never did ward rounds on the MAU. She also authorised payment for two additional sessions per week to Dr Copeland. Thus, Ms Baron secured for those nine Doctors payments for ten sessions per week to cover the Claimant's ward rounds, when she was only, prior to taking maternity leave, doing four ward rounds, as well as taking her turn as the on-call Physician at a weekend. Even without the appointment of Dr Sooltan these additional payments would appear to have been excessive but with his appointment they are obviously almost entirely without justification. Dr White, who gave evidence, certainly was not able to identify any additional work that he had to do as a result of the Claimant's absence on maternity leave. To make matters even worse, Ms Baron authorised two additional sessions per week to be paid to Dr Abbasi for the period 1 May to 31 July 2003 and an additional session per week from 1 August 2003 to be reviewed on 31 October.

117. There was a further inspection of the MAU by the Yorkshire Deanery in October 2003 whilst the Claimant was on maternity leave. That report suggested that the training of Registrars had improved and, at some point, it was suggested by the Respondents that this demonstrates the problems had been caused by the Claimant in that things improved during her absence. In reality the reason for the improvement was that the timing of ward rounds had changed during her absence, so that Registrars could take part.

118. Dr Michalak returned from maternity leave on 17 November 2003. Dr Abbasi then left to take annual leave and Dr Michalak entered into correspondence with Mr Garside as to the job plan that would apply for herself and Dr Sooltan during his absence. In her letter of 19 November 2003 she specifically reminds Mr Garside of her need to attend meetings at St James' Hospital on a Wednesday afternoon and to attend the Renal Clinic at St James' Hospital on a Friday morning. It was also agreed that to assist the Claimant in childcare arrangements, she would work compressed hours, which meant that she would not be required to attend work on a Wednesday morning, but would work additional hours to make up for those lost hours during the remainder of the week.

119. Dr Michalak attended a Key Players' Meeting on 5 December 2003. At that meeting she discovered that these additional sessional payments (which Dr DeHavilland called "Happy Pay" although the genesis of that term is far from clear) had been made to her colleagues during her absence. She asked if she was entitled to those additional payments and was laughed at. It

seemed clear to the Claimant that these additional payments were being made for little or no work, and that accordingly they amounted, effectively, to a pay rise. She contacted Ms Baron and asked that those additional payments should be made to her and and she was told that she was not entitled to them.

120. She felt that she was being treated less favourably by reason of the fact that she had been absent on maternity leave. She raised this complaint with Dr White, and on 26 January 2004, wrote to him confirming the nature of her complaint. In that letter she describes her complaint as being *"for unfair treatment upon my return to work from maternity leave*". She sets out the history of events as she understood them to be, and makes the following complaint:-

> *"I believe that this approach directly discriminates against me in comparison to my MAU colleague, Dr Abbasi, who during many months received additional remuneration in connection with changed working practices.*
>
> *In summary I wish to stress that I believe from the day of my return from maternity leave I am entitled to have my contract amended in a similar way as my colleagues."*

121. Dr DeHavilland points out that, unknown to Dr Michalak, on 19 March 2003 Dr White attended a meeting, at the conclusion of which it was agreed that when the Claimant returned from maternity leave, a procedure would begin to take her down a formal route leading to her dismissal. During her absence Dr White benefited from additional payments, which allegedly were worth something in the order of £5,000 per annum. Within two months of her return, the Claimant raises with him a formal complaint about the inappropriateness of these payments and demands that the payments are made to her as well.

122. It must also be born in mind that this Trust was in special measures having been criticised for poor financial management. Here was a comparatively newly appointed Consultant raising the issue of these payments which both Dr White, who had benefited from them and Val Baron, who had authorised them, knew to be unjustified. We have absolutely no doubt that these complaints must have caused them both anger and apprehension and no doubt also was to lead the Claimant subsequently to be described as a turbulent individual.

123. Having returned to work and having lost the services of the Locum, Dr White took on the complex task of trying to agree a job plan for both Dr Michalak and Dr Abbasi. The task was made all the more difficult by reason of the requirement to ensure that there was complete cover for the MAU, the need to meet Dr Michalak's aspirations in relation to doing renal work at Leeds and the need to dovetail her job plan with that of Dr Abbasi in order to provide the necessary level of cover in the MAU. On 9 March 2004 Dr White wrote to Dr Michalak effectively imposing his view upon her as to the appropriate way forward, telling her that if she did not like it was up to her to

appeal. That led to a lengthy and detailed response from Dr Michalak which ultimately resulted in an agreement being reached between her and Dr Abbasi. It was subsequently to be suggested that the Claimant was un-co-operative with her colleagues and made difficulties in relation to her job plan. This evidence however would appear to contradict that proposition.

124. By this stage therefore the Claimant was attending St James' Hospital on a Wednesday afternoon in order to attend a Multi-Disciplinary Team Meeting and was attending a clinic at St James' Hospital on a Tuesday afternoon. On 15 April Dr Newstead, the Consultant Renal Physician at St James', wrote to Dr Michalak proposing that over the course of the following three to four months Dr Michalak's attendance at the Tuesday clinic in Leeds should phase out and would be replaced by setting up a Specialist Nephrology Clinic in Pontefract. One difficulty that should be noted in relation to nephrology, as a specialism, is that treatment options normally involve a team of people of different specialities, such as Dieticians, Transplant Surgeons and Nephrologists. It was, therefore, always known that it would be difficult for Dr Michalak, in isolation, to be running a Nephrology Clinic in Pontefract. On 13 May 2004 Dr Newstead wrote to Dr White setting out that proposal to him and making it clear to Dr White why it was that Dr Michalak's clinics in Leeds would begin to run down.

Further Complaints

125. On 26 April three Ward Sisters on the MAU wrote collectively to Dr White complaining about the fact that sometimes ward rounds did not start until late morning, that sometimes ward rounds went on for too long and that, as a consequence, they had difficulty in fulfilling their obligation to transfer patients out of the ward as quickly as possible. They indicated that they were going to monitor the current position and accumulate information.

126. On 3 May 2004 somebody completed a Clinical Incident Form by reason of the fact that Dr Michalak was late arriving for the morning ward round. She had telephoned to say that she was going to be an hour late, arriving at 10:00, in fact she did not arrive until 11:15. We understand that the explanation for that was that she had childcare problems. We do not quite understand why a Doctor arriving late for a ward round justifies completing a Clinical Incident Form.

127. On 25 May 2004 a curious letter of complaint was written by the College Lane Surgery, a GP practice, to Dr White. The history behind that complaint lay in a letter of referral from the College Lane Surgery to the Department of General Medicine, at the Pontefract General Infirmary, dated 22 March 2004. This letter of referral was passed on to Dr Michalak. Dr Hanney was requesting a Consultant to see a 56 year old patient. He was described as suffering from fibromyalgia and depression. Fibromyalgia is a condition where a patient complains about pain, without any apparent physical cause, and the Doctor believes the complaint to have a psychiatric or psychological causation. Dr Hanney described the patient's symptoms as feeling terrible, saying that his "system just shuts down" and that he has a sensation of "something sending poison around his system". He was a patient who was

already being treated by a Consultant Psychiatrist and Dr Hanney concludes his letter by saying:-

> "*I am not sure what you can do for Mr H but I would be grateful for your assistance*."

128. Dr Michalak responded to Dr Hanney by letter of 7 April 2004. Not unreasonably she suggested that the patient was suffering from a psychological illness that should properly be referred to a Psychiatrist. She suggested that the symptoms described indicated a more severe psychotic disease, rather than just depression.

129. Dr Hanney responded on 23 April. He expressed agreement that the patient in question was suffering from a psychological illness, that he was being treated by a Consultant Psychiatrist, who was well aware of these symptoms. He provided Dr Michalak with the results of various tests that had been carried out upon the patient, all of which were, essentially, normal. Dr Hanney explained that:-

> "*As this gentleman has requested a referral I have little option but to refer him*."

130. Dr Michalak telephoned Dr Hanney on 26 April. She explained that if it was accepted that the patient's symptoms were as a consequence of his psychiatric state it made little sense to refer him to Physicians. It was Dr Michalak's understanding that Dr Hanney accepted that proposition, that the necessary information had been passed on to his psychiatrist and that, in addition, Dr Hanney was going to seek a referral from the Gastroenterology Department (which had nothing to do with Dr Michalak's speciality).

131. On the face of it therefore, it would appear to us that this was a GP under pressure from his patient to make a referral which both Dr Michalak and the GP accepted was not an appropriate referral. The GP's concern was to try to placate a difficult patient; Dr Michalak's concern was to not waste valuable NHS resources by seeing a patient to whom she had nothing at all to offer. In those circumstances, we find it difficult to understand the terms of a letter of complaint, signed by all five of the Partners of the College Lane Surgery, which includes the following:-

> "*We would like to express our disappointment with the Medical Department at PGI for the reluctance of one of its Consultants, Dr Michalak, to see and assess a patient who was formerly referred to the Department by Dr I Hanney on 22 March 2004.*
>
> *We feel Dr Michalak pre-judged the situation, despite having never seen or assessed the patient and may have deemed the referral "inappropriate" because the patient had a psychiatric problem. The patient was under the care of Dr E Millar, Consultant Psychiatrist at Fieldhead Hospital at the time, and this was clearly stated in the referral letter."*

132. When cross-examined as to this issue Dr White suggested that, as a matter of courtesy, if a GP sends a referral that patient should be seen by a Consultant. He did however accept that Dr Michalak was unlikely to be able to offer this patient any meaningful assistance. We do not, in those circumstances, understand why Dr White thought it appropriate, on 3 June 2004, to respond to Dr Hanney by saying:-

> "*Please accept my assurance that I will be taking this up with Dr Michalak in the strongest terms*."

133. We do note that Dr White was clearly on first name terms with Dr Hanney, amending the letter of 3 June to show that to be the case, and when cross-examined he accepted that he knows Dr Hanney and that he believes him to be a good General Practitioner. Although Dr White, when put to him, denied that he had spoken to this GP to encourage the making of this complaint, we believe that there was some such collusion by reason of the fact that we cannot understand why all of the partners of this practise would otherwise put their names to a complaint in relation to such a trivial matter.

134. Ms Baron wrote to Dr Michalak inviting her to attend a meeting on 2 July 2004, together with Dr White and Emma Lavery. The purpose of that meeting was said to be to informally discuss concerns raised with her regarding issues involving her clinical judgment and behaviour. She referred to an earlier meeting before Dr Michalak went on maternity leave when similar issues had been discussed. That meeting took place and two specific issues were raised with her. The first related to the complaint from the GP. Dr White suggested that Dr Michalak should have passed the referral on to another colleague if she felt unable to see the patient. Thus, we assume, wasting somebody else's time. The note reads "*Eva wanted to contact the GP as well but I advised her not do so*". That adds to our suspicions. It is possible that the reason why Dr White did not want Dr Michalak to speak to Dr Hanney was that Dr Hanney may have said something to suggest that the source of the complaint was indeed Dr White.

135. The second issue related to a Clinical Incident Form referring to a telephone conversation that Dr Michalak had had one evening with a Registrar. The issue related to a decision not to resuscitate the patient. Dr Michalak had no recollection of the incident, Dr White agreed to arrange for her to have the case notes so that she could refresh her memory and then have a further discussion with him. It was later ascertained that this patient in fact had nothing at all to do with Dr Michalak.

136. On 17 August 2004 a meeting took place between Neil Woodhall, the Hospital Manager, Emma Lavery and Dr Michalak, who was, at that point, represented by Ms Ursula Ross of the BMA. The discussion appeared to be fairly general in nature. The Claimant indicated that she felt discriminated against in relation to the refusal to make the sessional payments to her. She felt that she was being treated less equally than her colleagues. Dr Michalak made reference to the number of complaints that had started to appear. She complained that it appeared that Nurses were actually canvassing complaints from patients. It was agreed that additional information would be

given to her.

137. It is clear that Dr Michalak's relationship with Dr Abbasi was declining. On 28 September 2004 Dr Abbasi wrote to Mr Woodhall. On the face of it Mr Woodhall, as Hospital Manager, was not the right person to deal with a complaint made by one Doctor against another. He complained that Dr Michalak was frequently not available whilst on call. He pointed out that he was due to go on study leave on 30 September and 1 October and did not know whether Dr Michalak would be available to cover for him. He complained of her un-co-operative attitude, the fact she was late for ward rounds and that she displayed challenging and aggressive behaviour towards patients, Junior Doctors and Nurses. As Dr DeHavilland points out, it is difficult to know how Dr Abbasi could have any personal knowledge of such matters by reason of the fact that, from the very nature of the work that they did, when Dr Michalak was in the MAU, Dr Abbasi would not be. Notwithstanding that, these complaints were very serious in nature and were copied to Dr White and Ms Baron. We would have thought that such serious complaints would have immediately been copied to Dr Michalak, there would be discussions with her and perhaps meetings with Dr Abbasi to try and resolve difficulties between them. Nothing of that sort occurred.

138. As Dr Abbasi had indicated, he was going to be away on study leave, at a conference. He was responsible for doing the Friday afternoon ward round and, if he was going to be away, he was responsible for obtaining the necessary cover. He failed to do that and, as a consequence, Dr White was called in to do the ward round later on that evening. Dr White immediately blamed Dr Michalak believing that he was covering for her. He fired off an email of complaint to Mr Woodhall and Ms Baron, the email is prefaced by the comment "*Just to document another incident relating to Eva's job plan*". Dr Michalak met with Dr White on 5th October. Dr White raised the incident of 30 September with her, and, having received her explanation, he accepted that she was not to blame. Dr White did not, it would appear, write to Mr Woodhall correcting his earlier complaint about her.

139. On 12 October 2004 a Dr Khan, a Staff Grade Doctor, wrote a further letter of complaint to Ms Baron, copying that to Dr White and Mr Woodhall. He was on call for the MAU on 11 October. He saw Dr Michalak doing a ward round at 4:30pm and then went off to have a meal. At about 6:30pm he was bleeped and was asked to attend the MAU in order to finish seeing the patients that Dr Michalak had not managed to see. He contacted Dr Michalak who instructed him to do just that. It was Dr Khan's belief that before leaving the ward, Dr Michalak should have seen all the patients who had been "clerked" but had not yet been reviewed by a Consultant.

140. Once again we find it surprising that a Doctor would go to the trouble to write such a letter to senior managers. As Dr DeHavilland put in cross-examination, there is a constant input of new patients onto the MAU. The obligation is that they are to be reviewed by a Consultant within 24 hours of admission onto the ward. Dr Michalak was entitled to leave work at 6:00. There will almost always be patients on the ward when she leaves to go home who have been clerked but have not yet been reviewed by a

Consultant. If the situation were any different the Consultant would never be able to get home, because before leaving somebody else would arrive who would need to be seen. Patients who were not seen on the afternoon ward round, would be seen the following morning, within the required guidelines.

The Second "Secret" Meeting

141. On 14 October 2004 Mr Woodhall sent a letter of invitation to what has been described as the second "secret" meeting. This letter was sent to Rob Lane, the Medical Director, Dianne Nicholls, the Director of Human Resources, Paul Brooksby, a Consultant Cardiologist, Dr White, Emma Lavery and Ms Baron. All these people are White/British people. The letter reads as follows:-

> "*In the recent past I have shared with you the concerns being brought to my attention by several colleagues about and around the behaviour of Dr Michalak, one of our two Acute Physicians at PGI. Plotting a way through the problems being presented is not going to be straightforward, and could take us down a road that has been travelled with other senior colleagues.*
>
> *Being aware of this, senior approval of the process to follow is all important. On this understanding, I would like to invite you to contribute to an explanatory conversation both to understand the issues and assist in scoping out an agreed way forward*."

142. The Respondents have repeatedly described this meeting as being a normal management meeting to discuss difficulties with a professional colleague. The terms of Mr Woodhall's letter make it clear that there was more to it than that. Mr Woodhall indicated that Ms Lavery was involved in the decision to hold this meeting. He had been aware of the volume of complaints that had come in about Dr Michalak and he contended that the meeting was called simply to decide what could be done to resolve those problems. Mr Woodhall confirmed that the "*road being travelled with other senior colleagues"* related to another senior clinician who had taken Tribunal proceedings against the Trust. He acknowledged that because of the risks that that was going to happen with Dr Michalak "*senior approval of the process to follow was all important".*

143. That meeting took place. All the invitees, with the exception of Dianne Nicholls and Val Baron, attended, but Lynne Sherratt (also White/British), the Deputy Director of Human Resources, attended in place of Dianne Nicholls. Mr Woodhall opened the meeting. He pointed to the fact that because of restructuring within the Trust, he may not continue to be involved with this issue and so the Human Resources Department would lead to ensure continuity. That makes it perfectly plain that it was at least within his mind that this meeting was going to be the second of a number of similar meetings to discuss Dr Michalak. When giving evidence Mr Woodhall explained that Dr Brooksby had been invited as a senior clinician in order to give an

independent perspective as to these problems. That evidence was clearly untrue; the notes of the meeting disclose that:-

> "*Paul Brooksby invited on behalf of Physicians to give their concerns*."

We can only conclude from that that in some way Dr Brooksby had been canvassing the Physicians to obtain their concerns or that Physicians had been asked to feed any concerns through Dr Brooksby.

144. Dr Michalak was described as being an "*individual causing turbulence*". It was said that the Trust had:-

> *"Lost one Physician and others threatening to leave if issue not sorted*."

It was subsequently to be repeatedly alleged that Physicians had left as a result of Dr Michalak's conduct. Dr Hussain was identified as one such, but then it was accepted that she had simply moved hospital, within the same Trust, to work with elderly patients, being her speciality. At one point it was suggested that Dr Wong had also left the Trust until Dr De Havilland pointed out that he still worked for them.

145. Dr Lane is noted as asking the question:-

> "*If challenged at Employment Tribunal could we evidence that was individual's reason for leaving?*"

The answer given to him was "*no*".

146. The meeting was therefore clearly anticipating the possibility of an Employment Tribunal Hearing. The only event that was likely to precipitate such a Hearing was the Claimant's dismissal. That, clearly, was therefore within the contemplation of that meeting. The Respondents' witnesses who attended that meeting have repeatedly asserted that the purpose of the meeting was to look at problems that had occurred and to find ways to support Dr Michalak. Those explanations clearly fly in the face of the evidence of their own notes of this meeting.

147. Ms Lavery is noted as saying:-

> "*Have been exchange of emails demonstrating breakdown of relationships re cover arrangements – damaging. Inappropriate communication, ignored. Focused on formal clinical incidents/complaints*."

This clearly suggests that the Human Resources Department were already involved in a process of collation of the various complaints that had been made relating to Dr Michalak.

148. Dr Lane is then noted as saying:-

> "*Cannot ignore anything. Someone will keep emails as evidence. Need chronological evidence of picture*."

To which Lynne Sherratt responded "*put everything in, even if throw out*."

149. Those last words have been repeated many times by Dr DeHavilland during the course of this Hearing. He suggests that the Tribunal give those words their natural meaning. He suggests that this is the Deputy Director of Human Resources advising the meeting that they should collate every possible complaint against Dr Michalak, even if those complaints are subsequently shown to be without foundation. The Respondents' witnesses have repeatedly denied that those words should be given that meaning, but have given no convincing explanation as to any alternative meaning that could be ascribed to them. We have no doubt that, bearing in mind our findings as to future events, that is precisely what was meant by those words.

150. Somebody is then noted as having given the history of events relating to the alleged difficulties between the Claimant and Junior Doctors. It was noted however that Dr Harvey had confirmed that those issues had been resolved, and no further criticisms had been made of Dr Michalak since her return from maternity leave. The note then goes on to read:-

> "*Cannot be seen as witch-hunt. One approach to check current perceptions could be through Dr Harvey – to ask all juniors, opinion of teaching style of all Directorate or through appraisals due shortly*."

151. Once again the meaning of those words has been the subject of debate before the Tribunal. There is only one obvious meaning. Those attending this meeting were wanting to find out whether Junior Doctors would still make complaints about Dr Michalak. The process could not be seen to be a "*witch-hunt*" and so they could not be asked outright if they had a problem with Dr Michalak. It was therefore suggested that Dr Harvey would make arrangements to canvass the opinion of the Junior Doctors of the teaching style of all the Consultants within the Directorate, in the hope that some further criticism of Dr Michalak would be made.

152. Dr White suggested that:-

> "*Complaints from medical staff have decreased since return. Tends to be more nursing staff. Issues about lateness, lack of availability, length of ward rounds, non-contactability, does not examine patients*."

Dr Lane is then noted as saying:-

> "*Needs to be factual. Can evidence lateness against job plan. Examining patients, length of ward rounds – can be subjective, professional opinion*."

Dr Lane was, clearly, pointing Dr White to the difficulties inherent in the kind of generalised complaints that had been made and continued to be made about the Claimant. Precise factual events need to be referred to, not general allegations and, issues such as whether a patient should be examined physically or not, is a matter of professional judgment.

153. Dr White, astonishingly, then is noted as saying:-

> "*Clear job plan. States 8:30am start. Was doing sessions at St James' – Leeds – stopped it. Not stated reason why*."

Dr White knew precisely why the sessions at St James' were being stopped. Dr Newstead had written to him on 13 May 2004 and had told him.

154. Dr White is then noted as saying:-

> "*Does not feel E Michalak discusses things with juniors. Does not seek their opinion to reach consensus opinion*."

Surprisingly, Dr Brooksby is then noted as saying "*she therefore decides X. Juniors do Y*". When Dr Lane was asked about that comment (Dr Brooksby was not called to give evidence) he explained that he had understood that there had been occasions when Dr Michalak, during the course of a ward round, had given instructions as to tests or x-rays that were required to be done but, subsequently, the Junior Doctors had failed or refused to act upon her instructions. He recognised that, if true, it was a very serious matter for Doctors at the very start of their career to deliberately flout the instructions of a Consultant. Nothing, however, appears to have been done about this.

155. Dr Lane is then noted as saying:-

> "*Experience of other similar cases that have gone to ET. Obsessive individuals gathered evidence themselves, need to be watertight. Is this a cultural issue*?"

Dr White responded:-

> *"Does not feel E Michalak respects or values nursing opinion. Could be reason for incidents. Also does not value juniors' opinions. Could be cultural issues*."

156. We have already made reference to the nature of these comments earlier on in this decision. Dr DeHavilland suggests that this is clear evidence that Dr Michalak was being stereotyped by reason of her ethnic origins. We once again make the point that if these were genuine questions being asked by Dr Lane or Dr White, why did they not then raise these questions with Dr Michalak. Once again Dr Michalak was to learn nothing of this meeting for a considerable period of time.

157. Mr Woodhall then rounded up the meeting by thanking all those in attendance for their contributions and saying:-

> "*Will be difficult, rocky path. Need to catalogue information/evidence/behavioural aspects. Clinical information where doubt. Does evidence exist? How strong?*"

158. Clearly the "*rocky path*" that Mr Woodhall was referring to could only relate to the difficult process of moving the Claimant through formal procedures. Dr Lane having already indicated that somebody had to collate and store the evidence, Mr Woodhall was expanding as to the nature of that evidence that was required. Where there was any doubt about the Claimant's clinical competence, whether ultimately justified or not, that evidence was to be retained.

159. The note goes on to read:-

> *"Re-meet to discuss what strategic approach. Does she have case for harassment claim? Or, is there clinical competency route to take? Or, is there behavioural route?*"

This is clearly a debate as to whether the appropriate means of achieving the termination of Dr Michalak's employment was through the clinical competency route or the behavioural route.

160. The note concludes:-

> "*L Sherratt advised that N Woodhall and E Lavery do not proceed with next meeting with E Michalak until after all have regrouped to look at catalogue*."

It is clear therefore that, as requested by Mr Woodhall, senior approval of a process had been achieved. The process was clearly to collate and collect information upon Dr Michalak, keep such information no matter how weak it might appear and not to discuss those matters with Dr Michalak until the meeting has reconvened and the totality of the information looked at by this group of managers. We are informed by Dr DeHavilland that he repeatedly sought discovery of the file maintained by Emma Lavery pursuant to this meeting. That file was not, as such, disclosed to him and there was a denial that any such file existed. Emma Lavery however accepted that she did keep such a file, and Dr McInerny, who was to be called in to investigate Dr Michalak, accepted that she was shown that file. For what it is worth, Dr McInerny also agreed that it was highly inappropriate for an NHS Trust to maintain secret files of that sort upon clinical staff.

Further Complaints

161. On 18 November Dr White met with another junior Doctor, Dr Patel who raised familiar complaints in relation to the MAU. These complaints related to Dr Michalak starting ward rounds late and taking too long about them, her attitude towards patients her failing to examine patients, her teaching approach, leaving work whilst there was still a backlog of patients to see and never been seen her do an afternoon ward round.

162. Dr Patel, we understand, was only on rotation doing work at the MAU at night. Rather surprisingly, bearing in mind the nature of Dr Patel's complaints and the matters discussed only two days previously, Dr White did not ask Dr Patel to provide details of when Dr Michalak had started her ward round late, which patients she had failed to examine and when it was alleged that she had failed to do an afternoon ward round. Armed with this information, Dr White could have checked out for himself whether these allegations had any substance. When doing a ward round the Consultant will complete medical notes. If she missed out on an afternoon ward round, a check of the notes of the patient on the ward that afternoon would make it clear that that was the case.

163. On 9 December 2004 Dr White prepared a file note relating to a discussion that he had had with a Dr Lena Mahawish, a Registrar. She was complaining that Dr Michalak had chastised her, because she had not reviewed the patients on the MAU that night (which was clearly her responsibility) because she had been busy looking after critically ill patients. She complained about Junior Doctors leaving too much work to Registrars to do.

164. We do not understand why Dr White thought it important to retain this note, which is entitled "*File Note – Dr Eva Michalak*" when, it would appear, that all Dr Michalak was doing was her job. We would conclude that this was part of the "*put everything in even if throw out*" policy.

165. A further note refers to a conversation between Dr White and Dr Copeland, a Consultant Physician, when Dr Michalak had refused to countersign a radiology request for a head CT scan. This relates to what had become another source of contention on behalf of both Dr Michalak and Dr Abbasi. Without consultation, it would appear, the hospital had extended the MAU to incorporate another ten beds. That of course increased the number of patients who had to be reviewed by way of ward round. Assuming the guideline of 15 minutes per patient, that would be another 2 ½ hours work. Both Dr Abbasi and Dr Michalak, for a period of time, took the view that as they had not agreed to provide cover for these additional beds, and as they were not part of their agreed job plan, other Consultants would be responsible for those patients.

166. On 13 January 2005 the Royal College of Physicians and the Deanery carried out a follow-up visit to Pontefract. The report prepared by Drs Neligan, Tucker and Arnold, explained the purpose of the visit as being:-

> "*To assess the adequacy of the current training arrangements for medical trainees (SpR's) in the above hospitals in the light of the SAC visit to Yorkshire (October 2003), so that it could be determined whether the previous recommendations had been implemented and whether any new problems had emerged during the intervening period."*

167. It should therefore be noted that this visit was specifically to talk to the

Registrars. By the very nature of the way that the MAU was organised in Pontefract, Dr Michalak and Dr Abbasi had little direct contact with the Registrars. The Registrars provided cover for the unit overnight, they would be in the course of leaving the ward by the time the Consultant arrived for work, and would take no part in the weekday ward round. They would however attend the ward round at a weekend, which was of course conducted by the on-call Consultant and would only involve Dr Michalak on the occasions when she was rostered to be on-call over the weekend, alongside the other Physicians. The Registrar would of course also consult with Dr Michalak if she was on-call at night and her advice was needed.

168. The report sets out two principal concerns in relation to Pontefract. The first relates to the lack of on-site acute surgery, an Intensive Care Unit and a Blood Gas Machine. There was also concern expressed about the proposal that anaesthetic cover may be removed. The report describes the trainees as feeling very vulnerable as a consequence. The second concern is expressed in the following terms:-

> "*The Registrars also raised concern about the standards of patient care and of teaching/training on the MAU. There appeared to be issues around the ability of one of the Consultants in particular to teach juniors, and indeed around clinical competence. The SpR's felt that attending post-take rounds conducted by the MAU Physicians was of little educational value to them. Examples of poor patient care were also cited – inappropriate management of chest pain, excessive oxygen therapy for patients with Type II Respiratory Failure, and inadequate treatment of Status Epilepticus."*

We note that the reference to the MAU Physicians was in the plural. The report concludes:-

> *"The last concern to mention is a difficult one, relating as it does to comments about the competence of an individual Consultant on the MAU at Pontefract Hospital. We took care to be discreet, and avoided any direct reference to this matter during our feedback discussions. Following the general discussions we mentioned this matter in private to the Chief Executive of the Trust – he felt able to conduct further enquiries, and was reasonably confident that he could promote changes to the way in which the MAUs worked, and were supervised, such that this problem could be handled in a sensitive fashion and remedied."*

In his evidence Dr Neligan confirmed that the Consultant referred to was Dr Michalak. During the course of his cross-examination however, Dr Neligan confirmed that, in his view, the principal difficulties were firstly that Registrars needed to attend ward rounds as part of their training, but the system operated on the Pontefract MAU prevented them from doing that. He also confirmed that the Registrars were feeling very vulnerable because of service reconfiguration, namely that on occasions they required acute services which were not always immediately or easily available. Although there was clearly a discussion after this inspection with Mr Parkes, the Chief

Executive, as far as we are aware, no discussions then took place with Dr Michalak, neither did Mr Parkes do anything else to "*promote changes to the way in which the MAUs worked".*

169. It will be recalled that on 17 August 2004 a meeting had taken place between Dr Michalak, accompanied by Ursula Ross, Mr Woodhall and Emma Lavery. That meeting concluded on the basis that additional information was going to be given to Dr Michalak, and that her complaints relating to the additional payments were going to be reconsidered. A follow up meeting took place on 7 February 2005. Emma Lavery confirmed that the Claimant was entitled to some additional payments, as from the time that she returned from maternity leave, and arrangements were made for these to be paid to her.

