EMPLOYMENT TRIBUNALS

Claimant: Dr A Abdel-Bari

Respondent: East Lancashire Hospitals NHS Trust

Heard at: Manchester **On:** 27, 28, 29, 30 and 31 March 2023

Before: Employment Judge Cookson
Ms Ashworth
Ms Owen

REPRESENTATION:

Claimant: In person (accompanied by his son)
Respondent: Ms S Firth of Counsel

RESERVED JUDGMENT

It is the unanimous decision of the Tribunal that:

1. The claimant's complaints of race discrimination under the Equality Act 2010 are not upheld.

2. The claimant's claim is dismissed.

REASONS

Introduction

1. The claimant in this case, Dr Abdel-Bari, referred to as "the claimant" throughout, was engaged by the respondent as a locum registrar over a three-day period in December 2020. He is a senior doctor specialising on obstetrics and gynaecology.

2. The claimant undertook early conciliation and issued his claim on 5 March 2021. The complaints that the claimant sought to bring in those proceedings were clarified by Employment Judge Holmes at a preliminary hearing on 8 July 2021 and the Tribunal in this case was assisted by his detailed case management summary and

distillation of the claimant's claims. Employment Judge Holmes ordered that the respondent produce a draft List of Issues which was to be provided to the claimant, who in turn was required to provide comments on that to enable the Tribunal to approve it. That should have happened by October 2021. It is unfortunate that the parties were unable to agree that List of Issues before the start of our hearing.

3. At the outset of this hearing the claimant was asked to confirm if he was satisfied that the draft List of Issues prepared by the respondent was agreed as the issues to be determined by this Tribunal. The claimant told us that he was not pursuing a complaint of harassment and was pursuing only complaints of direct race discrimination. He also told us that he was not pursuing any complaint in relation to the initial meeting with Dr Wittersheim. It was clarified that some minor changes were required to the dates referred to in the List of Issues, and the claimant also confirmed that in terms of his allegation about statements being made blaming him for the treatment of a patient, those claims were pursued against Dr Wittersheim, Dr Hamer and Mrs Lord. The claimant told us that the List of Issues was otherwise agreed and it is that list which has formed the basis of our understanding of the claimant's complaints as a result.

Evidence

4. In reaching our judgment the Tribunal considered:

(1) a joint bundle of documents prepared by the respondent which runs to some 550 pages;

(2) the evidence in witness statements and given orally by the claimant;

(3) the evidence and witness statements given orally for the respondent by:

(a) Ms Suzanne Gawne, a Consultant Oncoplastic Breast Surgeon and Deputy Medical Director;

(b) Dr Hamer, Consultant Obstetrician and Gynaecologist and the Clinical Director for the Obstetrics and Gynaecology Department at the relevant time;

(c) Mrs Anjuli Ward, a midwife;

(d) Dr Nasira Misfar, who is now a Consultant in the Obstetrics and Gynaecology Department but at the relevant time was a Senior Clinical Fellow and Speciality Doctor in the Department;

(e) Ms Karen Phillipson, Systems Administrator;

(f) Dr Robyn Wittersheim.

(4) In addition we also received a witness statement for the respondent from Dr Yeneit Liew, a Consultant in Obstetrics and Gynaecology, who is not currently in the UK. We received no objection to the evidence contained in that witness statement and the evidence contained in his statement did not appear to be in dispute with that given by the claimant.

(5) Written submissions was received by the respondent in relation to the claimant's bankruptcy;

(6) Written and oral submissions from both parties on the question of liability.

Applications made at the start of the hearing and preliminary matters

5. The respondent made an opening application to admit some additional documents (audit records for the patient record system) which the claimant objected to. We allowed time for the claimant to consider those documents overnight and considered their inclusion at the outset of the hearing on the following day.

6. The claimant sought to submit a witness statement in addition to the one which had been exchanged with the respondent before the hearing. The respondent objected to that amended statement. On examination of the document in question it became clear it was not a witness statement in any conventional sense. It is called “Dissection of the legal, false and fabricated statements” and it is in essence a series of submissions and reiterations of the claimant's case and comments by him on the witness statements of the respondent’s witnesses.

7. In the circumstances the Employment Tribunal declined to accept that document as an additional witness statement but instead the claimant was encouraged to use that document as the basis of his cross examination of the respondent’s witnesses. The claimant told us that he was content to proceed on that basis. We also treated that document as written submissions and took it into account in reaching our conclusion.

8. Some time was spent by the Employment Judge explaining the process and the purpose of cross examination to the claimant who speaks good English but does not have English as his first language and recognising that he is a litigant in person.

9. At the preliminary hearing before Employment Judge Holmes, some time had been spent with the claimant both identifying his claims of discrimination but also emphasising to him that the purpose of this Employment Tribunal is not to carry out an enquiry into the claimant's clinical practice and that of others, but to determine whether in relation to the alleged less favourable treatment referred to by the claimant, the reason for that treatment had been the claimant's race. This was emphasised again to the claimant at the outset of this hearing because it was clear to the Tribunal from the claimant's witness statement that the focus of the evidence that he was presenting was about his clinical practice and his allegations that information provided by the respondent to the General Medical Council and others had been incorrect. It was clear that the focus of the claimant's discrimination case from the outset was based on a difference between his race and that of Dr Wittersheim and Mrs Lord, but without any focus by the claimant on what his evidence he said there was that the reason for the alleged unfavourable treatment was his race.

