EMPLOYMENT TRIBUNALS

Claimant: Dr G Challis

Respondent: (1) East Lancashire Hospitals NHS Trust
(2) Inder Kumar
(3) Victoria Rusius

Heard at: Manchester Employment Tribunal

On: 29, 30, 31 January and 1 February 2024
2 February 2024 (in chambers)

Before: Employment Judge Dunlop
Mr A Egerton
Mr P Stowe

Representation

Claimant: Miss M Martin (counsel)
Respondent: Mr B Williams (counsel)

JUDGMENT

1. The claimant's claims of discrimination on grounds of pregnancy or maternity (s.18 Equality Act 2010), indirect discrimination (s.19 Equality Act 2010), harassment (s.26 Equality Act 2010) and victimisation (s.27 Equality Act 2010) are not well-founded. The claims are therefore dismissed.

REASONS

Introduction

1. The claimant, Dr Challis, is a junior doctor who, at the time of the events giving rise to this claim, was in her second year of her foundation stage of training. She was employed in that capacity by the first respondent Trust.

2. The second year of training comprises three different clinical placements, or rotations. Dr Challis completed a rotation in neonatal care. From December 2021, she commenced her second rotation in General Surgery

(Breast), generally referred to by witnesses and in documents simply as "Breast". The rotation would have been due to end at the end of April 2022. Dr Challs was pregnant when she commenced the rotation, she was due to start maternity leave on 22 March 2022. As a result of covid, she was required to 'shield' from her 28th week of pregnancy, i.e. from 17 January 2022.

3. Dr Challis presented her claim on 12 October 2022. She complains that she was discriminated against as a pregnant employee in various ways, arising out of the management of her training post in the context of pregnancy-related illness, the shielding requirement and her maternity leave.

4. The second and third respondents are consultants within the Breast team. Dr Challis she holds them responsible for that discrimination. In this Judgment we will refer to individual respondents by name, and to the first respondent as "the Trust".

The Hearing

5. The hearing was converted to a video hearing at relatively short notice before it was due to commence due to the Trust's wish to minimise the time its witnesses spent away from their workplace. Dr Challis, who currently lives in London, did not object. Both parties were professionally represented. Despite some minor connection problems at times, there was no significant time lost as a result of the hearing being conducted in this way. We were satisfied that the fairness of the hearing was not adversely impacted by the use of video technology.

6. At the outset of the hearing, we held a discussion with the parties and their representatives. There were no preliminary issues raised by the parties. The Tribunal raised the following issues:

    6.1 Although the pleadings were clear, there was no List of Issues. Counsel agreed that they would seek to agree one during the Tribunal's reading time. This was duly done, and we were grateful to both counsel for their assistance with this. A copy of the agreed List of Issues is annexed to this Judgment.

    6.2 The agreed bundle ran in excess of 2,000 pages. No reading list had been provided. Both counsel acknowledged that much of the material in the bundle was repeated and/or superfluous. They contended that preliminary reading could be done in a morning by means of reading the witness statements and the specific documents referred to therein. The Judge confirmed that the Tribunal would take that approach, but that the parties could not assume that where references were made in statements to long documents (such as policies) or to compendious document (such as where Ian Stanley's statement referred to being provided with 832 pages of documents for the purpose of determining the claimant's grievance) those documents would be read in full. Counsel were instructed that it was important that no assumptions be made about what the Tribunal had read and documents relied on would have to be referred to explicitly in cross-examination and/or in closing submissions as appropriate.

7. The question of timetabling was also discussed at the outset of the hearing. The parties agreed it would normally be for the claimant to give evidence first as the burden of proof, at least initially, would be on her. However, the respondents wished to have the third respondent, Ms Rusius, as the first witness in the case, as her availability was restricted due to personal reasons. Dr Challis made no objection. The parties thereafter agreed a proposed timetable which would lead to the Tribunal adjourning for deliberations at lunchtime on Day 4. In the event, this timetable slipped slightly, with both counsel taking a little longer in cross-examination than envisaged. The Tribunal heard from the following witnesses, in this order:

   7.1 Miss Victoria Rusius (third respondent): Consultant Oncoplastic Breast Surgeon. Ms Rusius was also the Educational and Rota Lead for the Breast team.
   7.2 Dr Victoria Challis (the claimant)
   7.3 Miss Suzanne Gawne: Consultant Oncoplastic Breast Surgeon. Miss Gawne was also a Deputy Medical Director with responsibility for professional standards. She had previously held roles within the Trust's Foundation Programme. The Foundation Programme is the training stage which Dr Challis was in at the material time.
   7.4 Mrs Rocio Martin: Medical Administrator. Mrs Martin worked within the Trust's Foundation Programme.
   7.5 Mr Inder Kumar (second respondent): Consultant Breast Surgeon and Clinical Lead for Breast Surgery. Mr Kumar was Dr Challis's Educational Supervisor ("ES") for her F2 year, and her Clinical Supervisor ("CS") for her Breast rotation.
   7.6 Dr Helen Coutts: Consultant Paediatrician and Lead Foundation Programme Director for the Trust.
   7.7 Dr Ian Stanley: Consultant in Anaesthetics and Critical Care. Dr Stanley was, in employment law terms, the manager charged with determining Dr Challis's grievance or, in Trust terms, the Commissioning Manager for the Early Resolution process.