170. The meeting then looked at some of the patient complaints that had been received in relation to Dr Michalak. Dr Michalak pointed out that only one of those complaints had been raised with her at the time, and that when other clinical staff had been interviewed in relation to that complaint, the complaint had been found to be without justification. In relation to six other Clinical Incident Reports, Dr Michalak complained that these had never been raised with her at the time. In the light of that complaint, Mr Woodhall is noted as saying:-

> *"I think if information hasn't been shared where there is any criticism – then this does not stand because a fair process has not been followed. I need to ensure Dr Michalak has had full engagement to be able to respond. If there are any issues with regards to performance they will need to be pursued with evidence and clearly shared."*

Dr Michalak is noted as having responded "*I agree. I will always reply promptly".*

171. Dr Michalak went on to raise a concern that she felt that nursing staff on the MAU were undermining her and were effectively encouraging patients to complain about her. She referred to an incident when she had completed a Clinical Incident Report, that had been taken from her by the nursing staff with an assurance that it would be investigated, but she had heard no more. She discussed difficulties that she was experiencing in providing cover for Dr Abbasi, whom she felt was probably taking more leave than he was entitled to.

172. On 14 February 2005 Dr Playforth, a Consultant in Accident and Emergency Medicine, wrote a letter to Dr White complaining about Dr Michalak's failure to properly treat a patient who it was thought was suffering from Deep-Vein Thrombosis. This complaint was followed up by the patient's General Practitioner. It was investigated by Dr White. He noted that the patient in question was an intravenous drug user and that the Trust had a specific protocol for dealing with such patients suffering from Venous Thrombosis. That protocol suggested that the normal treatment by way of anticoagulants may not be appropriate and that management would normally be achieved

by prescription of a drug known a Clexane. This is exactly what Dr Michalak had suggested. Dr White wrote a letter of explanation to the GP explaining the contents of that protocol, but agreed that, ideally, Dr Michalak should have seen the patient before determining upon the treatment plan. He copied his correspondence to Dr Michalak and suggested that they should have a discussion about that matter. We are not sure whether any such discussion took place.

173. On 7 March 2005, a month after the meeting, Mr Woodhall wrote to Dr Michalak confirming the outcome of the meeting of 7 February 2005. In that letter he states:-

> *"In the future any incidents or complaints will be shared at the time they are received for you to be able to comment and for us to identify whether there is any issue with regards to performance or not. I accept where this information hasn't been shared in the past, it does not stand because a fair process has not been followed."*

This letter has become known as the "line in the sand" letter, on the basis that the Respondents agreed that anything predating that letter would not be the subject of any future action.

174. On 15 March 2005 Dr Michalak and Dr Abbasi sent a joint letter to Dr White relating to this ongoing issue involving the ten beds that had been added to the MAU. In the past they had been refusing to see patients in those additional beds (known as the "Step-Down Unit"), a situation that they both accepted was not desirable. The proposal, therefore, that they put forward was that they would ensure that the patients in both parts of the MAU would be seen during the morning ward round, but that the afternoon ward round should be taken over by a Registrar who could refer to the on-call Consultant if necessary.

Complaint by the Desk Clerks

175. Dr Hussain had previously been employed as an Acute Physician at Pontefract. She was the Doctor who had lodged complaints about Dr Michalak in relation to her care of two specific patients. Dr Hussain had moved to work on a Care for the Elderly ward in Wakefield. She had a specific interest in that area of medicine. Referrals continued to be sent by GPs to Pontefract addressed to Dr Hussain. Many of these referrals were sent to Dr Hussain because they related to problems with elderly patients. Dr White had decided that these referrals should be divided between Dr Michalak and Dr Abbasi, but it appears that this decision had not been shared with them.

176. Dr Michalak attended her clinic on 14 March 2005 to find that one of the patients she was due to see was a patient who had been referred to Dr Hussain. She was concerned about this. From her perspective, if a patient is sent by her GP to see a particular Consultant, that is the Consultant who

should see the patient, and the fact that that Consultant now operated out of a different hospital should not necessarily make any difference. The patient himself may have expectations that he was going to see that particular Consultant, who may have been specifically recommended to him by his GP. Dr Michalak did not therefore believe it was necessarily appropriate for her to see this patient.

177. She decided to go to speak to the Desk Clerks, who were responsible for arranging outpatient appointments, to investigate the matter further. She had the foresight to take a Nurse with her. There was then a conversation between Dr Michalak and the Clerks which became the subject of a formal complaint. On 15 March 2005 Susan Caine, a supervisor, lodged a formal complaint on behalf of her two staff members. She reported that:-

> *"Dr Michalak came into the room loudly and demanding to know why she had been given the referral and Karen had to apologise to a patient she was dealing with on the phone, as she couldn't hear her for Dr Michalak. Dr Michalak was asking questions of Ellen, who couldn't answer fully, explained this but Karen had to break off from her call to quickly explain to Dr Michalak, so as to be able to continue her call and be able to hear the patient. Dr Michalak appeared unwilling to accept Karen's reasons for giving her the letter and Karen advises me that she felt demeaned by Dr Michalak's attitude and aggression. Both she and Ellen were "shouted down" by Dr Michalak."*

178. This report was accompanied by handwritten statements from the two Clerks in question. This complaint was obviously passed onto Emma Lavery, who of course had been given the responsibility of collating complaints made against Dr Michalak in the second "secret" meeting, and she discussed this complaint with Dr White. They had agreed that formal disciplinary steps should be initiated. At some point, thereafter, Dr Michalak was made aware of these complaints. Fortunately she was able to rely upon the evidence of the Nurse who had accompanied her, who at her request provided a written statement in the following terms:-

> *"Dr Michalak asked me to direct and accompany her to the post-room to discuss why a letter with a specific specialist complaint had been placed in her file. In my opinion I do not feel that Dr Michalak entered the room abruptly, as Dr Michalak followed me into the room. I spoke to the ladies first and asked if Dr Michalak could speak with them, regarding the referral letters. At no time were we informed or no indication was given, that either Karen or Ellen were in conversation with patients via the telephone. I do not feel that Dr Michalak's behaviour during the conversation was unreasonable."*

179. Faced with that evidence, by letter of 26 August 2005 Mr Forster, the General Manager, dismissed this complaint as based upon a *"misunderstanding*" but wrote to Mrs Caine to tell her that the "*appropriate actions*" had been taken. Dr DeHavilland suggests that there was no such misunderstanding, but that this was a deliberately contrived complaint

against Dr Michalak.

The Complaint by Nurse Monkhouse

180. On 18 April 2005 a Clinical Incident Form was completed by Nurse Monkhouse on the MAU. That form, in part, reads as follows:-

> *"On the occasion in question the MAU was very busy, with patients queuing in A&E, and there was a backlog on the MAU. The Clinical Site Manager on duty was present on the MAU at the time, and was becoming increasingly concerned about the patient flow through the system.*
>
> *Dr Michalak was rostered to perform the afternoon ward round on this day. Dr Michalak left the MAU at approximately 17:45 and there were approximately eight patients to be reviewed for decisions awaiting admission or discharge.*
>
> *The Site Manager was informed and the manager on-call, which on this occasion was Sean Garside. I discussed the situation with him and was advised to complete an Incident Form, highlighting this problem, as this may have an impact on achieving the waiting targets."*

On 27 April a copy of this report was forwarded to Dr Michalak for her comment. Once again Dr Michalak finds this to have been an astonishing complaint to have made. Her working day finished at 6:00pm. She had administrative tasks to complete in her office. If eight patients had been left un-reviewed, nineteen patients had been reviewed by her, who would, therefore, have been able to be either discharged or moved onto the appropriate ward, thus removing the log-jam from the Accident and Emergency Department.

From her perspective, if she had stayed on to review those remaining eight patients, who may only recently been admitted into the MAU, she would have been working significantly beyond her contractual hours and, at any event, whilst she was doing that work, additional patients would then have been transferred from the Accident and Emergency Department into the MAU and she could have been there all night. She points again to the fact there will always be patients who have not been reviewed by the time the Consultant goes home. That does not matter because they will be cared for by the Registrar overnight, who will be an experienced Doctor who has access to the on-call Consultant if necessary, and the patient will then be reviewed either by Dr Michalak or Dr Abbasi when doing a ward round the following morning.

181. Dr DeHavilland points to this complaint as being a bogus complaint generated by a manager, Mr Garside, as part of the "throw anything in" strategy.

Dr Almari

182. Out of hours radiology services were provided by the Pinderfields Hospital in Wakefield. There had been an issue running between the Radiologists and the Acute Physicians relating to how out of hours referrals should be made. There was a school of thought amongst the Radiologists that exposing patients to unnecessary x-rays was potentially harmful to their health and that accordingly referrals, for example, for CT scanning, should only be made by a Consultant Physician to a Consultant Radiologist. This had been the subject of some discussion which, hopefully, had been put beyond debate when, on 5 April 2005, Dr Spencer, Consultant Radiologist and Clinical Director of Radiology at Pinderfields, wrote to Mr Playforth, the Clinical Director of A&E Services in the following terms:-

> *"In reply to your correspondence of 16 March 2005 confirming that referrals for emergency radiology will be accepted by the on-call Consultant from Consultant colleagues and the Trauma Team Leader who may be a Middle-Grade or Associate Specialist. I hope this clarifies the situation."*

183. It follows therefore that the agreement was that such a referral could be made either by a Consultant or by a Registrar or equivalent Middle-Grade Doctor.

184. On 30 May 2005 an incident arose when during the evening the Registrar in the MAU needed to refer a patient for a head scan. Radiology refused to accept that referral because it had not come from a Consultant. Dr Michalak was contacted who confirmed her understanding that this referral should have been accepted and expressed reservations about contacting the on call Radiologist, Dr Almari herself.

185. That incident however produced an astonishing response from Dr Almari. On 3 June 2005 he wrote to Dr White to complain about Dr Michalak's behaviour. He claimed that Dr Michalak had refused to contact him. His letter goes on to read:-

> *"On several previous occasions she insisted not to call me as a Locum Consultant Radiologist. My experience with Dr Michalak is that she does not care for the patients on the on-call and she leaves the matter to the junior staff to decide. I am not sure whether Dr Michalak does not like to abide by the hospital policy or does not like to speak to me as a Locum. Probably she does not know that I have resigned as a substantive Consultant and chose to work as a Locum for my personal reasons but in any case I deal with the Locum Consultants, Locum Staff-Grades and everybody who is directly or indirectly employed by the Trust. I am afraid Dr Michalak's behaviour puts patients in jeopardy."*

186. The terms of that letter do appear to be an outrageous attack upon Dr Michalak's professional standing.

187. When this letter was shown to Dr Michalak, she demanded an apology. This demand was passed onto Dr Barnes (who had become Clinical Director for Medicine in place of Dr White who had stepped down from that position as a result of the GMC ruling against him) and Dr Barnes thought it appropriate to try and arrange a meeting between Dr Michalak and Dr Almari to sort this matter out. In the usual way, Dr Barnes arranged for her Secretary to contact Mrs Ruth Sibary, Dr Michalak's Secretary, to identify a mutually convenient slot in their electronic diaries when such a meeting could be arranged. Such a slot was identified and noted in Dr Michalak's electronic diary. Mrs Sibary's intention was then, at her next opportunity, to tell Dr Michalak about the proposed meeting in order that it could then be confirmed with Dr Barnes through her Secretary.

188. Unfortunately Dr Michalak saw this entry in her diary and mistakenly believed that Mrs Sibary had agreed to this meeting without reference to her. She did not want to meet with Dr Almari. She tells us that she felt intimidated by him. It is clear that Dr Michalak was in a state of distress in relation to this incident. Mrs Sibary, of course, had no knowledge of that. There was a telephone discussion between Dr Michalak and Mrs Sibary when Dr Michalak was seeking to remonstrate with Mrs Sibary for arranging this meeting without her authority and Mrs Sibary was, unsuccessfully, endeavouring to explain to Dr Michalak precisely what had happened and that no such meeting had yet, in fact, been agreed. Mrs Sibary was subsequently to complain that Dr Michalak failed to listen to her explanations. It is a matter of note, at this stage, that that was one of the incidents which was ultimately to lead to the Claimant's dismissal.

Failure to Appoint

189. Dr Michalak then makes two complaints about her attempts to improve her role being blocked. In June 2005 she applied for the newly created post of Lead Physician for Acute Medicine. She believed that she had all the necessary experience for this position. It was effectively a co-ordination role between the three MAUs. It appears that there were three applicants for this job; the Claimant, Dr Abbasi and Dr Jenkins. It appears that Dr Jenkins persuaded Dr Abbasi to withdraw his application. He spoke to Dr Michalak, there is a dispute between them, which we do not need to resolve, as to whether he asked her whether he would have her support in the event that he was successful (as he contends) or whether he asked her to withdraw her application (as she suggests). At any event Dr Jenkins was appointed to that position, despite the fact that, Dr Michalak believes, she was more highly qualified.

190. The next incident related to an application by Dr Michalak to become a member of the Local Negotiating Committee, this was a group of Doctors who represented Doctors in discussions with Trust management. A place on that committee was normally secured by election from colleagues. Dr Barnes sent a circular around the Consultants, seeing if there was any interest. Dr Michalak responded "*I would like to join LNC, how should I proceed?"* Dr Barnes responded:-

> *"By expressing an interest in response to my emails so that there can be an election amongst your colleagues."*

Dr Michalak believed she had already expressed an interest and, in the absence of any other Doctor so doing, she should have been appointed by default. Dr Barnes did not interpret events in that way, in due course held an election when Dr Michalak was one of the candidates, Dr Barnes in fact voted for Dr Michalak who was, however, unsuccessful.

The Deanery Visit

191. On 2 June 2005 there was another GPT visit involving Dr Neligan and Dr Tucker (on behalf of the Royal College of Physicians) and the outcome of that investigation led to a telephone conversation between Professor Burr, the Post-Graduate Dean at the Deanery, and Mr Parkes, the Chief Executive of the Trust. That telephone conversation was confirmed in a letter from Professor Burr dated 7 June 2005, when he said as follows:-

> *"I am writing as a follow-up to my telephone call in which we discussed problems related to the complaint of possible bullying of SHOs by one of the Consultant Physicians working on the MAU at Pontefract. Complaints were made about the behaviour of Dr Michalak, and I understand from the recent visit on behalf of the JCHMT, that SpR's were concerned also about her clinical competence.*
>
> *We agreed that I should ask Patrick Neligan, who is my Associate Dean for West Yorkshire, to conduct in-depth interviews with the trainees who have come into contact with Dr Michalak, including SHOs, Trust Doctors and SpR's. I would be asking Patrick to do this in collaboration with the HR Department at the Trust."*

192. Dr Tucker wrote on 15 June 2005 to Dr Cadigan, of the Royal College of Physicians. He provided a copy of the report. In that letter he says:-

> *"Our main concern at the visit was the MAU, and it is largely around the behaviour of Dr Michalak, one of the Physicians in Acute Medicine based on the MAU. The SHOs were understandably reluctant to complain about a named individual but it was clear from the outset that they were unhappy with the MAU experience. With encouragement to be frank, and reassurance that no statements would be attributed to named individuals, they gradually opened up. My colleagues and I feel that we should make you aware, in confidence, of the details of the discussions.*
>
> *Dr Michalak is apparently particularly critical of the SHOs clerking and management of patients. The SHOs often feel humiliated by her approach, yet she actually makes very little clinical contribution to the post-take ward round, rarely taking any history from or examining patients. SHOs are criticised in front of patients and Dr Michalak's response to perceived mistakes by junior medical and nursing staff is*

to fill in an Incident Form, rather than to discuss the matter.

The problem of bullying by Dr Michalak came out at the external visit to Pinderfields and Pontefract in 2002 and was put, in confidence, to senior management at that time."

193. Dr DeHavilland extracted concessions from a number of the Respondents' witnesses that any patient on the MAU will already have been examined, either by a Doctor in the Accident and Emergency Department or by their GP, and a detailed history will already have been obtained. It is always, therefore, a matter of professional judgment as to whether any further examination is necessary and indeed, it was accepted, that it could be perceived as demeaning of the Junior Doctors if the Consultant conducts an examination of a patient in circumstances which would suggest that she does not trust the findings of the Junior Doctor or if the Consultant were to take her own history, suggesting that the Junior Doctors were themselves incapable of doing so. He also points out that Dr Tucker perpetuates this apparent myth about Dr Michalak completing Clinical Incident Forms rather than discussing matters with Junior Doctors when, on the basis of all the evidence before us, she only completed one such form, in relation to a Junior Doctor who had left work long before the end of his shift, leaving the ward without sufficient medical cover.

194. Accordingly Mr Parkes had specifically asked Professor Burr to ask Dr Neligan to revisit the hospital and to carry out specific interviews with the Junior Doctors in order to investigate these allegations of bullying. The only reason why Mr Parkes would have done that, as he accepted, was to use the outcome of that investigation as a basis of potential disciplinary action against the Claimant. It is on that basis that Dr DeHavilland suggests that Professor Burr and Dr Neligan knowingly aided the Trust to commit an act of unlawful discrimination (see Section 42(1) Sex Discrimination Act and Section 33(1) Race Relations Act).

195. The Yorkshire Deanery have a specific policy for dealing with the "Bullying and Harassment of Trainees". This was compiled by Professor Burr in January 2003. We record the following extracts from that policy, which shows how Dr Neligan should have proceeded with his task:-

"*When a complaint of bullying or harassment about a trainer is made by a trainee, and is brought to the attention of the Deanery, this will be taken very seriously. The trainee will be invited to the Deanery to explain the situation in confidence."*

"At this first meeting it will not be policy to attempt to document the events complained about in full detail. If it seems that there is a prima facie case to be answered, the trainee will be asked to prepare a written statement of the events with names and dates. He/she will also be asked to give written permission for the data to be held and shared with others."

"If the initial discussion of the complaint suggests there is a prima

facie case of bullying or harassment, then the Dean will set out for the complainant the options for further action… There are two potential routes, informal and formal.

Informal action: where possible, the Dean or his/her nominated deputy will attempt to help the trainee to resolve the differences informally, through discussion with the parties concerned."

"Formal action: the trainee will be asked to produce a written statement detailing the complaint with dates and witnesses. In the case of workplace bullying or harassment this will normally be brought to the attention of the Medical Director and/or Human Resources Director of the employing Trust."

"It must be remembered that trainers have the right to know about accusations made about their behaviour, and have the right to answer the criticisms. They must be allowed to defend themselves and may need help to change their behaviour if allegations are upheld."

"Wherever possible and appropriate, the Dean will attempt to resolve complaints informally. The Deanery will offer help to the trainer to modify their behaviour and will encourage raised awareness of bullying harassing behaviour through its trainee surveys, seminars and Deanery generic courses."

196. Dr Neligan attended at the Pontefract Hospital on 4 and 18 July 2005. He apparently interviewed eleven Junior Doctors. Eight allegedly reported problems with Dr Michalak. In breach of the Deanery's own policy, they were not asked to produce a written statement setting out the detail of those complaints. Dr Neligan made a conscious decision not to follow that policy and instead he simply noted generalised complaints that were allegedly being made. Whilst he was interviewing these Junior Doctors, nobody thought it appropriate to tell Dr Michalak that this process was taking place despite the fact that she was continuing to work with them.

197. Dr Neligan prepared a report dated 15 August 2005. One would have thought that Dr Neligan would have wanted to obtain a contribution from Dr Michalak before putting pen to paper, the Deanery's own policy giving Dr Michalak the right to know about the accusations made and the right to answer the criticisms. Dr Neligan however, on 24 August 2005, forwarded a copy of his report to Mr Parkes.

198. It was, initially, alleged, by the Deanery and by the Trust, that the Claimant had been given the opportunity to meet with Dr Neligan before this report was sent to Mr Parkes, but that she unreasonably delayed in arranging a meeting with Dr Neligan. Without going into the detail of the evidence within this Judgment, when taken through the chronology of events, Professor Burr accepted that that suggestion was entirely untrue, that Dr Michalak had immediately responded to a request to contact the Deanery with a view to arranging a meeting with Dr Neligan, had left messages on the Deanery's

answerphone and had agreed to meet with Dr Neligan on 31 August, being one of the first dates offered to her.

199. Dr Neligan, in his letter to Mr Parkes, says:-

> *"I spoke some weeks ago to Dr Sue Barnes, your Clinical Director for Medicine. She is aware that there is a concern but does not know details. I suggest that it would be helpful if you were to share this report with her, although I would prefer that no action is taken until I have had a chance to see Dr Michalak, or unless there is a new incident."*

200. Dr Neligan's report, dated 15 August 2005, was damning of the Claimant. He describes the circumstances which led him to conduct this investigation. He confirms that he interviewed eleven Doctors, of whom eight had criticisms of Dr Michalak. He comments that:-

> *"It was evident that the three Doctors who did not have any complaint were all self-confident, assertive characters, quite used to standing up for themselves."*

It is far from clear to us why self-confident and assertive Doctors would be any less likely to make complaints.

201. He summarised the complaints that he received. All these complaints are unspecific and are not ascribable to any particular individuals. The report alleges complaints of being criticised by Dr Michalak in front of patients and other staff. Doctors feeling belittled. They feel insulted and do not feel that they are respected at all. They complain that Dr Michalak gets angry easily and shouts at them. They complain that she is regularly late for ward rounds, as a consequence of which, she insists that Junior Doctors carry out tasks before going home, no matter how tired they may be. That they are required to stay on after the end of their shift. That if they leave early, before Dr Michalak arrives, they are then the subject of a Critical Incident Form (we assume that means a Clinical Incident Form, which we know happened on one occasion). They suggest that on ward rounds she does not listen or she contradicts Junior Doctors. That she does not take a history or examine patients herself. She tells the Junior Doctors exactly what to write in the hospital notes, word for word. She has been known to criticise decisions made by other Consultants. They complain that the ward rounds are too long and that, after the ward round when the Junior Doctor has tasks to do, they find it difficult to contact Dr Michalak.

202. Dr Neligan reaches the following conclusion:-

> *"There can be no doubt that Dr Michalak is bullying Junior Doctors. These are not occasional episodes, they consist a pattern reported by multiple observers over a period of time. It is leading to stress and distress among the Junior Doctors. Although many of the Junior Doctors are from overseas, there does not seem to be any racial or gender issue here. She does, however, pick on the more vulnerable*

Doctors, including some with previous experience of bullying."

203. Dr Neligan suggested that there may well be underlying factors relating to Dr Michalak's lack of awareness of the necessary skills of a teacher, and possibly insecurity about her own abilities. Dr Neligan was of no doubt that the problem needs to be addressed sooner rather than later. Rather surprisingly, bearing in mind that he has already concluded that there can no doubt that Dr Michalak was bullying Doctors, Dr Neligan suggested that Dr Michalak needed to be given the opportunity to give her side of the story in an open and supportive setting. Regardless of whether she was, in fact, guilty of bullying, Dr Neligan, not having heard her side of the story, recommended that if Dr Michalak accepted the concerns and agreed to remedy the situation, a programme of rehabilitation would need to be developed. Alternatively the Trust would have to consider taking disciplinary action and measures would need to be taken to protect trainees from her.

204. It is difficult to reconcile the tone of that report with the Deanery's own policy that Dr Michalak had the right to know about the accusations made about her behaviour and have the right to answer the criticism and to defend herself.

205. Curiously, although Dr Neligan had forwarded a copy of his report to Mr Parkes on 24 August 2005, on 26 August 2005 Professor Burr wrote to Dr Michalak complaining that she had failed to make an appointment to meet with Dr Neligan and threatening to disclose a copy of that report to the Trust if they did not hear from her soon.

206. So alarmed was the Claimant by this correspondence, that she cancelled prearranged annual leave to ensure that she could meet with Dr Neligan in accordance with the Deanery's timescales.

207. The meeting took place on 31 August 2005 at the Deanery. Professor Burr and Dr Neligan had arranged for Julie Honsberger, Professor Burr's PA, to attend to take notes. She clearly took very detailed notes. For the first time Dr Michalak was provided with a copy of Dr Neligan's report. It is difficult to understand why it was not sent to her in advance of the meeting so that she could give a considered response to it. Dr Neligan did not use that meeting in order to give Dr Michalak the right to defend herself and to answer the criticisms as the Deanery's procedure demanded, but it proceeded on the basis that Dr Neligan's conclusion, namely that Dr Michalak had bullied the Doctors, was not open for debate. As the note of the meeting makes clear, Dr Michalak was given two options:-

> *"The first option would be for Dr Michalak to accept the general conclusions raised in the report and to acknowledge that her behaviour had been unacceptable, and to seek help in improving the situation, which would result in further training, support and development from the Trust, Deanery and/or other methods. The second option was for Dr Michalak to refute the report, which would result in other measures being taken at the Trust/RCP/GMC level."*

208. Dr Michalak then tried to defend herself against some of the criticisms in Dr Neligan's report. She pointed to the fact that as a consequence of the earlier criticisms of her teaching methods, a system had been set up whereby concerns of Junior Doctors could be received. In response to this, Dr Neligan:-

> *"Stated that he needed to coax the SHOs and give them complete assurance that there would not be any sort of backlash should they wish to discuss their concerns. Dr Neligan stated that only when Dr Neligan gave complete assurance that their concerns would remain confidential, did they confess to feeling belittled and humiliated regularly."*

209. Dr DeHavilland points to the inherent problems with that approach. Whereas the Deanery's policy requires that if formal action is to be taken, trainees would be asked to produce a written statement detailing the complaints with dates and witnesses, here we have Dr Neligan specifically interviewing Junior Doctors because of allegations relating to Dr Michalak, coaxing them into making complaints on the basis that, no matter what they said, there would be no repercussions, and their identities would be kept entirely confidential. That is, as Dr DeHavilland suggests, a process which is designed to incite grumbles and complaints from subordinate employees. The notes prepared by Julie Honsberger record Dr Michalak as feeling "*threatened*" by the use of the word "*coax*". It speaks of her raising "*fears*" that she was being prejudged. Dr Neligan once again reminded Dr Michalak that she only had two options and described that second option as "*being hit by a ton of bricks".*

210. Unsurprisingly Dr Neligan expresses regret for the use of that language. His recollection was that, despite the wording of the notes of this meeting, he actually spoke about people "coming down" on the Claimant like a ton of bricks and said that he used this graphic language in order to emphasise to the Claimant the seriousness of her situation. On any version of events, Dr Michalak would have felt intimidated and distressed by being called to a meeting of this sort, where allegations were put to her, which she was not allowed to defend, and when a clear conclusion had already been arrived at that she was guilty of gross misconduct, namely bullying Junior Doctors. She was being given the choice of either admitting to being guilty of gross misconduct, leading to the possibility that she would be the subject of remedial help by the Deanery, or being subjected to the full force of disciplinary action by the Trust, the Royal College of Physicans and the General Medical Council. Of course if Dr Michalak had admitted to bullying Junior Doctors Dr Nelligan would have reported back to the Trust accordingly and Dr Michalak could have had no confidence that the Trust would feel constrained by Dr Nelligans assurance that all that would have happened would have been the offer of remedial training.

211. In that context to use such language was clearly intemperate and was designed, we have no doubt, to heighten Dr Michalak's alarm.

212. When cross-examined Dr Neligan accepted that he had conducted similar

interviews twice in the past with male Doctors. He accepted that in relation to both of those Doctors he had adopted what could be described as the third approach. That would involve not requiring the Doctor to admit that they were guilty of inappropriate conduct towards Junior Doctors, but simply asking them to accept that if such complaints were being made there may be a problem and that the easiest way to resolve the situation was for the Doctor to accept appropriate remedial assistance. This option was not however given to Dr Michalak by Dr Neligan.

213. The meeting concluded by Dr Neligan asking Dr Michalak to consider the position, to seek advice and to respond in writing regarding her decision (i.e. which of the two options she was willing to accept) by the week ending 9th September. There can be no doubt that the Claimant was, by that stage, in a state of acute distress. Dr Neligan was sufficiently concerned as to ask Dr Michalak whether she was driving home, because he wondered whether she was fit enough to drive. It appears that he did not reflect upon the cause for her distress. He thought it appropriate to touch her on the shoulder as he escorted her out of the room, which she felt a further threatening act. It is her contention that as he showed her out the room he said:-

> "*I will come down on you like a ton of bricks and send you back to Poland where you come from."*

Dr Neligan denies making that comment, but accepts that he might have come into physical contact with the Claimant in the way that she describes as he accepted that this would be his normal practise in these circumstances.

214. In so far as we have to make factual finding in relation to that issue, we are not satisfied on the balance of probability, that Dr Neligan used those words at that point in time. Shortly after the meeting, Dr Michalak drafted a long letter of complaint to Professor Burr. On the advice of the BMA, that letter was not actually sent, but it is clear from the terms of that letter that Dr Michalak was more than willing to make detailed complaints about Dr Neligan's conduct. Nowhere in that letter does she complain that that comment was made to her. That is a surprising omission and leads us to our conclusion that the comment was not in fact made.

The Third "Secret" Meeting

215. On 11 July 2005 a further meeting was called by Emma Lavery. In attendance were Dr Lane, Dr Jenkins, Dr Barnes, Mr Forster and Caroline Shepherd All these people are White/British people. This is clearly an updating meeting. The meeting was aware that the Deanery were in the course of interviewing Junior Doctors and that a report of their findings would be expected mid-August. The note reads:-

> *"On receipt of report (the receipt of Eva's response to staff complaints) if claims proven, group to re-meet. EL to hold central file of all incidents/complaints/file notes.*

All information to be shared with Eva at time it is received for her comment as per agreement with Ursula Ross."

216. Further actions were agreed, Mr Forster was to carry out job plan reviews with Dr Michalak and Dr Abbasi. Mr Forster was to deal with the complaint that Dr Michalak had raised against Mr Garside for inciting Nurse Monkhouse to lodge a formal complaint against her and:-

"Dr Jenkins to undertake audit of MAU ward rounds start times, finish times across Trust for monitoring performance activity."

"Dr Barnes to create database for Directorate for collating number of complaints per Consultant across Directorate to act as a benchmark."

217. So Dr Jenkins was being asked to collate information to build up a case against Dr Michalak in relation to the allegation that she started ward rounds late. In fact, when Dr Jenkins began that process and spoke to other colleagues at the other two hospitals, they all refused to co-operate with that audit and so he abandoned the effort.