The Claimant's Bankruptcy

10. It became apparent on the first morning that the claimant was bankrupt at the time that his Tribunal claim was lodged, although the Tribunal was informed that this bankruptcy order has since been discharged. There were some initial discussions about that and the possible implications for the case, and the Tribunal received further submissions from the respondent on the morning of the second day. Unfortunately it appears that this is a matter which had not received significant consideration in this case before the final hearing.

11. As the respondent's helpful submissions about this highlighted to us, in accordance with the Court of Appeal Judgment in *Khan v Trident Safeguards Limited & others* [2004] ICR 1591 compensation for purely financial loss caused by discrimination is a claim for property which vests in the trustee in bankruptcy at the moment of the trustee's appointment, but a claim for damages for injury to feelings is a purely personal claim which does not vest. A claim in relation to both property and personal damages is a hybrid claim. The Court of Appeal in *Khan* accepted that a claim ceases to be a hybrid claim if the bankrupt limits their claims for relief to personal damages, that is an award for injury to feelings and a declaration.

12. This case had been listed to determine liability and remedy. The issue for the Tribunal was whether we should continue to determine liability only or whether we needed to address the fact that the claimant had not sought the permission of his trustee in bankruptcy because, in accordance with the decision in *Ord v Upton* [2000] CH 352, if a course of action is not personal to the bankrupt it vests in the trustee and therefore any damages awarded before or after the discharge will be available to discharge the bankruptcy's liabilities.

13. It was not clear to the Tribunal that the claimant appreciated the significance of this matter. The only submissions we received from him were to reiterate that the bankruptcy has now been discharged, although that of course did not materially address the question of whether his claim had vested in his trustee. In light of the lateness with which this issue had arisen, the respondent submitted to us that it would be highly undesirable and contrary to the overriding objective to stay the proceedings at this late stage, and the Employment Tribunal agreed. The claimant was not prepared to limit his claim to damages for injury to feelings, and on that basis we determined that the correct way forward would be for us to determine the issue of liability only and, if we found that the claimant succeeded, his claim would have been stayed to enable him to seek permission from or assignment to his trustee in bankruptcy.

The Relevant Law on Discrimination

14. Direct Discrimination

s13 Equality Act 2010 (Direct discrimination

"(1)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."

15. The burden of proof

s136 Equality Act

"(1)This section applies to any proceedings relating to a contravention of this Act.

(2)If there are facts from which the court could decide, in the absence of any other explanation, that a person (A) contravened the provision concerned, the court must hold that the contravention occurred

(3)But subsection (2) does not apply if A shows that A did not contravene the provision."

16. This section reflects what is often called the shifting burden of proof. The law recognises that direct evidence of discrimination is rare and employment tribunals frequently have to infer discrimination from their findings of material facts. The law requires the claimant to show facts which could suggest that there was discriminatory reason for the treatment, but the claimant does not have to prove discrimination.

17. Significantly however in terms of this case, simply a difference in the racial origins of the parties is not enough. Justice Mummery explained this in *Madarassy v Nomura International plc* 2007 ICR 867, CA as follows 'The bare facts of a difference in status and a difference in treatment only indicate a possibility of discrimination. They are not, without more, sufficient material from which a tribunal "could conclude" that, on the balance of probabilities, the respondent had committed an unlawful act of discrimination.'

18. It is only of the claimant shows facts which would, if unexplained justify a conclusion that discrimination had occurred, that the burden shifts to the employer to explain why it acted as it did. The explanation need only be sufficient to satisfy the Tribunal that the reason had nothing to do with the protected characteristic.

19. Whether less favourable treatment has occurred is assessed by comparing what has happened to the claimant with a how a real or hypothetical comparator was treated. The legislation requires that must be no material differences between the circumstances relating to" the claimant and their comparator.

Our findings in this case

Credibility of witnesses

20. The Tribunal was required to determine factual disputes in this case between the parties which necessarily involved reaching conclusions about the credibility of the witness statement. Both parties have made assertions that the other side is dishonest or lying. We make this point about that. Tribunals are rarely able to determine with certainty who is telling the truth or whether someone is seeking to mislead us. We are required to assess the evidence and make findings upon which party's evidence is preferred on the balance of probabilities. That is what we have done in this case. In our findings below we have sought to explain why we have reached the conclusions that we did.

Findings of Fact

21. We made our findings of fact in this case on the basis of the material before us, taking into account contemporaneous documents where they exist and the conduct of those concerned at the time. We have resolved such conflicts of evidence as arose

on the balance of probabilities. We have taken into account our assessment of the credibility of witnesses and the consistency of their evidence with the surrounding facts. We have not made findings of fact about every contested matter of evidence before us but only those which we considered to be relevant and necessary for us to determine the legal claims.

22. Much of the background to this case is agreed, and the position can be briefly summarised.

23. Dr Abdel Bari ("the claimant") was engaged as a locum by the respondent via DRC Locums Limited. In his statement he describes himself as being a black British citizen of African origin. In the course of his evidence he told us that he is originally from Sudan. The claimant has worked in the UK for many years in his chosen area of specialism. He told us that he has worked as a locum across a large number of hospitals in the UK.

