THE EMPLOYMENT TRIBUNAL

SITTING AT: **LONDON SOUTH**

BEFORE: **EMPLOYMENT JUDGE BALOGUN**

MEMBERS: **Mr C Mardner**
Mr C Williams

BETWEEN:

MR P SRIDHAR

Claimant

And

KINGSTON HOSPITAL NHS TRUST(1)
KELVIN CHEATLE (2)

Respondents

ON: **1 - 17 December 2021**

Appearances:

For the Claimant: In Person
For the Respondents: Robert Moretto, Counsel

JUDGMENT

All claims fail and are dismissed

REASONS

1. By 3 claim forms presented on 16 November 2018, 29 August 2019 and 15 June 2020, the claimant claims direct race discrimination, indirect race discrimination and harassment against R1 (his employer) and R2 (an individual). All claims were resisted by the respondents.

2. The claimant gave evidence on his own account. On behalf of the respondents, we heard from Tracey Moore (TM) Director of Operations; Veronica Williams (nee Grant) (VW) former Head of Medical HR and Recruitment; Ann Jebb (AJ) Associate Director Operations, Planned Care; Kelvin Cheatle (R2) Director of Workforce; Adrian Fawcett (AF) Consultant & Colorectal Surgeon; Peter Wilson (PW) Jane Wilson (JW) former Executive Medical Director; Nadine Coull (NC) Acting Deputy Medical Director; Sarbjinder Sandhu (SS) Chief of Surgery and Planned Care; Sudip Ray (SR) Consultant Vascular Surgeon and Robert Jeffries (RJ) General Manager, Cluster 6.

3. We were provided with an electronic bundle running to 3052 pages. References in square brackets in the judgment are to the pdf pages within that bundle.

The Issues

4. The issues to be determined are set out in the updated list of issues, agreed at a Preliminary hearing on 20 August 2020 [175-181] These are referred to more specifically in our conclusions.

Findings of Fact

5. The claimant describes himself as being of Indian origin.

6. The claimant commenced his employment with the respondent on 14 November 2005 as a Locum Associate Specialist Registrar (LAS) – General Surgery on a fixed term contract. It was initially until 4 April 2006, but was extended until October 2007. In that role he was assigned to the vascular department working under the supervision of SR, Consultant Vascular Surgeon. [640-641]

The claimant's contract

7. There has been a lot of debate during these proceedings as to the nature of the claimant's contract between October 2007 and 2010. The respondent uses the terms bank worker, zero hours contract worker and locum interchangeably, though they don't necessarily denote the same thing. A bank worker denotes a person with no minimum hours who works on an "as and when required" basis, where there is no obligation on the hospital to offer work and no obligation on the worker to accept work. This is what, in other industries, would be referred to a zero hours contract. In the NHS, because of the insecure nature of bank work, doctors working under that arrangement receive an enhanced hourly rate, part of which includes statutory holiday pay entitlement. A locum, can be a bank worker or on a fixed term contract with regular hours. We are satisfied from the evidence that the claimant was a locum during this period, the issue between the parties is, what type.

8. At paragraphs 7 and 8 of his statement, the claimant says that he made repeated requests for a written contract or statement of employment to his line managers and persons in charge. Many of the people referred to have moved on from the Trust. There is scant evidence of those discussions, which the claimant says took place informally or in the corridors. No emails, letters or minutes of meetings have been produced.

9. The only document that we have seen between 2007-2010 in which the claimant raises an issue about his contract is an email on 27 February 2009 to Patrice Donnelly, then Deputy Divisional Manager Surgery The email does not appear to be a request for contractual documents in relation to his existing position (which he refers to as a weekly bank contract), rather, it is a request for a permanent AS contract [647].

10. At [642] is a letter dated 4 October 2007, confirming the claimant's appointment as from 3 October 2007 in the role of Associate Specialist (AS) in the Vascular Team and General Surgery. The claimant says in his statement that he was appointed to replace a consultant vascular surgeon that had left. However, the reality was that he was appointed to assist SR, Consultant Vascular Surgeon, pending the appointment of a replacement second consultant [642] The claimant's appointment was expected to last up until January 2008, but it continued until 8 July 2010.

11. The letter of the 4 October 2007 is silent on the type of contract. The respondent says that the claimant was a bank worker, the claimant denies this. The claimant was certainly being paid as a bank worker in that he submitted time sheets and had an enhanced hourly rate that included his holiday entitlement. Further, in correspondence dated 27.2.09, the claimant refers to himself as being on a weekly bank contract since October 2007 [647] Also, there is an HR document that refers to the claimant as being a locum bank doctor [692] We find he was a Bank worker even though he worked on a continuous basis.