8. We have attempted to use the correct professional titles of witnesses and others referred to in this Judgment. We apologise for any inadvertent errors we may have made in this respect.

9. At the conclusion of the evidence, both counsel presented written submissions of a conspicuously high standard, which they then spoke to. We record our gratitude for those submissions. The panel had hoped to deliver an oral Judgment on Day 5 but, unfortunately, we were unable to meet this timescale. The parties were released around midday on 2 February and informed that the Judgment would be reserved and sent out in writing in due course. The panel notes that the case was listed appropriately and both counsel worked hard to confine their cross-examination to meet the time available. It is likely that we would have been able conclude our deliberations earlier, and deliver an oral Judgment, had the bundle been reduced to a sensible size and compiled in a format which was easier to navigate.

The Issues

10. The issues, as agreed by the parties, are set out in the List of Issues annexed to this Judgment.

Findings of Fact

Background

11. Dr Challis was, as we have said, a junior doctor in her second year of foundation stage training (FY2) at the Trust. She became pregnant following IVF treatment with a successful embryo transfer taking place on 24 July 2021 following earlier unsuccessful cycles.

12. At some point during her IVF treatment Dr Challis had arranged to work at 80%, taking Monday as a non-working day. This enabled her to attend medical appointments and also reduced her workload.

13. The Trust supported trainee doctors working on less than full time ("LTFT") arrangements. The practice was that such doctors would change rotation at the same time as everyone else, making administration of the rotations easier and allowing them to participate in departmental inductions etc. However, a doctor could not complete their FY2 in one year if they were working LTFT. An additional placement, or part-placement, would be needed before they could move to the next level of training. In addition, sickness leave above a certain level would result in time being added to training, as would maternity leave.

14. At the end of FY2, junior doctors would be assessed by a panel ("the ARCP panel") to assess whether they had met the competencies specified by the General Medical Council to make them eligible to progress to the next stage of training. The panel considers an ePortfolio of evidence compiled by the doctor against various competencies. At the end of each rotation, the clinical supervisor would complete an end of placement report which would also form part of the ePortfolio and be placed in front of the ARCP panel.

15. The F2 year began on 4 August 2021. Dr Challis's first placement was in neonatal care. This was due to run until 1 December 2021 when she would move to General Surgery (Breast) until 5 April 2022 when she would move to a general practice rotation. Following Dr Challis becoming pregnant, it became clear that the third rotation would in fact be fully subsumed in her maternity leave, which was planned to start on 22 March 2022.

16. Unfortunately, Dr Challis became seriously ill as a result of IVF side-effects and was hospitalised for 5 days in August 2021. This resulted in her missing 14 days of work towards the start of her neonatal rotation. Her understanding was that missing more than 16 days in total in FY2 would result in a possible extension being required. Dr Challis was very reluctant to extend her training beyond the extension which would be necessitated by her maternity leave.

17. Mr Kumar was Dr Challis's Educational Supervisor (ES) for her FY2 year. This meant he had a general oversight responsibility for her training. In addition, there would be an Clinical Supervisor (CS) for each placement. Dr

Kumar was due to be her CS for the second rotation. He was an experienced supervisor, having taught or mentored junior doctors in some capacity for 32 years.

18. By email dated 31 August 2021 to Mr Kumar, Dr Challis introduced herself and informed Mr Kumar that she was pregnant and had recently been hospitalised. Mr Kumar was on leave and did not respond. However, on his return from leave there was further correspondence and an initial meeting was arranged for 29 September. There are no complaints about this meeting.

19. During the autumn period Dr Challis was also in contact with Dr Coutts, the head of the Foundation Programme. Dr Coutts had assisted Dr Challis in reaching her 80% arrangement and supported her through her IVF. It is apparent from Dr Coutt's emails that she was caring and sympathetic towards Dr Challis. In her oral evidence, Dr Challis said "*I had fantastic support from Dr Coutts*."

