THE EMPLOYMENT TRIBUNAL

SITTING AT: **LONDON SOUTH**

BEFORE: **EMPLOYMENT JUDGE TRUSCOTT QC**

Members: **Mrs AJ Sadler**
Dr RP Fernando

BETWEEN:

Dr A Barnbrook **Claimant**

AND

General Medical Council **Respondent**

ON: **22 and 23 March 2018**

Appearances:

For the Claimant: **In person**

For the Respondent: **Mr Ivor Hare QC**

JUDGMENT

The claimant's claims of disability discrimination and victimisation are not well founded and are dismissed.

REASONS

PRELIMINARY

1. Dr Barnbrook is a doctor registered with the General Medical Council ("GMC"). The GMC is the regulator for the profession of medical doctor under the Medical Act 1983. Dr Barnbrook brings proceedings against the GMC as a Qualifications body under section 53 of the Equality Act 2010 ("EqA"), specifically under sections 15 (disability arising from discrimination) and 27 (victimisation) of the EqA.

2. The claimant gave evidence on her own behalf. The respondent led the evidence of Mr Tariq Masood, a Case Review Manager within the Case Review

Team ('CRT'), which sits within the Fitness to Practise Directorate ('FPD'). His team is responsible for managing cases where doctors have either agreed to undertakings or are subject to a substantive order of conditions or suspension following the conclusion of a fitness to practise hearing before a Medical Practitioners Tribunal ('MPT') of the Medical Practitioners Tribunal Service ('MPTS'). His team monitors cases to ensure compliance with any agreed undertakings or substantive orders of conditions or suspension.

3. There was a bundle of documents to which reference will be made where necessary.

ISSUES

4. A list of issues was determined by EJ Cheetham on 19 December 2017 as follows.

1. Discrimination arising from disability S15

(1.1) Did the GMC discriminate against Dr Barnbrook by treating her unfavourably because of something arising in consequence of her disability?

(1.2) The alleged acts of unfavourable treatment are:

(i) Being offered undertakings that placed reporting and supervision requirements on Dr Barnbrook.

(ii) The circumstances in which Dr Barnbrook was unable to work on or about 9.8.17.

(iii) An unreasonable delay in reviewing her conditions of practice.

(1.3) If so, has the GMC shown that the treatment was a proportionate means of achieving a legitimate aim?

2. Victimisation (s.27)

2.1The protected act was Dr Barnbrook's letter of 18 May 2016.

2.2The alleged detriments are the same as (1.2)(ii) and (iii) above.

5. The claimant accepted in cross examination there was no basis for her claim of victimisation. The Tribunal was mindful that this may not be determinative of the matter. In her written closing submission which had been prepared at some earlier stage, she was still claiming victimisation but did not insist on it in oral submission. For the avoidance of any doubt, there is no evidential basis for suggesting that the 18 May 2016 letter of complaint had any effect on (1.2)(ii) or (iii). The Tribunal accepted Mr Masood's evidence that it had no effect on her treatment (Masood: 46 & 60) which was also not challenged. Accordingly, the Tribunal dismissed the victimisation claim.

6. The respondent made the following concessions:
The GMC admits that Dr Barnbrook was disabled at the relevant times.

As regards s. 15 of the EqA, the GMC accepts that:

- (1.2)(i)-(iii) constituted unfavourable treatment; and

- The treatment at (1.2)(i) & (iii) (but not (ii)) was because of something arising from her disability.

FINDINGS OF FACT

7. On 16 January 2015, Dr Barnbrook visited her GP, Dr Walbrook, and stated that she feared she has become addicted to opiates. The GP identified signs that she had taken morphine and transferred her to hospital [11 & 16]

8. On 22 January 2015, Dr Barnbrook spoke to Dr Walbrook again and explained that she was concerned she was becoming tolerant to oromorph and was worried that she might take too much [50]. Dr Walbrook raised concerns with East Sussex Healthcare NHS Trust ("the Trust") and the Deanery

9. On 30 January 2015, the Trust excluded her on full pay pending its investigation [23 & 24].

10. On 9 February 2015, the Trust interviewed Dr Barnbrook as part of its investigation [38-46]

11. On 16 February 2015, Dr Barnbrook became suicidal and was admitted as an in-patient at the Sussex Partnership NHS Foundation Trust for four weeks [239]

12. On 26 May 2015, Dr Berelowitz, Consultant Psychiatrist at the Priory Hospital Brighton and Hove, wrote to the Trust's Medical Director stating his "concerns about her returning to practice as a doctor at this stage". [48]

13. On 17 June 2015, the Trust concluded its investigation [8-12] and referred Dr Barnbrook to the GMC [1-2]. The respondent received an employer referral from Dr David Hughes, Medical Director, of the Trust. The referral informed the respondent that, among other things, Dr Barnbrook had been excluded by the Trust pending the outcome of their investigation. The referral noted that the Trust had lifted Dr Barnbrook's exclusion based upon the initial concerns being unproven, but that she was required to remain on sick leave until such time they had assurances that she was fit to return to her duties.

14. On 24 Jun 2015, the respondent opened an investigation [3] A member of the Triage team considered the information contained within the referral and determined that it amounted to an allegation that could call into question Dr Barnbrook's fitness to practise by reason of her adverse physical or mental health, in accordance with section 35C(2) of the Medical Act and Rule 4(2) of the Fitness to Practise Rules. The Assistant Registrar ("AR") therefore determined to open a fitness to practise investigation. In reaching a decision as to whether to open an investigation, the Team member would have had regard to the guidance available, including but not limited to the following:

- The meaning of fitness to practise (pages 748-750);
- Guidance for decision makers on assessing risk in cases involving health concerns (March 2013 version) (pages 794-797).

15. As there was potential for Dr Barnbrook to return to work shortly, due to her exclusion from the Trust having been lifted, consideration was given as to whether

to refer Dr Barnbrook to an Interim Orders Tribunal ('IOT') (prior to 31 December 2015, the IOT was known as the Interim Orders Panel) to consider whether it would be necessary to impose an interim order of restrictions on her registration pending the outcome of the GMC investigation. By decision dated 26 June 2015, it was determined that there was insufficient information and that it was not necessary at that stage to refer Dr Barnbrook to an IOT [4-5].