12. On 8 July 2010, it was agreed that the contract would be terminated with immediate effect, as it was realised that the claimant was being paid separately for holiday when he was off work even though holiday was included in his hourly rate. There was no suggestion that he was claiming this fraudulently, this was just another feature of the confusion around the type of contract he had. The claimant ended up being paid over £100,000 a year under that arrangement, which was more than a consultant and significantly, more than the NHS contract rate for an AS.

13. The respondent saw this contract as cost prohibitive and following discussions with TM, then Director of Operations, it was mutually agreed that the contract would be terminated with immediate effect. It was initially replaced with a fixed term contract [670-672 & 679-687] but eventually, on 29 March 2012, the claimant, agreed a permanent AS contract, backdated to 14 July 2010 [693-699]. That agreement was negotiated with input from the BMA (British Medical Association) and seemed to bring an end to the contractual uncertainty surrounding his employment.

14. However, on 11 February 2013, the claimant raised issues around his historical contractual position in a formal grievance, in which he refers to having worked from October 2007-2010 without any contractual paperwork.

15. One of the outcomes of that grievance was that Veronica Grant (now Williams) would issue the claimant with appropriate contracts retrospectively going back to 2007 [724] Despite the grievance outcome, Ms Williams did not issue the backdated contract to the claimant. However, on 13 February 2014, she issued a "To whom it may concern" letter confirming the claimant's full employment history from November 2005 to date, including his job title, and area of work [729] A similar confirmatory letter of employment, from October 2007 to date had previously been provided by Veronica Williams to the claimant on 19 November 2010 [662] Veronica Williams left the Trust in September 2014.

16. The claimant says that without the backdated letters he was not be able to apply for the specialist register through Article 14 which in turn had resulted in him missing out on a consultancy position in Jersey. He contends at paragraph 10 of statement that having passed the intercollegiate surgical fellowship examination, he had everything that he needed to apply for entry onto the specialist register of the GMC except his contract or employment statements and could not get onto the register as a result. He relies on this as a detriment for the purposes of less favourable treatment.

17. There is no evidence at all from any official sources, such as the GMC, that i) the claimant could not progress an application without a contract/particulars of employment or ii) that he met all other requirements.

18. There is also guidance on the categories of evidence to be included. Under this category is a heading: "*Employment letters and contract of employment*". It is clear from this section that the purpose of the contract in the application process was to confirm dates of employment, post, title, type of employment, grade etc [2822]. That criteria could have been satisfied by the 2 letters provided by Veronica Williams confirming his employment.

19. However, we will never know because the claimant never applied. In fact, by 2015, he had decided that he was not going to apply.

Emergency on-call rota

20. One aspect of the claimant's role was the emergency on-call rota. Members of the surgical staff are rostered to be available outside their normal working hours to work, mostly at night and weekends, as and when required, in the event of an acute adult emergency patient being admitted to the hospital.

21. The majority of acute admissions at the respondent hospital present with abdominal conditions and most of those are upper or lower gastro intestinal. Minor problems, such as people presenting with abscesses that need draining or uncomplicated surgery, can be dealt with by any doctor on the rota. However, more major conditions need to be consultant led.

22. At the time the rota was organised at four levels, each rota independent of the other three. There was one rota for junior doctors i.e. foundation year trainees; a second rota for the core trainees who were a little more experienced; a third rota for the middle grade trainees or specialist registrars, and the final level was for consultants.

23. The claimant was on the third tier rota but wanted to be on the rota at consultant level, even though he was not a consultant. That would have meant the claimant being the most senior person on shift. That request was declined by Mr AF, Consultant and Colorectal Surgeon, and the claimant claims that he did so because of his race.

24. Mr Fawcett's reasons for declining the claimant's are set out in his email to the claimant of 14 May 2012, and these were explained further in his witness statement and oral evidence. There were 3 reasons given:

25. Firstly, an NHS London review of adult emergency services specifically and repeatedly called for increased consultant involvement at all levels in the management of acute admissions. Putting the claimant in charge of the shift would have gone against that.

26. Secondly, consultants on the rota are responsible for the on-going care of the patient after initial admission, unless that care is more suited to a consultant with a particular sub-specialty, in which case it would be passed to that consultant. The claimant had not done upper and lower gastrointestinal problems. The last gall bladder that he had claimant had taken out was in 2001 and he had never performed laparoscopic surgery independently. Hence, if he were on the consultant rota, he would have ended up handing over the majority of cases as he did not have the experience to continue te on-going care.

27. Thirdly, the claimant's position on the middle rota would have needed back-filling with a locum, at a cost to the Trust.

Training

28. The claimant further alleges that in October 2013, he offered to undergo any training the respondent considered appropriate to place him on the rota at consultant level but AF turned down this request. The claimant contends that his request was refused because of his race.