24. The claimant attended the respondent for induction on 30 November 2020 and it was Dr Misfar who introduced him to the respondent's systems and procedures. There was some dispute about exactly what was covered in the induction process. Dr Misfar told us that the claimant told her that it was not part of his job to access the computer system used across the Obstetrics and Gynaecology Department which is called ICE, an acronym for "Integrated Clinical Environment". Dr Misfar told us that it is expected that everyone should be able to operate that system, although it does not appear to be absolutely necessary. She told us that the claimant told her that he would ask a junior member of the team to do this on his behalf if he needed to. Dr Misfar also told us that she had also tried to show the claimant local guidelines and protocols, but that the claimant had told her that he did not want to know what the local guidelines were and that he would only follow national guidelines. These matters did not appear to be disputed by the claimant. Dr Misfar told us that the claimant's approach in not wanting to know about local guidelines concerned her to some extent because she thought it indicated that he did not have a proactive approach to understanding the way the unit worked, but she did also concede that the claimant was not the only locum who insisted on only following national guidelines.

25. This had one aspect of significance for this case. The main disputes in this case relate to the circumstances leading to a caesarean section performed on a patient who is referred to throughout this decision as Patient A. We were told that National Guidelines issued by the National Institute for Health and Care Excellence ("NICE") categorise caesarean sections as category 1 and category 2, but at the time Burnley Hospital caesareans were further categorised into 2A and 2B. The significance of this is it would impact on how quickly a caesarean should be performed and what sort of anaesthetic would be used. We were also told that in the period since this case the unit has adopted the national categorisation of caesarean sections.

26. The claimant worked on the Obstetrics and Gynaecology Department on 1 December 2020. He worked an 8.00am to 8.30pm shift, with a half hour break. It was agreed by the parties that a registrar like the claimant working this shift would be covering the labour ward and gynaecology, antenatal and obstetrics. The claimant would be on call throughout the shift and as the senior registrar would be the next most senior doctor working in the department below the consultants. As such he would be

expected to deal with the most serious cases, with less serious or straightforward cases dealt with by less experienced junior doctors and midwives as appropriate.

27. We were told by the respondent witnesses that most staff on shift in the department would work from 8.00am to 8.00pm or 8pm to 8am. At the start of the shift starts there is a handover from the day shift to the night shift and likewise at the start of the night shift. This will involve a full ward round. Consultants work a slightly different shift pattern, working from 8.00am until 5.00pm during the week and then 24 hour shifts from 8.00am until 8.00am at the weekend or on Bank Holidays. As a result, at 5.00pm when the consultants come on shift for the evening there is a shorter handover in order to hand over to the consultant coming on shift for the evening.

28. It was the evidence of the respondent witnesses that no ward round is undertaken when the consultants come on shift. There is a handover during which the cases of all of the patients on the ward are reviewed in the handover room with all of the staff present, but there is no ward round as such at that time. This was a source of dispute with the claimant who insisted that there was or should have been a ward round at 17.00 which he says he was excluded from by Dr Wittersheim, but the Tribunal panel accepts and preferred the respondent witness' evidence on this point. It may be that at other hospitals the claimant had worked at when consultants come on shift there is a ward round, but we accept the clear evidence of the respondent witnesses that this was not the case in the Burnley unit.

29. It was not in dispute that the maternity unit at Burnley Hospital is a busy unit. We were told they have 16 patient rooms, a handover room, two bereavement rooms and a close observation unit. There is also a doctor's room.

30. Much of the evidence which the Tribunal panel heard was in relation to Patient A. Included in the bundle of documents were the patient records for Patient A. We are told that she was a young slim woman with her first pregnancy. She was admitted to the birth suite on 1 December 2020 at 13.40, so while the claimant was on shift but before Dr Wittersheim, the night shift consultant that day, began her shift. She was assigned one-to-one care with Mrs Lord, who is a midwife, because she was in labour with PROM at over 37 weeks' gestation. We are told, and it is not disputed by the claimant, that PROM is defined as the spontaneous rupture of foetal membranes before the onset of regular uterine contractions. For the first 24 hours there is no significant increase in neonatal infection rates but after 24 hours in cases of PROM there is an increased risk of infection, and because of that it is generally considered appropriate to induce labour in those circumstances.

31. Patient A's notes show that she was admitted by Mrs Lord, and it was agreed that Patient A would receive an intravenous drip of oxytocin to augment labour. At around 14.15 Patient A had requested an epidural. After the oxytocin was administered, Patient A was monitored closely with records kept of her respiratory rate, oxygen levels, pulse, temperature, blood pressure, urine rate, station and the foetal heart rate. We are told that a system called MEOWS, a "Maternal Early Obstetric Warning Score", is used based on observations at four hourly intervals unless there is a reason to be concerned with the mother's clinical picture.

32. At around 16.20 Patient A began to experience contractions and she reported to Mrs Lord that she was experiencing pain on her left side. By this point the baseline of the foetal heart rate had increased to 165 beats per minute ("bpm"). We are told,

and again it was not disputed, that a normal reassuring foetal cardiotocograph ("CTG") has a baseline of between 110-165bpm in accordance with NICE guidelines. As a result Mrs Lord determined that the foetal heart rate was still normal but she made Dr Nethra, the consultant on duty, aware of the raising baseline.

33. As already noted, at around 17.00 there is the consultant handover. Dr Wittersheim took over from Dr Nethra. It is not in dispute that the claimant attended that handover held in the handover room. In the handover room there is a large electronic screen which shows heart traces from each of the rooms across the birth suite for both the patient and the unborn baby, so the claimant was aware of Patient A and her baby at that time, even if he had not been aware of her earlier.

34. Patient A was discussed at the handover. By this stage Patient A's baby's baseline was around 170bpm. At 17:08 Dr Nethra had been made aware of the concern with the raising baseline of the foetal heart rate: in other words, the baby's heart rate had become tachycardic and it had been identified that somebody should attend Patient A following the handover meeting.