218. Dr Barnes was to create a database, presumably to demonstrate that the level of complaints against Dr Michalak was far higher than against any other Consultant. As far as we know that work was never in fact carried out.

Job Plan

219. During the course of this Hearing we heard a great deal of evidence relating to a process that was being carried out by Dr Jenkins to agree a job plan with Dr Michalak and Dr Abbasi. The simple fact of the matter was that, by reason of changes in the way in which the MAU was operating and, indeed, the increase in size of the MAU, the original job plans agreed with these Consultants were no longer appropriate. Dr Jenkins told us that this was the first time he had had to negotiate a job plan with a Doctor. There is a process whereby management attempt to agree a job plan with the Doctor concerned, if agreement cannot be reached there is a mediation process available, followed by a formal appeal process. Dr Jenkins believed the process would be an easy one. He had in mind a plan which consisted of ten PA's, the Claimant abandoning her compressed hours and ceasing to pursue her specialist interest as a Nephrologist, the plan to set up a Renal Unit in Pontefract having disappeared.

220. Not only were these proposals unattractive to Dr Michalak, but Dr Jenkins had the task of trying to create a dovetailed job plan with Dr Abbasi. In the event an attempt to agree a job plan with Dr Michalak came to an end when she was subsequently suspended in January 2006.

221. Curiously, however, Dr Jenkins thought it appropriate to raise a number of issues relating to Dr Michalak and her specialist interest. On 12 September 2005 he wrote to Dr Lane, the Medical Director. He repeated the previous

suggestion that Dr White did not understand why the clinics in Leeds had come to an end. He suggested, obviously incorrectly, that Dr Michalak had told him that the sessions had come to an end in January 2005. There is no reason whatsoever why she should have said that; everybody knew that they came to an end in June. Based upon this incorrect information, Dr Jenkins makes the following suggestion:-

> "*Since then she has continued to be paid for this activity without doing it. I feel uncomfortable that we do not know why and when the Renal Physician stopped her work and it would be useful to explore this to ensure that there was no clinical safety issue involved which may be relevant to her ongoing clinical work*."

222. We find this an astonishing proposition. If Dr Jenkins did not know why the Leeds clinics had come to an end, he could have asked Dr Michalak. At any event, Dr White knew exactly why those sessions had come to an end. On what basis would Dr Jenkins have any reason to believe that there may be clinical safety issues?

223. Although the Leeds clinics had come to an end, the Claimant still attended Multi-Disciplinary Team Meetings at St James' Hospital on a Wednesday afternoon. He makes the following suggestion:-

> *"It appears that she has also stopped this activity earlier this year, but again has continued to be paid for this time. It would be helpful to know what her attendance was at these meetings. She was unable to quantify it and I wondered if you could find out whether there is any record of attendance there?"*

224. When Dr Jenkins met with Dr Michalak she was, in fact, shortly to go to Leeds to attend a Multi-Disciplinary Team Meeting. As a consequence she was wearing a badge provided to her by St James' in which she was described as a Consultant Nephrologist. She did have an honorary contract with them. Dr Jenkins raised this issue as well with Dr Lane, suggesting that to wear such a badge was inappropriate and misrepresented her role. Finally, although everybody had accepted that Dr Michalak had the necessary qualifications and experience to deal with nephrology referrals, Dr Jenkins raised the question with Dr Lane:-

> "*I would like your opinion as to whether it is appropriate for a non-CCST holder to be offering specialist nephrology clinics."*

225. We do have to ask ourselves why, when Dr Jenkins was simply supposed to be pursuing the job planning process, he thought it necessary to become involved in such matters. In our finding the answer to that question is that he had attended the third "secret" meeting in July of 2005 and he knew that the plan was to seek out and collate any possible material that could be used against Dr Michalak and he was participating in the "throw everything in" process. Due to those enquiries Dr Jenkins wrote to Dr Barnes questioning Dr Michalak's right to provide a Consultant level service within a specialist area for which she does not have a CCST (it was established in the course

of cross-examination that the Claimant did not need to hold a CCST in order to do so). As the Joint Committee on Higher Medical Training had told her in 2000:-

> *"The JCMHT believes you are a well trained Nephrologist who could hold down a Consultant post without difficulty, but cannot recommend you for the Specialist Register on what are, effectively, technical grounds."*

Dr Jenkins wrote to Caroline Smyth, in the Human Resources Department, asking her to check Dr Michalak's original letter of appointment to see whether there was any reference to her providing specialist nephrology work. He asked her to check what arrangements the Trust had made in relation to charging for Dr Michalak's attendance at St James' Hospital and he asked her to check whether proper processes had been followed in relation to the compressed hours arrangement.

Pressure from the Deanery

226. Further to Dr Neligan's meeting with Dr Michalak on 31 August, Dr Neligan had written to Dr Michalak setting out the options. This letter says:-

> *"I told you that the Post-Graduate Dean is not prepared to allow trainees to continue to be subjected to this sort of treatment. One way or another it must stop. Either you must change your behaviour or you will no longer be allowed to work with Junior Doctors."*

Dr Michalak gave no substantive response to that letter. What response could she make? She denied the allegations, but that was not an option that was open to her.

227. There had clearly been ongoing discussions between Professor Burr and Mr Parkes. The Deanery were expressing the view that steps had to be taken to protect Junior Doctors, failing which they may withdraw authorisation for the MAU as a training establishment. Mr Parkes' problem however was that he had next to no evidence to justify taking action against Dr Michalak. He had expected that Dr Neligan would provide the Trust with chapter and verse as to precise allegations of bullying. All he had come up with was imprecise grumbles. Dr Neligan tells us that he had kept notes of his interviews with the Doctors and that there were, within those notes, more specific allegations. Those notes were not provided to the Trust and have not been provided to this Tribunal. On 20 September 2005 Professor Burr emailed Dr Cadigan in the following terms:-

> *"Dear Paddy,*
> *Just a note to say that I met with the CE yesterday (John Parkes). I am pleased to say that he seems to understand the serious situation on the MAU at Pontefract, and understands that because of the bullying, the Consultant has to be taken out of contact with the juniors (*i.e. suspended while investigation takes place*).*

> *Under the circumstances, it would help if RCP report "pulls no punches" in relation to the MAU problems. It is likely that there will be quite a battle, and the Trust action is quite high risk but necessary I think."*

228. Thus the Deanery were liaising with the Director of Post-Graduate Training at the Royal College of Physicians to put as much pressure as possible upon the Trust to secure Dr Michalak's suspension. Mr Parkes, in cross-examination, contended that the Trust were very anxious about issues involving the bullying of Junior Doctors. He described Junior Doctors as a very vulnerable group and that the Trust had a grave responsibility towards them. What this Tribunal finds difficult to understand is that if he really believed that the Neligan Report was a matter of consequence he did nothing at all about it for over three months. It is, of course, true that Dr Neligan had not provided him with the precise information that he needed, but there was nothing at all to stop the Trust interviewing those Junior Doctors themselves, they did after all employ them, to obtain such information if it existed. It is also clear that a Junior Doctor had also complained to Dr Nelligan that they had been bullied by Dr Wong. This allegation was later repeated to Dr McInerney. The Trust took absolutely no action in relation to that complaint.

229. The Department of Health run an agency called the National Clinical Assessment Services ("NCAS"). Part of their function is to provide advice to Trusts about the management of Consultants and, in particular, to deal with issues relating to potential disciplinary action and/or suspension. In September 2005 Mr Parkes telephoned Karen Wadman, a Senior Advisor at NCAS, to seek advice in relation to Dr Michalak. On 29 September 2005, as is their practice, NCAS wrote to Mr Parkes confirming the telephone conversation. Their letter reads:-

> "*You advised that you were attending a meeting with the Deanery regarding concerns raised by eight of a group of eleven House Officers relating to the bullying and harassment and the general treatment of Junior Doctors. However, questions have also been raised by the juniors about the competency of the Doctor who you understand trained abroad and you felt that there could potentially also be cultural factors related to the Doctor's behaviour.*
>
> *We agreed the matter required further investigation and it would be important to establish clearly from the House Officers the precise nature of their concerns giving examples wherever possible."*

NCAS then referred Mr Parkes to the new NHS procedures known as "Maintaining High Professional Standards in the Modern NHS" (known as the "MHPS").

230. That letter is of course significant. We wonder where Mr Parkes obtained the idea that the Claimant's conduct could relate to the fact that she trained abroad. As we understand it he had had no direct contact or involvement with Dr Michalak. That idea must have been given to him by somebody and

we know that those ideas were being openly discussed as the second "secret" meeting. Mr Parkes was being advised by NCAS that precise information should be obtained from the House Officers. That was in September, but that was not done, ultimately, until January 2006.

Dr Wass

231. On 2 August 2005 Dr Alistair Wass, a Consultant in A&E, wrote a letter of complaint to Dr Barnes. This letter was copied to many other people, including Mr Parkes, Dr Lane, Mr Foster and Dr Jenkins. He complained about the fact that a patient suffering from Terminal Cancer had been admitted the Accident and Emergency Department at Pontefract, suffering from a Gastro-Intestinal Haemorrhage. He was initially assessed by a Junior Doctor working within the Accident and Emergency Department, who endeavoured to seek help from a Middle-Grade Doctor, Dr Varma. Dr Varma was part of Dr Michalak's team. Dr Varma had no speciality in gastro-intestinal work, and he formed the view that he could do nothing whatsoever to help this particular patient.

232. Dr Wass, who was the on-call Consultant, telephoned Dr Michalak to complain that her Registrar had failed to provide any assistance. Dr Michalak confirmed to him that Dr Varma was not a Gastro-Enterology trainee, and would not be able to provide any meaningful assistance to this unfortunate patient. As a consequence Dr Wass, as Dr DeHavilland points out, doing no more than his job, had to attend at the Pontefract General Infirmary to deal with this patient who subsequently died. This letter was noted as a complaint against Dr Michalak and was subsequently used as a basis for a complaint that she did not provide co-operation to her medical colleagues.

233. The facts do not however support that proposition. It was well-known that there was a problem at Pontefract in that they did not have a sufficient level of skill in gastro-enterology. As a consequence, there was a standing protocol that any patient suffering from gastro-intestinal bleeding should not be taken to the Accident and Emergency Department at Pontefract, but should be taken by the Ambulance Service to Pinderfields, Wakefield, where such expertise existed. This patient was brought to the wrong hospital. The Junior Doctor on the Accident and Emergency Department correctly referred the matter to a Registrar. That Registrar, however, correctly identified that he could not provide the patient with the treatment that was required, and that the appropriate person to attend was the on-call A&E Consultant, Dr Wass. Dr Barnes conceded that this letter, in reality, was a complaint about procedures and not about Dr Michalak. That complaint was not brought to Dr Michalak's attention at the time.

Complaint by Dr Davis

234. On 10 October 2005 Dr Mark Davis, a Consultant in A&E Medicine at Pinderfields, wrote a letter of complaint to Dr Barnes. The Accident and Emergency Department at Pinderfields had been closed down on 3 October 2005, because of a bed shortage. Medical admissions were diverted to

Pontefract. Dr Davis therefore had no work to do at Pinderfields, and he was asked to attend to help out at Pontefract, the Accident and Emergency Department being very busy because of the increased amount of work that was being taken there. He would have arrived at Pontefract at about 8:30, he did find the A&E Department extremely busy, with a backlog of patients. There was a delay in getting patients transferred to the MAU. The Clinical Site Manager had suggested that the reason why patients could not be transferred from A&E to the MAU, was that there were seven or eight patients on the MAU who had not been reviewed by a Consultant and who, accordingly, could not be discharged or moved out to another ward. Dr Michalak was on-call that night and so Dr Davis telephoned her and suggested that she might like to attend the hospital to provide support to her Registrar to see whether patients could be moved out and space created. Dr Michalak then telephoned the Clinical Site Manager who told her that there was no need for her to attend at the hospital (there would have been an expense involved had she done so) and so she took no further action.

235. This complaint was also deemed to be a complaint against Dr Michalak. On analysis, however, Dr Barnes acknowledged that the Claimant could not be criticised because she telephoned and was told that her attendance was not necessary. This was a complaint, again, about a Doctor who was being asked to do his job, namely to turn out when he was on-call, when Dr Michalak had no obligation to do so.

The Meeting of the Professional Advisory Panel of 7 November 2005

236. On 31 October 2005 Dr Dawson was appointed Medical Director at Mid Yorkshire, having been invited by Dr Naftalin to apply for that position. The Respondent Trust had been in substantial difficulties for some years. Because of early complaints made by Dr Tobin there was an inspection at the hospital and it was decided that it needed to go into special measures. In simple terms that means that the management of the hospital is overseen by the Department of Health and by various agencies who they appoint to do so. One of these agencies is a body known as the Performance Support Team. This is a closely-knit group of experts in various areas of healthcare who are put together in order to provide support and help to an ailing NHS Trust. Dr Naftalin had a part to play in that support team (as indeed did Dr McInerny).

237. As part of the MHPS adopted by the Respondent Trust, if it is proposed to take disciplinary action against a Doctor, the Medical Director must convene a Professional Advisory Panel ("PAP"). This consists of at least three Medical Consultants who are to advise the Medical Director as to appropriate action. Shortly after his appointment, having heard about the difficulties relating to Dr Michalak, in particular in regards to the Deanery Report, Dr Dawson convened a meeting of the Professional Advisory Panel. In attendance were Lynne Sherratt, Deputy Director of Human Resources, John Parkes, Chief Executive, Mr Simon Harrison, a Consultant, Dr Simon Williams, a Consultant, Dr Claire McDonald, Clinical Director of Pathology, and Dr Rob Lane, the Associate Medical Director who attended in place of Dr Dawson. These are all White/British people. Lynne Sherratt had, of

course, been at the second "secret" meeting.

238. The letter sent by Professor Burr was discussed. The panel agreed that the contents of that letter caused concern and recommended that the case should be investigated fully to establish the facts. Possible exclusion (which is what Professor Burr had wanted) was discussed but at that stage it was felt to be inappropriate. Dr Dawson frankly told us that he was disappointed by that decision because he believed that, at that stage, Dr Michalak should have been suspended. He had not however had the support of the PAP; neither had he obtained the support of NCAS.

239. On 16 November Mr Parkes came under further pressure from Professor Burr. Mr Parkes was reminded that on 19 September he had agreed that the Trust would institute disciplinary action with a possibility of suspension. The letter concludes:-

> "*The Deanery and College take a very serious view of the allegations raised at these two visits and agree that this matter needs to be dealt with urgently. Since I have not received any further communication from yourself, I would be grateful if you could provide me with an update of the Trust's action thusfar."*

The Investigation Begins

240. Dr Dawson decided that positive action was required and that, finally, he would arrange for a formal investigation to take place. Under the terms of the MHPS, whilst Dr Dawson would have acted as Case Manager, he needed to appoint a Case Investigator. Usually Consultants within the Trust would fulfil that role. Dr Dawson informed us that he could not identify anybody who could do that for him. Those Doctors who had the necessary training and experience, were either too busy or had just completed other lengthy investigations. He decided to appoint an external investigator.

241. That decision was, in our view, a surprising one. Dr Neligan had arrived at his conclusion that Dr Michalak was guilty of bullying Junior Doctors from interviewing eight Junior Doctors. Those Doctors could, presumably, be readily identified, as could any other Junior Doctors with whom Dr Michalak had worked. It would be a very short and discreet piece of investigation to interview those Junior Doctors. We conclude that even at that early stage, Dr Dawson had intended any such investigation to have far reaching parameters.

242. The MHPS provides guidelines as to how such investigations should take place. Pursuant to Paragraph 1.18 of the policy the Case Investigator:-

> *"Must formally involve a senior member of the medical or dental staff nominated by the Medical Staff Committee Chair or their Deputy, and agreed by the Trust."*

That was not done. The Respondents suggest that that need only to be done where clinical judgment is at issue. The policy does not, however, say

that.

243. Paragraph 1.20 reads:-

> *"The practitioner concerned must be informed in writing by the Case Manager as soon as it has been decided that an investigation is to be undertaken. The practitioner will be informed of the name of the Case Investigator and made aware of the specific allegations or concerns that have been raised. The practitioner must be given the opportunity to see any correspondence relating to the case together with a list of the people that the Case Investigator will interview."*

It was not until some time later that the Claimant was informed that she was being investigated, and insofar as a much wider investigation was being anticipated, she was not made aware of the specific allegations which were being investigated.

244. Paragraph 1.24 says:-

> *"The Case Investigator should complete the investigation within four weeks of appointment and submit their report to the Case Manager within a further five days."*

As will be seen, that certainly did not happen in this case.

245. On 1 December 2005 Dr Dawson appointed Dr McInerny as an Investigator. Dr McInerny was not employed by the Trust, she had been part of the Performance Support Team, she had a background in Human Resources and she had her own consultancy business. The Trust agreed to pay Dr McInerny a daily rate of £600 and, by the end of her investigation, she had earned in excess of £59,000.

246. On the face of it the investigation required of Dr McInerny should have been a short-lived affair. The only substantive issue that appeared to require investigation was the allegation relating to the bullying of Junior Doctors. This matter had, of course, already been investigated by Dr Neligan and so, one assumes, that Dr McInerny could very easily have got to the heart of this investigation without difficulty. Indeed she told the Tribunal that at first she anticipated a very quick conclusion to her investigation. Dr Dawson was very anxious to capitalise upon the commencement of this investigation. On 1 December he wrote to Professor Burr to confirm that the investigation had been initiated and telling Professor Burr that the Case Investigator would be in contact with him shortly, in order to obtain the necessary information. On 2 December 2005 Dr Dawson asked Dr Barnes to conduct a risk assessment to identify:-

> *"1. Whether exclusion is required to protect the interests of patients and other staff.*
>
> 2. *Whether exclusion is required to assist the investigative process if there is a clear risk that Dr Michalak will impede*

the gathering of evidence.

The risk assessment should include an analysis of the impact and/or risk to service should Dr Michalak be removed.

The risk assessment should also consider alternatives to exclusion such as:-

1. *Redeployment, restriction of duties to administrative research, or audit.*

2. *Restriction of clinical practice to certain forms of clinical duties.*

3. *The risk assessment should identify how feasible each of the alternatives to exclusion are."*

247. It must be remembered that the PAP had determined that it was not appropriate for Dr Michalak to be excluded at that stage until the matter had been further investigated. That investigation had only just been initiated. It is difficult for us to understand why, without the outcome of the investigation being known, Dr Dawson thought that it was appropriate to consider the issue of exclusion. When all is said and done, these issues of bullying had first surfaced three months before, if the Junior Doctors were alleged to be at risk, the Trust had exposed them to that risk for that period of time. If it was thought that Dr Michalak would apply pressure to the Junior Doctors to persuade them to withdraw their complaints, she had had three months to do so. We do not know why Dr Dawson did not think he could wait for the short period of time necessary for Dr McInerny to produce her preliminary findings.

248. Dr Barnes was subsequently to arrive at a conclusion that the Junior Doctors needed protecting from Dr Michalak during the investigation, that because of the nature of her duties it would be difficult to protect the staff without excluding her and it would be difficult to investigate bullying whilst was still working with those members of staff. She considered that there were sufficient resources to cover for Dr Michalak in the event that she was suspended.

249. Surprisingly, Dr Barnes did not know of the views of the PAP. She had no idea what the allegations against Dr Michalak were. She seems to have ignored the fact that that three month period had elapsed since these issues had first been raised, without any apparent problems being caused. We find it difficult to understand how anybody can assess risk in such a situation without having a fairly clear understanding of what it is that the Doctor is supposed to have done wrong. Dr Barnes was not able to explain why Dr Michalak could not have continued with her outpatient clinics, which involved no contact with Junior Doctors. Dr Barnes' advice was given to Dr Dawson on 15 December 2005.

250. Dr McInerny had continued with her preliminary preparations for this investigation. In evidence she told us that in December she had anticipated

that her investigation would simply involve the Junior Doctors and it would be an investigation which would take two or three weeks to complete. Surprisingly, therefore, as evidenced by a file note which she maintained, on 12 December 2005, she agreed with Dr Dawson that not only would she interview these Junior Doctors, but would also interview the previous trainees, senior nursing staff on the MAU, current SHOs, current SpR's, her Consultant colleagues, any secretarial staff that she has dealings with and A&E Consultant colleagues. Dr Dawson was to provide her with a list of names of everybody who would fit into those categories. Here, therefore, we have a situation where Dr Michalak is still at work, is unaware that this investigation is about to begin, is unaware what it is that she is supposed to have done wrong, save for the conversation that she had had with Dr Neligan, but the Respondents are planning to interview everybody and anybody with whom she had worked. Dr DeHavilland fairly depicts this exercise as one of trawling for negative comment.

251. On 23 December 2005 Dr Dawson wrote to Dr Neligan to update him as to the current position. Perhaps his approach to the investigation of Dr Michalak is illustrated in the final paragraph of this letter, when Dr Dawson states:-

> *"I apologise if this seems bureaucratic and long-winded and especially if it appears that we are not trusting of fellow professionals' judgments but in a delicate situation such as this it is important that we are seen to have conducted an impartial and thorough review of all the evidence."*

252. This is of course has echoes of the first "secret" meeting, when it was agreed that the Trust had to be "seen to" be supportive of Dr Michalak .

253. Two further incidents then arose, which were ultimately used to justify Dr Michalak's suspension and then her subsequent dismissal.

The Complaint by Mrs Howe

254. On 8 December 2005 Dr Michalak was busy in her office dealing with clinical issues and endeavouring to deal with her email correspondence. She had a difficulty in accessing her email system and so she contacted the Trust's IT Support Department by telephone and spoke to Mrs Howe. Many of us will, no doubt, have had the experience of being busy, anxious to complete tasks on a computer, but then faced with the frustration of a computer that is not functioning as it should do. Lisa Howe obviously had difficulty in providing assistance to Dr Michalak. Dr Michalak no doubt became frustrated by this lack of help. Lisa Howe complained, in an email to her Service Delivery Manager, that:-

> *"Her attitude was less than professional. She spoke to me in an abusive and rude manner."*

There is no mention of the type of rude and abusive language allegedly used. Lisa Howe complained that Dr Michalak on occasions put a telephone

down whilst obviously attending to other demands on her time. Lisa Howe then complains that:-

> *"The user said that she was not happy with the level of assistance I had offered despite the fact that I had actually not only put up with being spoken to in a dreadful manner and continued to assist the user, but had given the user access to her email via alternative means."*

255. It is clear that that complaint was escalated to the Human Resources Department and formed part of Ms Lavery's file.

The Complaint by Mrs Paddock

256. This issue refers back to the earlier complaint made by Dr Almari, the Consultant Radiologist. Dr Michalak was on-call on 31 December, as was Dr Almari. Her Registrar contacted her in relation to a patient who he believed required a CT scan. Dr Michalak authorised the Registrar to make the appropriate referral to Dr Almari. The Registrar endeavoured to contact Dr Almari by speaking to the Switchboard Operator, Mrs Paddock. Mrs Paddock believed that such referrals should be made on a Consultant-to-Consultant basis. Whilst everybody is entitled to their own views, we find it surprising that a Switchboard Operator would think it appropriate to subvert an attempt by one Doctor to speak to another. Mrs Paddock however refused to put the Registrar through the Dr Almari, on the basis that such referrals had to be on a Consultant-to-Consultant basis. Instead, she put the Registrar through to Dr Michalak.

257. Shortly thereafter Dr Michalak spoke to Mrs Paddock on the phone and questioned why she would not put her Registrar through the Consultant Radiologist. Mrs Paddock explained to her that she was only following procedures set down by the Radiologists. Dr Michalak sought to explain that there was no such procedure and that she should have put the Registrar through to the Radiologist. Dr Michalak then asked to speak to the on-call manager, who was Mr Curtis. Clearly she wanted to prevent these difficulties occurring in the future. There was then a conversation between Dr Michalak and Mr Curtis, Dr Michalak was trying to explain her point of view and Mr Curtis told her to "shut up". Dr Michalak then spoke to the Consultant Radiologist direct with a view to resolving the difficulty.

258. It may well be that Mrs Paddock was upset at being caught in the middle of this dispute between two sides of the profession. She makes no suggestion, however, that Dr Michalak was abusive or rude to her. Mrs Paddock simply had a belief that a protocol existed which Dr Michalak was seeking to subvert, when in fact Dr Michalak had every good reason to believe that no such protocol did exist, Dr White having already confirmed that to her.

259. Notwithstanding this, the Respondents regarded this as an incident of "bullying", which would also justify her suspension and subsequent dismissal.

Suspension

260. By 3 January 2006 Dr McInerny had had informal discussions with Dr Neligan. She obviously wanted to find out from him what information he had actually received from the Junior Doctors and who had said what. On 3 January 2006 Dr McInerny wrote to Dr Dawson updating him as to her present position and her letter states as follows:-

> *"I would propose, at first, to deal only with the bullying and harassment allegations and, if issues about competence arise, review the situation. I understand that Sue has done a risk assessment which I haven't seen. However, having now had the opportunity to review Paddy's report and talk to him, unless there are other overriding considerations, I hope that the Trust will seriously consider excluding Dr Michalak during the course of the investigation and making it clear that any contact with potential witnesses before or during the investigation would constitute serious personal misconduct which could lead to dismissal. This is because of the nature of the allegations and the risk, or the perception of that risk, that she might threaten witnesses, especially the juniors, who might then be less willing to give evidence. Of course she may wish me to interview people to support her point of view, but if they are also on our list, I can't see that she needs to speak to them, merely supply their names."*

We sense the influence of Dr Neligan in the making of these recommendations.

261. On 4 January there is an email from Emma Lavery to Lynne Sherratt which makes it clear that by this time the Howe and Paddock complaint had been passed on to her and, in turn, Ms Lavery passed on this information to Lynne Sherratt suggesting:-

> *"Should they not be part of the current ongoing bigger investigation as they are potentially provide more of the same evidence*."

262. Prior to suspending Dr Michalak, as Dr Dawson wanted to do, he needed to seek the advice of the PAP. When that panel had met in November, they had refused to sanction her suspension. It is clear that that panel should have been reconvened before suspension was further considered. The importance of the PAP is that it would provide some independent scrutiny of Dr Dawson's actions. Dr Dawson accepts that he did not reconvene the PAP, although he tells us that he telephoned some of the individual members of that panel to canvass their views.

263. The other area of external scrutiny which is supposed to provide protection to Doctors, is that Trusts are required to obtain advice from NCAS before suspending a Doctor. Dr Dawson asked Caroline Smyth, the Deputy Director of Human Resources, to contact NCAS to obtain their advice. That conversation took place on 10 January 2006 and, as usual, was confirmed in

a letter from Karen Wadman from the NCAS. That letter states:-

> *"This case relates to an initial referral made by the Trust's Chief Executive, John Parkes, at the end of September 2005 following which the case was closed. You advised that since this time further complaints against the practitioner have been received alleging bullying and harassment. In response to this and the original concerns you told me that the Clinical Director for the area had undertaken a risk assessment and it is felt that the continued presence of the practitioner would compromise a full investigation. You also confirmed that redeployment was not thought to be an option because the Doctor would still come into contact with training grades of staff."*
>
> *"The Trust had deferred the decision to formally exclude pending discussion with NCAS and I agreed exclusion appeared to be an appropriate measure in the context as described above."*

264. The only "*further complaints*" that had been received since September 2005 were not from Junior Doctors but, presumably, related to Mrs Paddock and Mrs Howe. It seems improbable that Caroline Smyth provided NCAS with the actual facts relating to those incidents. It seems improbable that NCAS had been informed that the risk assessment that had been carried out by Dr Barnes was on the basis that she was wholly ignorant of the nature of the allegations made against Dr Michalak. It also seems unlikely that Caroline Smyth informed NCAS that Dr Michalak could easily have continued with her outpatient clinics without any significant contact with Junior Doctors.

265. By this stage however Dr Dawson believed all necessary pieces were in place. He had spoken to some of the PAP who had agreed with him that Dr Michalak should be excluded and NCAS had now provided the necessary advice, albeit based, it would appear, on inaccurate information.

266. Dr Michalak was called to a meeting on 16 January 2006 with Dr Dawson and Caroline Smyth. She was represented at that meeting by Ursula Ross. She was excluded. The terms of her exclusion were set out in a letter from Dr Dawson of 16 January 2006 in the following terms:-

> *"Throughout the period of your exclusion, you are able to attend the Trust's premises to participate in the investigation, to undertake continuing professional development and audit and to attend meetings with members of the Directorate Management Teams. Should you wish to attend the Trust's premises, I would ask that you inform, in advance, your Lead Clinician Dr Jenkins, your Clinical Director, Dr Barnes or Mr Forster, General Manager. I must ask that you do not discuss the investigation with colleagues or attempt to influence any individuals who may be interviewed as part of the investigation."*

267. The MHPS prescribes the rules relating to the exclusion of a practitioner. Paragraph 2.9 reads:-

> *"The Trust will not exclude a practitioner for more than four weeks at a time. The justification for continued exclusion must be reviewed on a regular basis and before any further four week period of exclusion is imposed. Key Officers and the Trust Board have responsibilities for ensuring that the process is carried out quickly and fairly, kept under review and that the total period of exclusion is not prolonged."*

268. Pursuant to Paragraph 2.35:-

> *"The exclusion will lapse and the practitioner will be entitled to return to work at the end of the four week period if the exclusion is not actively reviewed."*

269. Pursuant to Paragraph 2.37:-

> *"The Trust Board must take review action before the end of each four week period. After three exclusions, the NCAS must be called in."*

270. Pursuant to Paragraph 2.42:-

> *"Normally there will be a maximum limit of six months' exclusion, except for those cases involving criminal investigations of the practitioner concerned."*

271. Having been excluded, therefore, on 16 January 2006, within four weeks, namely by 13 February 2006, a formal review was required. In the absence of such a review the Claimant's exclusion would lapse. Review was the responsibility of the Trust Board. Dr Dawson alleged that he carried out a review within the four week period. Under cross-examination he made various suggestions as to when that review took place, when it was pointed out that his evidence could not be true, he adjusted his position. It was impossible for this Tribunal to form a view that any formal review had taken place and it therefore seems apparent that the Claimant's exclusion had become improper.