29. AF did not recall the request but says if it was made, he would have refused it. We believe the request was made as there is evidence that it was discussion during the claimant's grievance hearing in May 2013 and it is referred to in the grievance outcome letter 21 May 2013 [721, 724]

30. AF's evidence to the Tribunal was that, in order to be placed on the rota at consultant level, the claimant would have needed to undertake a lengthy programme of in-depth emergency training, of around1-2 years, which was not practicable for him to do by shadowing a consultant. He would have needed to apply for a registrar post, which would come with its own emergency work commitment. The claimant had repeatedly been told that this is what he needed to do but he was not prepared to. AF also explained that the claimant's request would have taken training opportunities away from CCT trainees. The respondent was under a contractual obligation to provide training to CCTs and if it failed to do so, there was always the risk of the Deanery taking them away, which would have had a financial impact on the Trust. That risk was more than theoretical; FY1s were withdrawn from the Trust in 2014 after the trainees completed a survey about their learning experience [2701]. AF's evidence was largely unchallenged and we accept it.

Consultant Contract

31. Historically, in order to become a consultant, it was necessary to be on the specialist register. The process for entry onto the specialist register is prescribed by statute – Medical Act 1983. Being on the register proves that a doctor has the skill and experience to work at the level of a consultant. One way to get on the register is to obtain a certificate of completion of training CCT. That is the normal deanery route but one that is only open to doctors who trained in the UK or Europe. The other route, for doctors who don't have CCT is CESR – Certificate of Eligibility for Specialist Registration, previously known as the Article 14 route.

32. The Postgraduate Medical Education and Training Board (PMETB) provides guidance on applying for CESR entry to the specialist register. As well as passing the exams, one of the key requirements, is that an applicant provide documentary evidence that they have a level of knowledge and skill consistent with the practice of a consultant in the NHS [2784,2789,2793]. That evidence needs to be up to date and would normally relate to the previous 6 years before the application date.

33. The claimant was primarily a vascular surgeon, with no sub-specialty. According to the guidance, in order to get onto the specialist register, he would be expected to have had recent practical experience in the matters set out in the guidance for General Surgery or vascular. As a vascular surgeon, he would have needed a wide exposure to elective and emergency vascular and endovascular surgery. He would also have had to demonstrate knowledge and understanding of the management of certain critical conditions [2441]

34. We accept the evidence of SR that the claimant did not have sufficient experience in vascular procedures to satisfy the requirements to obtain entry on the specialist register as a consultant vascular surgeon. Sudip Ray is a consultant vascular surgeon and the claimant has worked within his department since he joined the Trust. He was also an Educational Supervisor and Clinical Supervisor for core trainees. He is therefore ideally placed to understand the specialist register requirements and the claimant's capabilities.

35. The claimant accepts that he does not have a sub-specialism and that his range of surgical work is limited to arterial vascular work and minor plastic surgery. He also accepts that he was not doing complex elective laparotomies and had not done key-hole surgery since 2001. These are all things that a consultant general surgeon would do regularly. There were other aspects of a consultant's role that the claimant did not do. For example, he did not lead a team of junior doctors and did not admit patients.

36. The claimant never applied to go onto the specialist register and by 2015, had made a conscious decision not to do so.

37. From 1 May 2013, the respondent obtained foundation status. A Foundation Trust hospital is afforded more discretion and independence in the management of its own affairs and the NHS (Appointment of Consultants) Regulations 1996 and the good practice guidelines on the appointment of consultants, do not apply to Foundation Trusts. It is the claimant's case that once the respondent obtained foundation status, there was nothing preventing it from appointing him as a consultant. However, Foundation Trusts can continue to follow the guidance if they so choose and the

respondent chose to continue to apply the 1996 Regulations and Guidance on the appointment of consultants so still expected someone to be on the specialist register to be a consultant. [617].

Statement re superiority of consultants

38. The claimant alleges that at a meeting on 14.6.18, SS, Chief of Surgery and Planned Care said to him that consultants were superior to Associate Specialists. This was a meeting to discuss the claimant's concern about his contractual position and his desire to be a consultant.

39. SS recalls a general discussion at the meeting about the difference between consultants and associate specialists but not the remark attributed to him. AJ, Associate Director Operations, Planned Care, was at the meeting and told us that no such statement was made by SS.

40. Our observation of the claimant is that he places great store on status and seniority. The underlying theme to his claims is that he is equal to a consultant and should be treated as such and receive the same benefits. Therefore the notion that he was junior to a consultant would have been unacceptable to him. We find on balance that SS did not make the remark and consider it is more likely that, in the context of the comparison that was being made between roles, he would have referred to the seniority of consultants and the claimant would have seen this as derogatory. The claimant's use of the word "superior" is emotive and probably reflects his perception of what was being said rather than the reality.