16. The Investigation Officer ("IO") then commenced a series of investigation tasks including seeking further information from the referrer. The referrer provided a copy of their Investigation Report and supporting documents by email dated 8 July 2015 [7-48]. Whilst the Investigation Report concluded that, on the evidence collected, the concerns around Dr Barnbrook misusing opioid pain relief were not sufficiently made out, the report did not deal with Dr Barnbrook's inpatient stay or address her current health status as at July 2015. In a letter dated 19 February 2015, Dr Brendan Dooris, Occupational Physician, noted that Dr Barnbrook's behaviour was erratic and he advised caution with regard to signing her medically fit for work [15].

17. The GMC disclosed the information referred to it to Dr Barnbrook, who responded and also advised that she had instructed a legal representative, Ms Catherine Stock, Counsel [66].

18. Upon receipt of this additional information the Investigation Officer sought advice from a Medical Case Examiner ('CE'), a senior member of GMC staff who is responsible for making decisions on cases, as to whether Dr Barnbrook should be invited to undergo a Health Assessment [50-51]. CE advice was provided by Memo dated 17 July 2015. The CE based the recommendation on all of the information available, the inpatient stay was a significant concern. The CE noted that the reason for the admission was unknown and went on to recommend that a health assessment should take place in due course to consider a diagnosis of Opioid dependence syndrome. The CE also recommended that before any arrangements were made, it would be appropriate to obtain confirmation of Dr Barnbrook's current health status to check that she was well enough to engage in the process [79].

19. Enquiries were made with Dr Berelowitz, Dr Barnbrook's treating psychiatrist during her inpatient stay, who advised that he could not comment on her current health, as he was no longer treating her [80].

20. The Investigation Officer also contacted Dr Barnbrook's legal representative to advise that the GMC may in due course invite Dr Barnbrook to undergo a health assessment, and to enquire as to whether Ms Stock was aware of any concerns about Dr Barnbrook's current health that may impact on her ability to undergo the health assessment [81].

21. Following receipt of Dr Barnbrook's Work Details Form [70-76] the IO wrote to Professor Tavabie, the Responsible Officer for Health Education Kent, Surrey and Sussex in accordance with the GMC's employer disclosure obligations, due to Dr Barnbrook's status as a foundation year doctor. The response, dated 3 August 2015, raised a further concern relating to possible addiction to pain killers [93-94]. This information was subsequently considered by an Assistant Registrar who determined that it was a new allegation of impairment by reason of health that ought to be investigated as part of the current investigation [107-108].

22. An Assistant Registrar subsequently considered whether it was necessary to direct a health assessment. Having had regard to all of the information available at the stage and having considered the Medical CE advice and the 'Guidance for decision makers on directing a health assessment [789-793], the Assistant Registrar determined that it was necessary to direct a health assessment [95].

23. The invitation letter for the health assessment dated 12 August 2015 was copied to Dr Barnbrook's legal representative [97-101]. Ms Stock confirmed by telephone on 27 July 2015 that she had discussed the health assessment with Dr Barnbrook and that there were no concerns and that Dr Barnbrook would consent to the health assessment [88].

24. Dr Barnbrook consented to the health assessment, without any further significant issue [105-106]. The arrangements for the health assessment were made by the GMC's Health Assessment Team. Dr Barnbrook subsequently underwent drug testing [170-172] with DNA Legal and saw two health assessors, Dr Seivewright and Dr Winbow. Dr Seivewright opined that there did not appear to be a substance misuse problem but recorded that there was a substantial psychiatric history and a significant current disorder. He nonetheless concluded that Dr Barnbrook was fit to practise generally. Dr Seivewright diagnosed Bipolar disorder type 2 (ICD-10 (CM) F31.80 [184-186].

25. Dr Winbow diagnosed Bipolar Affective Disorder currently in remission (ICD-10 F31.7) [173-178]. In addition, in his first report Dr Winbow referred to a diagnosis of opioid dependence, which had been referred to by the GMC in its letter of instruction following the Medical CE advice [142-143. Dr Winbow concluded that Dr Barnbrook was fit to practise with limitations and made a number of recommendations as to what restrictions might be appropriate.

26. Having disclosed the reports to Dr Barnbrook, the GMC subsequently received comments from Ms Stock in relation to Dr Winbow's report [190]. The GMC reverted back to Dr Winbow, who provided a supplementary report which addressed the comments. Dr Winbow corrected the reference to a diagnosis of opioid dependency, confirming it was incorrect. Dr Winbow did not however change his diagnosis in relation to her bipolar disorder or his conclusion that Dr Barnbrook was fit to practise only with limitations. In addition, Dr Winbow provided further clarification as to why he had made the recommendations that he did in respect of locum working, which was specifically in response to a point of clarification sought by Dr Barnbrook [195].

27. Having obtained the health assessment reports, the next procedural step was for the respondent to write to Dr Barnbrook with full details of the allegation of impaired fitness to practise and to provide any supporting evidence in accordance with Rule 7 of the FTP Rules. However, before that, the IO arranged for a meeting to take place with a Senior IO and an IO from CRT to consider the case and to discuss the health assessment recommendations. This was with a view to considering whether it might be possible to offer Dr Barnbrook undertakings. Before any decision is made about undertakings, it is necessary to consider whether suitable, proportionate and workable undertakings can be formulated to address the recommendations by the health assessors, having regard to the bank of undertakings available. This meeting took place on 4 December 2015, and a draft set of undertakings was drawn up [208-220]. The draft undertakings would

be subject to change, as the ultimate decision as to whether to offer undertakings is a decision of the CE in accordance with Rule 8 and Rule 10 of the FTP Rules.

28. The final disclosure letter was sent to Dr Barnbrook on 8 December 2015 [222-227]. The GMC alleged that Dr Barnbrook's fitness to practise was impaired by reason of her health [225]. Dr Barnbrook responded to the Rule 7 letter [236-241], accepting that she had a diagnosis of Bipolar Affective Disorder, that she had taken too much oromorph before seeing Dr Walbrook and that she felt sleepy and drowsy at the consultation on 16 January 2015. She also described how during her suspension from the Trust, she became suicidal and tried to kill herself. Dr Barnbrook also attached a report from Dr Judith Mohring, Consultant Psychiatrist at the Priory Wellbeing Centre dated 7 January 2016 [260-1], which states:

> "Dr Barnbrook continues to suffer from Bipolar II disorder with emotionally unstable personality traits. Her current psychotropic medication is Lithium 1200mg at night, Escitalopram 20 mg daily and Trazodone 100mg at night . . .
>
> . . . Her concentration is fair . . .
>
> . . . Regarding work I would expect that should [sic] currently be able to undertake a part-time role."