272. By 20 January 2006 Dr McInerny had interviewed a number of Junior Doctors. Although it appeared that some Doctors may have criticised her style only one allegation of bullying had been made. Dr Polak had suggested that he had heard Dr Michalak call Dr Raju "stupid". When Dr Raju was interviewed however, she denied that that had occurred.

273. On 20 January Dr McInerny appraised Dr Dawson as to the current state of her investigations. Common-sense would have suggested that by that stage the disciplinary action should have been abandoned, the exclusion rescinded and further thought should be given to the necessity of providing additional training to Dr Michalak in relation to her dealings with Junior Doctors. Nothing of the sort occurred. Dr Dawson then gave Dr McInerny the file that Ms Lavery had been maintaining upon Dr Michalak. She was asked to read through that file and to broaden her investigation to include all matters

referred to within that file. Dr McInerny told us that she was surprised to see the existence of such a file, she did say that this was not the only Trust that kept files of that sort, but acknowledged that the practice of doing so was entirely unacceptable. Notwithstanding that she accepted the instruction to widen her investigation, Dr DeHavilland would suggest that she did so by reason of the attraction of the £600 a day fee. On 23 January 2006 Dr Dawson wrote to Dr Michalak to inform her that the investigation was being enlarged.

274. On 10 February 2006 Dr Barnes again wrote to Dr Michalak to inform her that her exclusion had been reviewed and extended. She was told that her exclusion would be further reviewed every two weeks. We have already noted that there is no evidence to show that such a review had in fact occurred.

275. Pursuant to MHPS, where a Doctor is excluded, the Trust has to appoint a Board Member as a "Designated Board Member". Paragraph 2.45 states:-

> *"The Designated Board Member must also ensure, among other matters, that timeframes for investigation or exclusion are consistent with the principles of Article 6 of the European Convention on Human Rights [which, broadly speaking, sets out the framework of the rights to a fair trial]."*

Mr Roger Grasby, a Non-Executive Director of the Board, was appointed Designated Member. This is yet another means whereby there is a check on the activities of the Trust where a Doctor has been excluded.

276. On 13 February 2006 Dr McInerny provided Dr Dawson with a written summary of the present state of her investigations. In relation to the allegation of bullying junior staff, she states as follows:-

> *"We have interviewed a number of people who have clearly been very distressed by Dr M's behaviour and consider it to be unacceptable. Equally we have also talked to a number who have not had a problem with the way that she behaves. The former group outweigh the latter, and many of those who did not have a problem with her, nevertheless regard her behaviour as different to that of other Consultants; "old-fashioned" was frequently used to describe her. A number of trainees, particularly those from the Indian sub-continent, seemed to prefer her style to the rather more informal approach taken by other Consultants. Some also remarked that while she was different she was not as bad as the Consultants at home. One trainee described having patients' notes thrown at him on ward rounds in India. While a number of trainees and nursing staff consider her behaviour to be unacceptable, the wide range of different reactions to her behaviour may mean that any case based purely on this problem would be difficult to prove."*

To the allegation of "bullying of other staff" the note reads as follows:-

> *"We have two corroborated statements of incidents when Dr Michalak's behaviour caused distress to staff, other than Junior Doctors, to the extent that they were reduced to tears. Both are robust witnesses*."

277. We assume that this relates to Mrs Howe and Mrs Paddock. As far as we are aware no witness statements were taken from those two people, certainly we have never seen them. We assume that the witnesses referred to are the managers to whom complaints were made.

278. The note continues:-

> *"Her Secretary can also describe instances of behaviour that I think could be said to be unacceptable by any reasonable person. Some of this is corroborated by other staff who, for example, heard Dr Michalak shouting at her, but we don't have specific dates."*

Dr Michalak's Secretary was Mrs Sibary. We have already spoken of the telephone conversation between Dr Michalak and Mrs Sibary in relation to the meeting that Dr Michalak thought Mrs Sibary had arranged with Dr Almari.

There was another incident of which Mrs Sibary complains. On one occasion Dr Michalak telephoned Mrs Sibary first thing in the morning to say that she was going to be late in and asked for the message to be passed on to a particular member of the clinical staff. Mrs Sibary passed on that message, but to the wrong person, which subsequently caused Dr Michalak some embarrassment. When Dr Michalak found out what had happened, Mrs Sibary complains that Dr Michalak spoke to her in a raised voice complaining about her failure to follow instructions and telling her to be more careful in the future. That conversation was apparently overheard by nearby nursing staff. Originally it was being suggested that the nurses were some 25 yards away, thus emphasising that Dr Michalak must have been shouting very loud. Whilst being cross examined Mrs Sibary accepted that that was a gross overestimate of the distance and that it was June Townsend who had suggested that distance to her.

There is no suggestion that Dr Michalak used inappropriate language. When Mrs Sibary gave evidence to us she accepted that she was a particularly shy and timid individual, that others may not have been upset by that incident, but that she was. She recognised that Dr Michalak probably did not know that she had upset her and that when she next saw Dr Michalak at the end of the ward round, matters continued as though nothing at all had happened. Those incidents were also considered to be of considerable significance and were given as a reason for her dismissal.

279. Dr McInerny's note then continues:-

> *"I also understand that, since Dr M was in the hospital last Friday and spent an hour with her, her Secretary is getting increasingly anxious and is threatening to withdraw her statement (which is one*

of the few that Dr M has not yet been sent."

280. There was of course no reason why, in the terms of her exclusion, Dr Michalak should not have been in the hospital. That note makes it clear that by 13 February 2006 Mrs Sibary had already made a statement to Dr McInerny. That statement had never been disclosed, although a subsequent statement was. We are then faced with the mystery that Mrs Sibary says that she only made one statement.

281. The note deals with issues relating to "*the compliance with her contract*". This notes makes reference to general allegations of poor timekeeping and it reports episodes of sickness and:-

> *"Seeming refusal to agree her job plan or to stick to what others had regarded as agreements*."

She then makes reference to an incident involving the X-Ray Register.

The X-Ray Register

282. On a Friday lunchtime the Post-Graduate Education Department arrange for the Radiology Department to do a presentation to Doctors. This is part of their compulsory personal development. Doctors having to accumulate so many hours of approved activity each year. In order to acquire those points a register was maintained which people signed to show their attendance. Attendance at the sessions was not compulsory. It seems to be accepted that a Consultant in Dr Michalak's position would have very little difficulty in accumulating the necessary CPD points each year.

283. These meetings began at 12:15pm. By reason of other commitments Dr Michalak, if she attended, was usually not able to get there until 12:30pm. She attended one such meeting on 23 September 2005. That meeting was also attended by Dr Abbasi and Dr Bangad. Allegedly Dr Abbasi observed Dr Michalak with the attendance register. He contends that he was surprised to see her at that meeting because she was an infrequent attender. At the end of the meeting, for reasons that are far from clear, Dr Bangad and Dr Abbasi decided to look at the register and noted that on previous dates Dr Michalak had signed the register, hers being the last name on the register for the day, on dates when Dr Abbasi believed the Claimant had not been at that meeting. Dr Abbasi gave this information to Dr McInerny suggesting that she had fraudulently signed the register to say she was present when she had not been.

284. That complaint was at best suspect. As the register reveals, on occasions Dr Michalak had signed to be in attendance when Dr Abbasi was not actually there. Also, as in cross-examination Dr Abbasi had to admit, on occasions he would sign Dr Bangad in when Dr Bangad was not there.

285. The note continues:-

> *"Included in this section is the episode of the alleged alteration of the X-Ray Meeting Register by adding her name to the bottom of the pages relating to previous meetings. We think that the person who saw her do this is Dr Abbasi but he is very reluctant to say so and now apparently wants to withdraw large chunks of his statement. Dr Dawson is going to talk to him but, if necessary, I will produce a statement setting out what he told me at the interview."*

286. Similarly Dr Abbasi allegedly only gave one statement, which post-dated this note. His first statement referred to in this note has never been produced. Dr McInerny acknowledged that if a witness seeks to withdraw evidence previously given, one interpretation must be that that witness is unhappy with the evidence.

287. The note then refers to "*issues of clinical conduct*". These relate to two alleged incidents when Dr Michalak refused to come in out of hours. We assume that these include the complaint of Dr Davis . The note refers to her refusal to see patients on HDU, it is common ground that the MAU Consultants were not required to see patients on HDU, and that she had refused to allow junior staff to leave the ward round to see patients in the resuscitation room. It alleges that she refuses to adhere to the policy of Consultant-to-Consultant referral for head scans at night, but it is now accepted that she had very good reason to believe that no such policy existed. It makes reference to the excessive length of her ward round, but it is clear that she was following what was regarded as good practice. The report refers to her insistence that as many juniors as possible stay with her on the round, our understanding is that that is precisely the training opportunity that Dr Michalak was supposed to give Junior Doctors. Dr McInerny suggests that:-

> *"These issues need to be considered as a whole by an external expert in acute medicine*."

In the event no such expert evidence was obtained.

288. Finally, Dr McInerny under the heading "Clinical Competence" raises the following issue:-

> "*One issue has repeatedly surfaced, in fact I don't think any of the clinical staff have failed to mention it, and that is the issue of her apparent obsession with the diagnosis of diabetes. This is obviously something about which I am not qualified to comment. It has been mentioned to such a degree that it should be considered in the first instance by the external expert who looks at the clinical conduct issues, and may then require a separate enquiry under the competence section of the guidance."*

289. Again there is undisputed evidence as to what the position in this regard was. It is accepted good practice that all patients admitted into the Accident and Emergency Department should have their blood glucose levels measured. That was regularly not occurring at Pontefract. Dr Michalak was

aware that such tests should be performed and repeatedly remonstrated with Junior Doctors who had failed to do so. This was translated as an apparent "obsession with the diagnosis of diabetes". It is true that at some stage an allegation was made that a patient had been informed by Dr Michalak that they suffered from diabetes when, in fact, the test results did not justify such a diagnosis. That patient has never, however, been identified or his or her records examined to see whether there was any truth in that assertion.

290. We would have thought that by that stage it would have been clear to an alleged skilled and experienced investigator, such as Dr McInerny, that the strategy in relation to this investigation and exclusion required review. In fact, on 8 February 2006, at the request of Dr Dawson, Dr McInerny had telephoned NCAS to update them as to the current position. We have been shown their file note of that telephone conversation. The note reads:-

> "*She explained that the exclusion of the Doctor now coming to the end of four weeks was set to continue, partly because the investigation was still ongoing and partly because, when a request had been made to interview Dr Michalak the Doctor had reported sick and was still on sick absence.*
>
> *Ms McInerny explained that the initial investigation had uncovered wider concerns both in the Doctor's alleged behaviour and also some clinical and other irregularities as well as some alleged concerns over professional behaviour on the part of the Doctor. This were being investigated and witness statements obtained*.
>
> *Ms McInerny raised the possibility that the Doctor may continue on protracted sick leave or that the Doctor may resign."*

291. Once again it is clear that the full picture was not being given to NCAS. We do not understand why Dr McInerny had not told NCAS that the incident that originally had led to the Claimant's exclusion, namely the alleged bullying of Junior Doctors would be "*difficult to prove*". We conclude that the Trust had in mind that their actions may have the desired effect of persuading Dr Michalak to resign .

292. On 3 March 2006 Dr Dawson wrote at length to Mr Grasby setting out the background behind Dr Michalak's exclusion. As was pointed out in cross-examination, that summary, at best, has some significant omissions, in particular there is a failure to inform Mr Grasby that the investigator had already concluded that the allegations relating to the Junior Doctors would be difficult to prove.

293. On 6 March 2006 a further PAP was convened. Retrospectively this panel approved the exclusion of Dr Michalak and the conduct of the investigation was discussed.

294. On 10 March 2006 a formal review meeting did take place between Dr Dawson, Dr McInerny, June Townend (HR), and Caroline Smyth (all White/ British people). That review was formally documented and agreed the

extension of Dr Michalak's exclusion. Of course it was Dr Michalak's contention that that exclusion had already lapsed in February, no formal review having then occurred. Dr Michalak made that plain to Dr Dawson by her letter of 20 March when she demanded that a plan be formed to arrange for her return to clinical duties. Unsurprisingly that letter did not have its desired effect. On 21 March 2006 Dr Dawson wrote to Dr Michalak confirming not only that her exclusion had been reviewed and extended, but the terms had been amended as follows:-

> "*The original terms of your exclusion should be amended so that you should not be allowed to make contact with anyone employed by the Trust either in person or via the telephone other than those individuals identified in the correspondence dated 26 January 2006, or those individuals directly involved in the case investigation. The reason for extending the terms of the exclusion to this extent is that should you make contact with those individuals who have been or are due to be interviewed as part of this investigation, this may be deemed as interference with the investigative process."*

295. Dr DeHavilland depicted these amended terms of exclusion as being equivalent to "house-arrest". He points out that many of his personal friends are employed by the Trust and accordingly he was not able to invite them to his home, nor take his wife to theirs. He was not able to invite their children to his infant sons birthday party because of the risk that other members of the Trust may be present. Access to Occupational Health was denied to Dr Michalak, because the Doctors there were employed by the Trust. We wonder why Dr Dawson believed that such draconian terms of exclusion were appropriate when, in effect, the evidence against Dr Michalak, if anything, was unravelling. The one possible explanation is that this was one further way of completely isolating Dr Michalak from her friends and colleagues to exacerbate her position and to increase the likelihood that either her health would deteriorate further or that she would be encouraged to give up the fight and to resign.

296. Predictably Dr Dawson acknowledged receipt of Dr Michalak's letter indicating her intention to return to work and he formally instructed her not to do so.

Clinical Excellence Awards

297. In 2003 the NHS introduced a means whereby Consultants could achieve additional pay by securing what were known as Clinical Excellence Awards. Essentially this involved Consultants being able to demonstrate that they had carried out work, research or other duties over and above their contractual duties which would justify an award. The Clinical Excellence Awards would range between one and five points and would reflect additional pay to which that Consultant would be entitled throughout the rest of their career within the NHS and would also contribute towards their pension entitlement. Clinical Excellence Awards are therefore extremely valuable things.

298. There has been an ongoing debate within the National Health Service as to

the appropriate way of granting Clinical Excellence Awards. Within the knowledge of this Tribunal there was a time when this was done by a committee of "men in grey suits", through a process that was entirely opaque and which led to many complaints of unfairness. Efforts have been made to create more transparent procedures to try and ensure that these awards were distributed in a way that truly reflected excellence as opposed to prejudice.

299. The Respondent Trust had created such a process. It involved all Consultants who, on the face of it, were eligible to apply, being invited to apply. There was a detailed application form to complete, setting out those matters that the Consultant wished to have taken into account to justify the award. It was made clear that one particular act of excellence could only attract one Clinical Excellence Award and that in subsequent years applications needed to be based on entirely different grounds.

300. The Trust created a panel of people who were eligible to mark the applications. Some of those scorers had permanent places on the panel, for example the Chief Executive, in this case Mr Parkes and the Finance Director, Mr Waite. Some of the scorers were clinicians employed by the Trust, and there were some who were external to the Trust who volunteered to perform this role. There were sixteen scorers in all. These scorers form the Local Awards Committee ("LAC").

301. The number of points available depended upon the number of Consultants employed within a Trust, and for the year 2004/2005 the Respondent Trust had 72 points available for allocation. Each application can achieve a maximum of 20 points. The scorers however are required to divide their scores into four separate domains, each of which can attract between 1 and 5 points. The domains are highly subjective and the scorers have to score each of the applications in relation to "delivering a high quality service, developing a high quality service, managing a high quality service, research, teaching and training", each of those domains being scored on the basis of "negligible" attracting 1 point, "slight" attracting 2 points, "moderate" attracting 3 points, "good" attracting 4 points and finally "outstanding" attracting 5 points. It would appear that the majority of Consultants who are eligible to apply for a CEA will apply. In the 2004/2005 round, 71 Consultants, including the Claimant, did apply.

302. In order to be eligible for the award the following criteria have to be met:-

Satisfactory appraisal process signed off by employer and Consultant.

Job plan and contractual obligations are fulfilled.

Observance of Private Practice "Code of Conduct".

No adverse outcome for the Consultant following disciplinary action by employer or General Medical Council or General Dental Council.

(See the NHS Guide of August 2003).

303. Believing that she was eligible for such an award, on 17 February 2006 the Claimant completed and submitted her application. She was, of course, at that time excluded. She did not therefore have access to her office or her personal records retained within that office neither did she have access to the hospital intranet system. When submitting her application to Mandy Williamson, the Trust Medical Staffing Manager who administered this process, she asked Mandy Williamson to obtain the relevant appraisal information and attach it to her application. The application is in three parts, Part 1(a) which is completed by the applicant containing full details of her identity and of her work history. Part 1(b) contains all the material upon which the applicant seeks to rely in support of her application and Part 2 is completed by the Medical Director who oversees the process. When Dr Dawson received Dr Michalak's application, the first question that he needed to answer on Part 2 was whether the Claimant met the eligibility criteria. He answered that question "*yes*". He was then required to indicate the level of his support, his response being "*do not support*". In response to the question:-

> "*Is the Consultant to the best of your knowledge working to the standards of professional and personal conduct required by the GMC and/or the GDC?"*

He responded with a "*?* "

304. In response to the question:-

> "*Has the Consultant during the last twelve months had a formal appraisal*?"

He put *"? No*"

To the question
"*Agreed a job plan*?"
He put "*no*".

To the question
"*Fulfilled their contractual obligation?"*
He responded "*?*"

To the question
"*Complied with the Private Practice Code of Conduct?"*
He responded "*yes*".

305. In response to the question:-

> "*Are you aware of any actual or potential disciplinary or professional proceedings inside or outside the Trust?"*

He responded "*yes*".

306. In the box entitled:-

> "*Any additional relevant information which may assist the panel to consider this application*."

He said:-

> "*Has not submitted appraisal documents although they have been issued. In dispute over current job plan which has changed from that stated in her submission. Subject to a formal investigation at the moment following allegations about personal and professional conduct."*

307. Dr Dawson, as Medical Director, was entitled to determine whether applications were eligible to go forward for marking. On 7 March 2006 he considered Dr Michalak's application. He concluded that she was not eligible. He contends that there was no documented confirmation of her having undergone an appraisal within the preceding twelve months. There was an ongoing dispute over her job plan. There was uncertainty as to whether she was fulfilling her contractual obligations and working to the standard of professional and personal conduct required by the GMC. He knew there to be an ongoing investigation which could give rise to potential disciplinary proceedings.

308. On 10 March 2006 the LAC met in preparation for the scoring process. Dr Dawson briefed the members of that committee as to the number of applications that had been received and those that he had rejected and he explained why. The committee agreed that Dr Michalak's application should not proceed to marking. It should be said that other applications were similarly rejected by reason of eligibility issues.

309. Dr Dawson then, apparently, had second thoughts. He was aware that Dr Michalak contended that she had been appraised in August 2005. Although it appears that the Post-Graduate Department had no computer record of that appraisal, there is no doubt that on 23 August 2005 Dr Michalak was appraised by Dr McDonald Hall. He accepted that it was not entirely Dr Michalak's fault that her job plan review had not been concluded and that, indeed, there were many other Consultants in the same position. He appreciated that the alleged disciplinary offences which were currently being investigated, post-dated the period for which these Clinical Excellence Awards were being granted. He therefore decided that Dr Michalak's application should go forward for scoring.

310. Her application was therefore distributed to all the panel members on 23 August 2006 by Mandy Williamson. What, however, she should have done was to omit Section 1(a) of the application form. The procedure that had been agreed within this Trust was that all applications would be scored anonymously. It was accepted that this process was less than perfect because the contents of the application itself could lead to those who worked within the Trust being able to identify who the applicant was. Notwithstanding that, that was the Trust process. Mandy Williamson then

realised the error that she had made and sought to recall or recover all the applications that had been sent out. The majority were recovered before the scorers had had the opportunity to look at the document, but by no means all.

311. The Claimant was oblivious to all that had happened. On 4 April 2006 she had written to Dianne Nicholls asking for a copy of the application as signed off by Dr Dawson and expressing her anxiety that her application be treated fairly, at the same time as other applications and without discrimination. Mrs Nicholls responded on 18 April saying:-

> *"I can confirm that your application has been received and was signed by Dr Dawson on 7 April 2006 and will be dealt with in accordance with procedure."*

312. At the date that Mrs Nicholls wrote that letter she knew full well that Dr Dawson had withdrawn the Claimant's application from the scoring process. There is absolutely no doubt that Mrs Nicholls deliberately misled Dr Michalak by writing to her in those terms.

313. The Scoring Committee met on 18 September 2006. Dr Dawson was in attendance. The minutes of that meeting record:-

> *"Dr Dawson confirmed that we had received both Mr Parkes' and Mr Waite's scores as well as Drs Batin and Nappers."*

It is accepted that that was not true. It is now conceded by the Respondents that Mr Parkes and Mr Waite had not scored any of the applications. This fact was only revealed by Dr De Havilland's analysis of the scores when he noted that Mr Parkes had submitted identical marks to those of Mr Waite. Bearing in mind that each applicant could score between one and twenty, that the marking process was extremely subjective and that there were 71 applicants to mark, it is conceded that it is statistically impossible for two scorers to mark all 71 applicants identically. It is now accepted that what happened was that Mr Parkes and Mr Waite either could not be bothered to score the applications or were too busy to do so. They asked Mandy Williamson to record their scores as the average of all the other scores given by each of the scorers for each of the applicants. In that way, it is said, they would be shown as having participated in the process whilst at the same time the average scores inserted would not materially alter the position that each applicant would appear on the league table.

314. It then transpired that although Dr Michalak's application had been distributed to all the scorers not everybody had got round to scoring her. One of the panel commented that it was unfair to score her now because she had forgotten the basis upon which she had scored the others. Dr Dawson suggested a process whereby she would be scored alongside a random number of other applications. Mrs Nicholls advised against that process and said that she should be scored with everyone else.

315. Surprisingly there was then a lengthy discussion as to how the points would

be allocated. An agreement was reached as to how the points would be distributed and where the cut-off point would be. Those who had not yet scored Dr Michalak were then asked to do so. Of course by that stage, it was highly likely that those scorers knew the identity of the Claimant, that she was the subject of disciplinary action and that Dr Dawson had not recommended that she receive an award. Unsurprisingly when all the awards were collated, and Mr Parkes' and Mr Waite's average scores adjusted, Dr Michalak fell below the qualifying line.

316. There is, however, an appeal process against that decision. The appeal lies only against procedural irregularities, it is not open for a candidate to appeal against the scores that have been awarded.

317. Mandy Williamson had the job of preparing a report to be submitted to the National Clinical Awards Committee. That report was approved by Dr Dawson. The report contains the following paragraph:-

> *"Four members of the original panel, Mr Parkes, Chief Executive, Mr Waite, Director of Finance, Dr Napper (PCT Representative) and Dr Batin, Consultant Cardiologist, were unable to attend the panel meeting held on Monday 18 September 2006. They had all previously scored the applicants and their scores were taken into consideration. They were asked if they would confirm their agreement with the outcome of the panel meeting held in their absence."*

That dishonest statement that Mr Waite and Mr Parkes had scored the applicants was thereby repeated.

318. The applicant was dissatisfied with the outcome of her application. She indicated an intention to appeal and began trying to seek out information. She had discovered from one of the members of the panel that her application had not been scored at the same time as those sent out to the panel members at the first sift and, on 27 April 2007, she wrote to Mrs Williamson asking for more information in relation to that. She also raised the following query:-

> *"I should also like confirmation of whether or not my then current appraisal information was submitted with my application. You will recall I had to ask you to attach this as a favour, in view of the fact that I was unable to do so myself."*

319. Mandy Williamson responded on 22 May 2007. She provided Dr Michalak with details of those who had attended the award panel and she said:-

> *"Your application was circulated to panel members prior to the scoring meeting held on Monday 18 September 2006 with current appraisal information and the scores for your application were taken into account at the same time the points were allocated for all applications received."*

320. Mandy Williamson accepted that that letter was entirely misleading. She knew that despite being requested by Dr Michalak to do so, she had not attached the appraisal information to Dr Michalak's application form because she could not find it. When cross-examined about this Mandy Williamson acknowledged that she knew that that part of the letter was deliberately misleading but that it was written upon the specific instructions of Dr Dawson. Dr Dawson did not deny having given those instructions but was unable to provide an explanation for them. The explanation however becomes self-evident in the light of subsequent events.

321. On 1 June 2007 Dr Michalak wrote to Mandy Williamson seeking further information in preparation for her appeal. Mandy Williamson responded to that letter on 4 June 2007. Once again she tells us that that letter was written upon the express instruction of Dr Dawson and Dr Dawson acknowledges that to be the case. In that letter Mandy Williamson says:-

> *"We have to ensure that decisions are properly documented and that decision-making processes are transparent, fair and based on clear evidence."*
>
> "*This is a robust regional and national process which the Trust adheres to and is designed as a check on diversity and equality."*
>
> *"I confirm that the scores received from all panel members were put onto the spreadsheet which I sent you and that all panel members scored your application. Four members of the original panel, Mr Parkes, Chief Executive, Mr Waite, Director of Finance, Dr Napper (PCT Representative) and Dr Batin, Consultant Cardiologist, were unable to attend the panel meeting held on Monday 18 September 2006. They had all previously scored the applications including your own and their scores were taken into consideration. All members of the panel therefore scored all applicatio*ns."

322. That falsehood was then repeated by Mandy Williamson when she spoke to a Mr Richard Griffin of the ACCEA on 5 June 2007, her note of that telephone conversation reading:-

> *"Dr Michalak informed Mr Griffin that she was aware that two panel members had not scored and instead their scores had been "ghosted" information fed into the spreadsheets. I assured him that this was not true."*

323. As we have already indicated the appeal against these awards could only proceed on the basis of procedural irregularities. It must have been apparent to Dr Dawson that the Claimant had significant grounds for demonstrating that such irregularities had occurred. Her application was withdrawn from the process without telling her that that had happened. It was then introduced back into the process but her anonymity was compromised. Her application was not scored by everybody until the decision had been taken as to where the cut-off point would be. Two of the alleged scorers had not scored any of the applications at all, despite an

assurance being given to the panel that they had done.

324. We have no doubt that a plan was created between Dr Dawson and Dr Nagar, who was to chair the appeal panel, to ensure that the appeal would not succeed and, indeed, effectively would not even be heard. There is email evidence to show that in May 2007 Dr Dawson was seeking confirmation that the Post-Graduate Department did not have evidence that Dr Michalak had been the subject of an appraisal. That was despite the fact that she obviously had been. We have no doubt that this information was passed on to Dr Nagar.

325. Mandy Williamson's letter of 4 June 2007 had suggested that Dr Michalak could provide a written submission to the appeal meeting. She therefore attended at that appeal with a pre-prepared document pointing to all the procedural irregularities upon which she sought to rely. At that appeal hearing however, the panel refused to accept that written submission saying that any written submissions should have been lodged in advance of the hearing. There is no procedure that requires that to be done neither had Dr Michalak been told that she should have done so. Dr Michalak then sought to go through her grounds of appeal, but she was then challenged as to whether she had had an appraisal in the relevant year. Dr Michalak confirmed that she had but, obviously, had not brought the evidence with her, relying upon the fact that Mandy Williamson (who was at that appeal hearing) had assured her that the appraisal information had been attached to her application. Her previous working history was then challenged as to whether her posts had been substantive posts or not.

326. Her appeal was then peremptorily dismissed on the grounds that there was no evidence of her having completed an appraisal in the year of her application and, on that basis, she was not eligible to apply for an award in the first place. Dr Dawson, of course, had already allowed the application to go forward for marking on the grounds that he accepted that the Claimant was eligible for an award.

327. That decision was outrageous. The Claimant had substantial grounds to challenge the original Award Panel's decisions. Dr Nagar knew that that was the case. We have no doubt that Dr Dawson was unwilling to accept the possibility of Dr Michalak receiving a Clinical Excellence Award at the same time that he was seeking to co-ordinate disciplinary action against her which he intended to lead to her dismissal. If given prior warning the Claimant could have proved that she had been appraised. The procedure, to which we have already referred, gives no requirement for the appraisal to be in the current year, simply that they had to have had an annual appraisal. We have no doubt that from the start Dr Dawson was determined that the Claimant was not going to receive an award and throughout the entirety of the process he manipulated matters to ensure that that was the case. As we will recount shortly in this decision Dr Dawson was of the view that Dr Michalak's exclusion should continue because to bring it to an end could prejudice the Trusts position in relation to any subsequent Tribunal hearing. We have no doubt that he had similar concerns should she receive a clinical excellence award.

328. In deference to the efforts that have been made by the parties it is part of Dr Michalaks case that a statistical analysis of the scoring process would demonstrate the possibility of direct or indirect Race Discrimination within the CEA process. We make no findings in relation to that evidence simply by reason of our conclusion that the reason why the Claimants application had no chance of succeeding was because Dr Dawson ensured that that was the case. We, of course, are not able to judge whether she would have succeeded if proper procedures had been followed.

The Investigation and Disciplinary Action

329. We have already referred to the role of Mr Grasby as Designated Board Member. He took his responsibilities seriously. When requested to do so he met with Dr Michalak and with her husband at their home and they expressed many of their concerns to him. In accordance with his responsibilities Mr Grasby then resolved to challenge the Trust, and in particular Dr Dawson, as to what was happening and on 24 July he met with Dr Dawson, who was accompanied by Dr McInerny, Lynne Sherratt and June Townend. Dr Dawson's note of that meeting reads as follows:-

> "*RG challenged robustly the evidence for each area in particular the lack of specificity in the bullying and harassment of Junior Doctors although it was acknowledged that there was good evidence for the bullying of other staff. The consensus was these would probably all be viewed by a Tribunal as a single offence*. (As all parties are aware Mr Grasby is a lay member of this Employment Tribunal and well aware of Tribunal processes).
>
> *The issues relating to the failure to observe a contract were possibly, or could be, construed as a failure of management to properly address these rather than difficulties with EM herself, particularly given the history over a number of years.*
>
> *Again, poor behaviour could have been tackled earlier.*
>
> *RG's concerns were that our actions may be disproportionate to the severity of these offences.*
>
> *He was also concerned whether we had any definite reasons for continuing the exclusion. He felt that our investigation was virtually complete and bringing her back would not interfere with evidence obtained from other witnesses. All others present felt that her return would potentially prejudice witness attendance at any subsequent disciplinary hearing and since it was still possible that she might be dismissed on the grounds of gross misconduct, any subsequent appeal to an Employment Tribunal would be weakened if we had allowed her to return to work."*

330. Mr Grasby, of course, was identifying the exact problems that these Respondents should be giving consideration to. Their response was, in the view of this Tribunal, astonishing. Before this investigation was completed, and before any decision had, ostensibly, even been taken to institute disciplinary action against the Claimant they were deciding that her exclusion should be continued because, if it was not, when she finally took the Trust to the Employment Tribunal the Trust's case would be weakened. Needless to say the MHPS does not provide that as being a good reason to continue the exclusion of a Doctor.