20. There was some discussion around this time as to whether the Breast team would be able to find appropriate work for Dr Challis to do whilst shielding. In particular, there was an email exchange between Dr Coutts and the consultants in the Breast team 15-20 October 2021. Both Miss Gawne and Miss Rusius responded positively to this query, expressing confidence that the department could accommodate Dr Challis. Miss Rusius, in particular, talked about giving consideration to "*what type of activities we can put in place to ensure her safety whilst providing suitable learning*".

21. Whilst there had been some initial conversations between Dr Challis and the Foundation Team about whether it would be better for her to be redeployed to another, non-surgical, department for her second rotation given the circumstances, we find that these did not progress because Dr Coutts was satisfied that the Breast team could provide appropriate training.

Preparations for the General Surgery (Breast) Rotation

22. We find that the focus of the rotation was to provide learning opportunities for Dr Challis. There was some debate about the extent to which FY doctors were supernumerary to requirements. We find that the absence of an FY doctor at short notice (for example, where they were on the rota to assist in theatre that day or the next day) could present a difficulty for the department and cover would have to be found. More broadly, however, there were other people who could be put on the rota to provide that assistance, or to cover clinics, and having an FY doctor on an extended, planned absence (such as maternity leave) would not be detrimental to the department.

23. Dr Challis has suggested in her evidence that the Breast team wanted to have the benefit of her services whilst she was well, but then wash their hands of her when she was no longer of use to them. Although that may have been what she felt, we found absolutely no evidence that that was the case. From everything we have seen and heard we are satisfied that everyone on the team saw it as a priority that Dr Challis should have access to appropriate learning opportunities and that that priority was key in the interactions between the members of the department and Dr Challis. As will

be seen, that priority may have been imperfectly realised in some ways, but we reject the suggestion that there was any bad faith in the approach of the consultants within the department in agreeing to host Dr Challis's rotation in the first place.

24. On 16 October 2021 Dr Coutts emailed Dr Challis a maternity 'pack'. This included information and forms to be completed. The maternity pack includes a blank risk assessment form. This did not relate to covid, but covers issues such as physical, biological and chemical hazards. There was no evidence as to whether this document was completed in respect of Dr Challis's then-current placement in the Neonatal department. There was no process within the Foundation Programme administration to check if the risk assessment had been completed and whether any action was required.

25. Dr Coutts met with Dr Challis on 27 October 2021 and summarised their meeting in a lengthy email dated 29 October 2021. In respect of the upcoming second rotation, Dr Coutts stated:
"We discussed that as an FY2 you can make this count towards your training so long as you complete 3 months as a minimum and meet all our your placements learning objectives. I believe you have 1.5 months of breast before you start to shield so you are going to have to be very hands on and proactive during this time to complete all the bits where you need Face to face after that you cannot have face to face contact with any patients but your time needs to be full of educational projects as you need to prove this to get signed of you don't just get it. I know the team have a lot of good ideas and you are hard working so this bit will be fine.

26. The email also covers some discussion about extension to the training period, the implications of LTFT working and sickness, noting that Dr Challis was not keen to extend her training time if this can be avoided. After discussing some further points the email ends with an action plan. That includes an action against Dr Coutts to "*refer to OH*" and an action against Dr Challis to "*Attend OH when your referral is received*".

27. An OH referral was necessary in the context of pregnancy and covid to determine what Dr Challis could safely do within the hospital, particularly she was shielding. This referral could have been made by the Foundation Team, the junior doctor themselves or potentially the department, although there was evidence that the department may not have ready access to personal details (phone number, home address) that would be required for a referral. In any event, it seems relatively clear in the context of this case that Dr Coutts undertook to make the referral and then omitted to do so. We have no doubt that this was an oversight and it is illustrative that busy medics will overlook things from time to time even where, like Dr Coutts, they are otherwise conscientious and have provided fantastic support.

28. Related to this, we find that there was an expectation on Dr Challis as a qualified professional responsible for her own progress and development to be proactive in ensuring that things happened. Dr Challis did not seek to make a self-referral to OH at this stage, nor to chase Dr Coutts when she did not receive an appointment.

29. This is also an appropriate point to remind ourselves that all of the medics (and administrators) involved were carrying out their substantive roles against the backdrop of an NHS battling the height of the covid pandemic. We take judicial notice of the fact that the omicron variant had been identified as a variant of concern in late November 2021, and that the East Lancashire region, served by the Trust, was one of the worst hit areas nationally throughout the pandemic. This was a period in which case numbers were going up rapidly. Although the Breast unit was less directly impacted by covid than other areas of the hospital, it would be subject to knock-on effects in many different ways.