29. On 5 January 2016, Dr Barnbrook had a telephone conversation with the IO, during which the IO explained the possible outcomes of the investigation. Dr Barnbrook indicated that she may not be happy to have restrictions placed on her practice. The IO advised that Dr Barnbrook should ensure her representative addressed this in her response, but that ultimately it was a decision for the CEs [233]. By email dated 7 January 2016 the GMC received Dr Barnbrook's written representations and supporting documents in response to the allegation via her legal representative [235-257]. An updated letter from Dr Barnbrook's treating psychiatrist, was provided the next day [259-261].

30. The next procedural step was for the matter to be referred to the CEs for a decision pursuant to Rule 8 of the FTP Rules. The CEs had the following options available to them:

- take no action;
- offer undertakings;
- give a warning; or
- refer to an MPT hearing.

31. The CEs determined to offer undertakings. The decision document dated 24 February 2016 sets out their rationale for reaching the conclusion that undertakings were appropriate [271-273]. The CEs did not place any weight on the substance abuse issue that had prompted the initial investigation by the Trust, and were instead focused on the mental health diagnosis confirmed by the health assessors. It is not the role of the CEs to resolve disputes of fact between health assessors where the health assessors are not in agreement with one another or there is otherwise a dispute of facts. The CEs specifically addressed their minds to the question of the proportionality of the proposed undertakings in light of the GMC's overarching objective to protect the public.

32. The offer of undertakings was made on the basis that there was a realistic prospect of a finding of impaired fitness to practise having regard to all of the

evidence and the guidance for decision makers, including but not limited to the following:

- The Realistic Prospect Test (pages 803-804)
- Guidance on Undertakings (pages 805-811)
- Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners (June 2014 version) (pages 812-831)

33. Having received the offer of undertakings Dr Barnbrook telephoned the IO on 4 March 2016 [288-289]. During this conversation Dr Barnbrook asked what would happen if she did not accept the undertakings. The IO confirmed that she could make additional representations, and that the CEs would then make a further decision. From the telephone note there appears to have been no discussion about referral to a hearing; the call ended with Dr Barnbrook thanking the IO for answering her questions about the undertakings.

34. On 26 March 2016, Dr Barnbrook agreed to the Undertakings, including that she should have a workplace reporter (no 4) and a clinical supervisor (no 9) appointed before working [290-293]. Dr Barnbrook provided additional comments saying she did not agree with several statements the case examiners had written and that she wanted them to be reviewed as soon as possible. The respondent considers the undertakings to be voluntary although their own website says that if 'you do not agree to the undertakings, you will be taken to a fitness to practice tribunal' [952].

35. Dr Barnbrook made a number of complaints about having restrictions put on her practice and claiming discrimination.

36. At the end of March 2016, the IO arranged for Dr Barnbrook's case to be transferred over to CRT [308-309 and 321-322] in order that her case could be monitored for compliance with the undertakings.

37. In addition to notifying Dr Barnbrook's employers and the Deanery of the agreed undertakings, CRT took steps to appoint a Medical Supervisor. Initially a Dr Rampes was contacted, however following receipt of comments from Dr Barnbrook [333] in relation to the travel time and costs associated with meeting a Medical Supervisor based in London the GMC sought to identify an alternative. Dr Agrawal was approached and confirmed that he could supervise Dr Barnbrook, but again the location was not ideal and so further enquiries were made. The GMC identified Dr Rank as a third possibility, but Dr Barnbrook took objection due to his work at The Priory where she had previously been an inpatient [346]. Subsequently Dr Barnbrook accepted Dr Paul McLaren as her Medical Supervisor.

38. By email dated 18 May 2016, Dr Barnbrook made a complaint [356-358]. The complaint raised the issue about the conflict of opinion between the two health assessors with regards to her fitness to practise. This conflict was not resolved by the CEs as it is not their role to do so. The CEs did however determine that there was a realistic prospect of a finding of impairment in light of the evidence of Dr Winbow.

39. The respondent responded by email dated 23 May 2016 [360]. The writer (Abi) advised that if Dr Barnbrook still had concerns she should revert to Abi who would escalate the concerns as appropriate. Instead of responding to Abi, Dr Barnbrook instead reverted to the Complaints and Correspondence team stating that Abi had told her that the GMC would not do anything about her complaint [361]. This is disputed by Abi. Alan Boyle in the Complaints and Review team responded to Dr Barnbrook advising her of the policy and noting Abi's response. He advised again that if she remained dissatisfied she could respond to Abi's email and that her complaint would be escalated accordingly [362].

40. Dr Barnbrook did not respond to Abi's email, and so her complaint was closed as it was assumed that she did not wish for it to be escalated further in accordance with the complaints policy.

41. In June 2016 Dr Barnbrook appeared distressed in respect of the requests for information from her GP by Dr McLaren [374 and 377]. Dr Barnbrook appeared not to appreciate that by signing the undertakings she had consented to the exchange of medical information. However, Dr Barnbrook took issue with not being copied into the requests for information, and so the GMC acceded to her request to be copied in [381]. The first Medical Supervisor report was received in July 2016 (pages 389-392). Dr McLaren opined that Dr Barnbrook was fit to practise with limitations.

42. In July 2016 Dr Barnbrook was in contact with the respondent in relation to her new role at Tunbridge Wells, which she was due to start on 3 August [419]. Hayley sought to help Dr Barnbrook by contacting her new employer [426-429].

43. In August 2016 Dr Barnbrook provided written representations in response to Dr McLaren's Medical Supervisor report [444-450]. These comments were sent to Dr McLaren [453] and he responded direct to Dr Barnbrook by letter dated 26 August 2016 [459-460].

44. In October 2016 Dr Barnbrook contacted the GMC indicating that she was feeling stressed as a result of the GMC having requested numerous reports. In her email dated 7 October 2016 [499-500] Dr Barnbrook refers to having been 'given undertakings'. Hayley responded to Dr Barnbrook reiterating that the undertakings allowed exchange of information [499]. Dr Barnbrook acknowledged Hayley's email on 12 October 2016 [501].