331. On 4 August Dr Dawson had a further telephone discussion with Ms Wadman of NCAS. His note of that discussion shows him as having presented the issues to her relating to:-

> *"1. Persistent bullying and harassment of Junior Doctors.*
>
> 2. *Bullying and harassment of other staff.*
>
> 3. *Failure to comply with contract for issues of clinical conduct.*
>
> 4. *Potential fraud."*

332. On the basis of the information that Dr Dawson had, at that point in time, there was no justification to accuse the Claimant of *"persistent bullying and harassment of Junior Doctors"* and we have no idea what he had mind when he suggested that the Claimant had been guilty of "*potential fraud*".

333. Throughout this process it is clear that the Trust were taking legal advice from their existing solicitors. On 4 August Dr Dawson had a meeting with a Mr Nuttman of that firm. On the basis of Dr Dawson's own note, Mr Nuttman is noted as suggesting that:-

> *"The Trust was probably trying to be too reasonable to an employee in that we had bent over backwards to provide all the information that was requested. However this was simply dragging out the process which could be challenged in itself as being unreasonable by an Employment Tribunal. In his view, EM has contributed to at least 50% of the delay so far and we need to document that. If we are not careful, she could be creating an artificial constructive dismissal complaint. In his view the next stage is to draw a line under the investigation and insist on a meeting as we originally agreed in June. The legal advice on exclusion was "if it was reasonable at the outset, it is reasonable now"."*

334. On 20 August 2006 Mr Grasby, the Non-Executive Director, sent a lengthy email to Dr Dawson. He expressed his concern about Dr Michalak's mental health and welfare. The process of exclusion and investigation was having, unsurprisingly, a significant impact upon her mental health. Mr Grasby comments:-

> "*After all, Dr M remains a Trust employee and we all have a duty to her with regard to her mental health and welfare. It is hard to see evidence thus far that any of this had had any material recognition in the way the procedure, as far as Dr M is concerned, has been applied. I would like to see this change*."

335. He made trenchant submissions relating to Dr Michalak's continued exclusion. It has to be borne in mind that by this stage Dr Michalak had been excluded for some seven months. The MHPS only permits exclusion in excess of six months where there is a criminal investigation. No such investigation applied in this case. Mr Grasby suggested that the terms of the exclusion should be reconsidered. He raised the issue of whether the exclusion was valid in the first place, as there had been no reconvened PAP. He points to the fact that Dr DeHavilland had analysed 28 statements taken from Junior Doctors, and there was no evidence within those statements of bullying (as, effectively, Dr Dawson already knew). Mr Grasby concluded his email by saying:-

> "*I have been forced to write at some length because, to be frank, my concerns about the way in which this investigation has been prosecuted, continue to grow. My immediate concerns however are firstly, that the Trust shows greater compassion as far as dealing with one of its employees is concerned and, secondly, to ensure that my oversight role is performed as thoroughly as circumstances dictate."*

336. Mr Grasby's role as a Designated Board Member was yet another important part of the checks and balances involved in the MHPS process. He had the responsibility effectively to act as an advocate for Dr Michalak before the Board and to actively challenge the process, as Mr Grasby was doing to great effect.

337. Unfortunately, for Dr Michalak, shortly thereafter Mr Grasby was appointed to a new position which led him to have to resign from Board Membership of the Trust. Ms Anita Fatchett was appointed in his place. It is to be remembered that she was a member of the Clinical Excellence Appeal Panel. In short, Ms Fatchett wholly failed to meet the obligations imposed upon her as Designated Board Member. She made it clear that she wanted nothing at all to do with any of the issues that Mr Grasby had previously raised. She refused to speak to Dr Michalak or Dr De-Havilland and refused to let them have her telephone number or her address. All correspondence addressed to her had to be sent via the Trust. Several items of correspondence were sent to her in that way by Dr DeHavilland but, she tells us, she did not receive any of that correspondence.

338. Dr DeHavilland endeavoured to obtain some response from her via the Chairman of the Trust who wrote to Ms Fatchett but once again, allegedly, those letters were not received by Ms Fatchett. There is no evidence whatsoever that Ms Fatchett took any active step in monitoring the Claimant's ongoing exclusion or the gross subsequent delays in the disciplinary process. We have no doubt that Dr Dawson and/or senior

members of the Human Resources Team created a situation whereby Ms Fatchett's role was effectively nullified. It is clear to us that correspondence sent to her by Dr DeHavilland was being intercepted and not forwarded on and that the purpose of doing this was simply to ensure that Dr Michalak was once again deprived of the benefits that external supervision would provide so as to enable the Trust to continue in this predetermined fashion without hindrance.

339. The Claimant was ultimately to be criticised for failing to co-operate with Dr McInerny's investigation. It certainly is true that, with the encouragement of the BMA, the Claimant was looking to be provided with precise allegations so that she knew the case that she was being asked to meet. She was being deluged with written statements, but these did not, of course, provide her with the precise information that she needed as to what, exactly, she was supposed to have done wrong. She suggested that Dr McInerny could provide her, in advance of any interview, with details of the material that she wished to cover in that interview. In that way she could have prepared better for the interview and come armed with the necessary information.

340. Dr McInerny and Dr Dawson were unwilling to provide her with this advance information. After a period of stand-off in relation to those issues, the Claimant attended in all ten meetings with Dr McInerny. We have been told that these totalled some thirty hours in all. We have lengthy and detailed notes of these interviews prepared by Dr DeHavilland, when it is clear that she was endeavouring to provide every assistance to Dr McInerny.

341. We should make some reference within this Judgment to the fact that during the course of her exclusion Dr Michalak lodged two formal grievances, the first against Dr Barnes and the second against Dr Dawson. Those grievances were dealt with by Dr Lane and Ms McErlain-Burns, the Trust's Chief Nurse, respectively. Save that we note that the Trust's own procedures required that an external investigator should have been appointed to deal with the grievance against Dr Dawson, whereas Ms McErlain-Burns was a manager at an equivalent status to Dr Dawson within the Trust, we do not intend within this Judgment to deal at length with the grievances, nor with the Trust's findings.

342. In relation to Dr Barnes, the grievance was upheld in relation to one minor aspect and Dr Barnes was required to provide an apology which, belatedly, she did. The grievance against Dr Dawson was dismissed. Of course if an external investigator had been appointed, as the Trust policy did require, this would have been yet one further opportunity for some external examination of what precisely was going on. Dr DeHavilland points to the obvious contrast of appointing Dr McInerny, an external investigator, at vast expense to the Trust, to investigate Dr Michalak, whereas they were not prepared to go to those lengths, at all, to investigate Dr Dawson. He also points to the fact that Dr Barnes was provided with advance notice of the questions that Dr Lane intended to ask her whereas the Trust steadfastly refused to give similar consideration to Dr Michalak.

343. Twelve months after her initial appointment, Dr McInerny delivered her

report. The report arrives at the following conclusion:-

> *"Taking everything into account, in this case I consider that there is a longstanding and intractable problem. I would specifically draw the Case Manager's attention to the following areas where he might wish to test the evidence in a hearing:-*
>
> - *The reports from the Royal College and Deanery especially in relation to the allegations of bullying and harassment and lack of supervision of the juniors.*
> - *The allegations of bullying and harassment of the non-medical staff.*
> - *The issue of the concerns about Dr Michalak's apparent absences, including the transfer of the Leeds sessions and what replaced them at Pontefract, her unreported sick leave and the number of her clinics that were cancelled, or done, on her behalf, by the Staff Grade Dr Droste.*
> - *The allegation concerning the register of the X-Ray Meetings.*
> - *The issues of her relationships with clinical and managerial colleagues.*
> - *Her response to the investigation and the concerns that have been raised about her behaviour."*

344. This finally gave Dr Dawson the material that he needed to commence disciplinary action against Dr Michalak.

345. On 17 January 2006 Dr Dawson had a further telephone conversation with Karen Wadman of NCAS. Again she wrote in confirmation of that conversation and her letter reads:-

> *"You advised that you anticipated the case would progress to a disciplinary hearing. In order for you to attend as a member of the hearing panel you were delegating the role of Case Manager to Dr Nagar who is currently Acting Medical Director, and he will be responsible for the final decision on whether the case should proceed to a disciplinary hearing."*

346. Dr Dawson, as we have already found, manipulated and engineered the situation leading to the Claimant's exclusion. He ignored the earlier

indications that the complaints against Dr Michalak were un-provable and simply widened the enquiry so that everybody who had any dealings with Dr Michalak would be interviewed to see what other matters could be identified that could be used against her. He allowed her exclusion to continue despite failing to carry out the mandatory review, he allowed that exclusion to continue beyond the six months in breach of the MHPS. He manipulated the Clinical Excellence Award process to ensure firstly that no award was made to the Claimant, and secondly to ensure that the gross procedural defects that had occurred, in part, to achieve that end were not revealed at an appeal hearing by creating a strategy with Dr Nagar which sidestepped that appeal. He had told deliberate lies to the Claimant in that process. He now wanted to make sure that, if possible, he could sit on the disciplinary panel, no doubt to make sure that the right decision was made, and so he stepped down from being Case Manager passing on that task to Dr Nagar, somebody upon whom he could clearly rely.

347. Ms Ross saw that the arrival of Dr Nagar as Case Manager would provide an opportunity for review of matters and a review and consideration of issues that had caused Dr Michalak distress. She wrote to Dr Nagar on 2 March drawing his attention to many of those matters. Dr Nagar was not, of course, going to be diverted from the predetermined plan in relation to Dr Michalak. Dr Nagar made the formal decision to commence disciplinary action against Dr Michalak and on 26 March he wrote to her setting out the charges. His letter reads as follows:-

> *"Having now considered the report at length my decision is that the following allegations should be considered by a panel constituted in accordance with the Trust's Disciplinary Procedure;*
>
> *1. Bullying and harassment of Junior Doctors and other staff.*
>
> *2. Not being contactable when on-call.*
>
> 3. *Refusing to deal with problems when contacted for assistance*.
>
> *4. Deficient supervision and training of Junior Doctors.*
>
> *5. Being responsible for poor professional relationships with colleagues.*
>
> *6. Altering the Attendance Register of the Friday X-Ray Meeting to represent that you had attended meetings when you had not.*
>
> *7. Failing to comply with your job plan.*
>
> *8. Failure to co-operate with this enquiry and lack of insight into your own behaviour and its effect on others.*
>
> *These are serious allegations and if proved one possible outcome is*

that your employment could be terminated."

He then promised to write further with full particulars of those allegations. As is apparent, there is a gross lack of particularity in relation to all eight of those alleged offences. Dr Nagar then provided Dr Michalak with a copy of Dr McInerny's report, together with all the extensive appendices.

348. An issue was then to be raised by the BMA which this Tribunal has declined to become involved in, believing that it is not of relevance to the issues that we have to determine. The Trust made it clear that they were going to institute disciplinary action pursuant to the MHPS. It was the view of the BMA that that procedure had not been adopted within the Claimant's contract of employment and that an earlier, and potentially to her more favourable, procedure should be followed. It seemed to this Tribunal that that was not an issue which was likely to be of any significance to us. It seemed to us that we were only concerned with whether the Claimant's subsequent dismissal would be a fair dismissal within the meaning of Section 98 of the Employment Rights Act, whether it was an automatically unfair dismissal within the terms of Section 98A of that Act, and whether the Claimant's dismissal was influenced by unlawful discrimination. Whether the procedure adopted fell within or without the Claimant's contractual terms, it seems to us, did not impact upon those issues and were perhaps matters to be resolved in the Civil Courts.

349. Notwithstanding that, the BMA were wishing to pursue these issues and the Claimant was encouraged to the belief that these were matters that she needed to raise with the disciplinary panel.

350. On 23 May 2007 Mrs Squire, who by now was the Chief Executive of the Trust, wrote to Dr Michalak to inform her that she would be part of the disciplinary panel. The earlier charges were simply repeated and she was invited to attend a disciplinary hearing that was scheduled to commence on 27 June with three days allocated. Dr Michalak was told who else would be sitting on the panel.

351. In terms of the Claimant's representation, the BMA would provide her with that representation in relation to allegations relating to personal conduct. If, however, there were to be criticisms of her clinical practice, the Claimant would be represented by the Medical Defence Union.

352. On 1 June 2007 Dr Michalak wrote at length to Mrs Squire. To be more precise, Dr DeHavilland composed this letter which was sent under Dr Michalak's name. She provides Mrs Squire with an item by item rebuttal of the charges against her. In relation to bullying Junior Doctors, she points out that no Junior Doctor has ever made this claim. In relation to the allegation that she was not available when on-call, she points out that this was never raised with her prior to her exclusion and that she has not been provided with any specific dates when that was supposed to have happened. She points out that without that information she is unable to defend herself against that allegation. In relation to the third allegation of refusing to deal with problems when contacted for assistance, she again points out that that

allegation was not raised with her prior to her exclusion and that no specific incidents have ever been referred to. In relation to the fourth allegation of providing deficient supervision and training, she points out again that nobody has informed her in what way her supervision and training was deficient. In relation to the allegation relating to poor working relationships, she again points out that this was never raised with her prior to her exclusion, that it is a generic accusation which is impossible for her to deal with.

353. In relation to the sixth allegation, involving the X-Ray Register, she points out that this was also not raised with her prior to her exclusion, that it is not true and that nobody had ever told her when it was that she was supposed to have not attended the meeting but to have completed the Register to show that she had.

354. In relation to the seventh allegation of failing to comply with her job plan, again she points out that this had not been raised with her prior to her exclusion and that nobody had provided her with any specific instances, events or dates to which she could respond.

355. In relation to the final allegation, that she had failed to co-operate with the enquiry, she contended that that allegation was unsupported by facts, that the allegation had never been investigated and never put to her.

356. That letter was, therefore, a detailed denial of each of these charges and pointing Mrs Squire to the very essence of what needed to be done by the panel, namely to identify precisely what it was alleged that the Claimant had done and when, and to see what evidence there was to support that. It is within the experience and knowledge of our non legal members that it is a fundamental principle of good employment practise that disciplinary charges should, where possible, be framed in precise terms as to what happened, who to, where and when. The fact that highly qualified and senior H R managers ignored these basic principles can only lead us to conclude that it was a deliberate decision on their part to do so.

357. Dr Michalak then deals at length with the procedural issues that arise. She points out that she had pre-booked annual leave on the date that the disciplinary hearing was due to be convened and offers to meet with Mrs Squire and Dr Nagar to explore the option of an informal resolution of these issues. Her letter then reads:-

> "*If you decide this is not possible, please accept this as a Step 1 letter in regard to my grievance against the secret group exercise detailed above relating to Dr Colin White, Ms Emma Lavery, Ms Lynne Sherratt, Ms Caroline Smyth, Dr Robert Lane, Mr Neil Woodhall, Dr Richard Jenkins, Dr Susan Barnes, and I believe with the full knowledge of Mrs Dianne Nicholls. It is my sincere hope that an informal resolution will be considered worth exploring but if I need to submit further information at Step 1, I shall reserve the right to do so."*

358. The Claimant's ill-health continued. She was referred to see a Specialist on

27 June. On her behalf Ursula Ross wrote to Mrs Squire requesting a postponement of the hearing by letter of 21 June. That request was granted. The Respondents attempted to arrange for the Claimant to see their Occupational Health Department to establish her fitness to attend a disciplinary hearing. Dr Michalak was willing to attend such an appointment, but no agreement could be reached as to the terms of the referral. The management side's case was then prepared and served upon Dr Michalak and her representatives. This comprised eleven lever-arch files of documents. There had not however been any response to that simple request that she had repeatedly made, namely to be told in clear and specific terms what it was that she was supposed to have done wrong.

359. Finally Dr Michalak got a response to her letter of 1 June. This response came from Mrs Nicholls, about whom of course she had lodged a grievance. In relation to the specific request for details of the charges, Mrs Nicholls, unhelpfully, comments as follows:-

> "*As part of the process for the hearing, you have been asked to provide a statement. In that statement you are required to address the allegations against you. The panel as a whole will consider whatever you say in that statement together with all other evidence in the hearing. It is not appropriate for Mrs Squire to respond to your comments on the allegations at this stage as she will be a member of the disciplinary panel."*

360. In relation to her grievance, Mrs Nicholls says as follows:-

> *"You refer to a wish to raise a grievance against "the group exercise", which I take to be a reference to what you describe as "the special committee" on Page 1 of your letter. I regard this as a matter which can be dealt with in part or in whole at the disciplinary hearing and if anything is outstanding, further considered after the disciplinary hearing."*

361. The Director of Human Resources was, therefore, suggesting to the Claimant that the disciplinary hearing would also be used to deal with her grievance. Unfortunately Mrs Nicholls did not tell Dr Nagar that that was what was intended, neither did she tell any members of the disciplinary panel. In relation to the issue of procedure, Mrs Nicholls said:-

> "*You may of course raise any concerns you have about fairness of the process or adequacy of the investigation at the disciplinary hearing."*

362. The only response that Dr Michalak got from Mrs Squire was by letter of 29 June when Mrs Squire wrote to her to say that her letter had been referred to Mrs Nicholls and that she did not think it was appropriate for her to meet with Dr Michalak.

363. The disciplinary hearing was rearranged for dates in September, but those dates were not convenient to Ms Ross.

364. We should make some further comments about additional issues that arose in relation to the preparation for this disciplinary hearing. The first was that Dr Nagar clearly believed that Dr McInerny's investigation in relation to the X-Ray Register issue needed to be "beefed up". Despite having the role of Case Manager, he decided to pursue some investigations for himself. He examined the Register showing the dates upon which Dr Michalak signed indicating her attendance. He compared those dates with her electronic diary and with the Trust's records relating to sickness and annual leave. He identified a number of dates when, he believed, that the Claimant was either on annual leave, sick leave or study leave, at times when she purported to attend these X-Ray Meetings.

365. At no time did he put these specific dates to Dr Michalak to enable her to investigate the position. Had he done so, he would have discovered that the annual leave had been cancelled, that although the Claimant had gone on sick leave on a particular date it was after lunch and that the study leave involved consisted of a morning meeting, which would have made it possible for her to have attended at the X-Ray Meeting.

366. The second supplementary issue relating to the investigation is how far and wide the Respondents sought to take it. Without any reason, at all, to believe that the Claimant had made any false expense claims, the Trust decided to examine her claims for travelling expenses. This presumably had something to do with whether she claimed expenses for travelling to Leeds when perhaps she had not been there. In fact, what those investigations revealed was that the Claimant never made any travel expense claims.

367. There is then the existence of what was known as the "control group". This consisted of a team of people who provided assistance to Dr Nagar in his task of collating what had turned into a mountain of bits of paper, witness statements and disparate allegations. Some notes prepared by this control group, were, Dr DeHavilland would say, accidentally disclosed to him. The documents suggest that they should have been shredded. Those documents show an astonishing picture of a group of people co-ordinating the prosecution of this case against the Claimant, organising a weekend away to deal with the investigation and prosecution and even organising what were described as "coaching sessions" with the witnesses who were going to be called to give evidence. The Respondents deny that this amounted to "coaching" of witnesses as lawyers would understand that term to mean. It is however accepted that the witnesses were provided, in advance, with the questions that they were going to be asked by Dr Nagar. It is denied that suggestions were given to them as to what might be the appropriate answers. The setting up of this group, however, gives the clearest impression of the efforts that this Trust were prepared to go to secure the dismissal of Dr Michalak.

368. Finally, on 28 September 2007, an agreement was reached that the disciplinary hearing would commence on 2 November 2007, continuing on the afternoon of 8 November, 14 November and it was proposed that the matter then continue on 13, 18 and 20 December. In the event, the

December dates were lost because of Ms Ross' ill-health and in fact the proceedings continued on 18 February, 20 February 10 March, 31 March and, finally, 14 July 2008.

369. We have the most detailed of notes in relation to those eight days of hearing consisting of a total of 327 pages. We have read those notes with care. It seems to us that despite the eminent nature of the panel hearing this matter (all of whom were White/British people), and all the administrative and HR support that they had available, the hearing was wholly lacking in structure and failed to follow any sort of process that could lead to proper decisions being made in relation to a matter as important as the future career of a Consultant.

370. The panel were, of course, overwhelmed by documentation and a mass of witness statements. Dr DeHavilland points out that there were as many witnesses interviewed by the Trust to deal with his wife as were interviewed by the War Crimes Enquiry into the Bosnian conflict. Graphic though that comparison might be, it does bring this matter into some perspective. Both the panel and Dr Michalak were under the gross disadvantage of not being provided with the simple specific allegations that were required to make sense of the documentation. Instead they were just provided with a mountain of information and left to make the best of it that they could.

371. Surprisingly the panel left it to management to decide which witnesses they intended to call. Their choice was somewhat curious. They called Dr McInerny, Dr Neligan and Dr Polak, they called Mrs Sibary, Mr Curtis (the manager of Mrs Paddock) and Dr Abbasi. They called Dr Jenkins, Dr Copeland, Dr Bangad and, curiously, Dr Nagar. Bearing in mind the emphasis that was subsequently placed on the bullying of staff, it was a surprise that they did not call Mrs Howe or Mrs Paddock.

372. The third difficulty that the panel faced related to the problems that the Claimant, by that time, had clearly developed. We understand and appreciate that we should not seek to form any views ourselves as to the way in which parties present themselves when giving evidence to this Tribunal and in particular should not form any views as to their state of health. What is, however, abundantly clear from reading the notes of the disciplinary hearing, was that the panel suffered just the same difficulties in taking evidence from Dr Michalak that troubled this Tribunal. For all that they endeavoured, as did Mr Sutcliffe, to pin Dr Michalak down to giving exact responses, she was simply unable to do so. Common sense would have suggested that her state of mental health adversely contributed to that difficulty. It is clear from the notes that the panel, particularly Mrs Brain England, increasingly became frustrated at her inability to provide simple responses. Ursula Ross tried her best, it is clear, to guide Dr Michalak appropriately, but she was as unsuccessful before this panel as Dr DeHavilland was before us.

373. The disciplinary charges brought against the Claimant could in fact have been very straightforward. If the Respondent had been able to make reference to specific incidents on specific dates, they could have focused

their evidence upon those specific allegations and Dr Michalak would have found it easier to deal with those specifics. Instead, however, the Respondents continued this "throw it all in" policy, swamping everybody with information so as to produce a highly complex and diverse enquiry. If the panel had been properly advised, they would have required management to reformulate their case into those simple component parts. They did not however do so.

374. It has taken this Tribunal 36 days of hearing evidence to deal with many of the same issues that that disciplinary panel attempted to deal with in 8. We had the benefit of a professional advocate presenting the case on behalf of the Respondents and Dr DeHavilland representing the Claimant in the clear and articulate way in which he did. We have been able to case manage extensively in advance of the Hearing so that parties knew exactly what it was that they were here to deal with. This disciplinary panel did not have a hope of dealing with the case in the way it was presented in the timescale that they allowed to themselves.

375. The other problem of course was that Dr Michalak believed she was attending this disciplinary hearing not only to deal with the allegations made against her, but to deal with the grievances that she had lodged against this group of clinicians and managers who she believed to have conspired against her. Mrs Brain England and Dr Nagar had no idea that that was part of the agenda. Dr Michalak also believed that this disciplinary hearing was the right forum to deal with the procedural errors and omissions which she contended had taken place.

376. We mean no criticism of the BMA when we say this, but it is our common experience that trade unions are often inclined to absorb large amounts of energy in pursuing procedural issues, rather than focusing upon the heart of any enquiry. We understand that procedures are of importance to representative bodies, because often these are procedures that they have had a part in negotiating and agreeing. Dr Michalak was determined to pursue these procedural issues before the panel. Discussions in relation to them absorbed a disproportionate amount of time and once again either that should have been controlled by the panel or, if they believed procedural issues were of importance, far more time needed to be allocated.

377. On 13 March 2008, when there had been six days of hearing already, Susie Brain-England, who was chairing the panel, wrote to Ms Ross with a view to imposing a timetable upon the remaining hearing. She indicated that staff side had already had three days to present their case, they could have the further date in March, 31 March, and the final date, which turned out to be 14 July, would be used by both parties to sum up, permitting each side 1 ½ hours to address the panel. Mrs Brain-England made it clear that the matter "*must be concluded in the time available*".

378. As the notes of the disciplinary hearing make clear, by that point in time Dr Michalak had dealt, extensively, with the procedural issues and had also given extensive evidence relating to the allegation involving the bullying of Junior Doctors. There was a vast amount of material which she still needed

to be gone through in order to deal with the remaining allegations, such as they were. It would have been impossible for her to have done that within the day allowed. Ms Ross, on her behalf, protested that timetable. Her letter of 18 March reads as follows:-

> *"It was the Trust's decision to instigate a wide-ranging investigation and to interview over sixty witnesses. There are no less than eight allegations to be responded to by Dr Michalak and it is acknowledged that some allegations will take more time than others to give a response to. There were some thirty hours of investigative interviews conducted by Dr Deborah McInerny in which Dr Michalak gave a full response to those matters which were put to her. It should be noted, however, that a number of matters have been brought to Dr Michalak's attention since those meetings with Dr McInerny, and she is of course entitled to be afforded the time to respond in full to any additional matters which the management case has presented."*
>
> *"It has been stated by myself on Dr Michalak's behalf already in the course of the proceedings that we have concerns with regard the time estimate which has been allowed in terms of the number of days for the hearing of this case. I have on a continuing basis brought this to the attention of the panel. I am most concerned that the panel have at this point effectively decided to guillotine the time period within which Dr Michalak should present her case*."

379. Mrs Susie Brain-England responded to Ms Ross on 28 March refusing to allow any more time.

380. On 31 March 2008 Dr Michalak called Mr Grasby to give evidence on her behalf. It is said to be a coincidence that that same evening Dr Dawson resigned from his position as Medical Director.

381. The hearing was then adjourned with a view to identifying one final day. There were, as always, significant difficulties in finding dates which were convenient for everybody involved. Ultimately the 14 July was identified.

382. The panel reconvened on that date and Dr Nagar was present on behalf of the management. Neither Dr Michalak nor her representatives were present. It is suggested to us by Mrs Brain-England that no thought was given as to why it was that Dr Michalak was not present and no enquiries were made of the BMA to find out why Ms Ross was not there. They simply proceeded to take final submissions from Dr Nagar and the panel then concluded their determination. That hearing began at 9:10 and we are told that the decision had been arrived at by lunchtime. Dr Nagar's presentation was clearly a lengthy one and so, it is clear, that very little time was spent by the panel in analysing the evidence and arriving at a detailed finding.

383. The previous evening Dr Michalak, who was at any event the subject of a current and valid sick note, began to suffer acute chest pains. Dr DeHavilland called for an ambulance, she was taken to St James' Hospital,

Leeds, where she was admitted onto a cardiac ward. First thing the following morning Dr DeHavilland telephoned Ms Ross to explain that she was not going to be able to attend that hearing and telephoned Mr Forster, the General Manager at the hospital, to explain what had happened. We are being asked to believe that this information was not passed on to the panel and that they proceeded to make their decision in ignorance of the Claimant's ill-health.

384. We simply do not believe that to be the case. It cannot be everyday that this Trust sees a disciplinary hearing of this magnitude involving a Consultant who has been the subject of such a far-ranging investigation. We simply cannot believe that Mr Forster would not have known that this disciplinary hearing was due to take place that day and at any event Dr DeHavilland would have explained that she was unable to attend that hearing when he telephoned the Trust. If the panel had, indeed, been in ignorance of the true situation, they would have been bound to have wondered what had gone wrong and to have pursued proper enquiries. Mrs Brain England specifically told the Tribunal that if she had been aware that Dr Michalak had been hospitalised she would not have proceeded at this hearing to dismiss the Claimant. In our finding she either did know that to be the case or senior HR managers deliberately concealed the truth from her.

385. We are told that they found out about Dr Michalak's hospitalisation after their decision had been arrived at. If that were true we cannot believe that they would not have been advised to reconvene the disciplinary hearing when she was sufficiently well to enable her to present her final submissions. The fact that neither of those things occurred demonstrates to us that this panel took the opportunity of completing this hearing without the hindrance of having to hear, again, at length from Dr Michalak or her representative.

386. The panel's decision was communicated to Dr Michalak on 16 July by letter signed by Mrs Squire. We are informed that each of the members of the panel had been provided with a copy of that letter before it was sent and had approved the contents of it. The panel had consisted of Mrs Squire, Dr Naftalin, Mr Lewis (who was not called to give evidence) and Mrs Brain-England. The panel's decision was set out as follows:-

> ***"Whether your actions against junior colleagues and other staff constituted bullying and harassment as defined by the Trust's Prevention of Bullying and Harassment Policy – Allegation 1***
>
> *The panel concluded that the evidence presented in respect of Junior Doctors did not substantiate the allegation; however it was satisfied that your actions in respect of other staff (namely Lisa Howe, Deborah Paddock and Ruth Sibary) constituted bullying and harassment as defined by the policy. Bullying and harassment is recognised as an example of gross misconduct within Appendix B of the Trust's Disciplinary Procedure and we find this to be the case in respect of this allegation."*

387. The single allegation that had led to the institution of this investigation and to

the exclusion of the Claimant was the allegation that she had bullied Junior Doctors. That was, in reality, the single allegation that she had been able to deal with extensively in evidence before the panel. Dr McInerny had predicted 2 ½ years before that was an allegation which would be difficult to prove and that allegation was dismissed by this panel.