35. There was an incident which we were referred to during the handover meeting. Dr Wittersheim had not previously met the claimant and she introduced herself to him. She told us that she did as she often did when meeting new staff, which was to show him her name badge so that he could see how her surname was written down. That is because her surname is not pronounced how it is written and she finds it helpful to make this clear to colleagues. Dr Wittersheim told us that her name badge was attached by a retractable string, and she pulled the string so that the claimant could read the name badge clearly.

36. Although the allegation was not actively pursued at this hearing, the claimant had alleged in his original witness statement produced at the time of his claim that Dr Wittersheim had thrown the name badge at him, and we accept her evidence that this did not happen. We accept Dr Wittersheim's evidence that in fact they had a short discussion about the claimant, how long he had worked in obstetrics, and about the that he had worked for the Trust some time before with one of Dr Wittersheim's senior colleagues.

37. After the handover meting Dr Wittersheim told us that she went to attend on a patient who had had a difficult labour. She did not take the claimant with her because she did not consider his attendance would be necessary because the intervention and support of a registrar was unlikely to be required. This was disputed by the claimant, and he appeared to suggest that incident suggested some discrimination or hostility towards him from Dr Wittersheim. However, we could not see any basis for drawing an adverse inference about that. The claimant appeared to suggest that this patient attendance was part of a ward round, but it appears this may have been a misunderstanding on his part, perhaps based on the practice in other hospitals. Dr Wittersheim told us that she needed the claimant to be available as registrar to deal with any serious issues which arose while she went to see the patient and the last thing that the patient needed after a difficult time was to be seen by more doctors than necessary. There was nothing in that which suggested discrimination.

38. At 17:19 Dr Ashar attended Patient A at the request of Dr Wittersheim and as discussed in the handover. In light of the PROM, the tachycardia and the fact patient was feeling cold and shivery, there was now a concern about possible infection and

Dr Ashar was asked to take blood tests to perform what is known as a sceptic screen, to see if there was an infection present.

39. Whilst Dr Wittersheim was attending that patient who had had the difficult birth, the claimant attended Patient A. There was some dispute between the parties about the precise circumstances of that. The claimant says that he was asked to attend Patient A by the shift coordinator (who is a senior midwife). Mrs Lord says that she asked the claimant to attend, but the Tribunal found it difficult to see what turned on that.

40. What is significant is the reason why it was necessary for the claimant as the senior registrar to attend at that point in time. At around 17.30 the baby's heart rate had increased to over 180bpm. This indicates that the heart rate had become pathological.

41. Precisely when the foetal heart rate became pathological was a matter of some dispute between the parties. In her witness statement Mrs Lord says that the baseline had become pathological at 17:08 but at the beginning of her evidence she told us that this had been a mistake in her witness statement and at that time the heart rate had been elevated and was tachycardic but not pathological. The claimant objected to Mrs Lord changing her evidence in this way. He says that she was being untruthful and it appeared to the Tribunal that he was suggesting that this is something from which we should draw an adverse inference. However, we declined to do so.

42. The Tribunal panel accepted that Mrs Lord had made an error in her witness statement. The CTG printouts for this particular baby were included in the bundle and we heard evidence from Dr Wittersheim, Dr Hamer, Mrs Lord and the claimant himself about what those printouts show. The interpretation of these scans is clearly a matter which requires professional interpretation and this panel does not have the expertise to make its own assessment. However we found the evidence of Dr Wittersheim and Dr Hamer about the heart rate to be compelling and credible. They were clear that it was at around 17.30 when the rate tipped into being pathological. What is clear is that by 17:08 the baseline had started to rise suggesting some concern, but we accept it was not until a little while after that that the foetal heart rate became pathological.

43. One of the matters which struck the Employment Tribunal panel was that although the claimant has sought to criticise Mrs Lord in relation to this matter, he was the senior registrar on duty at the relevant time. Dr Wittersheim had gone to attend another patient and he knew that. The claimant had attended the handover when Patient A had been discussed and the foetal heart rate would have been available to him in the handover room during this period. The claimant offered us no explanation as to why, if the foetal heart rate had become pathological at the time he insisted, he had not attended Patient A sooner on his own initiative if that was what was required. We think the most likely explanation is that at the time of the handover the heart rate was a cause for concern, hence the blood tests, but the trace did not suggest to the claimant (or anyone else) that the immediate intervention of a senior registrar was required because the heart rate was not pathological. Even if we had preferred the claimant's evidence about this matter we could not see why it would suggest what happened over the next hour or so was race discrimination. Rather it would raise questions about why, as the senior registrar, the claimant had not acted more quickly.

44. It is agreed by all that the claimant entered Patient A's room at 17.33. That time was recorded by Mrs Lord in the patent notes by her using her thumb print to access the electronic patient records and recording that the claimant had entered the room.

45. There is a further dispute between the parties about what happened next. The claimant is insistent that he decided it was necessary to perform a vaginal examination of Patient A. He provided us with a description of what happened and explained the time which had been taken as shown in the records was because he needed to give time for Patient A to get ready for the examination (to remove her underwear and so on) before he began examining her.