45. In early November 2016, the respondent received an enquiry from Dr Reynolds, Dr Barnbrook's Workplace Supervisor in relation to the Case Based Discussion ('CBD') requirements [510]. Dr Barnbrook subsequently spoke with Hayley about CBD, in addition to discussing increasing her part-time working from 60-70% [511]. Hayley confirmed that she was looking into the query regarding the CBD requirements. On 9 November 2016 Hayley sought advice from a CE in relation to this. Any decisions about amending the requirements would have to be made by a CE. Hayley pressed the CE for a response [524] and on 3 January 2017 the CE responded and advised that the CBD requirements should not be adjusted, noting that Dr Barnbrook was aiming to return to work at full capacity and the regular CBD would ensure that she was appropriately supervised during the transition.

46. Having confirmed this to Dr Barnbrook, Hayley then received emails in which Dr Barnbrook expressed that she was having difficulties with ensuring the CBD was taking place [553]. Hayley contacted Dr Reynolds to reiterate the importance of the CBD so as to assist Dr Barnbrook with the difficulties she was having [554].

47. Dr McLaren provided his second Medical Supervisor's report in January 2017 [549-551]. Dr McLaren opined that Dr Barnbrook was fit to practise with limitations, explaining in his report that whilst she remained at risk of relapse in the mood disorder, this risk had probably diminished since his first report. In light of Dr McLaren's conclusion there was no basis upon which, at that stage, to either revert to Dr McLaren for further explanation, or to consider revocation of the undertakings.

48. In February 2017 Dr Barnbrook again contacted Hayley with regard to the difficulties she was having in undertaking CBD [553]. Hayley followed this up with Dr Davies, Dr Barnbrook's new Clinical Supervisor, by way of a reminder that the CBD was a requirement of the undertakings [554].

49. On 8 February 2017 Dr Barnbrook emailed the GMC in relation to her dissatisfaction with the how things were going with Dr McLaren [559]. Hayley responded to Dr Barnbrook reiterating that it was important for Dr McLaren to be able to exchange information with her treating doctors on a regular basis but that the GMC would only request a formal report from him on a five to six month basis [558].

50. Because of a change to the respondent's consenting process, it wrote to Dr Barnbrook on 12 April 2017 seeking updated consent in respect of the medical supervision process and the exchange of information [574-575]. Dr Barnbrook's response to this makes it clear that she perceived the reference to the possibility of non-engagement leading to a referral to an MPT as a threat [591. Dr Barnbrook did however go on to sign and return the consent form [592] noting that she felt forced into doing so and stating that the GMC could take her to a Tribunal if it wanted.

51. By email dated 24 June 2017 Dr Barnbrook sent a complaint to Anthony Omo, Director of Fitness to Practise [599-601]. As this was a new complaint, it was treated in accordance with the respondent's complaints procedure and was passed to Hayley to respond to as the case handler [610]. Hayley's response primarily addressed Dr Barnbrook's concerns about the fact that the undertakings were still in place and had not been reviewed. Dr Barnbrook telephoned Hayley following receipt of the response, setting out her dissatisfaction that the GMC had to wait for Dr McLaren to say that she was fit to practise. Hayley said that she would take advice as to whether the GMC could submit the current information to the CEs but noted that it was not the usual practice to seek advice on revocation without a Medical Supervisors report that said a doctor was fit to practise [612]. This usual practice is underpinned by the 'Guidance for decision makers on the variation and revocation of undertakings' [919-929], which sets out that the CEs can only make a recommendation to revoke undertakings where there is sufficient evidence.

52. A further telephone note from that same day between Hayley and Dr Barnbrook and a follow up email suggests that Hayley did seek clarification as to

whether the matter could be referred to the CEs without a positive report from a Medical Supervisor [613, 615-616], as she indicated that the GMC would only look to have the undertakings removed once the Medical Supervisor had opined that she was fit to practise generally.

53. In her email of 20 July 2017 Dr Barnbrook appears to threaten to disengage with the process if Dr McLaren would not assess her as fit to practise.

54. On 3 August 2017 Dr Barnbrook emailed the respondent noting that she had started working at Royal Sussex County Hospital that day, but did not know who her supervisors were, and attaching copies of her end of year work reports [624-633].

55. On Monday 7 August 2017, Hayley responded to Dr Barnbrook asking for confirmation of her clinical supervisor and workplace reporter in accordance with her agreed undertakings and also asking if Dr Barnbrook had sought approval from her Responsible Officer [635]. Dr Barnbrook responded stating that she did not know what Hayley had meant by these requests. Dr Barnbrook was responsible for ensuring this was all sorted before she started her new job but she nonetheless started the role without having the appropriate arrangements in place. On the face of it Dr Barnbrook had started work without the appropriate approval and without having an approved workplace reporter or clinical supervisor in place, which was a technical breach of her undertakings. Hayley did not refer to her non-compliance in her email to Dr Barnbrook. However, Dr Barnbrook's response was to suggest that the respondent take her to a Tribunal [640].

56. On the morning of 9 August 2017, Hayley was directed by Mr Masood to contact the employer/Deanery to make them aware that they had a doctor who was working, who was potentially breaching her undertakings. The main concern was to have the situation resolved so that Dr Barnbrook could carry on working, but also in ensuring that there were no patient safety or public interest risks.

57. Hayley went on to contact Rory Lawton at Health Education, London and South East [647, 649 and 652]. Having been notified, the hospital took the decision to ask Dr Barnbrook to refrain from her clinical duties until the matter had been resolved and the appropriate arrangements had been put in place [641-645]. Dr Barnbrook was not suspended but was asked to leave work [650-651]. The respondent did not make contact with Dr Barnbrook. By the end of the day on 9 August 2017 the matter had been resolved and the appropriate arrangements for her supervisors had been made [653-660].

58. Because Dr Barnbrook had been working without the appropriate arrangements in place, the matter was referred to an AR to consider whether the GMC wished to take any action in relation to a breach of the undertakings. In reaching a decision the AR had regard to a letter from Professor Dewhurst [662-663] where it was noted that the there was a gap in their processes in relation to the appointment of supervisors for trainees on rotation, and he advised that he felt there had been an honest mistake born out of a complex system as opposed to any deliberate fault on behalf of Dr Barnbrook. The AR determined that it was not necessary to take any action in relation to the breach of undertakings having considered the circumstances, however the AR noted in the reasons for that decision that Dr Barnbrook should be reminded that it was her responsibility to ensure that she adhered to her undertakings and that the workplace reporter and

clinical supervisor should be in place prior to her commencing clinical work [674-675].