Starting the General Surgery (Breast) Rotation

30. Dr Challis duly started her rotation in General Surgery (Breast). The respondent's witnesses gave unchallenged evidence that she attended only 11 days on-site between starting the rotation and commencing shielding on 17 January. This seems to broadly equate with the ten days of theatre and clinic attendance later noted by Dr Challis in her ePortfolio reflection form. How six weeks reduced to 11 working days is not fully accounted for in the evidence. Dr Challis' 80% working pattern obviously reduced the time available to her, as did the commitments that she had as an FY2 to attend teaching outside the department. She also had to self-isolate pending a covid test result from 21-24 December and she spent time doing on-call duties across the hospital.

31. It is also clear from the evidence of both parties that Dr Challis was experiencing significant pregnancy-related ill-health during this period, but was reluctant to take sick leave due to the likelihood that this would lead to her having to extend her training. There were evidential disputes about whether particular events happened on particular days, but it is not necessary to make specific findings. We are satisfied that Dr Challis was unwell at work, including fainting in theatre, on several occasions.

32. All of this, evidently, would have had an impact on the amount of progress that Dr Challis was able to make in evidencing her competencies during this period. As had been noted by Dr Coutts in the email referred to above, it was a curtailed period of face-to-face training in any event, and to be fully successful, Dr Challis needed to be proactive and make the most of it. It is nobody's fault that, as things turned out, she was unable to do so.

33. On 15 December, Miss Rusius emailed Dr Challis to ask when she was due to start shielding and if she could come to the offices or would be working from home. Dr Challis replied to give the date and suggest doing a mixture of work at the hospital and at home. Miss Rusius then pressed her to ask if she had seen occupational health. When Dr Challis responded to say she hadn't, Miss Rusius suggested "*having a chat*" with them to "*see if they need to see you*" and noted "*if they say you have to shield at home we will need to see how to source you a computer etc*." and asked Dr Challis to "*keep me posted*".

34. Prompted by her exchange with Miss Rusius, Dr Challis then made a self-referral to occupational health on 16 December 2021. There was no appointment or consultation. Occupational health simply responded the

following day, 17 December, with a report consisting of a 'cut and paste' of the applicable covid guidance. No doubt this response reflected a degree of overwhelm on the service at the time. The key point of this guidance was that, as a pregnant worker, Dr Challis was recommended to work from home from 28 weeks gestation. The report noted that staff could choose not to follow the guidance, in which case they must not be deployed to patient-facing roles. The report was also provided to Mr Kumar.

35. In common parlance 'shielding' means minimising all social contacts and, generally, in employment situations, it means that employees will be required to work from home. Not so in the NHS. It was agreed by both parties that the understanding in autumn 2021 was that staff could 'shield' by coming into non-clinical areas of the hospital, having no contact with patients and minimal contact with colleagues. At some point the guidance had been tightened to also preclude contact with physical patient notes.

36. All of the prior discussions which had taken place between Dr Challis, Dr Coutts and the Breast team about the work Dr Challis could do whilst shielding had been predicated on the basis that Challis would still come into work whilst shielding. In recommending work from home, the occupational health report of 17 December 2021 therefore represented a fundamental change in the position.

37. This distinction between shielding at home and shielding at work was even more important when it is recognised that there was no ready access to the Trust's IT systems for employees working from home. There was a severe shortage of laptops across the Trust. That reflected both a difficulty in obtaining funding for equipment, but also a broader practical difficulty for the NHS generally, including this Trust, in actually getting hold of laptops in the required numbers given the sudden move to remote working and supply-side squeeze, both precipitated by covid. The problems were not simply about getting the devices themselves, but about NHS IT infrastructure. We accept, for example, that to be effective a laptop would require a VPN connection and that if the Trust tried to issue too many VPN connections the system could crash.

38. The Trust had 'geared up' to facilitate shielding on site by making Trust computers available in areas of the hospitals where employees could work in isolation, and was continuing this process by utilising an on-site graduate training building as an area where shielding employees could attend and use computers. There was no process within either the Breast department nor the Foundation Programme for employees to obtain laptops to use from home, nor was there any centralised process to apply for these.

39. It is Dr Challis' case that she had a further discussion about the laptop with Miss Rusius after these emails and that Miss Rusius informed her it was "incredibly difficult" to get a laptop within the Trust and that she and Miss Yip (another consultant in the department)) had given up and simply used the office computers. Dr Challis notes that when she started work with IHSS (see below) she was given a laptop within 1-2 weeks and concludes that the Breast team and, in particular, Miss Rusius simply failed to request one for her.

40. Miss Rusius does not recall the specific conversation in December, but does recall informing Dr Challis that laptops were difficult to come by and that she herself had been impacted by this. These points are not made in the emails and so we find that there were further conversations between the two of them.