Supervision when operating children with appendicitis

41. In 2017, the respondent introduced a policy on the management and treatment of children with abdominal pain and possible appendicitis (the "Appendicectomy Policy"). The unchallenged evidence of the respondent was that appendicitis is one of the most common surgical emergencies in the UK and is most common in young adults. In young children, presentation may not be classical and children may progress rapidly to perforation. Diagnosis therefore requires significant additional clinical skills to elicit signs.

42. In 2017, following investigations into serious incidents involving children with appendicitis, the respondent was advised by the Royal College of Surgeons (RCS) that changes in practice were necessary to ensure the best possible outcome for children with suspected appendicitis, hence the Appendicectomy Policy.

43. Paragraph 10 of the Appendicectomy Policy provides that: " ***Children aged 6 to10 years should have an open appendicectomy unless performed by a consultant with specific expertise in paediatric laparoscopic surgery. A Consultant surgeon should perform the surgery or directly supervised (Consultant present in theatre), appropriately trained senior HST***" [448].

44. The claimant contends that the policy meant that he was not permitted to carry out appendicectomy's on children over 6 without supervision and that this amounted to indirect race discrimination.

Use of Private Treatment facilities

45. As well as his role with the respondent, the claimant practised privately as a surgeon in Harley Street. That practice was limited to small procedures in a small clinic. In April 2019, the respondent took over a private patient unit from BMI. As the respondent had no formal policy of its own, it continued with the one that had been applied by BMI in the interim while it devised its own policy. That meant that those who already had practising privileges under the BMI policy would continue to do so. That was mainly consultants.

46. On 8 July 2019, the claimant wrote to the respondent querying why use of the private health facility was limited to consultants and suggested that such a policy was discriminatory [965-967]. In reply, the respondent explained that it was in the process of developing its own policy for the use of the private facility and that in the meantime, the Medical Advisory Committee (MAC) had decided to continue with the existing BMI rules. [971].

47. The respondent's new policy came into force in January 2020. The claimant's new policy was in place. Under paragraph 5.2 of the new policy, medical practitioners within the Trust who wanted to use the private facility had to register an interest to do so by completing an initial application, for consideration by the MAC. [539].

48. The policy does not exclude non consultants and on 5 March 2020, the claimant was expressly invited to apply for use of the facility in time for consideration at the next MAC meeting on 18 March 2020 [1004]. The claimant replied o the 17 March 2020 stating that he intended to submit an application that evening [1004]. He did not do so and has not done so since.

Use of Clinic Rooms

49. The claimant alleges that whenever there was a need for a consultant to have a room for an ad hoc clinic, his room would be given to the consultant and he would be required to relocate to a less appropriate room. The claimant contends that this amounts to racial harassment.

50. In an email from the claimant to SS and JR dated 19 August 1015, he complains, amongst other things, that "***When there is a need for an OPD*** (outpatient department) ***room I feel and believe that my clinic is the one that is moved out to give way for any adhoc clinic or for consultant clinic***…" The claimant has provided no details as to when this occurred, who was responsible or the surrounding circumstances. He raises the issue again in an email dated 11.2.19 where he gives examples of this. The explanation he was given on that occasion was that it was an error with the room booking system [919. 920] This is a general allegation which appears to be based on the claimant's perception. It is not supported by any evidence and we find that it has not been made out on the facts.

Nurses

51. In a similar vein, the claimant alleges that if there was a shortage of nurses, his would be taken away and given to a consultant. This is also said to be racial harassment.

52. It is clear from a number of emails we were taken to that the respondent on occasion had a shortage of nursing staff due to sickness absence and that this sometimes meant

that the claimant did not have a dedicated nurse for his clinics and would have to share. However, the claimant was not the only one that this affected. SS had previously told the claimant and told the Tribunal that there had been many time when he had done clinics without a nurse due to sickness as had most of his colleagues. We accept that evidence.

Failure to assign Junior Doctor to the claimant

53. The claimant says that he was the only surgeon who operated regularly without any assistance of a junior doctor and that his formal requests for help were ignored. The claimant accepts that he had assistance for laparoscopic hernia repairs. His complaint relates to solely to open repair procedures. He says that this was because of his race.

54. The respondent accepts that it is possible that there have been occasions when the claimant has not been assisted by a junior doctor than the consultants. This is put down to 2 things i) the removal of vascular FY1s by the deanery and ii) Trainee preferences. I deal with these in more detail below:

55. Prior to July 2015, the vascular department was staffed with a number of FY1-2 trainees, as well as CT1-2 trainees and ST3-8 trainees. However in July 2015, the Deanery withdrew FY1 trainees from the Trust's breast and vascular departments - the main reason given was a lack of supervision on the wards. Arrangements were made for one FY1 to stay in the breast department and they provided cross-cover with the ears, nose and throat department ("ENT"). Cover for ward-based vascular work was provided by the FY1s working in the upper gastrointestinal ("Upper GI") department.