59. Dr Barnbrook sent a further complaint email to Anthony Omo on 10 August 2017 [669-670]. As this complaint was relatively close in time to her complaint from June 2017, it was treated as an escalated complaint. It was passed to the Assistant Director, Joanna Farrell, who responded to the complaint by email that same day [668-669]. Joanna offered an apology to Dr Barnbrook in respect of how the respondent could have been quicker in communicating with Dr Barnbrook. Dr Barnbrook's response was to suggest that Hayley ought to be the one apologising.

60. Hayley also apologised in an email dated 11 August 2017, in respect of Dr Barnbrook's perception that she had not handled things very well [671]. Hayley also clarified that she did not threaten Dr Barnbrook with a referral to a Tribunal; it was in fact Dr Barnbrook who repeatedly asked that we take her to a Tribunal. Hayley had simply confirmed that a referral to a Tribunal was one option that was available due to the breach of undertakings.

61. In the meantime, the respondent had been waiting for Dr McLaren's Medical Supervisor report following his meeting with Dr Barnbrook at the end of July 2017. There was some confusion as to when the report as initially going to be made available. It was expected in the week commencing 14 August 2017. Dr McLaren however then took annual leave prior to finishing the report. There was also a misunderstanding as to how long he would be away on holiday for; the respondent had been advised that he was away for three weeks and so intended to follow up the report once Dr McLaren was back from his holiday in early September.

62. Dr Barnbrook continued to email requesting a review of her undertakings. She was advised that the respondent was awaiting the Medical Supervisor's report [679-680].

63. This delay led into a further series of complaint emails from Dr Barnbrook to Joanna Farrell [682-683]. Joanna suggested that Dr Barnbrook send through her most recent report from her treating psychiatrist, given there was a delay with Dr McLaren's report, and that Hayley could refer the matter to the CEs to be reviewed.

64. On 24 August 2017 Hayley arranged for the case to be reviewed by the CEs [694]. However, upon review, John Smyth, then a Senior Case Examiner, determined that without the opinion of a medical supervisor, in accordance with the 'Guidance for decision makers on the variation and revocation of undertakings' [919-929], he was not satisfied that Dr Barnbrook's fitness to practise was no longer impaired. He confirmed that he was therefore unable to revoke the undertakings at the present time [693].

65. Hayley confirmed the position to Dr Barnbrook by email on 29 August 2017 [695], which prompted another email to Joanna Farrell [696].

66. Dr McLaren sent a draft report to the respondent dated 30 August 2017 [697-703]. The reason it was in draft was because he had determined that he needed further information from Dr Barnbrook's treating psychotherapist before he could make a definite recommendation. Dr McLaren noted that Dr Barnbrook might find this request intrusive but he clearly felt it was a necessary part of the

risk assessment in light of Dr Barnbrook's views on the GMC process and wanted to reassure himself that she had appropriate support in place before he could recommend that she was fit to practise without any restrictions. The respondent had a number of telephone conversations with Dr McLaren in respect of his report to try to speed up the process so as to be in a position to refer the matter back to the CEs for a review [704-706].

67. There were a series of emails between Dr Barnbrook and Joanna Farrell in relation to both the CEs decision not to review the case without a Medical Supervisors report, and in relation to the delay in Dr McLaren providing his final report [708-711]. Mr Masood replied directly to Dr Barnbrook's email of 1 September 2017 [707]. Dr Barnbrook continued to email both Mr Masood and Joanna, furthering her complaint about the delay between 1 September and 7 September 2017 [712-715, and 729-732]. Attached to one of the emails of 7 September 2017 was a written statement of Dr Barnbrook, further reiterating her complaints [716-717].

68. On 7 September 2017 Dr McLaren provided his final Medical Supervisor report [720-728] which confirmed his opinion that Dr Barnbrook was fit to practise without restrictions. Mr Masood informed Dr Barnbrook on 8 September that the GMC had referred here case back to the CEs [733]. The CEs reviewed the case and by decision dated 11 September 2017 confirmed that the undertakings could be revoked [734-736]. The decision was communicated to Dr Barnbrook by Hayley that same day [737] and Hayley also went on to send out all of the appropriate notifications to the relevant bodies such as her employer and the Deanery [739-745].

69. By email dated 28 September 2017 Dr Barnbrook advised that she had not been sent a copy of Dr McLaren's report. Hayley responded the next day with a copy and apologised that it had not been sent sooner [746]. However, Dr Barnbrook was not satisfied with the response and asked Joanna Farrell for a further explanation [747] which Mr Masood subsequently replied to, explaining that it was simply a mistake; there was nothing further to add by way of explanation.

SUBMISSIONS

70. The Tribunal received written and oral submissions from both parties. Without intending any disrespect, these submissions are not repeated here.

Law

71. The burden of proof provisions in relation to discrimination claims are found in section 136 of the Equality Act 2010 ("EqA"). In the Explanatory Notes to the Act it is said that in any claim where a person alleges discrimination, harassment or victimisation under the Act, the burden of proving his or her case starts with the claimant. Once the claimant has established sufficient facts, which in the absence of any other explanation, point to a breach having occurred, in the absence of any other explanation, the burden shifts onto the respondent to show that he or she did not breach the provisions of the Act.

72. This effect of the pre-EqA authorities is summarised at para 14 of the judgment of the Court of Appeal in **Chief Constable of Greater Manchester Police Force v. Bailey** [2017] EWCA Civ. 425. The Court of Appeal has confirmed

the approach in the earlier authorities continues under the EqA in **Ayodele v. Citylink** [2018] IRLR 114 CA.

73. The relevant provisions of the EqA provide:

15 Discrimination arising from disability
(1) A person (A) discriminates against a disabled person (B) if—
(a) A treats B unfavourably because of something arising in consequence of B's disability, and
(b) A cannot show that the treatment is a proportionate means of achieving a legitimate aim.
(2) …

74. Unfavourable treatment is not the same as "detriment" or less favourable treatment **Trustees of Swansea University Pension & Assurance Scheme v. Williams** [2018] ICR 233 CA. To assess whether something is "unfavourable" there must be a measurement against "an objective sense of that which is adverse as compared to that which is beneficial". As Bean LJ concluded in **Williams**:

> *Shamoon* is not authority for saying that a disabled person has been subjected to unfavourable treatment within the meaning of s 15 simply because he thinks he should have been treated better.

75. There is no need for a comparator, merely to show that the unfavourable treatment is because of something arising in consequence of the disability.