41. We accept Miss Rusius's evidence that she had no budget and no channel to request a laptop in these circumstances. Miss Rusius had only been in post for a few months. She spoke to Miss Gawne, who was much more experienced in the department and had held her role previously, and Miss Gawne spoke to Dr Coutts to see whether the Foundation Programme could assist. The Foundation Programme also did not have access to laptops.

42. Although Miss Rusius's initial email had made it sound as if 'sourcing a laptop' would not be too much of a difficulty, it had proved that this was not the case. We find that Miss Rusius did inform Dr Challis of that over the course of one or more conversations in around December 2021.

43. The occupational health report did not go to Miss Rusius. It went to Dr Challis and Mr Kumar. It would have been helpful if either of them had acted to bring it to the attention of Miss Rusius, but it is hard to criticise them for failing to do so. Miss Rusius was on leave between 24 and 31 December. Dr Challis had her period of self-isolation. It was Christmas and everyone involved had other things going on.

44. Mr Kumar and Dr Challis met on 31 December to conduct the risk assessment advised by occupational health. This took the form of a 'chat' on Teams and was not documented. Dr Challis confirmed that she would follow the guidance and work from home whilst shielding and there was some discussion about the tasks she would be able undertake. There is no complaint about this meeting.

January 2022 – illness and removal from on-call

45. Dr Challis undertook some on-call shifts in early January. On 10 January she was taken ill during an on-call shift with a loss of vision. She was sent home from the shift and the consultant in charge (from a different department) decided that she should be removed from on call shifts. The respondents accept that this was a pregnancy-related illness. This gave rise to a Teams meeting between Dr Challis and Mr Kumar on 12 January 2022 to conduct a risk assessment and formalise her removal from on call duties.

46. It is Dr Challis's case that during this meeting Mr Kumar told her that as she was not completing her on-calls he would not be able to pass her for the rotation. She said that she felt like she was being given the choice between putting her health in danger or failing the rotation.

47. It is a theme – indeed the central theme – of Dr Challis's case that Mr Kumar was going to fail (or not pass) her for the rotation, and that this was due to her pregnancy and/or pregnancy related illness. We accept the respondent's evidence that whilst junior doctors would use the terminology 'fail' that is not something which their supervisors would say. A junior doctor will be assessed at the end of a rotation to see the extent to which they have

evidenced meeting the competencies set by the GMC. If there are competencies where evidence is lacking this can be made up in later rotations. It is the ARCP panel, not the supervisor, which decides if a junior doctor has passed the FY2 training stage, and is ready to progress.

48. Whilst we accept that Mr Kumar would not use the phrase fail, we find he would use the phrase 'pass' as a shorthand for a doctor having demonstrated all the required competencies within that rotation. Indeed, in what appeared to be a verbal slip, Mr Kumar used that terminology in his evidence to us.

49. We further find (and it is accepted by Mr Kumar) that there was a discussion in this meeting about the impact that stopping doing on-calls would have on Dr Challis's ability to evidence the competencies as those shifts would give doctors the chance to demonstrate surgical skills such as history taking, patients examination and assessment, catheterisation and suturing. We accept Mr Kumar's evidence that the discussion was about ensuring that these skills were evidenced in Dr Challis's ePortfolio and the extent to which she could fill in gaps by undertaking other non-patient facing work.

50. We find that it was Mr Kumar's role, both as an ES and a CS, to discuss frankly and openly with Dr Challis the extent to which she was, and wasn't, managing to evidence her competencies and, therefore, to progress through her training. We find that this is what happened during this meeting and reject Dr Challis's evidence that the aim was to put pressure on her to continue doing on-calls, or that she could reasonably have perceived this to be the case. There would have been nothing for Mr Kumar to gain by doing so.

51. There are a number of meetings between Dr Challis and Mr Kumar which were not documented at the time and in respect of which we have had to decide whose account we prefer. That is always a difficult task. Mr Kumar did not help himself by not documenting important meetings and by being somewhat confused in his recollection. However, we find that many of Dr Challis's allegations about what was apparently said to her in meetings are vague and difficult to pin down. We are concerned that she was under a fundamental misapprehension about the nature of the training process and Mr Kumar's role in relation to 'passing' or 'failing' a rotation. We also find there were certain instances where she put an interpretation on events which was manifestly unsustainable. Unfortunately for her, that inevitably calls into question the interpretation she has put onto other events.

52. Fundamentally, we conclude that Dr Challis's evidence to the Tribunal has been focused on the feelings she has experienced in the difficult circumstances she has found herself in, rather than focused on the actual words and actions of Mr Kumar. So, in this instance, we find Mr Kumar factually noted that not doing on-calls would put Dr Challis in a more difficult position when it came to demonstrating competencies. It is Dr Challis, who has (genuinely but, in our view, unreasonably) interpreted that as a sanction or a threat.