56. At the time the vascular surgery team consisted of two part-time consultants, SR and Paul Moxey, and the claimant. The removal of the vascular FY1 had a direct effect on the claimant. As the only full-time senior surgeon in the department, the claimant was particularly affected by the removal of the FY1 as it meant that there was no full time junior doctor cover for elective ward patients in Vascular or to assist with inpatient admission, prescriptions or discharge. That continues to be the case. However, that situation was not unique to the claimant, consultants were not assigned junior doctors all of the time and we accept the respondent's evidence that a number of named consultants performed hernia procedures without assistance.

57. The other point to note is that FY1s are primarily at the hospital to be trained. Hence. whilst sometimes they are placed where they are required, they are also afforded a level of autonomy to attend the clinics that would best help them achieve their training and developmental requirements. The trainees will often prefer to work in an area they have identified as their future surgical career rather than one which holds less interest. In addition, Consultants are often acting as clinical supervisors to trainees and as result, the trainees tend to want to work directly for that consultant to help ensure that they are signed off at the end of their training programme for meeting the required competencies.

Supervision of Trainees

58. In September 2015, the claimant expressed an interest in becoming a supervisor for Foundation Year 1 (FY1) and Foundation Year 2 (FY2) (doctors in training). However, in order to be so, he needed GMC accreditation which he did not have at the time. PW, Consultant, was at the time Surgical Supervisor and took the claimant through the accreditation process. That process was completed in April 2017 when PW signed off

the claimant's GMC trainer accreditation and thereafter was responsible for allocating him 2 FY1s. One of the FY1s left shortly afterwards to continue their training elsewhere and the claimant was then left with one, PR.

59. Although the claimant considered PR to be his trainee. However, there is no property in a trainee. A trainee will have a number of supervisors for each rotation and at some point, they will decide which supervisor they want to spend time with. That person will become the principle supervisor and the person most likely to sign off their training record. At the relevant time, SR, was an Educational Supervisor for some of the core trainees and also Clinical Supervisor of all core trainees assigned to the vascular department. SR was one of PR's named Clinical Supervisors and was unaware that the claimant was also assigned to PR as the claimant had not told him. SR signed off PR's training record though in this instance, it was PR who approached SR to do so. PR's reasons for doing so are set out in his email to the claimant of 21.2.19. In it he explains that he went to SR because he had worked with him the most and had not worked much with the claimant [935-936]

The appointment of Carine Bowen as locum upper GI Consultant

60. Around May 2020, the respondent needed to recruit a locum upper GI consultant surgeon to cover for a consultant surgeon who was on sudden extended sick leave. The position was advertised internally and required applicants to be on the Specialist Register or within 6 months of CCT at the date of interview [1022-1023].

61. Locum appointments are exempt from the GMC requirements to be on the specialist register and it is the claimant's case that that requirement was included in the advert to exclude him from applying because of his race. [609-610]

62. The allegation of discrimination is directed at R2 on the basis that he was Head of HR and had aided the respondent in including a racist provision into the advertisement, contrary to section 112 EqA. R2 told us that he had no involvement in the drawing up of the advert and we accept his evidence.

63. The people involved in issuing the advert were NC, Acting Deputy Medical Director, and RJ, General Manager, Cluster 6. RJ told us that the advert was adapted from an old job description used for a previous advert. We have seen the person specification contained in that old job description and it included being on the specialist register as one of the essential requirements [1012-1020]

64. The reality is that the respondent did not need to introduce this requirement to exclude the claimant from applying as there was never any possibility of the claimant applying because the role was outside of his area of practice and expertise. The claimant does not dispute this.

Submissions

65. The respondent provided written submissions which were spoken to. The claimant made oral submissions. These have been taken into account.

The Law

Direct Disrimination

66. Section 13 of the Equality Act 2010 (EqA) provides that a person (A) discriminates against another (B) if because of a protected characteristic, A treats B less favourably than A treats or would treat others.

67. Section 23 EqA provides that on a comparison of cases for the purposes section 13, there must be no material difference between the circumstances relating to each case.

68. "The relevant circumstances" for the purposes of the statutory comparisons are those which the respondent took into account when deciding to treat the claimant as it did. If the relevant circumstances are to be "the same or not materially different" all the characteristics of the claimant which are relevant to the way his case was dealt with must be found also in the comparator. They do not have to be precisely the same but they must not be materially different. *MacDonald v Advocate General for Scotland and TSB Governing Body of Mayfield Secondary School* [2003] IRLR 512 House of Lords.

Indirect Discrimination

69. Under section 19 EqA, where A applies a provision, criterion or practice (PCP) to B , it is discriminatory in relation to the protected characteristic (in our case race) if:

    a. A applies or would apply the PCP to persons who do not share B's age

    b. It puts or would put persons of B's age at a particular disadvantage compared with persons not of his age.

    c. A cannot show that the PCP is a proportionate means of achieving a legitimate aim.