76. If the Tribunal finds that there has been unfavourable treatment of the clamant, it must consider what caused that treatment – more specifically, was the treatment "because of something arising in consequence of disability" (i.e. applying the 'reason why' analysis, as is familiar in the context of direct discrimination claims)?

77. The correct approach to the 'first stage' of a section 15 EqA claim was outlined by the EAT in **Basildon & Thurrock NHS Foundation Trust v. Weerasinghe** [2016] ICR 305, in which Langstaff P held (at paras. 26 – 27):

> **"26** The current statute requires two steps. There are two links in the chain, both of which are causal, though the causative relationship is differently expressed in respect of each of them. The tribunal has first to focus on the words "because of something", and therefore has to identify "something"—and second on the fact that that "something" must be "something arising in consequence of B's disability", which constitutes a second causative (consequential) link. These are two separate stages. In addition, the statute requires the tribunal to conclude that it is A's treatment of B that is because of something arising, and that it is unfavourable to B. I shall return to that part of the test for completeness, though it does not directly arise before me.
> **27** In my view, it does not matter precisely in which order the tribunal takes the relevant steps. It might ask first what the consequence, result or outcome of the disability is, in order to answer the question posed by "in consequence of", and thus find out what the "something" is, and then proceed to ask if it is "because of" that that A treated B unfavourably. It might equally ask why it was that A treated B unfavourably, and having identified that, ask whether that was something that arose *in consequence of B's disability."*

78. As to causation, the crucial question is whether "a matter arising from the disability" has been a significant influence or effective cause of the treatment. This approach was approved in **Pnaiser v. NHS England** [2016] IRLR 170 EAT, at [31(b)], per Simler P:

> The "something" that causes the unfavourable treatment need not be the main or sole reason, but must have at least a significant (or more than trivial) influence on the unfavourable treatment, and so amount to an effective reason for or cause of it.
>
> . . .
>
> (d). . . the causal link between the something that causes unfavourable treatment and the disability may include more than one link. In other words, more than one relevant consequence of the disability may require consideration, and it will be a question of fact assessed robustly in each case whether something can properly be said to arise in consequence of disability.
>
> (e) For example, in Land Registry v Houghton UKEAT/0149/14, [2015] All ER (D) 284 (Feb) a bonus payment was refused by A because B had a warning. The warning was given for absence by a different manager. The absence arose from disability. The tribunal and HHJ Clark in the EAT had no difficulty in concluding that the statutory test was met. However, the more links in the chain there are between the disability and the reason for the impugned treatment, the harder it is likely to be to establish the requisite connection as a matter of fact.
>
> (f) This stage of the causation test involves an objective question and does not depend on the thought processes of the alleged discriminator.

79. The EHRC Code explains, at paragraph 5.9:

> "The consequences of a disability include anything which is the result, effect or outcome of a disabled person's disability. **The consequences will be varied, and will depend on the individual effect upon a disabled person of their disability.** Some consequences may be obvious, such as an inability to walk unaided or inability to use certain work equipment. Others may not be obvious, for example having to follow a restricted diet." [Emphasis added]

80. The EqA provides that the employer can rely on the justification defence under three sections; section 19(2) (indirect discrimination); 13(2) (direct age discrimination) and section 15(1) – as is the case here.

81. It was pointed out in **Essop v. Home Office** [2017] ICR 640 SC para 29 said:

> "Some reluctance to reach this point can be detected in the cases, yet there should not be. There is no finding of unlawful discrimination until all four elecents of the definition are met. The requirement to justify a PCP should not be seen as placing an unreasonable burden upon respondents. Not should it be seen as casting some sort of shadow or stigma upon them. There is no shame in it."

82. There are two elements to justification, there must be a legitimate aim that the body is pursuing and the treatment in question must be a proportionate means of achieving that legitimate aim.

83. There must be a legitimate aim that the body is pursuing. That is a question of fact for the Tribunal. That aim may be established by reasoned and rational judgment, rather than concrete evidence (**Chief Constable of West Yorkshire Police and West Yorkshire Police Authority v. Homer**):

> What is impermissible is a justification based simply on subjective impression or stereotyped assumptions.

84. The treatment in question must be a proportionate means of achieving that legitimate aim. This may still be made out even if there is a less discriminatory means of achieving the legitimate aim in question (**Kapenova v. Department of Health** [2014] ICR 884). There is nothing to prevent an employer relying on "after the event" justifications which were not actually considered at the time (**Cadman v. Health and Safety Executive** [2005] ICR 1546).

85. The Tribunal must balance any discriminatory effect (as it has identified) against the legitimate aims being pursued by the employer. The relevant principles of proportionality are discussed in **Seldon v. Clarkson Wright and Jakes** [2012] IRLR 590; ***Homer v. Chief Constable of West Yorkshire Police*** [2012] IRLR 601; and **Harrod v. Chief Constable of West Midlands Police** [2017] IRLR 539. The Supreme Court in **Essop** said:

> The Tribunal had adopted the "no more than necessary" test of proportionality from the **Homer** case [2012] ICR 704 and can scarcely be criticised by this court for doing so."

86. In **Seldon v. Clarkson Wright and Jakes** [2009] IRLR 267 EAT which was affirmed by the Court of Appeal and Supreme Court although this point does not appear to have been argued before them, it was said at paragraph 73:

> "73. We do not accept the submissions of the appellant, and indeed repeated by the Commission, that a tribunal must always have concrete evidence, neatly weighed, to support each assertion made by the employer. Tribunals have an important role in applying their common sense and their knowledge of human nature. So, to take an example from this case, it seems to us plain that it will assist retention of associates, at least to some degree, that they know that partners are going to have to retire at a particular age. It is also self-evident, we think, that it will assist forward planning, particularly in relation to the operation of particular departments, to have the predictability of knowing when a partner will leave. It does not need a business planner to give evidence about that. Tribunals must, no doubt, be astute to differentiate between the exercise of their knowledge of how humans behave and stereotyped assumptions about behaviour. But the fact that they may sometimes fall into that trap does not mean that the tribunals must leave their understanding of human nature behind them when they sit in judgment."

87. This point was reiterated by Mr Justice Langstaff in **Seldon v. Clarkson Wright and Jakes (No. 2)** [2014] ICR 1275 EAT. As Lord Justice Bean pointed out in **Air Products plc v. Cockram** [2018] EWCA Civ 346 at para 28: "the detail and weight of evidence required will depend on what proposition the employer is seeking to establish." He said that the proposition in that case was so obvious that it barely required evidence at all, it was common sense.