53. There was a conversation between Dr Challis and Miss Rusius on the same day, picking up the issue of laptops. We find that this was the first occasion

that Miss Rusius had been made aware that Dr Challis would be shielding entirely from home and, therefore, that the lack of a laptop would seriously restrict the work she would be able to do. At 2.08pm, Miss Rusius emailed Dr Coutts asking for a call to discuss the situation.

54. Mr Kumar emailed Dr Challis after this, at 2.46pm on 14 January, noting that she was going to 'abandon' her on-call commitments following their risk assessment and also that she had experienced illness whilst attempting to assist him in theatre. He suggested that Dr Challis "*organise a meeting between all of us involved with you included so that we can all come to consensus regarding your ability to continue to work from home and how it would contribute to your training."* Sometimes, Mr Kumar's choice of words could be better. For example, it was probably not helpful for him to talk about Dr Challis 'abandoning' her on-call commitments in circumstances where she had no choice but to give them up due to the serious pregnancy-related ill-health she was experiencing. We find, however, that he did not intend any criticism of Dr Challis and that, taking the whole thing in context, she could not reasonably have read any criticism into that comment. We also note that the suggestion that Dr Challis organise a meeting is in-keeping with the broad expectation that foundation stage doctors take responsibility for their own training and professional development.

55. Dr Challis's witness statement suggests that she spoke to Miss Rusius after receiving this email. On the basis of the timings in the emails we find that this conversation had already taken place. In response to Mr Kumar's email, Dr Challi very quickly suggested that she could meet Mr Kumar's in his office '*now*' and he responded '*You certainly can!*'.

56. This was due to be Dr Challis's last day working in the hospital before she formally started shielding on the 17th. She was due to take some annual leave which meant that she would not actually be working whilst shielding until 24th January.

57. The impromptu meeting which then took place forms an important part of Dr Challis's claim. Again, both Dr Challis and Mr Kumar give detailed accounts of this meeting in their witness statements. Broadly, for reasons we have stated in relation to the earlier meeting, we prefer Mr Kumar's account. We find that Dr Challis's account of the meeting, both in her email to Dr Coutts and in her evidence, misinterprets comments, or takes them out of context, in order to find grounds for criticism of Mr Kumar. For example, in Dr Challis's email she records that Mr Kumar started the meeting by saying that he preferred "*to do these things face to face as then there's nothing in writing*". There is a sinister implication to that comment that Mr Kumar will be saying things that he would not or could not say officially. We remind ourselves, however, that it was Dr Challis who had instigated the impromptu, one to one meeting, whereas Mr Kumar had invited her to arrange a meeting with "everyone involved". Mr Kumar accepts he may well have made a comment about it being good to meet face to face, and that he dislikes emails. Neither of these comments necessarily carries the sinister implication of the version recorded by Dr Challis, and we reject her account.

58. Both agree that there was a discussion about the lack of a laptop. Dr Challis asserts that Mr Kumar told her that it was her responsibility to chase the Breast team to get her a laptop. Mr Kumar says that he told her he did not have the power to get a laptop and that Dr Coutts would be better placed to assist as she hold the budget for the Foundation Programme. We find that Mr Kumar's explanation of the laptop conversation fits more readily with the situation about the provision of laptops as we have found it to be.

59. Subsequently, as we will come to, Dr Challis undertook some remote working for a different team within the hospital that was carrying out covid-related remote triaging work. By joining that programme, she was quickly able to be issued with a laptop. This seems to have reinforced Dr Challis's view that the Breast team had simply not bothered to ask for a laptop for her, and if they had it would have been quickly sorted out. Unfortunately, that view is naïve. We accept the evidence of the respondent's witnesses that there are separate funding streams within the Trust and that there was "plenty of money" for covid at the relevant time. The fact that Dr Challis was issued with a laptop when she joined a remote triaging service for covid patients does not justify the conclusion that the Breast team could also have quickly got one for her. Whilst we have some sympathy for Dr Challis reaching that conclusion at the time, it seems less justifiable that she has clung to that conclusion with the benefit of hindsight and following disclosure in this case. We find that no criticism can be made of Mr Kumar's explaining in the meeting that it was hard to see how a laptop could be obtained for Dr Challis to work from home.

60. Most significantly, there was a discussion about Dr Challis's progress against the competencies and the difficulty she would face in continuing that progress whilst working from home. We find that Dr Challis's expectation was that Mr Kumar would simply 'sort it' for her to be provided with work that she could do from home and then give her a positive sign off at the end of her rotation. There were real practical difficulties with this, arising both from her ill-health and the limitations that had caused to her being able to evidence competencies up to this point, as well as the difficulties with working from home going forward. We find that Mr Kumar simply raised these difficulties in a direct and honest way. He was entitled, and indeed obliged, to do that as a supervisor.