Harassment

70. Section 26 EqA provides that a person (A) harasses another (B) if – A engages in unwanted conduct related to a relevant protected characteristic, or engages in conduct of a sexual nature, and the conduct has the purpose or effect of –

    (i) violating B's dignity, or
    (ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

71. In deciding whether the conduct has the effect referred to above, account must be taken of: a) the perception of B; b) the other circumstances of the case; c) whether it was reasonable for the conduct to have that effect.

Burden of Proof

72. Section 136 EqA provides that if there are facts from which the court could decide, in the absence of any other explanations that a person (A) contravened the provision concerned, the court must hold that the contravention occurred.

73. The leading authority on the burden of proof in discrimination cases is Igen v Wong 2005 IRLR 258 That case makes clear that at the first stage the Tribunal is to assume that there is no explanation for the facts proved by the Claimant. Where such facts are proved the burden passes to the Respondent to prove that it did not discriminate

74. In the case of Madarassy v Nomura International PLC [2007] IRLR 246 it was held that the burden does not shift to the Respondent simply on the claimant establishing a difference in status or a difference in treatment. Such acts only indicate the possibility of discrimination. The phrase "could conclude" means that "a reasonable Tribunal could properly conclude from all the evidence before it that there may have been discrimination."

75. In Laing v Manchester City Council [2006] IRLR 748 the Employment Appeal Tribunal (EAT) made clear that it would not be an error of law for a Tribunal not to follow the two-stage approach and that there might be cases where it would be sensible for a tribunal to go straight to the second stage and consider the subjective reasons which caused the employer to act as it did. Assuming that the burden may have shifted causes no prejudice to the employee. The EAT here followed the dictum of Lord Nicholls in Shamoon v Chief Constable of the RUC [2003] IRLR 285, where he held that sometimes the less favourable treatment issue cannot be resolved without at the same time deciding the reason-why issue. He suggested that Tribunals might avoid arid and confusing disputes about identification of the appropriate comparator by concentrating on why the claimant was treated as he was, and postponing the less favourable treatment question until after they have decided why the treatment was afforded.

Conclusions

76. Having considered our findings of fact, the parties' submissions and the relevant law, we have reached the following conclusions on the agreed issues:

Failure to provide statement of terms and conditions

In November 2007 and on various occasions up until June 2018 the claimant requested an employment statement of terms and conditions for his post of Associate Specialist. The respondent failed to provide this statement.

77. This is an allegation of direct race discrimination and harassment and relates to contractual documentation for the period between 2007-2010.

78. Our findings in relation to this matter are at paragraphs 7-19 above. We have found that between October 2007 and July 2010 the claimant was a bank worker. The evidence of the respondent, which we accept, was that bank workers were not issued with contracts.

The claimant has not pointed to other bank workers not of his race who received a contract/statement of terms and conditions.

79. As stated at paragraph 15, one of the outcomes of the claimant's grievance was that he would be issued with appropriate contracts retrospectively going back to 2007. This did not happen but instead he was issued with a letter confirming his employment history.

80. We are not satisfied that the lack of a retrospective contract caused the detriment relied upon as the reason the claimant could not apply for entry onto the specialist register was not because of lack of contractual documentation but because he did not have a sub-specialism or sufficient evidence of practice and experience.

81. Even if this was a detriment, there are no facts from which we could conclude that the failure to issue backdated contracts was because he is Indian.

82. VW did not have a clear recollection of why she issued a confirmatory letter of employment rather than a retrospective contract as agreed in the grievance outcome but she surmised that it may have been because the respondent did not issue contracts to bank workers at the time. We do not draw any adverse inferences from VW's lack of recollection. These events were after all 7 years ago and she left the Trust in 2014, so there were no subsequent events to jog her memory.

83. In any event, as the claimant has not satisfied the first limb of the Igen v Wong test, the evidential burden has not shifted to the respondent to provide an explanation.

84. The direct discrimination allegation is not made out.

85. Further, we find that the "failure" to issue the claimant with a contract/statement of terms and conditions was not unwanted conduct related to race. The harassment claim is not made out.

Emergency on call rota

From July 10 to September 2016 the claimant wished to work on the consultant emergency on-call rota but was given shifts on the rota at junior doctor level.

86. This is an allegation of direct discrimination and harassment. The relevant findings are at paragraphs 20 to 27 above.

87. We are satisfied that the explanation given by AF was genuine, reasoned and had as its focus the safety and quality of patient care. Further, the claimant accepted the explanation as reasonable at the time. The only reason he now rejects it is because he considers there to be an inconsistency in the appointment of Corine Bowen. However, we do not consider that that appointment has any bearing on this issue.