Qualifications bodies

88. Section 53 EqA provides:

. . .

(2) A qualifications body (A) must not discriminate against a person (B) upon whom A has conferred a relevant qualification—

(a) by withdrawing the qualification from B;

(b) by varying the terms on which B holds the qualification;

(c) by subjecting B to any other detriment.

. . .

(5) A qualifications body (A) must not victimise a person (B) upon whom A has conferred a relevant qualification—

(a) by withdrawing the qualification from B;

(b) by varying the terms on which B holds the qualification;

(c) by subjecting B to any other detriment.

89. The relevant parts of the Medical Act 1983 provide:

1(1A) The over-arching objective of the General Council in exercising their functions is the protection of the public.

(1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—

(a) to protect, promote and maintain the health, safety and well-being of the public,

(b) to promote and maintain public confidence in the medical profession, and

(c) to promote and maintain proper professional standards and conduct for members of that profession.

35C.— Functions of the Investigation Committee

(1) This section applies where an allegation is made to the General Council against—

(a) a fully registered person; or

(b) a person who is provisionally registered,

that his fitness to practise is impaired.

(2) A person's fitness to practise shall be regarded as “impaired” for the purposes of this Act by reason only of—

. . .

physical or mental health;

35D.—Functions of a Medical Practitioners Tribunal

. . .

(2) Where the Medical Practitioners Tribunal find that a person's fitness to practise is impaired they may, if they think fit—

. . .

(b) direct that his registration in the register shall be suspended … during such period not exceeding twelve months …

(c) direct that his registration shall be conditional on his compliance, during such period not exceeding three years …., with such requirements so specified

90. The relevant parts of the General Medical Council (Fitness to Practise) Rules 2004 (“the 2004 Rules”) provide:

> Rule 4
>
> (1) An allegation shall initially be considered by the Registrar.
>
> (2) Subject to paragraphs (3) to (5) and rule 5, where the Registrar considers that the allegation falls within section 35C(2) of the Act, he shall refer the matter to a medical and a lay Case Examiner for consideration under rule 8.
>
> Rule 2
>
> “allegation” means an allegation that the fitness to practise of a practitioner is impaired and includes an allegation treated as arising by virtue of section 35CC(3) of the Act and an allegation relating to a person whose registration is suspended;
>
> Rule 7
>
> (2) The Registrar shall carry out any investigations, whether or not any have been carried out under rule 4(4), as in his opinion are appropriate to the consideration of the allegation under rule 8.
>
> (3) The Registrar may direct that an assessment of the practitioner's performance or health be carried out in accordance with Schedule 1 or 2.
>
> Rule 8
>
> (1) An allegation referred by the Registrar under rule 4(2), 5(2), 12(6)(b) or 28(2)(b) shall be considered by the Case Examiners.
>
> (2) Upon consideration of an allegation, the Case Examiners may unanimously decide–
>
> (a) that the allegation should not proceed further;
>
> (b) to issue a warning to the practitioner in accordance with rule 11(2);
>
> (c) to refer the allegation to the Committee under rule 11(3) for determination under rule 11(6); or
>
> (d) to refer the allegation to the MPTS for them to arrange for determination by a Medical Practitioners Tribunal.
>
> (3) The Case Examiners may unanimously decide to recommend that the practitioner be invited to comply with undertakings in accordance with rule 10(3) and, where they do so the practitioner confirms he is prepared to comply with such undertakings in accordance with rule 10(4), they shall make no decision under paragraph (2) accordingly.
>
> Rule 10
>
> (2) If after considering the allegation it appears to the Case Examiners that—
>
> (a) the practitioner's fitness to practise is impaired; or
>
> (b) the practitioner suffers from a continuing or episodic physical or mental condition which, although in remission at the time of the assessment, may be expected to cause a recurrence of impairment of the practitioner's fitness to practise,

they may recommend that the practitioner be invited to comply with such undertakings as they think fit (including any limitations on the practitioner's practice).

(3) Where the Case Examiners make a recommendation under paragraph (2), they shall inform the Registrar who shall write to the practitioner accordingly, inviting the practitioner to state within the period of 28 days from the date of the letter (or such further period as the Registrar may allow) whether the practitioner is prepared to comply with such undertakings.

(4) If within the period of 28 days from the date of the letter (or such further period as the Registrar may allow) the practitioner confirms in writing that he is prepared to comply with the undertakings recommended under paragraph (2), the Case Examiners shall cease consideration of the allegation and make no decision under rule 8(2), and the Registrar shall notify the practitioner and the maker of the allegation (if any) in writing accordingly.

. . .

(6) Where the Case Examiners have ceased consideration of an allegation in accordance with paragraph (4), the Registrar may carry out any investigations, which may include (but are not limited to) requesting the provision of reports or directing an assessment be carried out in accordance with Schedule 1 or 2 or directing that the practitioner undertake an assessment of knowledge of English in accordance with Schedule 3, that are, in the Registrar's opinion, appropriate to the consideration of—

(a) whether the practitioner has complied with any undertakings in place; or

(b) the practitioner's fitness to practise.

(7) Where, as a result of information received by the General Council, it appears to the Case Examiners that any undertakings the practitioner has agreed to comply with under this rule should be varied or cease to apply, they shall inform the Registrar accordingly and the Registrar shall—

(a) write to the practitioner inviting him to comply with such varied undertakings as appear to the Case Examiners to be appropriate; or

(b) direct that the undertakings should no longer apply and that the allegation should not be considered further.

(8) Where the Registrar receives information that—

(a) the practitioner has not within the period of 28 days from the date of the written invitation (or such further period as the Registrar may allow) agreed to comply with the undertakings with which the practitioner was invited to comply under paragraph (3) or (7)(a);

(b) the practitioner has failed to observe an undertaking he has agreed to comply with under paragraph (4) or which has been varied following an invitation to comply with it under paragraph (7)(a); or

(c) the practitioner's health, performance or knowledge of English has deteriorated, or otherwise gives rise to further concern regarding his fitness to practise,

the Registrar may refer the allegation to the MPTS for them to arrange for determination by a Medical Practitioners Tribunal.