46. Mrs Lord told us that this account was incorrect and she had performed the vaginal examination on Patient A. The Tribunal Panel found it significant in resolving this dispute that, as Mrs Lord pointed out, it would not be necessary for Patient A to get undressed for the examination to be carried out. A catheter had been fitted so she was not wearing any underwear and was already on the bed. The claimant's repeated description of what had happened included Patient A being given or requiring time to remove her clothing in every version of the events that he gave us. That is not consistent with the contemporaneous records in the Employment Tribunal bundle about the fact that Patient A would not need to remove any clothing. It is possible that the claimant was recalling to us the examination of a different patient, or perhaps he was simply giving us an account of what he would typically expect to happen when he entered a patient's room in these circumstances, but in terms of what happened with Patient A we preferred Mrs Lord's account. We accept that the vaginal examination was carried out by Mrs Lord.

47. It is unfortunate that the patient's records do not appear to record who performed the vaginal examination. We find that surprising although the situation was evolving quickly, and it is not in dispute that when a vaginal examination was undertaken it revealed that Patient A was only five centimetres dilated.

48. The parties are also agreed that in light of the pathological heart rate and the risk of infection it was appropriate for Patient A's baby to be delivered by caesarean section as soon as possible.

49. It is also relevant for us to note that the claimant told us that it cannot be true that Mrs Lord undertook the vaginal examination because he would not have been prepared to rely on a midwife's vaginal examination and indeed at one point he appeared to suggest that Mrs Lord was not qualified or experienced to make a decision based on such an examination. We accept that the decision about whether or not a caesarean section should be performed was a matter for the claimant as the registrar and not the midwife. However, the claimant's suggestion that Mrs Lord would not be an appropriate person to provide accurate information about the extent to which a woman was ready to give birth or not was difficult to understand. Clearly midwives undertake vaginal examinations to assess the extent of dilation on a frequent basis. Many women will give birth with only a midwife in attendance and the care of those individuals receive would be based on midwives undertaking such examinations and assessing how labour is progressing. We found a suggestion that Mrs Lord could not have undertaken an assessment of the extent of dilation to be incomprehensible. Dr Wittersheim and Dr Hamer both expressed in the clearest terms that they would not hesitate to accept an assessment about this from an experienced midwife.

50. The significance of this matter in terms of the claim relates to what happened next. We were told that there is an electronic screen in the room which enables notes to be inputted electronically after the practitioner has accessed the system using their thumb print. Patient A's notes do not refer to the claimant and it was explained that this was because he had not used his fingerprint to access the system. There are some notes which Mrs Lord told us were the notes which the claimant had started to enter after she had logged in (so appear to have been made by her) but she had become concerned because between entering the room and her undertaking the vaginal examination, the claimant had not given any instructions or communicated any care plan to either her or Patient A or done more than enter a few words. By this stage she perceived the situation to be an extremely serious one which required urgent action.

51. The claimant told us that he had undertaken the vaginal examination and then began to complete the patient's electronic notes. The claimant gave us confusing and at times conflicting evidence about what happened. The claimant suggested that he entered fuller notes into Patient A's record, at one point suggesting that he had completed those notes on a separate handheld device, although we heard clear and consistent evidence from the respondent's witnesses that no such separate entry into the respondent's system is possible and no such devices are used. We also heard evidence from Mrs Phillipson (Systems Administrator) who was clear that it is not possible for patients' notes, once entered, to be deleted. If that happened, it would show in the audit record for the system and there is no such record of deletion for Patient A.

52. Mrs Lord told us that in light of the claimant's indecision, she sought assistance from another doctor. Her account about this is consistent with the account given by Dr Wittersheim, that Dr Wittersheim had been coming from the patient referred to above and saw Mrs Lord looking out from one of the patient rooms. When Mrs Lord saw Dr Wittersheim she had asked her to come to see the patient. Dr Wittersheim had quickly reviewed the electronic screen to look at the foetal heart rate and she had seen that since the handover meeting the baseline had increased to the point that it was pathological.

53. Dr Wittersheim told us that when she entered Patient A's room the claimant was standing at the touchscreen. Mrs Lord told her that Patient A was not fully dilated. Dr Wittersheim told us, and we accept, that a decision in those circumstances needed to be made quickly. Dr Wittersheim told us that if Patient A was not fully dilated an assisted birth using forceps or ventouse would not be possible, and in the circumstances Dr Wittersheim's view was that it was clear that a caesarean section was required as matter of urgency. At this point Dr Wittersheim took over. She had a discussion with the patient to inform her that she needed a caesarean section and why. Patient A agreed and Dr Wittersheim made the call to the emergency team to start preparations for a caesarean section. Dr Wittersheim then took over from the touchscreen to record her decision, and the electronic system shows that Dr Wittersheim ended the claimant's partially completed notes at 17:46 and started her own at 17:47.

54. In his account the claimant told us that he had undertaken the vaginal examination and had decided that a caesarean section was required, and that he instructed Mrs Lord to call for the consultant because he thought it was important that

she was informed as a matter of professional courtesy. The panel found the claimant's evidence about this to be somewhat strange. As a senior registrar he was fully qualified and authorised to direct that a caesarean section was required. His own evidence was that this was an extremely serious situation, one which he describes as a "crash situation", and we found a suggestion that in such an emergency he would wait for the approval of the consultant as a "professional courtesy" to lack credibility. The claimant says that he decided that this was a category 1 caesarean section but that although Dr Wittersheim had entered the room and agreed with his findings and decision, she had downgraded the caesarean section to a category 2 caesarean. Dr Wittersheim explained that this was because according to the local guidelines, it was a category 2A caesarean because it was urgent, but it did not need to be undertaken with a general anaesthetic. The situation was still serious and urgent. The claimant also alleged that Dr Wittersheim had prevented him from finishing his records. However, the claimant did not raise any concerns about that either at the time, after he finished his shift, or indeed the next day when he also worked a shift at the hospital.