88. The claimant was unable to give an example of any occasion when the respondent had allowed an Associate Specialist without relevant experience to act as the most senior person on the emergency rota. We are satisfied that the decision of AF had absolutely nothing to do with the claimant's race and that a non-Indian comparator would have

been treated the same in those circumstances. We are also satisfied that this did not amount to unwanted conduct related to race.

89. The complaints of direct discrimination and harassment fail.

Supervision of Trainees

The Claimant will say that he is a GMC accredited trainer and a trainer for trainers at the Royal College of Surgeons. However from 2013 to date, he has only been allocated 2 trainees by the Respondent and this was in 2017 Even then, the Claimant did not supervise the trainees. Rather, his consultant colleagues supervised one of the trainee's allocated to the Claimant without the Claimant's permission (the other trainee having left the Respondent Trust for an alternative role elsewhere).

90. This is an allegation of direct discrimination and harassment directed at PW. The facts relevant to this allegation are at paragraphs 58-59 above.

91. It is unclear what treatment the claimant has been subjected to. PW could not have assigned the claimant a trainee before he was accredited and it seems that he was assigned a trainee almost immediately once he was. When I asked the claimant to put the allegation of discrimination specifically to PW so that he could respond, he asked: "*if I had been a UK graduate, would I have got more trainees*". Being a UK graduate is not a protected characteristic. His claim is that he was treated less favourably because he was Indian and that was not the allegation that was put to the witness. In our view, the reason the claimant was reluctant to put the specific allegation to PW was because he did not really believe PW had discriminated against him. By all accounts, the claimant and PW had a good working relationship. As chairman of the Medical Staff Committee, PW had supported the claimant in his 2014 grievance. PW had also supported the claimant by promoting Associate Specialist representation on the Medical Staff Committee, resulting in the claimant joining that committee. PW remained in contact with the claimant after leaving the Trust in 2018. There was no evidence that the process of allocating trainees to the claimant was any different to that which applied to other newly accredited GMC trainers, not of Indian origin and nothing within the above chronology from which we could infer race discrimination. This complaints of direct discrimination and harassment ares not made out.

92. Also as part of this allegation, the claimant claims that SR signed off PR's training log without seeking his permission. Like the claimant, SR is of Indian origin. The claimant attempted to draw a racial distinction between Indians who received their medical training in India and those who were UK educated by asking SR whether he would have treated him differently if he was of a different race or had been UK trained. As I have already said, being UK trained is not a protected characteristic or a feature that is relevant to the statutory comparison in this case. Section 23 of the Equality Act 2010 makes clear that the circumstances of the hypothetical comparator must be the same or similar to the claimant, apart from race.

93. SR told us that had he known that the claimant had wanted to sign off PR's record, he would gladly have let him do so. We accept that evidence.

94. From correspondence that we have seen and from the way in which the claimant cross examined the respondent on this, it is clear to us that the matter that had exercised him was his perception that trainees preferred to be supervised by consultants rather than Associate Specialists. So, when PR asked SR to sign off his training record, the claimant took this personally.

95. The training programme is for the benefit of the trainee and the trainees best interest is at its core. The fact that the claimant felt slighted by PR's decision does not amount to direct discrimination or harassment by the respondent. This complaint is not made out.

Consultant Contract

The claimant says that he has worked at consultant level at the Trust since 4 October 2007. However the respondent has failed to give the claimant a consultant contract to reflect this. This was most recently requested by the claimant in June 2018

96. This is an allegation of direct discrimination. The relevant findings are at paragraph 31-37 above.

97. The claimant's assertion that he was working at consultant level was based on his own assessment of his skill and experience. He presented no evidence to back this up but there was plenty of evidence to the contrary, including the claimant's own admission that he had no sub-specialism and that his range of surgical work was limited to arterial vascular work and minor plastic surgery. There is no evidence at all that the claimant was working at consultant level. The allegation is therefore not made out on the facts.

98. In any event, we are satisfied that the reason the claimant could not be appointed a consultant was because he was not on the specialist register. This was a decision taken in the interests of patient welfare and quality of care and had nothing whatsoever to do with the claimant's race.

99. This complaint is not made out.

Training

In October 2013, the claimant offered to undergo any training the respondent considered appropriate to place him on the emergency surgical rota at consultant level but AF turned down this request.

100. This is an allegation of direct race discrimination.

101. We deal with this at paragraphs 28-30. Based on our findings, we are satisfied that the decision of the respondent was not because of the claimant's race. The claim is not made out.

Statement made by SS at Meeting 14 June 2018

At a meeting on 14 June 2018, SS told the claimant that Consultants were superior to Associate Specialists.