61. In the period between 17 December and 14 January, Mr Kumar could be criticised for not having made the connection between the OH requirement to shield from home, and the lack of laptop availability, and to realise that proactive steps had to be taken to come up with a plan for what Dr Challis was going to do from home. Equally, however, Dr Challis could have raised the point more directly with Mr Kumar, or Miss Rusius (who only became aware of the issue around the 14th). These criticisms have to be set against the backdrop, which we have already emphasised, of the pressured roles which the witnesses had. It is not legitimate for Dr Challis to say that the department had had since August 2021 to prepare, because no one anticipated the changing covid situation and the requirement to shield from home. There had also been other relevant changes – for example in autumn 2021 the department had been running a number of telephone clinics, which would potentially have provided a role for Dr Challis, but these were discontinued around the end of the year.

62. Finally, there was a discussion about what Dr Challis might want to do as a result of the situation she found herself in. Mr Kumar raised with her the suggestion of a 'career break' which would involve her leaving work instead of shielding, and then returning in August 2022 when her baby was 3-4 months old. He suggested that she could ask family members to look after the baby, or enroll it in nursery.

63. The use of the term 'career break' was unfortunate. It implies a termination, or possibly suspension, of employment, which would potentially have a detrimental impact in terms of pay, pension etc. It would, as Dr Challis pointed out, be a very poor choice to take a career break instead of maternity leave with the protections and benefits associated with that. Mr Kumar's evidence is that by saying 'career break' he meant 'maternity leave'. Mr Kumar is a breast surgeon, not an HR Advisor. We reject the notion that by suggesting a 'career break' he was in some way being vindictive and trying to encourage Dr Challis to do something that was against her own interests. Effectively, what Mr Kumar was suggesting was that Dr Challis start her maternity leave early instead of attempting to work from home. As Dr Challis was 28 weeks pregnant she would have been entitled to start her maternity leave within the next week or so, depending on the exact due date on her MATB1 (although it is unlikely that Mr Kumar would be aware of the details around that).

64. Our conclusions as to whether Mr Kumar's actions in making this suggestion were discriminatory are set out below. We record here that we find it was made as a suggestion, and that he did not attempt to dictate that this was a course of action Dr Challis must take. We also record that he shared his own experience of using family to help with childcare and queried whether this would be possible for Dr Challis. We reject the assertion that he told Dr Challis that she should get her mother to look after the baby.

65. We accept that Mr Kumar drew a link between the possibility of the career break and his ability to 'pass' her rotation. Dr Challis presented this as being given an unacceptable ultimatum – either she took a career break or Mr Kumar would fail her rotation. The implication is that he would fail her as a vindictive act due to her not agreeing to the career break. We reject that interpretation and find, as we have already said, that Mr Kumar was doing his job in raising concerns about how Dr Challis was going to evidence the competencies. If Dr Challis has chosen to go on maternity leave and complete the rotation afterwards, she may have been able to evidence her competencies more completely for that rotation. However, it was a matter for her whether she chose to take that approach or not.

Events following 14 January meeting

66. Following the meeting, Dr Challis sent a short email to Mr Kumar, informing him that the suggestion of a career break was not acceptable to her and that she intended to continue to work whilst shielding. As we have said, she also contacted Dr Coutts about her concerns about the meeting.

67. These events prompted a flurry of emails amongst the breast surgeons and Dr Coutts, to which Dr Challis was not copied, discussing what could be

done to enable Dr Challis to undertake effective and valuable training activities from home. It is evident from these emails that those involved recognised this would be challenging, but, equally, there is no suggestion of any reluctance or hesitation in attempting to come up with a plan. Miss Gawne and Miss Rusius, in particular, made a number of suggestions of tasks that might be accessible and appropriate. It is at this point that there was a direct request from the Breast team (Miss Gawne in an email dated 19 January) to Dr Coutts to see if the Foundation Team can provide a laptop with VPN. The response was that the Foundation Team had put a bid in for laptops but "*the baby will probably have started nursery by the time they arrive*". Whilst probably exaggerated, that comment underlines the resourcing difficulties we have discussed. Clearly, it would have been better if the Breast team had asked this question in late December or early January after receiving the OH report, but we are content that it would have made no practical difference to their inability to obtain a laptop from the Foundation Programme for Dr Challis.