388. In relation to Mrs Howe, the panel had not heard any evidence from her and they only had, before them, the same documents to which this Tribunal have already referred. When cross-examined Mrs Brain-England was not able to say what evidence was before the panel to support the contention that Mrs Howe had been bullied. She was then taken to the only documentation which we have seen in relation to that incident and acknowledged that there was nothing within that document that could support an assertion that Mrs Howe had been bullied.

389. In relation to Mrs Paddock, she did not give any evidence before the panel. Mr Curtis, her manager, however did. Mrs Brain-England was taken to the note of that evidence and was also taken to the document that recorded that event. She accepted, on analysis, that there was no allegation of bullying made out either within the evidence that they heard from Mr Curtis or within Mrs Paddock's own account.

390. Mrs Brain-England was, however, very impressed by the evidence of Mrs Sibary. As the notes of the disciplinary hearing show, she described the two incidents which had caused her distress. She described how she had become tearful and Mrs Brain-England was particularly impressed by the fact that Mrs Sibary became tearful in front of the panel. She described how she had felt frightened for the first six months of her employment, but that she had regained her confidence by the time Dr Michalak returned from maternity leave. Specifically Mrs Sibary was not asked whether she felt bullied by Dr Michalak, but Mrs Brain-England drew the conclusion from the evidence that she had heard that that was the case.

391. That was, in fact, entirely the wrong conclusion to draw. We heard evidence from Mrs Sibary who was called by the Respondents. As her own witness statement makes clear, Mrs Sibary acknowledges that she is an unusually timid person, frightened of speaking before a number of people. She was intimidated by having to give evidence before this Tribunal and had not slept for some nights before. She was equally intimidated by having to give evidence before this disciplinary panel, and it was that that caused her the most distress.

392. In response to Dr DeHavilland's questions, she accepted that the relationship between herself and Dr Michalak had been a very good one. She described how she had been initially appointed by Dr Michalak to the position of her Secretary. She explained that she believed that she had been given the job because she had been able to tell Dr Michalak at interview that she had prior experience as a Medical Secretary. Unfortunately that prior experience was at a different hospital, in a very different type of department, to which very different procedures applied. During the early part of her employment at Pontefract, she had the feeling

that Dr Michalak assumed that she knew what to do, when in fact, on occasions, she did not. She did not like to ask Dr Michalak what to do, because she thought that Dr Michalak would then think she had misled her at interview.

393. Dr Michalak then went on maternity leave and was replaced by a Locum. Mrs Sibary provided secretarial support to that Locum. He did not know the procedures any more than she did and in that period of time she had been able to learn what was expected of her. That was why matters were much better when Dr Michalak returned from maternity leave.

394. She accepted that her relationship with Dr Michalak was a good one, they both had children of a similar age, which they often talked about together. She described the two incidents as being the only occasions when Dr Michalak had upset her, she accepted that Dr Michalak may not have known that she had upset her and that other Secretaries less timid than herself may not have been upset by those incidents. She told us that up to the date when Dr Michalak was excluded she was happy working for her and when the Tribunal specifically asked her the question of whether she had ever felt bullied by Dr Michalak she said that nothing could be further from the truth.

395. Whilst we accept that the disciplinary panel were entitled to form a view on the information before them, they were, in our view, obliged to ask a few pertinent questions before jumping to the conclusion that Mrs Sibary had been bullied.

396. The next part of the decision reads :

> *"**Whether you had failed to comply with your job plan, including whether you had failed to be contactable when on-call and whether you had refused to deal with problems when contacted for assistance – Allegations 2, 3 and 7***
>
> *The panel considered these allegations together and found that you did not comply with your job plan in particular, your unilateral decision to use the time available from the cessation of the Leeds session as private study at home, and that you were difficult to contact when on-call. There was evidence from both senior and junior colleagues that they were unable to contact you when you were needed and specifically when you were on-call. You were unable to provide a satisfactory explanation of your absence and lack of availability in those hours when you should have been contactable. To not be contactable when on-call is a breach of contract – and not being readily accessible to colleagues when on duty is viewed by the General Medical Council as a breach of trust. The panel found that the breach of contract was gross misconduct equivalent to the examples given in the Trust's Disciplinary Policy.*
>
> *In addition the panel found the evidence presented from clinical and other colleagues that you refused to deal with problems when contacted for assistance substantiated the allegation. Not being*

> *readily accessible to colleagues when on duty is regarded by the General Medical Council as a breach of trust and by the panel as an act of misconduct."*

397. The alleged *"unilateral decision to use the time available from the cessation of the Leeds session as private study at home*" was an allegation that was never put to Dr Michalak. It was based upon the entirely false proposition that her sessions at Leeds had come to an end and had not been replaced by any other substantive work at Pontefract. Mrs Squire was asked to explain on what basis she came to that view. Her response was:-

> *"I have no idea what the basis of that belief may be, I cannot offer you anything to help."*

She then said:-

> *"I now accept that there is no evidence upon which we could have come to the conclusion that the Claimant was staying at home doing private study when she said that she was at Leeds."*

398. In relation to the allegation of "*being difficult to contact when on-call*" Dr Naftalin conceded that there was no duty to be contactable when somebody was not on-call. He relied upon the evidence of Dr Abbasi who made that allegation. It was Dr Naftalin's view that it was not necessary to give specific details "*we assumed that if he said it it was right*". He conceded that other Consultants would not necessarily know who was on-call, that if a Doctor who was not on-call was contacted by switchboard he might reasonably ask who the on-call Doctor was but that Dr Abbasi had given no specific incidents to demonstrate that that had happened. He was not therefore in a position to provide any specific details in relation to this allegation or as to why he found that the allegation was proven.

399. In relation to the allegation that "*She refused to deal with problems when contacted for assistance"* Dr Naftalin thought, when prompted by Dr DeHavilland, that that might involve the complaint made by Dr Davis. Dr Naftalin was taken through the complaint that Dr Davis made. He accepted that when reading that complaint, Dr Davis was not in fact looking for help from Dr Michalak. He further accepted that even if Dr Davis had been looking for help, all that could be said is that it would have been a matter of courtesy for Dr Michalak to have attended to provide that help, but it could not be regarded as a matter of misconduct if she had not done so. Just to be certain Dr DeHavilland took Dr Naftalin to the complaint made by Dr Wass to see whether or not that was an issue that he had in mind; Dr Naftalin confirmed that he could not remember that issue being discussed before the panel arrived at their decision.

400. In relation to the Allegation

> "**Whether you were deficient in the supervision and training of junior staff – Allegation 4**"

The panel found that the allegation was not proved. Once again of course this was one of the issues that Dr Michalak had been able to deal with extensively in her evidence before the panel.

> *"**Whether you were responsible for poor relationships with colleagues – Allegation 5***
>
> *Within the management case several colleagues said that it was difficult to work with you for a variety of reasons. The evidence included two cases of medical colleagues where the poor professional relationships had been a factor in their decision to either resign or move place of work. The panel felt that the evidence was substantiated by the witnesses. You offered no evidence to refute this allegation. Good medical practice requires you to respect the skills and contributions of colleagues and to communicate effectively with them. Healthcare is delivered through team working and effective communication and team working is essential to save patient care. The panel found this to be a further example of gross misconduct."*

401. Mrs Brain-England was asked to identify the two medical colleagues who had resigned or moved place of work because of the poor working relationship with Dr Michalak. She believed that one of those Doctors was Dr Wong. She then accepted that Dr Wong was still employed by the Trust. She then suggested that the other Doctor might have been Dr Hussain. She was then taken to the only evidence relating to Dr Hussain that was before the disciplinary panel, namely Dr Hussain's interview with Dr McInerny. Mrs Brain-England conceded that there was nothing within that interview that gave rise to that allegation, that Dr Hussain did not give evidence to the disciplinary hearing and that there was, accordingly, no basis for that suggestion.

402. The following finding was then made:

> *"**Whether you had altered the Attendance Register of the Friday X-Ray Meeting to represent that you had attended meetings when you had not – Allegation 6***
>
> *The panel found that you did not respond to these allegations and provided no explanation for the occasions when you were absent on sick leave or annual leave and yet your signature appeared on the register. The panel found that you had falsified the Attendance Register. The Trust, as an employer, requires its staff to be honest and trustworthy, as does good medical practice. Falsification of records is recognised as an example of gross misconduct within Appendix B of the Trust's Disciplinary Procedure."*

403. It is, rather paradoxical, to read this Judgment of this disciplinary panel, when we take into account the findings of fact that we have already made in relation to the falsification of information provided by the Chief Executive and the Finance Director in relation to their scoring of the Clinical Excellence

Award process, the deliberate lies told by Dr Dawson in relation to that process and the fact that Dr Bangad and Dr Abbasi were clearly complicit themselves in falsifying this register, but no action was ever taken against them.

404. Mrs Squire and Mrs Brain-England were asked by Dr DeHavilland to provide a specific example of an occasion when Dr Michalak had signed that register to say that she was at the X-Ray Meeting, when in fact she was not. They could not give such examples. In order to assist Dr DeHavilland then took the witnesses to the submissions advanced by Dr Nagar who gave some specific examples, arising out of his own investigations, which had not previously been put to Dr Michalak. One by one Dr DeHavilland was able to demonstrate to the witness that there was no compelling evidence to justify the proposition that Dr Nagar was advancing. In reality this finding was based purely upon an opinion given by Dr Abbasi, whose evidence before us was less than satisfactory but, more importantly, who himself admitted to falsifying entries on the register, but against whom no disciplinary action whatsoever has been taken.

405. The following finding was then made :

> *"**Whether you failed to co-operate with the enquiry and whether you demonstrated a lack of insight into your own behaviour and its effects on others – Allegation 8***
>
> *The evidence submitted by management showed that you sought to delay and avoid the enquiry through criticism of the process and not being available to participate in the process for a variety of reasons. You had both a professional and contractual duty to co-operate. In addition the evidence given by your senior colleagues demonstrated your lack of insight into your behaviour, and an unwillingness to seek to improve it; a further example of misconduct."*

406. The Respondents' witnesses were unable to identify where the Claimant was culpable in causing delays in fixing the disciplinary hearings. It is true that on occasions she was ill or her representatives were ill, but it was accepted that those reasons were good ones. In terms of the investigation, as we have already said, Dr Michalak spent some thirty hours with Dr McInerny. It may be that the commencement of that interview process was delayed, because the Claimant was wanting to know exactly what it was that she was supposed to have done wrong. The Respondents cannot realistically criticise her for that.

407. Finally in relation to the "*lack of insight*", all that realistically appears to be is that because she does not admit that she had done something wrong, when the Respondents have been unable to prove that she had done something wrong, she demonstrates "*lack of insight*".

Appeal

408. The Claimant of course had a right to appeal that decision. Perhaps

strangely whilst that appeal was still to be concluded, on 1 August 2008, the Director of Finance, Mr Waite, wrote to the General Medical Council inviting them to commence proceedings against Dr Michalak on the basis that she was unfit to practice.

409. Within the deadline imposed, on 13 August 2008, Dr DeHavilland, on Dr Michalak's behalf, lodged an appeal against the decision to dismiss her. Pursuant to the Trust's Disciplinary Procedure:-

> *"The appeal hearing should take place within four weeks of the receipt of the appeal by the Director of Human Resources, although the sub-committee may, in exceptional circumstances, be entitled to extend this period. The member of staff shall be given at least fourteen days' notice of the date of the appeal hearing."*

The sub-committee referred to is the sub-committee of the Trust Board designated to hear the appeal. The appeal having been lodged on 13 August 2008, it should therefore have been heard by 3 September.

410. On 18 August 2008 the Deputy Director of Human Resources, Susan Tyler, wrote to Dr Michalak indicating that the appeal hearing would not be arranged within the four week period and that it was hoped that it would be heard during the week commencing 20 or 27 October 2008. There was no suggestion that the sub-committee had authorised the extension of that period, nor that there were any exceptional circumstances. On 9 September Ms Ross wrote to Mrs Tyler as follows:-

> *"Dr Michalak is currently unwell and is finding great difficulty dealing with the process to which she is subject. Her ability to function day to day is such that she considers herself to be disabled and potentially disadvantaged by her disability and requests that the panel allow her husband to attend the appeal hearing to support her and prompt her where appropriate. Dr Michalak is particularly concerned that her ability to recall matters whilst in a formal hearing has been affected by her ill-health and she is not able to immediately bring to mind relevant matters without prompting. Dr Michalak's view is that her husband has supported her throughout the process and would be an appropriate person to support her throughout the appeal hearing. Dr Michalak considers that her request for this adjustment to the procedure is reasonable and I would ask you to confirm the panel's view in due course."*

411. The Respondents were then provided with a copy of a report from a Dr Rider, a Consultant in Liaison Psychiatry, which says as follows:-

> *"I agree that as a consequence of her ill-health she has difficulties in attention, concentration and recall and would benefit from an appropriate person to support her through the hearing."*

412. The Respondents were also provided with a report from Dr Singh, the Claimants General Practitioner, which reads as follows:-

> *"Mrs DeHavilland has been under a lot of stress for the last two years due to her grievance case with the said Trust. I have seen her on several occasions during this period. Her health has been constantly deteriorating during this time. She is now having problems with her memory and concentration. She cannot always recall past events without prompting. She considers herself to be disabled and unable to represent herself. Her husband has supported her throughout this period and is very familiar with her case. Therefore, I feel her husband is the most appropriate person to support her during the appeal hearing.*"

413. The appeal hearing was fixed for 5 and 6 November 2008. Eight weeks beyond the time limit imposed by the Trust's own procedures. That hearing was, however, then cancelled, by reason of the fact that Dr Michalak had to appear before the GMC as a result of the Respondent's complaint to them. It was accordingly rescheduled for 16 December 2008, fourteen weeks outside of the time limits provided by the Respondent's own procedures. Again there is no evidence that that delay was sanctioned by the appeal sub-committee.

414. On 7 November Mrs Tyler responded to Ms Ross' request that Dr De-Havilland should be entitled to support Dr Michalak at the appeal hearing. Dr Faull, who was to hear the appeal, determined that Dr DeHavilland could attend and sit with Dr Michalak, but that he may not address the panel and "*must not interfere with the proceedings in any way*". He was permitted to assist Dr Michalak by organising her papers and drawing her attention to relevant material, but he was not permitted to speak on her behalf or answer questions for her or suggest responses to her. Ms Ross was told that if Dr DeHavilland breaches those terms, he would be required to leave the hearing.

415. The Respondents had the clearest evidence from Dr Michalak's General Practitioner, supported by a Consultant Psychiatrist, that Dr Michalak had difficulty in attention and concentration and recall. The Respondents knew that Dr DeHavilland did have a clear understanding of the basis upon which Dr Michalak sought to appeal. The conditions therefore that were being imposed upon his attendance were, in our view, entirely unreasonable.

416. By this stage, Dr DeHavilland had come to the view that there was no useful purpose to be served in pursuing this appeal. For perhaps good reason he concluded that his wife was unlikely to be given a fair hearing. Despite being criticised herself for failing to co-operate with the Trust's procedures it seemed to him that the Trust paid no regard to their own obligation to comply with those procedures. He knew his wife's state of health was such that she could not adequately represent herself and he knew that he was the person with the most intimate knowledge of events who would be able to assist her. The conditions being imposed by Dr Faull incidentally made sure that that simply could not happen. He therefore resolved that there was no useful purpose to be served in attending that appeal hearing.

417. The Appeal Hearing took place, the management being represented by Dr Nagar. Detailed notes of that appeal hearing were made and have been read by this Tribunal. The appeal was not designed in any way to be a re-hearing or a reconsideration of the evidence and, indeed, it was clear that Dr Faull had little or no knowledge of the evidence that existed. Dr Nagar was asked to explain the Respondent's case in relation to the heads of appeal that had been advanced by Dr Michalak. Dr Nagar's submissions can be summarised by the suggestion that the panel simply got it right. Dr Faull accepted that to be the case and dismissed the appeal.

418. We should perhaps finally note that Dr Michalak lodged her first Employment Tribunal application in relation to the Clinical Excellence Award process. She complains that the failure to award her points was an act of direct and/or indirect discrimination. That Tribunal Hearing was listed for hearing on the week commencing 21 July. The Claimant was therefore dismissed, in her absence, in the preceding week, being notified of her dismissal only a few days before that Tribunal Hearing was due to take place. That Hearing was then postponed by reason of the fact that it was clear that a further application was going to be lodged, arising out of the Claimant's dismissal and all that had gone on before, and it was thought appropriate that all matters should be dealt with together.

The Law

419. In relation to the complaints of sex discrimination, we have referred ourselves to various sections of the Sex Discrimination Act as follows:-

> *"Section 1(2)*
>
> *In any circumstances relevant for the purposes of a provision to which this subsection applies, a person discriminates against a woman if:-*
>
> *(a) On the ground of her sex, he treats her less favourably than he treats or would treat a man, or*
>
> *(b) He applies to her a provision, criterion or practice which he applies or would apply equally to a man, but*
>
> *(i) Which puts or would put women at a particular disadvantage when compared with men,*
>
> *(ii) Which puts her at that disadvantage, and*
>
> *(iii) Which he cannot show to be a proportionate means of achieving a legitimate aim."*

420. Section 3A of the Act says as follows:-

> *"In any circumstances relevant for the purposes of a provision to*

which this subsection applies, a person discriminates against a woman if:-

(b) On the ground that the woman is exercising or seeking to exercise, or has exercised or sought to exercise, a statutory right to maternity leave, the person treats her less favourably."

421. Section 4 of the Act says as follows:-

"(1) A person ("the discriminator") discriminates against another person ("the person victimised") in any circumstances relevant for the purposes of any provision of this Act if he treats the person victimised less favourably than in those circumstances he treats or would treat other persons, and does so by reason that the person victimised has:-

(a) Brought proceedings against the discriminator or any other person under this Act…

(d) Alleged that the discriminator or any other person has committed an act which (whether or not the allegations so state) would amount to a contravention of this Act

Or by reason that the discriminator knows the person victimised intends to do any of those things, or suspects the person victimised has done, or intends to do, any of them.

(2) Subsection (1) does not apply to treatment of a person by reason of any allegation made by him if the allegation was false and not made in good faith."

422. Section 6(2) of the Act reads as follows:-

"It is unlawful for a person, in the case of a woman employed by him at an establishment in Great Britain, to discriminate against her:-

(a) In the way he affords her access to opportunities for promotion, transfer or training, or to any other benefits, facilities or services, or by refusing or deliberately omitting to afford her access to them, or

(b) By dismissing her, or subjecting her to any other detriment."

423. Section 41 of the Act says as follows:-

"(1) Anything done by a person in the course of his employment shall be treated for the purposes of this Act as done by his employer as well as by him, whether or not it was done with the employer's knowledge or approval.

(2) Anything done by a person as agent for another person with the authority (whether express or implied and whether precedent or subsequent) of that person shall be treated for the purposes of this Act as done by that other person as well as by him.

(3) In proceedings brought under this Act against any person in respect of an act alleged to have been done by an employee of his it shall be a defence for that person to prove that he took such steps as were reasonable practicable to prevent the employee from doing that act, or from doing in the course of his employment acts of that description."

424. Section 42 of the Act reads as follows:-

"(1) A person who knowingly aids another person to an act made unlawful by this act shall be treated for the purposes of this Act as himself doing an unlawful act of the like description.

(2) For the purposes of subsection (1) an employee or agent for whose act the employer or principal is liable under Section 41 (or would be so liable but for Section 41(3)) shall be deemed to aid the doing of the act by the employer or principal."

425. Section 63 reads:-

"(1) A complaint by any person ("the complainant") that another person ("the respondent"):-

(a) Has committed an act of discrimination against a complainant which is unlawful by virtue of Part II, or

(b) Is by virtue of Section 41 or 42 to be treated as having committed such an act of discrimination against the complainant,

may be presented to an Employment Tribunal."

426. Section 63A of the Act reads as follows:-

"(1) This Section applies to any complaint presented under Section 63 to an Employment Tribunal.

(2) Where, on the hearing of the complaint, the complainant proves facts from which the Tribunal could, apart from this Section, conclude in the absence of an adequate explanation that the Respondent:-

(a) Has committed an act of discrimination against the complainant which is unlawful by virtue of Part II, or

> *(b) Is by virtue of Section 41 or 42 to be treated as having committed such an act of discrimination against the complainant,*
>
> *the Tribunal shall uphold the complaint unless the Respondent proves that he did not commit, or, as the case may be, is not to be treated as having committed, that act."*

427. Section 76 of the Act says as follows:-

> "*(1) An Employment Tribunal shall not consider a complaint under Section 63 unless it is presented to the Tribunal before the end of:-*
>
> *(a) The period of three months beginning when the act complained of was done.*
>
> *(5) A Court or Tribunal may nevertheless consider any such complaint or claim which is out of time if, in all the circumstances of the case, it considers that it is just and equitable to do so.*
>
> *(6) For the purposes of this Section:-*
>
> *(b) Any act extending over a period shall be treated as done at the end of that period."*

428. Very similar provisions appear within the Race Relations Act 1976 and we do not intend, within this decision, to set out those provisions, but we have them in mind.

429. The First to the Thirteenth Respondents refers to a number of authorities. The first is **Robertson v. Bexley Community Centre** [2003] IRLR 434. This relates to the discretion that the Tribunal have to extend time on the grounds that it is just and equitable to do so. In short, the Court of Appeal determined that although a Tribunal has a wide discretion in determining whether it is just and equitable to extend time, the starting point is that time limits are to be applied and only disapplied if good reason can be shown. The exercise of the discretion therefore being the exception rather than the rule.

430. The next case to which we are referred is **Hendricks v. Commissioner of Police for the Metropolis** [2003] IRLR 96. This is the standard authority to determine what amounts to "an act extending over a period", the relevant part being summarised in the head-note, which reads as follows:-

> *"The approach of both the Employment Tribunal and the EAT to the language of the authorities on "continuing acts" was too literal. They concentrated on whether the concept of a policy, rule, scheme, regime or practice, in accordance with which decisions affecting the treatment of workers are taken, fitted the facts of this case. The concepts of policy, rule, practice, scheme or regime in the authorities*

were given as examples of when an act extends over a period. They should not be treated as a complete and constricting statement of the indicia of "an act extending over a period". Instead, the focus should be on the substance of the complaints that the Commissioner was responsible for an ongoing situation or a continuing state of affairs in which female ethnic minority Officers were treated less favourably. The question is whether that was "an act extending over a period" as distinct from a succession of unconnected or isolated specific acts, for which time would begin to run from the date when each specific act was committed."

431. The next is the well-known decision of **Igen Limited v. Wong** [2005] IRLR 258. The significance of that decision is that the Court of Appeal reviewed and approved the guidelines set out in **Barton v. Investec Henderson Crosthwaite Securities Limited** [2003] IRLR 332, with certain revisions. That guidance appears within the annex to the decision, has been considered by this Tribunal and we do not intend to set out that guidance within this Judgment.

432. The next authority to which we are referred is **Laing v. Manchester City Council** [2006] IRLR 748 where the Employment Appeal Tribunal considers the **Igen** guidelines. That decision makes it clear that, in looking at the first stage of the **Igen** guidelines, the Claimant can rely not only upon the facts which he has proven, but upon supporting facts adduced by the Respondents. The sub-heading goes on to read:-

"*Moreover, the obligation for the employer to provide an explanation once the prima facie case has been established strongly suggests that the employer is expected to provide a reason for the treatment. The employer must explain why he has done what could be considered to be a discriminatory act. That is not the language that would be expected to describe facts that may be adduced to counter or put into context the evidence adduced by the Claimant.*

Thus, if a manager acts rudely to a black employee, that will not necessarily raise a prima facie case if there is evidence that that conduct is manifest to all indiscriminately, regardless of race.

In most cases it will be sensible for a Tribunal formally to analyse a case by reference to the two stages, but it is not necessarily an error of law for a Tribunal to fail to adopt a two-stage approach. The focus of the Tribunal's analysis must at all times be the question whether or not they can properly and fairly infer discrimination.

There are cases where it might be sensible for a Tribunal to go straight to the second stage of considering the subjective reasons which caused the employer to act as he did. The reason for the two-stage approach is that there may be circumstances where it would be to the detriment of the employee if there were a prima facie case and no burden was placed on the employer, because that would be imposing a burden on the employee which he cannot fairly be

expected to discharge and which evidentially should be shifted to the employer. But where the Tribunal has effectively acted at least on the assumption that the burden may be shifted, and has considered the explanation put forward by the employer, then there is no prejudice to the employee whatsoever."

433. We were then referred to **Madarassy v. Nomura International Plc** [2007] IRLR 246 and again, reading from the relevant part of the head-note, the Court of Appeal said:-

"The burden of proof does not shift to the employer simply on the Claimant establishing a difference in status (e.g. sex) and a difference in treatment. Those bare facts only indicate 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. "Could conclude" in Section 63A(2) must mean that "a reasonable Tribunal could properly conclude" from all the evidence before it. This would include evidence adduced by the Claimant in support of the allegations of sex discrimination, such as evidence of a difference in status, a difference in treatment and the reason for the differential treatment. It would also include evidence adduced by the Respondent contesting the complaint. Subject only to the statutory "absence of adequate explanation" at this stage, the Tribunal needs to consider all the evidence relevant to the discrimination complaint, such as evidence to whether the act complained of occurred at all, evidence as to the actual comparators relied on by the Claimant to prove less favourable treatment, evidence as to whether the comparisons being made by the Claimant were of like with like as required by Section 5(3), and available evidence of the reasons for the differential treatment. The correct legal position was made plain by the guidance in Igen v. Wong. The detailed guidance in that case does not need to be amended.

Although Section 63A(2) involves a two-stage analysis of the evidence, it does not expressly or impliedly prevent the Tribunal at the first stage from hearing, accepting or drawing inferences from evidence adduced by the Respondents disputing and rebutting the Claimant's evidence of discrimination. The Respondent may adduce evidence at the first stage to show that the acts which are alleged to be discriminatory never happened; or that, if they did, they were not less favourable treatment of the Claimant; or that comparators chosen by the Claimant or the situations with which comparisons are made are not truly like the Claimant or the situation of the Claimant; or that, even if there has been less favourable treatment of the Claimant, it was not on the ground of her sex or pregnancy. Such evidence from the Respondent could, if accepted by the Tribunal, be relevant at showing that, contrary to the Claimant's allegations of discrimination, there is nothing in the evidence from which the Tribunal could properly infer a prima facie case of discrimination on

> *the proscribed ground. The approach of Elias J in Laing v. Manchester City Council would be approved. It was sound in principle and workable in practice*."

434. They helpfully refer the Tribunal to the authority of **Oyarce v. Cheshire County Council** [2008] IRLR 653 to support the proposition that the reversed burden of proof provisions apply to the victimisation claims brought under the Sex Discrimination Act, but not those brought under the Race Relations Act. Mr Sutcliffe helpfully, and we think accurately, concedes that this authority makes little practical difference to the way in which we are likely to approach this case.

435. They then take us extensively to the very helpful decision of the Employment Appeal Tribunal in **The Law Society v. Bahl** [2003] IRLR 640. Mr Justice Elias, within that Judgment, expands upon the principle founded by the House of Lords in **Glasgow City Council v. Zafar** [1998] IRLR 36 as to whether it is legitimate for a Tribunal to infer discrimination purely from unreasonable conduct on the part of an employer. We set out Paragraph 94 of that decision because Mr Sutcliffe places considerable emphasis upon it within his submissions, and because it is, in our view, important that we ensure that we have the principles described by Elias J clearly in our minds when arriving at this decision. The decision reads:-

> *"Employers often act unreasonably, as the volume of unfair dismissal cases demonstrates. Indeed, it is the human condition that we all at times act foolishly, inconsiderately, unsympathetically and selfishly and in other ways which we regret with hindsight. It is, however, a wholly unacceptable leap to conclude that whenever the victim of such conduct is black or a woman then it is legitimate to infer that our unreasonable treatment was because the person was black or a woman. All unlawful discriminatory treatment is unreasonable, but not all unreasonable treatment is discriminatory, and it is not shown to be so merely because the victim is either a woman or of a minority race or colour. In order to establish unlawful discrimination, it is necessary to show that the particular employer's reason for acting was one of the proscribed grounds. Simply to say that the conduct was unreasonable tells us nothing about the grounds for acting in that way. The fact that the victim is black or a woman does no more than raise the possibility that the employer could have been influenced by unlawful discriminatory considerations. Absent some independent evidence supporting the conclusion that this was indeed the reason, no finding of discrimination can possibly be made. The inference cannot be drawn from the fact that other employers sometimes discriminate in such circumstances; it cannot be inferred that A discriminates merely because B, C and D have been known to do so in similar circumstances. That is a plainly deficient basis for inferring discrimination. It would be wholly unjust to make a finding of such serious import on such a flawed basis. Nor does it help to say that it is a finding which is open to a Tribunal but which it is not obliged to make. It is unjustifiable to make it in any circumstances."*

436. In relation to the complaints of direct discrimination contrary to Section 1 of the Sex Discrimination Act 1975 we are reminded of the provisions of Section 5 of the Act which require us to find a comparator, real or hypothetical which "must be such that the relevant circumstances in the one case are the same, or not materially different in the other." That provision does not of course apply in relation to the claims brought under Section 3A of the Act. We are however reminded of the well-known statement of Lord Nicholls in **Shamoon v. Chief Constable of the Royal Ulster Constabulary** [2003] ICR 337 when he said:-

> "*Employment Tribunals may sometimes be able to avoid confusing disputes about the identification of the appropriate comparator by concentrating on why the Claimant was treated as she was, and postponing the less favourable treatment issue until after they have decided why the treatment was afforded.*"

437. When reading and considering those words we do of course have to bear in mind that **Igen** predated the advent of the reverse burden of proof provisions and must be read subject to those provisions. We do, however, have to keep it clear in our mind that when looking at the first-stage of the **Igen** test, findings of unreasonable conduct on the part of any of the Respondents, does not, of itself, provide evidence of unlawful discrimination.