102. This is an allegation of direct discrimination and harassment.

103. Based on our findings at paragraphs 38-40, this allegation is not made out on the facts. Even if SS had made the alleged remark, there is no evidence to support the claim that it related to or was because of race. SS is also of Indian origin and whilst that does not necessarily rule out the possibility of discrimination, we find on balance of probability that in this case, it was unlikely. This claim is not made out.

Appointment of Carine Bowen on 9 June 2020

104. This is an allegation of direct discrimination. The claimant contends that the respondent included in the advert for the role a requirement that applicants be on the specialist register in order to exclude him from applying because of his race.

105. Based on our findings at paragraphs 60-64, we are satisfied that the respondent has provided an explanation for the requirement which had nothing to do with race. The claim is not made out.

Applying for management posts

106. This is a complaint of indirect discrimination. The claimant contends that the respondent applied a PCP that only consultants could apply for management posts. The respondent denies this.

107. It is for the claimant to show that such a PCP was applied yet this was disproved by his own evidence. During cross examination, the claimant was taken to a number of management positions within the respondent's organisational structure , including CEO (Chief Executive Officer) COO (Chief Operating Officer) and Clinical Lead. The claimant conceded in each case that one did not need to be a consultant to apply for the position. Indeed neither the CEO or COO are consultants. That is further demonstrated by the fact that claimant was invited to apply for the management post of Clinical Lead. He turned it down because he was not interested.

108. We are satisfied that the respondent did not apply the stated PCP and this claim therefore fails at the first hurdle.

The requirement to have consultant supervision when operating on children with appendicitis

109. This is an allegation of indirect discrimination. Our findings in relation to this are at paragraphs 41- 44. The respondent accepts that this was a PCP that it applied.

110. For indirect discrimination there must be group disadvantage. In other words we have to be satisfied in this case that people of Indian origin were at a particular disadvantage compared to others by the application of this policy. There is absolutely no evidence before us of such disadvantage. Indeed, when one does a comparison of the ethnic breakdown of the medical staff, 14% define themselves as being of Indian origin and 16% of consultants at the Trust are of Indian origin. [2762] Those figures do not suggest that Indians as a group are at a particular disadvantage compared to people who are not Indian.

111. There is also no actual disadvantage to the claimant. He decided to come off the emergency rota in September 2016, which was before this policy came into force. He was therefore unaffected by it. Also, in cross examination when put to him that having a consultant supervise such operations was a good thing in case anything went wrong, he agreed.

112. Finally, the respondent's aim behind the policy is to ensure the utmost safety of children and we are satisfied that restricting such operations to consultants or consult-supervised medics was a proportionate means of achieving that aim.

113. This complaint fails

Requirement to be a consultant in order to be able to use the respondent's facilities to provide private treatment

114. This is an allegation of indirect discrimination. Our findings on this are at paragraphs 45-48.

115. The claimant has not shown that the application of the policy put Indians at a particular disadvantage. Further, the fact that he did not apply to use the facilities when invited to do so suggests that he was not at a disadvantage either. The claim is not made out.

Clinical Rooms

Where there is a need for a consultant to have a room for an ad hoc clinic, the claimant's room is given to the consultant and the claimant would be required to relocate to a less appropriate room.

116. This is an allegation of harassment. Based on our findings at paragraphs 49-50, the allegation is not made out on the fact and is therefore dismissed.

Nurses

If there was a shortage of nurses in the outpatient department, the nurse allocated to the claimant's was taken away to support a consultant clinic.

117. This is an allegation of harassment and our findings on this are at paragraphs 51-52. Shortage of nursing staff is a problem across the NHS, as it was at the respondent Trust. In such circumstances, the respondent was entitled to deploy its nursing resource where the need was greatest. The claimant has not satisfied us that when there was a reallocation of nurses away from his clinic, that this was conduct related to his race and it was unreasonable for him to perceive this as harassment.

Failure to assign junior doctor to the claimant

118. This is an allegation of harassment. Based on our findings at paragraphs 53-57, the claimant has not satisfied us that this was unwanted conduct related to race and we find that it was unreasonable for him to perceive it as harassment. This complaint fails.

General

119. The underlying theme of all these allegations is the claimant's belief that he should be afforded consultant status and privileges. Any treatment that did not recognise this was perceived to be because of his race. The reality was that the only person preventing the claimant from becoming a consultant was himself. There was a clear and established path to consultancy, which we have already referred to and which the claimant was not prepared to take. In his words: "*why take a step backwards just to tick a box with no guarantee of a consultancy*". The claimant was seeking a short-cut to consultancy that was not open to anybody else. It was therefore unreasonable for him to expect the respondent to treat him more favourably by acceding to his request. We are satisfied that all of his claims were totally without merit.

Judgment

120. The unanimous judgment of the Tribunal is that the claims are totally without merit and are dismissed.

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Employment Judge Balogun
Date: 1 February 2022