DISCUSSION and DECISION

91. The Tribunal found Mr Masood to be a credible and reliable witness.

92. Notwithstanding the concession that the offer of undertakings constituted unfavourable treatment, the evidence in support of the decision to offer undertakings was substantial at the relevant time (March 2016):

- The initial referral which the GMC was entitled to rely on [1-2]
- Dr Dooris, Occupational Physician, advised caution with regard to signing her medically fit for work and described Dr Barnbrrok's behaviour as "erratic" [15]
- Dr Berelowitz' letter [48] Consultant Psychiatrist, stating his "concerns about her returning to practice as a doctor at this stage"
- Professor Tavabie, RO and Interim Dean, stated that concerns "could indicate that Dr Barnbrook's fitness to practice may be impaired" [93]
- The Medical Examiners' reports [173-8 & 195] and [183-186] both diagnosed Bipolar disorder
- Dr Barnbrook's own witness statement [236-241] refers to her becoming "suicidal and tr[ying] to kill [her]self which led to … (voluntary) hospital admission" [239]
- Dr Mohring, Dr Barnbrook's own treating psychiatrist, in her report [260-261] states that "her concentration of fair"; that hypomania does not cause "marked impairment to functioning" and that she "should currently be able to undertake a part-time role"
- Dr McLaren's report [389-392]
- Dr Barnbrook had not been working since January 2015.

93. The Tribunal found that the offering of these undertakings was justified since:

- The Case Examiners did not rely on matters which were unfounded such as the substance abuse allegation [272-3];
- The alternatives included being referred to an Interim Orders Tribunal or Medical Practitioners Tribunal with power, after a finding of impairment, to impose conditions or suspend registration; or a Warning on her record for five years (Rule 8(2) of the 2004 Rules);
- The undertakings were not onerous (see the definition of clinical supervision [858-873]) and did not prevent Dr Barnbrook from working between August and December 2016 (with which the GMC assisted [405-437]) and from August 2017 onwards;
- The Case Examiners expressly considered the question of proportionality [273];
- Dr Barnbrook voluntarily agreed to the undertakings. If she was confident that she was not impaired at that stage, she could have gone to an MPT and called her medical experts (including Dr Mohring and Dr Seivewright) and cross-examined Dr Winbow about his recommendation and sought to persuade the MPT that she was not impaired and there should be no action whatsoever on her registration;
- The undertakings were, at least in part, to protect her own interests [273] and provided the benefit of clinical supervision in order to ensure that she was supported in her move back into the workplace;

- The GMC demonstrated flexibility in relation to the undertakings: by agreeing to a series of changes to her proposed Medical Supervisor for her convenience (Masood: 41); changing its usual practice to copy her into requests for information at her request [381] and Masood: 47; explaining why the restriction on locum posts was in her best interests (Masood: 39); and assisting her to locate suitable Workplace Reporters and Supervisors in 2016 [405-437].

94. As to Issue 1.2(iii), Dr Barnbrook had changed roles the previous summer in July/August 2016 and had been advised then that she needed to ensure that appropriate arrangements were in place and approvals obtained prior to commencing her new role [419-429]. Having been through that process already and having been subject to the undertakings for almost 18 months at that point, Dr Barnbrook should have known that she needed to have the appropriate arrangements in place before she commenced her role.

95. Dr Barnbrook should have contacted the hospital and the Deanery well in advance on the commencement date and should have refused to start working until the arrangements had been put in place. She could have contacted the GMC to assist her if she was having difficulty, as she had done the previous year [419-429], and the GMC could have intervened and sought to speed up the appointments and get everything sorted so that she could start her new role on time. It was Dr Barnbrook's responsibility to ensure this was all sorted before she started her new job but she nonetheless started the role without having the appropriate arrangements in place.

96. It is not disputed that Dr Barnbrook had asked for the details of her new supervisors and not been told who they would be, however that is not the same as making sure that the arrangements were in place in advance of her starting the role. On the face of it Dr Barnbrook had started work without the appropriate approval and without having an approved workplace reporter or clinical supervisor in place, which was a technical breach of her undertakings.

97. The events of 3 August 2017 may have caused Dr Barnbrook significant stress but they were of her own doing, as she had failed to make the arrangements in good time before commencing her new job.

98. It was submitted by the respondent that the circumstances in which Dr Barnbrook was unable to work on 9 August 2017 (Issue (1.2)(ii)) was not because of something arising in consequence of her disability. The reason Dr Barnbrook could not work on 9 August 2017 was because she had breached her undertakings (Masood: 2 & 6). The submission was first, the relevant undertakings (4 and 9) may be imposed for reasons not related to disability: for example, in a misconduct case or one involving deficient professional performance (or one for health reasons which did not amount to a disability. These undertakings are in a separate section of the undertakings from those which related to her health (and hence were confidential). More generally, undertakings can be offered (and accepted) for a number of reasons which are unrelated to disability. The Tribunal did not accept these submissions and concluded that the undertakings in this case were entered into in consequence of Dr Barnbrook's mental health. By parity of reasoning, the reason for breach of the undertakings was also in consequence of Dr Barnbrook's disability even though as Mr Masood says (Witness Statement para 69), the decision to instruct the Trust that Dr Barnbrook should not be doing clinical work

in breach of her undertakings would have been the same “in any case where there was a doctor who was . . . breaching their undertakings”. The Tribunal considered the action taken by the respondent to be justified.

99. As to (1.2)(iii), the delay here was not long and was justified: Dr Barnbrook requested revocation on 24 June 2017 [600]; the undertakings were revoked on 11 September 2017 [734-736]. The reason for the delay was sound and entirely in accordance with the respondent’s published guidance [919-920 and 924]. Even so, the respondent sought the Case Examiner’s view [693-694] and chased Dr McLaren repeatedly for his report [704-706]. Dr McLaren accepted that the delay was at his end, not the respondent’s [966]. Once the report was received, the respondent moved very promptly to get a Case Examiner decision [729. In the meantime, Dr Barnbrook was able to work.

100. Whilst it was clear that Dr Barnbrook found her dealings with the respondent stressful, she had very high expectations as to what the respondent could achieve in a short space of time. Whilst there was some delay in obtaining Dr McLaren’s report, through no fault of the respondent, between the date of her appointment with Dr McLaren at the end of July 2017 and the final CE decision in September 2017 to revoke the undertakings, there was only a period of just over six weeks, and this was during a busy summer period when staff levels are generally lower due to people taking annual leave during school holidays.

101. The claimant’s claims of disability discrimination and victimisation are dismissed.

Employment Judge Truscott QC
Date: 3 May 2018