438. We do however also note the learned Judges comments at para 96 when he says

> *"We do, however, respectfully accept that Sedley LJ was right to say that racial bias may be inferred if there is no explanation for the unreasonable behaviour. But it is not the mere fact of unreasonable behaviour which entitles the Tribunal to infer discrimination; it is not, to use the Tribunals language ,unreasonable conduct "without more", but rather the fact that no reason is advanced for it."*

At para 100 he goes on to say

> *By contrast, where the alleged discriminator acts unreasonably then a Tribunal will want to know why he has acted in that way. If he gives a non discriminatory explanation which the Tribunal considers to be honestly given, then that is likely to be a full answer to any discrimination claim. It need not be, because it is possible that he is subconsciously influenced by unlawful discriminatory considerations. But again, there should be proper evidence from which such an inference can be drawn. It cannot be enough that the victim is a member of a minority group. This would be to commit the error identified above in the Zafar case: the inference of discrimination would be based on no more than the fact that others sometimes discriminate unlawfully against minority groups.*
>
> *The significance of the fact that the treatment is unreasonable is that a Tribunal will more readily in practise reject the explanation given*

> *than it would if the treatment were reasonable. In short, it goes to credibility. If the Tribunal does not accept the reason given by the alleged discriminator, it may be open to it to infer discrimination."*

From that we infer that when applying the first stage of the **Igen** exercise unexplained unreasonable conduct on the part of the Respondents may be a fact from which we could conclude that there has been unlawful discrimination.

Mr Sutcliffe, in his submissions, refers extensively to the observations made by Mr Justice Elias as to the statutory scheme between Paragraphs 77 and 79 of his Judgment and the "undisputed principles" set out between Paragraphs 80 and 90 of that Judgment. Those principles clearly have far less relevance in the light of the reversed burden of proof provisions, although to the extent that they provide us with guidance, we have considered those principles. We do however take to heart the section of the Judgment quoted of ***MacDonald v. Advocate General for Scotland*** [2003] IRLR 512 which states:-

> "*These two appeals demonstrate the importance, in my opinion, when dealing with complaints under the 1975 Act and the other anti-discrimination Acts, of keeping in mind that they are intended to combat discrimination. They are anti-discrimination statutes. Absent discrimination, objectionable conduct by employers must be countered by other means than complaints under these Acts*."

439. Whatever findings of fact, therefore, we have made in this case, and no matter how astonished in some instances we have been as to the conduct of some of these Respondents, we cannot simply provide Dr Michalak with a remedy by labelling that conduct as unlawful discrimination unless, following the **Igen** principles, we are able to establish that unlawful discrimination indeed has occurred.

440. In relation to the issue of vicarious liability, Mr Sutcliffe does not seek to rely upon, what is commonly known as, the statutory defence as set out in Section 41(3) of the Sex Discrimination Act. Mr Mumford has, however, referred us to a number of authorities to deal with the issue of whether, whatever the conduct of the other Respondents may amount to, any liability can attach to Dr Neligan or Professor Burr. He refers us to the authority of **Anyanwu v. Southbank Student Union** [2001] 2 All ER 353; the House of Lords suggest that in considering whether somebody has knowingly aided another person to perform unlawful discriminatory acts, we should ask ourselves two questions:-

> "*The first question which must be asked is: what is the act of the student union made unlawful by Part II of the Act which it is said that the university knowingly aided the student union to do?....*
>
> *The second question is: what is it alleged that the university did which knowingly aided the doing of that unlawful act by the student union."*

Mr Mumford in his submissions helpfully transposes the parties in this case

to the relevant parts of those questions. We are then referred to the meaning of the word "aids" as set out at Paragraph 5 of the speech of Lord Bingham in the following terms:-

> *"The expression "aids" in Section 33(1) is a familiar word in everyday use and it bears no technical or special meaning in this context. A person aids another if he helps or assists him. He does so whether his help is substantial and productive or whether it is not, provided the help is not so insignificant as to be negligible. While any gloss on the clear statutory language is better avoided, the subsection points towards a relationship of co-operation or collaboration; it does not matter who instigates or initiates the relationship. It is plain that, depending on the facts, a party who aids another to do an unlawful act may also procure or induce that other to do it. But the expressions "procure" and "induce" are found in Sections 30 and 31, not Section 33, and are differently enforced; they mean something different from "aids" and there is no warrant to interpret "aids" as comprising these other expressions. By Section 12 of the Race Relations Act 1968, the predecessor of the 1976 Act, those who deliberately aided, induced or incited another person to do an act made unlawful by Part I of that Act were to be treated as themselves doing that act, but they could not be subjected to proceedings at the direct suit of the injured party and the 1976 Act adopted a different legislative approach. It is plain that a party who causes another to do an unlawful act does not necessarily aid him to do it. A farmer who starves his sheepdog, with the result that the ravening dog savages a newborn lamb, may reasonably be said to have caused the death of the lamb, but he could not be said to have aided the dog to kill the lamb. In the present appeal no issue arises on the meaning of "knowingly" in this context and it is unnecessary to consider what an aider must know to be liable under Section 33(1)."*

441. Mr Mumford refers us to another House of Lords decision of **Hallam v. Avary** [2001] 1 WLR 655 where, again Lord Bingham, referring to the decision at first instance, said:-

> *"But the Judge was at pains to point out that Section 33(1) required more than a general attitude of helpfulness and co-operation. As he accurately puts it: "the Act requires them to have knowingly aided the council to do an act made unlawful by the Act." The Judge there highlighted the important point that it is aid to another to do the unlawful act in question which must be shown and this is what the Appellants had failed to establish against the police officers."*

Mr Mumford helpfully draws out attention to the comments of Lord Millett when he says:-

> *"The man who helps another to make up his mind does not thereby and without more help the other to do that which he decides to do. He may advise, encourage, incite or induce him to do the act; but he does not aid him to do it. As I said in Anyanwu v. Southbank*

> *Student Union aiding requires a much closer involvement in the actual act of the principal than to either encouraging or inducing on the one hand or causing or procuring on the other."*

442. Mr Mumford then refers us to the Court of Appeal decision in **Hallam** [2000] WLR 966, with a particular reference to the meaning that should be imported to the word "knowingly". At Paragraph 27 of that decision reads as follows:-

> *"Providing aid for a completed discriminatory act by another person, even causing or contributing to such an act, do not of themselves found liability under Section 33(1). Knowledge is the essential requirement. Section 33(1) does not encompass the individual who either recklessly aids the commission of a prohibited discriminatory act or provides aid in circumstances where there is a foreseeable risk of discriminatory action by someone else."*

443. We are then taken to Paragraph 36 of the Judgment which reads:-

> "*This lengthy analysis leads me to the conclusion that liability under Section 33(1) is not established unless the secondary party knows that the party from whom his liability is alleged to derive is treating, or is about to treat, or is contemplating treating someone "less favourably" on racial grounds, and with that knowledge, or knowing that such treatment would be the likely result of doing so, he provides him with aid."*

444. Finally Mr Mumford takes us to the authority of **Sinclair Roche and Temperley v. Heard** [2004] IRLR 763 where, applying the Judgment in **Hallam**, Mr Justice Burton makes the following observations:-

> "*In those circumstances the Court of Appeal decision remains binding on the Employment Appeal Tribunal and the Employment Tribunal, although, as can be seen, it leaves a very wide ambit of fact finding open to the Tribunal. However two matters are clear;*
>
> *53.1 The element of knowledge is on any basis additional to the element of aid. Whereas discrimination can be, and very often is, unconscious, aiding cannot be.*
> *53.2 If there is the conclusion that this additional element exists, it is not satisfactory or sufficient for the Tribunal simply to say that it does, without giving its reasons and making the relevant findings, none of which occurred in this case."*

445. Finally Mr Mumford, in his supplementary submissions, refers us to the authority of **Yearwood v. Commissioner of Police of the Metropolis** [2004] ICR 1660 as to the meaning of the word "agent". Mr Mumford helpfully summarises the effects of that decision, which we agree with and adopt.

446. In terms of the claim brought under the Disability Discrimination Act, as indicated earlier on in this decision, we are not going to be resolving that

claim at this stage, by reason of the fact that the issue of whether the Claimant was or was not a disabled person has not yet been resolved and, if necessary, is to be resolved at a further Hearing once further evidence has been obtained. In order to determine whether the Respondents have treated the Claimant less favourably for reason that relates to her disability, or that they failed to make reasonable adjustments, we would need to identify what disability, if any, existed. We therefore do not intend to set out the law in relation to disability discrimination in this section of the Judgment.

447. Turning, then, finally to the issue of unfair dismissal, we start off by considering the words of Section 98 of the Employment Rights Act 1996, which requires us to determine whether the Claimant was dismissed for a potentially fair reason, in this case the reason relied upon by the Respondents is that of her conduct, which is a potentially fair reason. We then have to go on to determine whether they behaved reasonably in using that as a reason to dismiss the Claimant, we have to determine that issue in accordance with equity and the merits of the case and we have to take into account, as we do, the size and administrative resources of the Respondents, which are considerable.

448. In that regard we have been referred to the longstanding and well-known authority of **Iceland Frozen Foods Limited v. Jones** [1982] IRLR 439. It is not for this Tribunal to substitute our view as to whether dismissal was the right course of action for this employer to adopt. The question we have to ask ourselves is whether dismissal was within the band of reasonable responses, which a reasonable employer might have adopted.

449. We are invited to consider the well-known guidance in **BHS v. Burchell** [1978] IRLR 379 in determining whether the Respondents behaved reasonably in using the Claimant's conduct as a reason to dismiss her, what we have to consider is not whether the Claimant was guilty of misconduct, but whether the Respondents reasonably believed that she was, whether that belief was reasonably held, all reasonable investigations having been pursued and whether thereafter, as previously indicated, dismissal lay within the band of reasonable responses.

450. The Claimant was dismissed on 14 July 2008. That dismissal is therefore one to which the Dispute Resolution provisions applied. By Section 98A of the Employment Rights Act:-

> *"(1) An employee who is dismissed shall be regarded for the purposes of this Part as unfairly dismissed if –*
>
> *(a) One of the procedures set out in Part I of Schedule II to the Employment Act 2002 (Dismissal and Disciplinary Procedures) applies in relation to the dismissal,*
>
> *(b) The procedure has not been completed, and*
>
> *(c) The non-completion of the procedure is wholly or*

mainly attributable to failure by the employer to comply with its requirements."

451. We are therefore required to consider the provisions of the Statutory Dismissal and Disciplinary Procedure that appears in Schedule II to the Employment Act 2002 and which applied to this dismissal. The only matter of relevance appears within Part III which says as follows:-

"*11. The following requirements apply to each of the procedures set out above (so far as applicable).*

12. Each step and action under the procedure must be taken without unreasonable delay.

13. (1) Timing and location of meetings must be reasonable.

(2) Meetings must be conducted in a manner that enables both employer and employee to explain their cases."

452. Finally this is a claim alleging that the Claimant was subjected to a detriment and/or was dismissed for having made a qualifying protected disclosure. The definition of what amounts to a protected disclosure is contained within Section 43B of the Employment Rights Act 1996 in the following terms:-

"(1) In this Part a "qualifying disclosure" means any disclosure of information which, in the reasonable belief of the worker making the disclosure, tends to show one or more of the following:-

(a) That a criminal offence has been committed, is being committed or is likely to be committed,

(b) That a person has failed, is failing or is likely to fail to comply with any legal obligation to which she is subject,

(c) That a miscarriage of justice has occurred, is occurring or is likely to occur…

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

453. To become a protected disclosure it needs to be made to an appropriate person, in this case the alleged disclosures were made to the Claimant's employer, which is such an appropriate person pursuant to Section 43C(1)(a).

454. Pursuant to 47B of the Employment Rights Act:-

"(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.

(2) This Section does not apply where:-

(a) The worker is an employee, and

(b) The detriment in question amounts to dismissal (within the meaning of Part X)."

455. Pursuant to Section 103A of the Employment Rights Act:-

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

456. In his submissions Mr Sutcliffe helpfully refers us to the decision in **Kuzel v. Roche Products Limited** [2008] IRLR 530 and in his submissions he quotes extensively the relevant parts of that Judgment dealing with the issue of where the burden of proof lies in establishing that a dismissal was for an inadmissible reason. We have taken that guidance into account.

457. Finally, and in deference to Mr Sutcliffe's researches, he has referred us the following authorities:-

London Ambulance Service NHS Trust v. Small [2009] IRLR 563
Sainsbury's Supermarkets Limited v. Hitt [2003] IRLR 23
Abbey National Plc v. Fairbrother [2007] IRLR 320
O'Neill v. Buckinghamshire County Council [2010] UKEAT0020
Selvarajan v. Wilmott [2008] IRLR 824

That latter case will provide us with assistance when determining whether this was an automatically unfair dismissal pursuant to Section 98A of the Employment Rights Act. That is authority for the proposition that a failure to comply with the general requirements of the Dismissal and Disciplinary Procedure is of no significance once the procedure has been completed.

458. He also refers us to **Perkin v. St George's Healthcare NHS Trust** [2005] IRLR 934 and **D'Silva v. Natfhe** relating to significance that we should place upon a party's failure to respond to a statutory questionnaire.

459. As far as we find those authorities to be of assistance, we will make reference in the body of our findings.

Findings

460. We begin by considering the Claimant's case as summarised by us at Paragraph 28(a) of this decision. Having done so we will then identify which issues within the Schedule of Issues our findings have then resolved and will

then deal with the remainder of the issues within that schedule.

461. As we have found the Claimant was appointed as a Consultant within the MAU on 29 April 2002 in order to carry out duties, together with her colleague Dr Abbasi, which were not popular with the other physicians within the PGI. She became pregnant towards the end of that year and it would be clear to those colleagues, including Dr White,that she would be going off on maternity leave. As Mrs Nicholls has told us it is probable that Dr Michalak was the first Consultant Physician at this hospital to have become pregnant and taken maternity leave. We find that discontent was created amongst her colleagues by reason of the fact that, having just been appointed to this position, she became pregnant with the consequence that they were going to have to resume carrying out ward rounds on the MAU. It is our finding that that then sowed the seeds as to what thereafter was to happen. We believe that this discontent lay behind the investigation that, out of the blue, Mr Woodhall began in November 2002 relating to the alleged high number of cancelled clinics. We also believe that this discontent was causative of the meeting of 28 January 2003 when the Claimant was told that her specialist interest in nephrology was not to be pursued within the PGI, when her behaviour was, for no apparent good reason, criticised and Val Baron threatened her with disciplinary action in the future.

462. We also believe that that discontent led to the first "secret" meeting on 19 March 2003. The purpose of that meeting, as we have found, was clearly to identify whether or not the Claimant's recent appointment could be reversed and when the meeting was told that they had to "live with this decision" the plan was created that although the Trust would ostensibly support Dr Michalak that was always on the basis that she would, at some point, be taken down a formal route. At that meeting there was overt reference to the Claimant's ethnic origins. The conclusion of that meeting was clearly that the Respondent would "pick up" these proposals once Dr Michalak returned from maternity leave.

463. On her return to maternity leave she agreed with the Trust to work compressed hours. That again would have the effect of imposing a greater burden upon her colleagues. At the key players' meeting of 5 December she discovered the existence of "happy pay" and raised her entitlement to that payment in front of her colleagues to be met by laughter. We have no doubt that her colleagues believed that as a newly appointed Consultant she should not be "making waves" but unfortunately it was not in the nature of Dr Michalak to allow such matters to be ignored. This led to her making the formal demand for payment from Ms Baron and then lodging a formal grievance to Dr White.

464. We have to determine whether that grievance was a protected act within the meaning of Section 4 of the Act. She was complaining that she was being treated less favourably upon her return to work from maternity leave. She was complaining of direct discrimination as a consequence. That is clearly a complaint pursuant to Section 3A(1) of the Act being a complaint of discrimination on the ground that she had exercised a statutory right to maternity leave. We have already described at Paragraph 122 of this

decision the impact that that grievance must have had upon Dr White and upon Val Baron. We find that the combination of those factors that led to the holding of first "secret" and the performing of this protected act led to the plan that then followed which was ultimately to lead to her dismissal.

465. We would also find that the grievance amounted to a qualifying disclosure within the meaning of s 43B (1) (b) and(f) of the Employment Rights Act. By complaining that she was being discriminated against Dr Michalak was contending that the Respondents were failing to comply with a legal obligation that they had not to treat her less favourably than her male colleagues, she was also disclosing information that tended to show that the Trust had made payments to Consultants to which they were not entitled and, as a consequence, may have been breaching their legal obligation to ensure that such improper payments were not made or received.

466. Three complaints then surfaced in relation to Dr Michalak. The complaint made by the three ward sisters, as their letter of complaint makes clear, arose as a consequence of a conversation that they had had with Dr White. We have already found that the complaint made by the College Lane Surgery had been initiated by Dr White. On the basis of those two findings we can only suspect that he had a hand in encouraging somebody to complete a Clinical Incident Form simply because she arrived late for work because of childcare problems.

467. On 17 August 2004 Dr Michalak poured further petrol on the flames of dfiscontent by repeating her complaint of discrimination to the Hospital Manager Neil Woodhall. Dr Abbasi, of course, had significantly benefited from the "happy pay" and he joined in the complaints against Dr Michalak. When he went off on study leave leaving Dr White, unknowingly, to cover his ward round Dr White was quick to blame Dr Michalak. It is clear that by that stage Dr White, Mr Woodhall and Ms Baron had begun the process of collating information upon Dr Michalak to be used against her by reason of the wording of Dr White's email "*just to document another incident relating to Eva's job plan*". We can only conclude that as part of that arrangement Dr Khan was encouraged to complain about Dr Michalak requiring him to do no more than to do his job.

468. Our findings of fact have dealt extensively with the second "secret" meeting. This meeting was not, as the Respondent depicts, a normal management meeting. It was a sinister covert gathering of senior managers and clinicians following up on the plan that had been first discussed on 19 March 2003 and creating a clear strategy as to how the Trust were to get rid of Dr Michalak.

469. That agreed strategy clearly directly relates back to the Claimant having become pregnant, having gone on maternity leave, having complained about discrimination and, it is clear, that her ethnic origins had a part to play.

470. Those events of course go all the way back to October 2004. We need to be satisfied that, what happened thereafter, was indeed attributable to that

strategy, otherwise that act of discrimination, as in our finding it clearly was, would of itself be out of time.

471. We have asked ourselves the question what would we expect to have happened if, as the strategy dictated, there was going to be a concerted attempt to seek out information or material which could, in due course, be used as a means of getting rid of Dr Michalak.

472. The first thing of course that we would have expected to happen would be that somebody would collect and collate information upon Dr Michalak. We know that happened. Emma Lavery told us that it happened and that file was, in due course, shown to Dr McInerny. The existence of that file was then, subsequently, denied.

473. We would expect to see complaints coming from lots of different people. We would expect to see complaints about minor issues, generalised complaints, excessive language being used in order to "beef up" complaints and we would expect a process whereby many of those complaints would not be raised with the Claimant at the time.

474. We would also expect evidence to show that the matter was reviewed from time to time.

475. In our finding that is precisely what happened. Dr Patel, a junior doctor, makes unjustified complaints about Dr Michalak, a Senior Consultant. Dr Mahawish makes similar complaints logged by Dr White in a file note entitled "*Dr Eva Michalak*". Generalised complaints are raised by the Royal College of Physicians which allegedly related to Dr Michalak. A complaint is received from Dr Playforth about entirely appropriate treatment having been recommended by Dr Michalak in relation to an intravenous drug user. The complaint made by the desk clerks, shown to be entirely false and apparently orchestrated by their manager Ms Caine. A Clinical Incident Form which Nurse Monkhouse was encouraged to complete by her manager just because the Claimant left work at the end of her shift. That outrageous offensive and unjustified attack made by Dr Almari and then the Deanery visit when Junior Doctors were coaxed into making complaints about Dr Michalak which, ultimately, upon investigation proved to be groundless.

476. The third "secret" meeting then takes place. This demonstrates the Respondents' reviewing the strategy agreed at the second such meeting. Dr Jenkins and Dr Barnes were then commissioned to try and gather up evidence of other potential misconduct.

477. Dr Jenkins, who had been brought into this strategy by being invited to that third meeting, then did his bit by pursuing investigations in relation to Dr Michalak to try and identify other potential misconduct. We then have the unjustified complaints made by Dr Wass and by Dr Davis.

478. We accept of course that this finding involves us arriving at the view that discussions had taken place between the instigators of this strategy and other managers and clinicians so as to encourage the making of these

complaints. We accept that there is no actual evidence that this occurred save for the fact that this pattern of events suggests that it did. You would not, of course, expect such a process to be documented. You would not expect the process to be initiated by way of formal meetings or discussions. The non-legal members of this Tribunal have both experience of working in large organisations. That experience tells them how easy it is to disseminate a message that senior managers are looking for information in relation to a particular individual. It involves having "quiet words" with managers or other senior clinicians. They in turn have "quiet words" with their subordinates and so the process evolves.

479. It seems to us probable that Dr Michalak was not the most popular of people. She had, of course, already ruffled a number of peoples' feathers by raising the issue of "happy pay". Her actions and correspondence at the time suggest that she was the sort of person who would impose very high standards upon herself and upon others and would not hold back upon making what she would perceive to be legitimate criticism. We suspect she is a fairly pedantic individual. Those are qualities that may well be valuable qualities in a medical practitioner. They do not, however, always generate popularity amongst colleagues. It is within the experience of us all that when encouraged by senior managers to do so people will readily create and make complaints about unpopular colleagues. Junior members of staff do so in order to curry favour amongst their senior clinicians or managers.

480. This process we believe was demonstrated by the evidence of Dr Michalak when she described how, during this period, she felt isolated and under attack and reached a stage where she would always try to have somebody else with her, as she did when the desk clerk incident arose, so that they could give evidence in support if necessary.

481. We are also encouraged to this belief by reason of the fact that when Dr Dawson began the formal, overt, investigation he very quickly expanded the investigation into an exercise of interviewing a large number of people who had had dealings with Dr Michalak to invite negative comment from them. This was, in effect, only a continuation of what had, covertly, gone on before.

482. It was that process that led Dr Dawson to mount his formal investigation and to suspend Dr Michalak. We have already made findings of fact in relation to the impropriety of that process. Dr Nagar then took over as case manager and continued the process by commencing disciplinary proceedings against the Claimant, adopting the "throw it all in" strategy which was ultimately to lead to her dismissal.

483. Looking, to begin with, at the liability of the First Respondent and applying the provisions of Section 63A of the Act we have no doubt that those facts, proven by the Claimant, are facts from which we could conclude that the Claimant was subjected to a campaign, described by Dr DeHavilland as a campaign of harassment, was suspended, had her suspension unnecessarily prolonged and was then dismissed for a reason that related to the Claimant's pregnancy, the fact that she had exercised her right to maternity leave and the fact that she had performed a protected act within

the meaning of Section 4 of the Act. For the sake of completeness as our findings of fact will have made clear we believe that the allegation which amounted to the protected act was an allegation that was true and was made in good faith.

484. That throws the burden of proof upon the Respondents to provide an explanation that their treatment of the Claimant was in no sense whatsoever on the grounds of her sex. We are entitled to expect the Respondents to adduce cogent evidence to discharge that burden of proof.

485. The explanation provided by the Respondents for the three "secret" meetings were that these were just normal management meetings to discuss problems that they were having with a senior clinician. We reject that explanation. There was nothing "normal" about these meetings. If they were "normal" management meetings you would expect the employee concerned to have been informed of the meetings, for the meetings to be looking for ways of working with a difficult employee in order to improve their behaviour or performance. Nothing of that sort occurred here.

486. The Respondents' explanations for the various complaints that were made were that the complaints were entirely spontaneous and arose out of Dr Michalak's improper or unreasonable behaviour. As this Tribunal, with the assistance of Dr DeHavilland analysed the complaints one after the other they all proved to be without justification.

487. The Respondents' explanation for the Claimant's suspension lies in Dr Barnes' risk assessment and the risk that the Claimant presented to the welfare of Junior Doctors. That does not explain why they had allowed her to continue to work with the same Junior Doctors for three months after the outcome of the Deanery investigations was known or why they continued the suspension after Dr McInerny had shown that there was little or no evidence to support the allegations in relation to Junior Doctors. The Respondents allege that it was to prevent the Claimant from interfering with their investigation. There is absolutely no evidence to show that the Claimant had sought to interfere with that investigation. They suggest that the Claimant was dismissed for various serious acts of gross misconduct. No such acts, of course, were substantiated. Accordingly we conclude that having established those facts from which we could find that there has been unlawful sex discrimination the Respondents have failed to provide an explanation to demonstrate that her sex played no part whatsoever and the allegation of sex discrimination against the First Respondent must succeed.

488. For the avoidance of doubt we have directed ourselves in accordance with the principles set out by Mr Justice Mummery in **O'Neill v Governors of St Thomas Moore School** [1996] IRLR 372 and by adopting what we believe to be a simple, pragmatic and commonsensical approach we conclude that whereas there may have been a number of factors that ultimately lead to the Claimants dismissal, including, for example, the failure by the disciplinary panel to properly fulfil their obligation to the Claimant by making sure that the management formulated coherent disciplinary charges and then by requiring them to present concise and relevant evidence in order to substantiate those

charges, the "*effective and predominant cause*" of the decision to create a strategy to find a way of removing the Claimant from her post, her suspension, the commencement of the disciplinary action and her dismissal was the fact that she had become pregnant shortly after her appointment, took maternity leave and then raised the complaint of Sex Discrimination.

489. We, of course, do not need to worry about the "comparison element" by reason of the fact that those matters are inherently gender related.

490. We then turn to the allegation of Race Discrimination as against the First Respondent. We need to determine whether or not the Claimant has proven facts from which, on the balance of probabilities, we could conclude, that in the absence of an adequate explanation, the First Respondent had committed an act of unlawful discrimination.

491. The first fact, so proven, is the repeated reference made to the Claimant's ethnic origins or the potential cultural issues that may arise. Comments relating to her Polish origin began at the first "secret" meeting on 19 March 2003, reference to cultural issues were repeated at the second "secret" meeting on 14 October 2004 and repeated in a telephone conversation between Mr Parkes and Ms Wadman of the NCAS as confirmed in her letter of 29 September 2005 when Ms Wadman reported Mr Parkes as having told her that:-

> "*Questions have also been raised by the juniors about the competency of the doctor who you understand trained abroad and you felt there could potentially also be cultural factors related to the doctor's behaviour*."

492. The Respondents' explanation for those repeated comments is set out in Paragraph 107 of this decision but for the reasons set out at Paragraph 109 that is an explanation which we reject.

493. The second very significant issue relates to the fact established by the Claimant that, despite the fact that approximately 50% of the Consultant body of this Trust comes from ethnic minority backgrounds, as demonstrated repeatedly within our findings of fact, decisions taken about Dr Michalak's future either at the three "secret" meetings, the PAP, the CEA Appeal Panel and the Disciplinary Panel consisted either entirely or predominantly of white British people. That evidence suggests that the First Respondent has failed entirely to have regard to the need to ensure diversity amongst such groups a failure that could lead the Tribunal to conclude that there are discriminatory attitudes amongst senior managers within the Trust. The Respondents have advanced no explanation for this.

494. The Claimant can then rely upon the litany of unreasonable conduct that we have identified within our findings of fact. Those findings include the holding of these entirely improper "secret" meetings. The co-ordinated strategy to gather and collate information which can be used ultimately to effect her

dismissal. The failure to follow proper procedures when effecting and continuing her suspension. The extraordinary efforts put into securing her dismissal. The efforts made to avoid any external scrutiny of the Trust's activities including the failure to provide NCAS with accurate information, the failure to appoint an external investigator to deal with the Claimant's grievance against, in the first instance, Dr Dawson and then those mentioned in the Claimant's letter of grievance of 1 June 2007. The efforts made by the Trust to ensure that Dr Michalak no longer had the benefit of non-executive director advocating her cause, as Mr Grasby has done, by telling Mrs Fatchett that she need have no contact with the Claimant and thereafter insulating her from that contact. That conduct is not the subject of any satisfactory explanation on the part of the Respondents and to adopt the Judgment of Mr Justice Elias in **Bahl** unreasonable treatment without explanation can lead us to infer discrimination. By so doing the burden of proof passes to the Respondents who have failed to provide a satisfactory non-discriminatory explanation for their behaviour.

495. We therefore find the complaint of direct race discrimination to be proved in that the Respondents have failed to show that their behaviour was in no way whatsoever tainted by Race Discrimination. If we had been hearing this case after the advent of the Equalities Act this may well have been a dual discrimination case. As a matter of fact we have no doubt that the Claimants Ethnic origins had a part to play in the decisions that were made about her. That does amount to subjecting her to a detriment by reason of her race or national origins. If, however we were to have to determine what was the "real and predominant" cause of the Claimants suspension and dismissal we would conclude that the cause lay within the Claimants pregnancy, going on maternity leave and then performing a protected act, all amounting to acts of sex discrimination.

496. Similarly, although we have found the "Happy Pay" complaint to have amounted to a protected disclosure we would not find that the principal reason for the Dr Michalak's dismissal was because she had made that disclosure, it was, however a contributory factor. By reason of the fact that it was an issue that was taken into account in determining upon this strategy to oust Dr Michalak we would conclude that she was subjected to a detriment by reason of having made a protected disclosure.

497. We then look at the position in relation to the individual Respondents. Although the First Respondent does not seek to rely upon the statutory defence Dr DeHavilland was keen that we should consider the position in relation to each of the individual Respondents.

498. We begin by considering the position of Dr White. He of course has an established record of having improperly bullied a junior colleague. He caused the meeting of 19 March 2003 to be convened, agreed upon the strategy that was the outcome of that meeting and made reference to the Claimant's Polish origin. On the basis of our earlier findings he thereafter co-ordinated complaints being made against the Claimant and then was a leading participant in the second "secret" meeting. At that meeting he falsely alleged that he did not know why the Leeds sessions had come to an end.

He once again made reference to cultural issues.