55. We accepted Dr Wittersheim's account in this regard and accept that she did not delete any of the notes that the claimant had begun to write. If she had the system would show that. Dr Wittersheim told us that she told the claimant that if he wanted to record anything further, he would need to follow the patient into surgery and input his notes there because the patient notes stay with the patient at all times. The priority at this point was to get Patient A to surgery. Alternatively the claimant could have written supplemental handwritten notes for the claimant and entered those into her record. He did neither.

56. The Tribunal Panel thought it was unlikely that a senior experienced doctor like the claimant would have failed to take steps to protect his own professional position by ensuring his record was recorded in the notes if there had been any suggestion of his care plans being overridden or inappropriately downgraded as he now suggests. By contrast, we found Dr Wittersheim and Mrs Lord had provided us with consistent and credible accounts which were consistent with the contemporaneous notes, and we prefer their accounts in terms of what happened.

57. Dr Wittersheim told us that she considered it was appropriate for the required caesarean section to be undertaken by a doctor junior to the claimant. The claimant is critical of that and suggests that he should have undertaken the caesarean section. The reasons given by Dr Wittersheim for that decision were that she had experienced junior doctors who needed appropriate experience of more challenging deliveries as part of their training, and she pointed out that that is part of her responsibility to ensure. Patient A was young and slim, and although the situation was urgent there were no indications that the surgery itself would be unduly complicated, notwithstanding the degree of urgency involved. She also considered that it was more appropriate to keep the claimant, as the senior registrar on duty, available to cover any situations which might arise which would require his higher level of skill and experience. She therefore directed the surgery to be undertaken by two more junior doctors, one of whom happened to be Black British. Dr Wittersheim told us that this was a decision which was in no way critical of the claimant's abilities, she was simply making a decision based on her experience and what would be the best use of the team's clinical resources at that time. We accept that and found nothing in this from which we could draw an adverse inference of discrimination.

58. There was a delay before the caesarean section was undertaken. The claimant is critical of that and suggests that it shows that he should have undertaken the caesarean section. Dr Wittersheim told us that the reason for the delay, such as it was, was that the patient had already had an epidural. In the circumstances she wanted to avoid a caesarean under general anaesthetic. It would be safer for both mother and baby for the epidural which had already been given, to be "topped up" so the caesarean could be performed. Dr Wittersheim disputed that there had been any complications in the delivery of the baby, and again we found that this was consistent with the notes included in the bundle, and we accept the respondent's evidence about that.

59. There were however signs of infection and once the baby was born the child was admitted to neonatal intensive care to receive antibiotics. The claimant suggests that this means there was a negative outcome for the baby, and he repeatedly suggested in his evidence to us that the baby had come to harm. That was disputed by the respondent, who told us that the antibiotic treatment was given as a matter of course, but there had been no adverse consequences for this child or the mother. Not only is the tribunal not qualified to make any findings about whether there was an adverse outcome or not in any event we could not see how that was relevant to our findings about whether there had been discriminatory conduct towards the claimant.

60. The claimant's case about discrimination centred on the incident involving Patient A, but it is significant that we make findings about what happened the following day when he was also on duty. Again the claimant worked a shift from 8.00am to 8.30pm. At lunchtime he went to see Dr Liew to get his timesheet signed and his assessment undertaken. Dr Liew is what is called the "rota master", which means he is responsible for organising the rota for the department ensuring cover, and where necessary overseeing any gaps in provision has been covered by locums. Although it seems surprising that an assessment of performance should be undertaken before the end of an assignment, we were told that this is usual practice. Dr Liew had a brief discussion with the claimant and completed a feedback form, but he did not discuss the claimant's performance with anybody on the ward. This too seemed somewhat surprising to the Tribunal Panel, but again it appears to be standard practice. Dr Liew completed the feedback form to record the claimant's performance as satisfactory.

61. That afternoon Dr Wittersheim raised concerns with Dr Liew about the claimant's performance the previous day because she was concerned that the claimant had failed to act promptly in the circumstances. Her concerns were recorded in an email. Dr Wittersheim told us that it would be standard practice for her to report concerns of this nature, and she told us that she had done this on a number of occasions for colleagues at different levels and of different racial backgrounds. She considered it a professional responsibility. It is clear to us that the claimant regards this as evidence of discrimination, but he did not explain to us why that was so. He did not for example challenge Dr Wittersheim about whether she did have a professional responsibility to do this or whether she had done so in relation to other doctors.

62. After Dr Liew received Dr Wittersheim's email he reported the concerns to Dr Hamer as the Clinical Director. Dr Hamer told us that she then became aware of other concerns about the claimant's performance. Concerns were raised that the claimant had not made himself accessible when he had been on shift, and he was described

as having been missing for most of the day, apparently because the claimant had gone to seek a prescription for some tablets because he had forgotten to bring his own high blood pressure tablets with him. Dr Hamer told us about a number of other concerns which were raised about the claimant, and these included her own concerns following a conversation which she regarded as inappropriate because of its timing. As a result she decided to inform the Medical Staffing department that she would not re-engage the claimant and that led to a request that she complete a second feedback form on the claimant to send to the locum agency. This is the document the claimant also refers to as a reference. In the document Dr Hamer recorded the claimant's performance as being “less than satisfactory”, but not “unsatisfactory” which is the lowest category of performance.

63. Dr Hamer was very clear in her evidence that while the claimant appears to believe it was the incident with Patient A which had led to her changing the feedback assessment, she disputed that. She was clear that she had changed the assessment because of the range of her concerns which she had. The claimant’s evidence about those other matters was somewhat vague and he failed to suggest why he says any of these things were race discrimination.

64. The claimant described that second feedback form as being akin to an “execution”. He alleges that it destroyed his career. Dr Hamer disputes that and told us that she had provided more critical feedback in relation to other clinicians where it was necessary in her view to do so. She acknowledged that the feedback was such that she would not employ somebody with that assessment, but she maintained that for a locum working in a range of settings and after such a short assignment, the reference would be viewed alongside others. She pointed out that the claimant had undertaken such a short assignment that her concerns could have been explained simply by someone having a bad day or being under the weather. However it was her professional obligation to provide frank feedback.

65. In the list of issues there was an additional complaint relating to the contact Ms Gawne had with Dr Ian Grant, the claimant’s “responsible officer”, passing on the concerns of the Trust. Every practising doctor has a responsible officer who has a statutory role in evaluating a doctor’s fitness to practice and acts as a contact point with the General Medical Council.

66. Ms Gawne gave us evidence that her contact with Dr Grant was essential because when an employer has concerns about a locum or other doctor who longer works for them, the employer has no ability to undertake any remedial action or retraining. She contacted Dr Grant directly because she could not be sure that the locum agency would pass on any concerns appropriately. In her evidence she pointed to the Trust’s Policy for Responding to Concerns about Clinical Performance. The process is in place to ensure that, if necessary, action can be taken to support or take action in terms of underperforming doctors in the interest of patient safety. Ms Gawne told us, and it was not disputed by the claimant, that this was a regulatory obligation she was required to meet. Dr Grant queried why there had been two feedback forms and there was some liaison between him and Ms Gawne about the concerns.

67. The claimant appeared to believe that the respondent had raised concerns with the General Medical Council directly, but Ms Gawne explained that it was Dr Grant as the responsible officer who passed on concerns to the GMC. The claimant appeared

to regard the responsible officer as being synonymous with the GMC, but we accept the respondent's explanation that this is not correct. Ms Gawne's evidence was that she could have raised concerns directly to the GMC via an employment liaison officer if she believed that the claimant posed a significant risk to patients but Ms Gawne's concerns, and those of Dr Hamer, had not met that threshold and that had not happened. What happened with Patient A was not a clinical incident because there was no suggestion that any harm had been caused to Patient A or her child because of the claimant's indecision.

68. There was subsequently some contact between the claimant and the GMC about his performance and the respondent was involved in that, but we accept those matters were under the control of the GMC and at the instigation of Dr Grant, not the respondent. It is not necessary for us to make any further findings about that in the circumstances, but for completeness we note that it is not suggested that the claimant is subject to any continuing concerns about his performance or fitness to practice.

Our conclusions and findings

69. In order to succeed with a claim of direct race discrimination the claimant is required to show facts which could show that he was subject to unfavourable treatment because of his race, without having to prove that. The claimant suggested to us that the appropriate comparator when we assess whether there has been less favourable treatment is Dr Wittersheim. However, that cannot be correct. The claimant alleges that Dr Wittersheim is the person who subjected him to less favourable treatment. Rather we find that the appropriate comparator is a hypothetical one, that is a white British locum senior registrar engaged for a three-day period by the respondent.

70. We received submissions from the respondent's counsel that the claimant's factual case had not been made out and that even where it was that the claimant had failed to produce evidence to link the treatment that he complained of to his raxe. She was right about that. Despite being reminded by the Employment Judge that this was a discrimination case and that the enquiry for the Tribunal was about the reason for any less favourable treatment, the claimant repeatedly failed to put any allegations that the reason for what happened was his race, let alone showing us any facts from which we could conclude that the reason for any unfavourable treatment was his race. It was clear to us what the claimant wanted the tribunal to do was to "clear his name" in relation to his perception that he had been unfairly criticised about his clinical performance in relation to Patient A by Dr Wittersheim.

71. Taking the legal claims in turn as shown in the List of Issues:

(1) Did Dr Wittersheim throw her ID badge at the claimant on 1 December 2020?

72. This allegation was withdrawn by the claimant at the start of the hearing.

(2) Was the claimant excluded from the ward round by Dr Wittersheim on 1 December 2020?

73. We found as a matter of fact that no ward round was conducted at the time that the claimant alleged. A ward review was undertaken in the handover room, but it is not in dispute that the claimant attended that.

74. On the basis of Dr Wittersheim's own evidence the panel accepts that immediately after the review she attended a patient who had had a difficult birth experience. The claimant may have asked if he needed to accompany her but was told that he did not. The claimant had failed to offer us any facts which suggest the reason why Dr Wittersheim did not want him to accompany her was related to his race, and in the circumstances the burden of proof did not shift to the respondent to show the reason for that particular treatment, but in any event we accepted Dr Wittersheim's evidence that there was no reason for the claimant to attend with her to see that particular patient. The patient had had a traumatic birth with complications but the need for her to seen by other senior doctors had passed and it was better that she was seen by one doctor on her own. There was nothing in that which suggested any discrimination.

(3) Was the claimant excluded from the treatment of a patient requiring a caesarean which was then carried out by others on 1 December 2020?