499. We have little doubt that thereafter he took a leading part in co-ordinating complaints against the Claimant. Insofar as we have already found such conduct to amount both to sex and race discrimination as against the Trust Dr White was personally responsible for many of those earlier actions that led to the Claimant's dismissal and accordingly we conclude that, in the absence of any satisfactory explanation from him, that he was guilty of both sex and race discrimination.

500. We then turn to the position of Dr Dawson. He of course joined the Trust as Medical Director when this campaign, as against the Claimant, was already in place. We have little doubt that senior colleagues and managers made him well aware of what the Trust was seeking to achieve. He clearly adopted the cause with enthusiasm. He effected the Claimant's suspension without obtaining specific PAP approval. He failed properly to review that suspension but continued to enforce it. He ensured that the suspension was continued for an unnecessary period in part, as we have found, because he ultimately anticipated Tribunal proceedings and he did not want the Claimant's return to work to jeopardise the outcome of those proceedings. He altered the terms of the suspension to an entirely unnecessary and draconian extent.

501. He ignored Mr Grasby's proper representations. He expanded the investigation entirely improperly when he was told that the complaints relating to Junior Doctors were likely to be unsustainable.

502. He manipulated the CEA Award process. He manipulated the CEA Appeal process. He deliberately misled NCAS. He caused deliberate lies to be told to Dr Michalak by Mandy Williamson. We have no doubt that he manipulated the failure by Mrs Fatchett to fulfil her duties. All that is unreasonable behaviour. That is unreasonable behaviour for which no reason, or acceptable reason, has been advanced. When a senior clinician behaves in that way towards a junior colleague that is a fact that could lead us to conclude that such a person may be capable of committing an act of unlawful discrimination. No acceptable explanation for that conduct has been given by Dr Dawson.

503. We conclude that Dr Dawson adopted this strategy as against the Claimant with such enthusiasm knowing precisely why it was that the strategy had been put in place. It is, in our view, probable therefore that Dr Dawson was influenced by issues relating to the Claimant's gender and by issues relating to the Claimant's ethnic origins. He certainly has not provided an explanation to show that such matters had no part whatsoever to play in the reason for his actions. We would, accordingly, find that Dr Dawson was guilty of unlawful sex and race discrimination.

504. We then turn to the position of Dianne Nicholls. She is the Human Resources Director within this Trust, a position of enormous responsibility and influence. She was invited to the second "secret" meeting, she was not able to attend but sent her deputy in her place. She suggested to us that her

deputy did not report back the outcome of that meeting. We find that to be implausible. If the meeting was regarded as being so important as to require the attendance of the Director of Human Resources and such as to justify the Director sending her deputy we have no doubt that her deputy would have reported back to her and we have no doubt that the minutes of that meeting would have been copied to Mrs Nicholls. We conclude, therefore, that Mrs Nicholls knew full well what strategy had been agreed and knew why that strategy was being followed. We have no doubt that thereafter she took a leading part, on behalf of the Human Resources Department, in overseeing what was to subsequently occur.

505. Mrs Nicholls lied in her statement to the High Court. Somebody who behaves in that way may be capable of unlawful discrimination.

506. Mrs Nicholls lied to Dr Michalak about the fact that her CEA application was proceeding normally when she knew that it had been withdrawn from the process.

507. Mrs Nicholls had us believe that her position was of such seniority that she really had little or nothing to do with the disciplinary action that was taken against Dr Michalak. We think that improbable. We have no doubt that by the time that Dr Michalak had been suspended this action against her had achieved a very high profile within this Trust. It was, when all is said and done, being orchestrated by the Medical Director. Mrs Nicholls was a board member and would have been answerable to the board in relation to this process including the ongoing suspension. She should have been required to justify that ongoing suspension to the board. She must have known what was going on, we have no doubt that she knew that the continued exclusion was entirely unjustifiable but she allowed the process to continue.

508. We do not believe that the insulation of Mrs Fatchett would have happened without the knowledge of Mrs Nicholls. Mrs Nicholls accepted that she had spoken to Mrs Fatchett and told her that she did not need to deal with those issues that Mr Grasby had raised. We have no doubt that she went on to tell her that she did not need to talk to Dr Michalak and she put in place arrangements so that communications from Dr Michalak to Mrs Fatchett were intercepted.

509. Mrs Nicholls encouraged Dr Michalak to believe that her grievances would be dealt with at the disciplinary hearing. She knew full well what the statutory grievance procedure required and deliberately misled Dr Michalak as to how those grievances were going to be dealt with whilst at the same time taking no steps to ensure that those who were dealing with the disciplinary hearing knew what to expect. That had the effect, and we believe intention, of making those proceedings all the more difficult for Dr Michalak.

510. In cross-examination Mrs Nicholls accepted that a significant number of replies that she had made to questions posed within a statutory questionnaire were not true.

511. Mrs Nicholls has provided no explanation for that conduct in part simply denying that these things had occurred.

512. We conclude that from that second "secret" meeting Mrs Nicholls knew what was happening and why. She then encouraged and assisted the process that ultimately led to the Claimant's dismissal. Those are facts from which we could concude that Mrs Nicholls had committed acts of unlawful discrimination. No satisfactory explanation has been advanced by Mrs Nicholls for that conduct. We conclude that Mrs Nicholls has also been guilty of sex and race discrimination.

513. We then turn to the four members of the disciplinary panel, Mrs Susie Brain-England, Mrs Julia Squire (the Chief Executive), Mr Toby Lewis and Dr Nick Naftalin.

514. We have in our decision criticised the way in which these disciplinary hearings were conducted, we have criticised them for going on to make a decision at a time when the Claimant was a patient in hospital and we have criticised them for making a decision to dismiss Dr Michalak without really understanding the basis of that decision.

515. On the other hand there is no evidence to show that they took any part in the strategy that led to that disciplinary hearing. In some measure they were, we think, victims of the Trust's strategy of putting forward unspecific allegations of misconduct and bombarding them, and Dr Michalak, with a mountain of paperwork designed, we have no doubt, to overwhelm both Dr Michalak in her ability to prepare for this hearing and the panel in their ability to conduct it. They should have insisted upon the Trust recasting the charges so that simple evidential matters could be focused upon. They took the view that it was their job simply to deal with that that was presented before them. For all our criticisms of them we do not believe that there are matters from which we could conclude that they were guilty of unlawful discrimination.

516. Dr Nagar was, we believe, a ready and willing accomplice of Dr Dawson in subverting the CEA Appeal process and continuing where Dr Dawson had left off in pursuing this unjustified, unwieldy and burdensome disciplinary action against the Claimant. He certainly stands to be criticised for so doing. We conclude that he behaved in this way because he was under the malign influence of Dr Dawson and failed in his obligation to assert the professional independence required of someone in his position. Those are not, we conclude, facts from which we could conclude that he was guilty of discrimination.

517. Dr Barnes, Dr Lane and Dr Jenkins had their part to play in the ultimate demise of the Claimant. To one extent or another they were sucked into the strategy that was being advanced. There is not however, in our view, evidence from which we could conclude that they were guilty of unlawful discrimination.

518. Dr McInerny was the person who investigated the Claimant. Once again we view her as being a willing accomplice to Dr Dawson's improper conduct.

She should reflect on the propriety of having agreed to extend the investigation against the Claimant when the bullying allegation relating to Junior Doctors had all but collapsed because of the contents of the secret file that had been kept by Miss Lavery. Dr DeHavilland would suggest that her motivation was that of financial reward. That clearly must have had a part to play. For all that we would criticise Dr McInerny for breaching what she knew to be the principles of good practice there is not, we believe, any evidence upon which we could rely to conclude that she was guilty of unlawful discrimination.

519. We then turn to the position of Dr Neligan and Professor Burr. Their position is of course different to the other individual Respondents because they were not employed by the Trust. As a consequence they are not liable to the Claimant for any discriminatory behaviour that they may have committed on their own behalf nor are the Trust vicariously liable for that conduct. Their only liability arises under Section 42 of the Act if the Claimant can demonstrate that one or both of them knowingly aided the Trust to perform an unlawful act of discrimination.

520. We may well find that Professor Burr agreed to ask Dr Neligan to investigate the complaint relating to the bullying of junior doctors as a favour to Mr Parkes knowing that the Trust were looking for information to use against the Claimant because of the perceived difficulties that the Trust was having with her. This is corroborated, in our view, by the fact that Professor Burr forwarded to Mr Parkes a copy of Dr Neligan's report before it had ever been discussed with Dr Michalak. We have no doubt that Dr Neligan accepted Professor Burr's request to revisit these junior doctors and to coax them into making complaints against Dr Michalak in the spirit of seeking to assist the Trust in their endeavours to get rid of Dr Michalak. We have little doubt that Dr Neligan would not have treated Dr Michalak in the way that he did on 31 August if she had been a male doctor. As he accepted to us on the two earlier occasions that he had spoken to male doctors about such issues he had offered them the easy way out of not having to accept the validity of the complaints made against them but being willing to acknowledge that the fact that complaints had been made demonstrated the possibility of a problem and adjusting their conduct accordingly. We may conclude that that was discriminatory conduct on the part of Dr Neligan but because he did not employ the Claimant and was not in the employment of the First Respondent's the Claimant has no cause of action against him within this Tribunal for those actions.

521. Her only claim against Professor Burr and Dr Neligan relies upon her showing that they knowingly aided the First Respondent to commit an act of unlawful discrimination. It may well be that their actions contributed to the process that ultimately led to her dismissal but, as noted by Mr Justice Burton in **Sinclair Roche**:-

> "*The element of knowledge is on any basis additional to the element of aid. Whereas discrimination can be, and very often is, unconscious, aiding cannot be.*"

522. There is no evidence to demonstrate that Professor Burr and Dr Neligan knew that the First Respondent was embarking on a course of conduct which was not just unreasonable but was also discriminatory. Accordingly the claims against them must fail.

523. For the sake of completeness we then deal with the remaining issues within the Schedule of Issues. In relation to Item 1(a) we have not been able to identify any complaint of discrimination made by the Claimant in September 2002. Even if such a complaint had been made it is clear to us that the strategy to remove the Claimant began at her pregnancy and any such complaint would have significantly predated that.

524. We have already found the happy pay complaint to have been a protected act.

525. We are not able to deal with Item 1(c) because of the general nature of that issue. At any event in the light of our substantive findings previously given there is no purpose to be served in pursuing that matter.

526. We have already concluded that by reason of her happy pay grievance she was ultimately suspended and dismissed. As part of that process Dr Dawson subverted the process in relation to her CEA application and subsequent appeal. He did so, in our finding, because he believed that ultimately the Claimant was going to be dismissed, would bring Employment Tribunal proceedings and to have given her a Clinical Excellence Award would have embarrassed the Trust's position in relation to such Tribunal proceedings. To that extent, therefore, depriving her of that award was part and parcel of the overall act of discrimination.

527. In relation to the third issue as we have already found her ethnic origins had a part to play in the decision that was made to create the strategy to get rid of the Claimant. The way in which her CEA application was dealt with was simply part of that strategy. We do not, in fact, know what the ethnic origins of the members of the awarding panel were. At any event we do not believe that the constitution of that panel was a matter of relevance in the Claimant's failure to obtain this award. What led to that outcome was the way that Dr Dawson manipulated the process.

528. In relation to the fourth item on the schedule we have already made findings in relation to issues (d), (e) and (f). Dr Michalak complained about an unfair allocation of work, relating to issues such as adding the additional step down unit. We do not believe that there is any evidence from which we could conclude that this related to her race.

529. The campaign of harassment we have in reality already dealt with.

530. In relation to denying or blocking her specialist interest in nephrology we would not conclude that this occurred by reason of the Claimant's race or ethnic origin if at all. Dr White, against whom we have already made significant findings, actually appointed her to the position knowing that she had this specialist interest and, as she conceded, actively encouraged that to

begin with. We believe practical difficulties then got in the way of enabling her to expand that specialist interest within Pontefract.

531. We then turn to the indirect discrimination claim dealt with at Paragraphs 6, 7, 8 and 9 of the schedule. There clearly was a criterion which required that a doctor should have been the subject of an appraisal before being considered for a CEA Award. We suppose it is likely that such a pcp could place women at a particular disadvantage by reason of the fact that they would be more likely to be absent from work for extended periods whilst on maternity leave. We do not however conclude that the Claimant was placed at that disadvantage. Dr Dawson allowed her application for a CEA to go forward on the grounds that she was eligible to apply for that award. The awarding panel did not refuse the application because of lack of eligibility relating to her appraisal record. It is true that her appeal was refused for reasons relating to that appraisal but not because she had not had one, it is Dr Michalak's case that she had been appraised, but because she could not, there and then, prove that she had. We do not therefore find that the Claimant has been indirectly discriminated against in this way. Accordingly we do not need to determine whether the Respondents have shown that that pcp was a proportionate means of achieving a legitimate aim.

532. In relation to paragraphs 10-13 of the schedule we do not believe that the Respondents had a provision, criterion or practice of not having an ethnically diverse panel to determine the CEA Awards. We are not, in fact, aware, evidentially, as to whether that panel was or was not ethnically diverse but if it was not we have no reason to believe that that was an actual practice of this Trust. We are not quite sure what is meant by the Respondents applying a pcp in the points allocation system which applied to CEA candidates. What however we would conclude is that whatever pcps existed Dr Michalak was not put at a disadvantage by reason of her ethnicity or national origins as a consequence in relation to her CEA application. She was put at a disadvantage because of the way that her application and subsequent appeal was manipulated.

533. In relation to Paragraph 14 of the schedule we have no doubt that the preparation and serving of her witness statement in her first Tribunal claim and the issuing of that claim would amount to a protected act within Section 4 of the Sex Discrimination Act. We are not sure which Clinical Incident Forms relating to patient safety referred to in Paragraph 14(c) the Claimant is referring to.

534. We do not believe that the Claimant was dismissed or subjected to detriment by reason of having performed those acts. The issuing and pursuit of that first Tribunal claim was, in reality, nothing more than a preliminary skirmish in the battle that was ultimately to come and for which the First Respondent was preparing. We have no reason to believe that her position was made any worse because she brought that claim. The Claimant suggests that it is not a pure coincidence that she was dismissed a few days before that first Hearing was due to come before this Tribunal. We do not however believe that there is a connection between those two events. We believe that the disciplinary panel was simply determined to put an end to these

proceedings, 14 July had long been arranged as the final hearing date and, whether or not they knew that the Claimant was in hospital, they were simply determined to come to their decision that day.

535. We then turn to the issue of whether the Claimant's dismissal was automatically unfair by reason of the fact that the Respondents breached the general requirements set out in Part 3 of Schedule 2 to the Employment Act 2002 in particular that they continued with the hearing of 14 July at a time which was unreasonable by reason of the fact that the Claimant was in hospital.

536. We have however been referred to the decision of the Court of Appeal in **Selvarajn v. Wilmott** [2008] IRLR 824. Within that decision Lord Justice Mummery assisted us all to understand how Tribunals should approach the failure by an employer to comply with the now defunct statutory procedures. In short he concludes that the first issue to be determined is whether the statutory procedure applies which in this case it did. The second question to be asked is whether the procedure was completed and if the procedure has been completed the failure to comply with any of the general requirements is not an issue that thereafter arises.

537. In this case whatever defects there may have been the procedure was completed. For those reasons we are not able to find that this was an automatically unfair dismissal contrary to Section 98A of the Employment Rights Act.

538. We then turn to Paragraphs 16-20 which relate to the straightforward unfair dismissal claim relying upon the provisions of Section 98 of the Employment Rights Act.

539. The Claimant was dismissed for a potentially fair reason namely a reason which related to her conduct. We do not find that the Respondents behaved reasonably in using that as a reason for dismissing the Claimant. We believe that they behaved unfairly in failing to provide her, at any time, with particularity of the offences allegedly committed. They behaved unreasonably in pursuing a completely unstructured disciplinary process deliberately made the more difficult by the unnecessary production of a vast amount of documentation deliberately designed, we conclude, to confuse both the Claimant and the panel. This conduct being made all the more unfair by reason of the Claimant's ill health and comparatively limited resources that she had in comparison to the resources that the management of the Trust put into her prosecution.

540. The process was unfair by reason of the fact that both the management and the disciplinary panel failed to focus on those key questions of where, when, who and why events occurred.

541. The Trust behaved unreasonably in failing to postpone the last Hearing when senior Trust management knew that she was unable to attend, whether or not the panel themselves knew that to be the case.

542. Turning from procedural issues to the **Burchell** issues even if we were to conclude that the panel held a genuine belief that the Claimant was guilty of misconduct that belief could not have been reasonably held by reason of the fact that they were simply unable to justify that belief when asked to do so. As we have already described each of the members of the panel who gave evidence were incapable of explaining the rationale behind their decision.

543. We would also conclude that whatever had been established against the Claimant dismissal was wholly outside the band of reasonable responses. The Claimant was a Senior Consultant. To end her career on findings of gross misconduct required, in our view, both clear and compelling evidence and also evidence that an offence had been committed that was so serious as to warrant the termination of her career. In reality the only matters that were raised of any substance against the Claimant were those issues relating to Mrs Sibary. Taking into account Mrs Sibary's timid personality there was undoubtedly an occasion when Dr Michalak upset her by remonstrating with her with a raised voice. There was a second occasion when Dr Michalak did not allow Mrs Sibary to tender an explanation as to why a meeting had been placed in Dr Michalak's electronic diary.

544. No doubt such behaviour is regrettable. If this had been brought to Dr Michalak's attention at the time, particularly when she had chance to calm down, we have no doubt that she would have apologised and that Mrs Sibary would have accepted that apology.

545. Common sense tells us that in any working environment where stress and pressure abound, such as within a busy hospital, those who bear the brunt of that stress, the medical practitioners, will often take that out on those around them. If every doctor and consultant who ever spoke harshly to a nurse or secretary were dismissed for gross misconduct we suspect that we would rapidly become short of doctors. To end somebody's professional career for such conduct was far outside the band of reasonable responses.

546. The only other specific issue perhaps worthy of comment relates to the x-ray register. The Respondents made much of this allegation suggesting that it impacted upon the professional integrity of Dr Michalak. If they believed that to be the case we wonder why they did not feel the same about Dr Abassi forging Dr Bangad's name on the register. The fact that no action was taken against him demonstrates that any disciplinary action against Dr Michalak for similar conduct lay outside that band of reasonable responses.

547. Whilst perhaps not strictly pertinent to the way in which we should approach this complaint of unfair dismissal we are bound to note that if we compare the very worst of the behaviour alleged against the Claimant with the dishonest, disreputable and fraudulent conduct that we have found against some of the Trust's most senior clinicians and managers any such allegations against Dr Michalak simply fade into insignificance.

548. We would therefore conclude that this dismissal was an unfair dismissal.

549. We would not find that Dr Michalak was guilty of contributory fault. Such a

finding relies upon us determining what actually occurred as opposed to what this disciplinary panel believed had occurred. We have already commented upon the only allegation which had any substance to it namely the issues relating to Mrs Sibary. Any sensible employer would have resolved those issues by having a quiet word with Dr Michalak who, we have no doubt, would have immediately apologised to Mrs Sibary once she realised that she had caused her distress. That would have been the end of the matter. Such conduct in no way contributed towards this dismissal it was simply used as an excuse to dismiss her.

550. Dr Michalak was criticised for failing to co-operate with the investigation. We have already made findings relating to her unwillingness to participate in interview without knowing precisely what it was that she was supposed to have done. That was an entirely legitimate approach for her to adopt. She then ultimately participated extensively in the investigation by sitting through some thirty hours of interview with Dr McInerny. She participated fully, as best she could, in the disciplinary hearing.

551. Paragraph 20 of the issues relates to the **Polkey** issue. If proper and fair procedures had been followed the Claimant would not have been the subject of disciplinary action let alone dismissal.

552. Paragraphs 21-23 relate to her disability claim which we are not determining.

553. Paragraph 24 relates to the issue of whether any of the allegations of discrimination are out of time. We conclude, without difficulty, that there was a continuing act of discrimination which started with the first "secret" meeting, continued through to the second "secret" meeting when the strategy to remove her was determined and which then was pursued up until her final dismissal. That is a classic act extending over a period and this complaint was brought within three months of the date of her dismissal, being the last of those acts, and was, accordingly, within time.

554. Even if we were wrong about that we would conclude that it would be just and equitable to extend time such as it was necessary to do so. At all times the Claimant made clear what her complaints were and pursued internal grievance procedures. Any such delay as there may have been, although we find none, would be of no prejudice to the Respondents.

555. Paragraph 25 of the issues relates to whether the Respondents failed to comply with the statutory grievance procedure. It is clear that they did. On 1 June 2007 Dr Michalak wrote to Mrs Squire and in that letter she specifically set out a grievance which she even described as Step 1 of the procedure. Pursuant to Part 2 of Schedule 2 of the Employment Act 2002 the Respondents were firstly under an obligation to invite Dr Michalak to attend a meeting to discuss the grievance. Although there was a disciplinary hearing at which Dr Michalak believed her grievance was going to be discussed it was not so discussed. Pursuant to Paragraph 7(4) the Trust were under an obligation to inform Dr Michalak of their decision as to that grievance. They failed so to do. In reality they failed to deal with the grievance at all.

556. That may of course be viewed as a very technical issue although it will no doubt attract an uplift to such award as we may make for discrimination. It should however be borne in mind that the Claimant was making incredibly grave and serious allegations within that grievance. Our findings show that those allegations were justified. If the Trust had followed procedures, both their own and the statutory procedures, they should have appointed an external investigator who may then have revealed precisely what was going on. By that time Dr DeHavilland had the evidence to produce. If that had happened events could have turned out very differently.

557. We made no findings in relation to Paragraph 26 of the schedule that issue relating to remedy which will be determined in due course.

558. Case Management Directions in relation to the Remedy Hearing will follow shortly.

_____
Employment Judge Burton

RESERVED JUDGMENT SENT TO THE PARTIES ON

….....

….....
FOR THE SECRETARY OF EMPLOYMENT TRIBUNALS

Appendix 1

CAST LIST

Name	Role
Abbasi, Dr S	Consultant Physician MAU at PGI
Almari, Dr	Locum Consultant Radiologist
Anderson, Dr A	RCP visitor 2002
Arnold, Dr T	Hospital visitor complained to Dr Judkins re Claimant's behaviour in the Hospital car park
Barnes, Dr S	Clinical Director Medicine
Barron, Mrs V	General Manager Medicine PGI
Beaumont, Ms C	Ward Sister MAU PGI
Burkin, Dr E	Consultant Cardiologist RCP Deputy Regional Advisor
Brain England, Mrs S	Non-executive Director Chair Disciplinary Panel
Burr, Professor W	Postgraduate Dean of Yorkshire Deanery
Cadigan, Dr P	RCP Director of Postgraduate Training
Copeland, Dr L	Consultant Physician
Dawson, Dr D	Trust Medical Director
De Havilland, Dr J	Claimant's husband
Fatchett, Mrs A	Non-executive Director of the Trust Chair CEA Appeal Panel
Faull, Dr M	Non-executive Director of the Trust Chair Disciplinary Panel
Fortune, Dr A	RCGP representative Deanery/RCP visit
Garside, Mr S	Currently Trust General Manager for medicine. 2003 to April 2005, Assistant General Manager for the Medical Directorate and was based at PGI
Grasby, Mr R	Non executive director of the Trust. Designated board member in the Claimant's case.
Golightly, Mrs D	Assistant Director of HR
Fairfield, Dr M	Consultant Anaesthetist , Leeds Teaching Hospitals NHS Trust. Msc Supervisor of Computer Science. University of Leeds. Developed systems for CV q assessment
Forster, Mr M	

French, Mr R	Previous CE of the Trust
Hart, Janie	Complaints co-ordinator
Harvey, Dr A	Consultant Rheumatoligist RCP College Tutor
Hussain, Dr R	Consultant Geriatrician
Jenkins, DR R	Consultant Physician Acute Medicine Lead
Johnson, Dr O	RCP Tutor PGI
Judkins, Dr	Consultant Anaesthetist
Kaladindi, Dr	Consultant Radioligist
Khan, Dr	Junior Doctor
Lavery, Ms E	Corporate HR Manager
Lane, Dr R	Consultant in Palliative Care MedicalDirector
Lewis, Mr T	Chief Operating Officer at the Respondent Trust. From 1 April 2008 to 31 March 2009, was seconded to University College Hospital NHS Foundation Trust, but remained employed by the Respondent Trust.
Mascie-Taylor Dr H	Medical Director, Leeds Teaching Hospitals NHS Trust
Makawish, Dr	
McErlain-Burns, Ms T	Trust's Chief Nurse; Investigator into the grievance against Dr Dawson
McDonald Hull	Consultant Dermatologist – One of Claimant's comparators
McInerny, Dr D	Independent investigator, previous associate postgraduate dean Northern Deanery.
Michalak, Dr E	Claimant
Monkhouse, Ms	Sister MAU
Monroe, Dr A	Junior Doctor RCP Assistant Tutor
Murphy, Dr	Trust Occupational Health Physician
Naftalin, Dr N	Retired consultant O&G and Medical Director. Independent Disciplinary Panel Member.
Nagar, Dr M	Consultant Anaesthetist and Associate Medical Director. Interim Medical Director 10/07 – 04/08
Nahk, Mr S	Trust Director of Information Services
Neligan, Dr P	Associate Postgraduate Dean
Newstead, Dr	Consultant nephrologist, Leeds Teaching Hospitals
Nichols, Mrs D	Trust HR Director

Parkes, Mr J	CEA resigned October 2006
Playforth, Mr	Consultant in A&E
Pasko, Mr M	Trust Service Delivery Manager
Ross, Ms U	BMA industrial relations officer
Sands, Dr K	RCP rep on Deanery/RCP assessments
Semple, Dr C	RCP rep on Deanery/RCP assessments
Sherratt, Mrs L	Deputy Director of HR
Sibary, Mrs R	Claimant's secretary
Smyth, Mrs C nee Shepherd	Deputy Director of HR
Squire, Mrs	Current Trust Chief Executive
Tucker, Dr J	Consultant Physician and RCP Regional Advisor
Tyler, Mrs S	Deputy Director of HR
Wardman, Ms K	NCAS Case Manager
Wass, Dr A	Consultant in A&E
White, Dr C	Consultant
Williamson, Mrs M	Trust Medical Staffing Manager
Wong, Dr	Consultant Physician
Woodhall, Mr N	Hospital Manager

Appendix 2

SCHEDULE OF ISSUES

1. Did the Claimant perform protected acts by

   a). By complaining of discrimination in September 2002

   b) In 2004 by complaining that she was being deprived of "happy pay" by reason of the fact that she had been on maternity leave

   c) By variously complaining about unfair treatment, Unequal treatment, discrimination, victimisation and harassment between 2005 and 2008

2. Was she subjected to a detriment by reason of those protected acts by

   a) depriving her of a CEA award

   b) suspending her from work

   c) dismissing her

3. Was she treated less favourably by reason of her ethnic origins in failing to give her a CEA award. One of the facts upon which she will rely to demonstrate that she may have been the subject of unlawful discrimination was the failure of the Respondents to ensure that the awarding panel was ethnically diverse.

4. Did the Respondents treat her less favourably by reason of her race, ethnic origins or nationality by

   (a) an unfair allocation of work

   (b) subjecting her to a campaign of harassment

   (c) denying or blocking her specialist interest in Nephrology

   (d) suspending her

   (e) prolonging that suspension unnecessarily

   (f) by dismissing her

5. Did the Respondents treat the Claimant less favourably for a reason that related to her gender, including getting pregnant and that she had taken maternity leave, in the ways described at para 4

6. Did the Respondents apply a provision criteria or practise in requiring that a doctor should have been the subject of an appraisal before being considered for a CEA award

7. If they did, did that p.c.p. place women at a particular disadvantage by reason of the fact that they would be more likely to have been deprived of the opportunity of being appraised by reason of the fact that they had been on maternity leave.

8. If it did was the Claimant placed at that disadvantage

9. If she was can the Respondents show that the p.c.p. was a proportionate means of achieving a legitimate aim.

10. Did the Respondents apply a p.c.p by not having an ethnically diverse panel to determine the CEA awards.

11. Did the Respondents apply a p.c.p. in the points allocation system applied to CEA candidates in 18/09/06

11. If they did, did those p.c.p.'s place persons of the Claimants ethnicity or national origins at a disadvantage in applications for such awards.

12. If they did, was the Claimant placed at that disadvantage

13. If she was can the Respondents show that those p.c.p.'s were a proportionate means of achieving a legitimate aim.

14. Did the Claimant perform a protected act by

a) preparing and serving a witness statement in case number 1808465/07

b) issuing that claim.

(c) Submitting clinical incident forms relating to patient safety

15. Was the Claimant dismissed or otherwise subjected to detriment by reason of having performed any of the protected acts referred to in this schedule

16. Did the Respondents comply with the statutory dismissal procedure, in particular did they breach para 13 by dismissing her at a meeting which was not at a reasonable time by reason of the fact that the Claimant was hospitalised.

17. Did the Respondents dismiss the Claimant for a potentially fair reason

18. Did the Respondents behave reasonably in using that as a reason for dismissing the Claimant ; if it be found that the dismissal was unfair –

19. Did the Claimant contribute to her dismissal by any culpable conduct.

20. If the dismissal was unfair by reason of the Respondents failing to follow fair procedures what were the chances that if fair procedures had been followed the outcome would have been the same.

21. Was the Claimant at the relevant time a disabled person within the meaning of the Act.

22. If she was did the Respondents fail to make reasonable adjustments in relation to that disability in particular by failing to take her mental health condition into account in the course of the disciplinary proceedings or any other actions that were taken against her.

23. In relation to any of the acts of discrimination did any of the individual Respondents aid and abet the 1st Respondents to commit unlawful acts of discrimination.

24. Are any of the allegations of discrimination out of time, if they are

(a) Are they part of a continuing act the last of which was an act that is within time. If not

(b) Would it be just and equitable to extend time.

25. In relation to any complaints found to be made out did the Respondents fail to comply with the Statutory Grievance procedure.

26. Has the Claimant suffered any personal injury or illness by reason of any acts of unlawful discrimination committed by any of the Respondents.