75. We accept in our findings of fact that Dr Wittersheim did ask another doctor to perform the caesarean section on Patient A, but we found the claimant had failed to adduce any facts to suggest the reason for that decision was his race. We accepted Dr Wittersheim's reasons for intervening in the decision making relating to the caesarean section. She had been asked to come to the room by Mrs Lord because Mrs Lord perceived that there had been a lack of urgent action by the claimant, and that the circumstances of Patient A and her unborn child were such that it was appropriate for Dr Wittersheim the consultant to step in to ensure that Patient A received the appropriate urgent treatment.

76. It is clear that Dr Wittersheim did take over from the claimant but from the evidence before us we are entirely satisfied that a white British senior registrar in similar circumstances would have been treated in exactly the same way by Dr Wittersheim. We find no basis for the burden of proof to shift to the respondent in relation to this, but in any event we are satisfied that there was no discrimination. Dr Wittersheim's focus had simply been on the patient and the unborn child rather than the claimant.

(4) Was the claimant excluded from access to the computer by Dr Wittersheim to document his findings on 1 December 2020?

77. We accept that Dr Wittersheim took over from the claimant inputting information into the computer. We were satisfied that her reasons for doing that were the urgency of the situation. Dr Wittersheim told us that she asked the claimant if she could do that, but it is likely that in essence she issued him with an instruction to allow her to take over. It is likely that she was relatively curt in her manner given the circumstances. However we accept Dr Wittersheim's account, that she told the claimant he could input his own records for Patient A after the event and he failed to do so. Further, the claimant failed to show us any fact which could suggest Dr Wittersheim's reason for acting as she did was his race. We are satisfied that Dr Wittersheim took over to ensure that Patient A's baby was delivered by caesarean section as quickly as possible. The notes on the computer screen had to be "closed" so that they could transfer with the Patient A as she was moved to surgery. The claimant could not reasonably perceive that as less favourable treatment and we are satisfied that Dr

Wittersheim would have intervened to take over the inputting of the notes on the computer if there had been a white on-call senior registrar in the room at the time.

(5) Was the claimant treated less favourably than a white comparator in respect of Ms Gawne, Deputy Medical Director, informing the claimant's responsible officer of concerns that the respondent had about his behaviour and/or clinical competence during his employment by the Trust between 30 November 2020 and 2 December 2020?

78. In relation to this allegation, it appears that the claimant no longer alleges that what happened was motivated by his race. The claimant's position was somewhat hard to follow in that it appeared that he continued to maintain what had happened was inappropriate, even though he did not appear to have any particular criticism of Ms Gawne herself.

79. Insofar as it is appropriate for the avoidance of doubt for us to make findings about that matter, the Tribunal panel accepted that Ms Gawne had a professional obligation to inform the claimant's responsible officer about the concerns which had been drawn to her attention. That was appropriate because by the time she became aware of the concerns the claimant was no longer working for the respondent and would not be able to take any action, for example in terms of addressing any training needs on the part of the claimant. We find no basis for finding that Ms Gawne did anything other than comply with the regulatory and professional obligations she and the respondent were subject to, and we find no basis for finding that was tainted by discrimination.

(6) The reference provided by Dr Hamer on 4 December 2020 in which the claimant was assessed as being less than satisfactory.

80. The Tribunal panel accepted the evidence of Dr Hamer based on the information that she received about the concerns surrounding Patient A, and she emphasised in her evidence to us that it was not the sole reason for her assessment about the claimant. She had witnessed behaviour which she found concerning and she was aware of other concerns which had been raised by colleagues. We accept the evidence of Dr Hamer that in her view she had a professional obligation to correct the reference which had been provided, and the claimant failed to show any facts from which we could conclude that she would have completed the reference differently if the claimant had been a white British on-call locum senior registrar.

Additional finding sought by the respondent

81. The respondent's counsel raised in her submissions that the Employment Tribunal should make a finding not only that the claimant's claims fail, but that his complaints were "totally without merit". Miss Firth referred us to the decision of the *Nursing and Midwifery Council v Harrold* and referred us to the decision of Justice Lang who said:

> "Now that this court has recognised the power to make civil restraint orders and the inherent jurisdiction extends to the powers to protect the process of the Employment Tribunal from abuse, it would desirable for Employment Tribunals, when they make decisions in weak claims, expressly to consider, and to make a finding on, the question whether the claim (or application) is totally without

> merit. I echo that and hope that Employment Tribunals will take notice of this suggestion. It will greatly help to have the views of the Employment Tribunal on the totally without merit issue in any case in which a respondent to Employment Tribunal claims applies for a civil restraint order in this court."

82. The Employment Tribunal panel considered this submission, but we had some concerns about making a finding in relation to a particular legal test about a case being "totally without merit". As far as we are aware, this had not been identified as a legal issue about which the claimant as a litigant in person, had been warned he would have to respond. We had little or no guidance from the respondent in relation to how the Employment Tribunal should apply such a legal test. It is not a test which appears in the Employment Tribunal Rules. We decline to make that finding but as our reasons explain we were concerned that the claimant had failed in this case to engage with the relevant legislation or the basis on which a tribunal may find discrimination on grounds of race. We decided the case on the basis of the evidence before us. We can record that the claimant in this case failed to show any facts from which we could conclude that he had been subject to unlawful discrimination. He brought a claim in which the burden of proof did not shift to the respondent under section 136 of the Equality Act 2010 but we make no further findings than that.

Employment Judge Cookson
Date: 1 June 2023

RESERVED JUDGMENT AND REASONS
SENT TO THE PARTIES ON 12 JUNE 2023

FOR THE TRIBUNAL OFFICE