68. From the discussion in these emails the proposal which emerged was for Dr Challis to do one or more QI projects. Those are audit projects which serve a particular function within the Trust and some of the Foundation competencies can be achieved by doing them. This was discussed between Dr Challis and Miss Rusius on her return from leave around 24/25 January. Dr Challis and Dr Coutts had come up with a proposal for her to do a project around work available for surgical trainees who have to shield. However, Mr Kumar proposed a project based on work in the Breast department. We accept the respondent's evidence that this was a more appropriate project as it was related to the rotation. There was a short delay in Dr Challis being provided with the data she needed to commence the project. That delay was not unreasonable in the circumstances, although it was unfortunate given the short time available to Dr Challis before she went on maternity leave.

69. At Dr Coutt's suggestion, Dr Challis also offered her services to the 'IHSS team' who operated the virtual triaging service for covid patients referred to above. A laptop request was submitted by that team on 28 January and it was ready for collection by Dr Challis on 7 February. We find it remarkable that Dr Challis did not then inform Mr Kumar or Miss Rusius that she had secured a Trust laptop via that route, and could therefore now potentially undertake a much wider range of work.

9 March meeting

70. On 9 March Dr Challis had a Teams meeting with Mr Kumar. She remained at work as she was due to start her maternity leave on 22 March. Dr Challis complains that during this meeting she was waiting for a call from her obstetric consultant. The call came during the meeting, and she asked Mr Kumar if she could take it, but he refused to allow her to do so. She had some difficulty afterwards in making contact with the hospital that was treating her, and this left her distraught and upset. Mr Kumar agrees that a meeting took place on 9 March, but does not recollect the incident over the call.

71. Dr Challis has never suggested that she explained at the start of the meeting that she was expecting a call, and the nature of that call. She also accepted in evidence that she was not sure if she was going to be called by the consultant or by a midwife or other member of staff. We find that if she had explained the situation at the start of the meeting then Mr Kumar would have had no objection to pausing the meeting to allow her to take it. We find it likely that when the call came in Dr Challis asked, as a courtesy, if she could take a call and Mr Kumar asked her not to, explaining (as Dr Challis has stated) that it would be difficult to re-arrange the meeting for another time. There would have been no time, as the phone was ringing, for Dr Challis to explain exactly what the call was and why she couldn't easily call back. Dr Challis continued the meeting feeling upset about what had happened, but not explaining the nature of the issue to Mr Kumar.

Maternity Leave and 6 May meeting

72. Dr Challis formally commenced her maternity leave on 22 March 2022. Around the same time, she returned to London to live with her partner. It has always been her intention to spend her maternity leave in London. However, Dr Challis now decided she did not want to return to the Trust to complete her F2 year, and was supported by Dr Coutts in requesting a mid-year transfer to a London Trust, which was ultimately successful. She gave birth in early April.

73. Dr Challis arranged an end of placement meeting with Mr Kumar, which took place by Teams on 6 May 2022. In the broader employment law context it is unusual for meetings to take place during maternity leave, particularly at a point when the baby is still very young (4 weeks). However, we accept that this meeting was instigated by Dr Challis and, in common with other medical trainees on maternity leave, she was keen to progress her training so far as possible.

74. Dr Challis had informed Mr Kumar by email that she had an appointment at 13.30 but was available before that. The meeting was arranged to take place at 10.00. It ran until approximately 13.00. Dr Challis complains that this gave her little time to prepare her son to leave the house and get to a medical appointment. However, she accepted in cross-examination that she had never told Mr Kumar that she needed to prepare her son to leabe the house, far less what time it would take. The clear words of her email were that she was available until 13.30. Mr Williams invited Dr Challis to accept that Mr Kumar did not "have a crystal ball", and could not possibly be criticised in those circumstances. Although Dr Challis conceded it was not "the main point" of her complaint, she still maintained that Mr Kumar had done something wrong and discriminatory by "allowing the meeting to overrun".

75. Similarly, Dr Challis maintains her complaint that Mr Kumar's actions meant that she was unable to breastfeed her son during the meeting, and that this was discriminatory, even although she accepted that she had done nothing to make Mr Kumar aware that she needed or wanted to feed her son at this time. We found Dr Challis complaints about the meeting to be simply unsustainable in the circumstances, and the fact she maintained them was

one of the matters which caused us to call into question Dr Challis's interpretation of certain other events.

76. Dr Challis complained that Mr Kumar said during the meeting that he was failing her for the rotation and that there were some concerns formally documented on her portfolio. We find that Mr Kumar told Dr Challis, factually, that she had not completed the competencies in full. He advised that there should be scope for her to complete her competencies during her third rotation, and advised her to seek support from Dr Coutts in planning how to do this.

77. During the call, Mr Kumar completed the Clinical Supervisors End of Placement Report on Dr Challis's ePortfolio. We find that the report is a genuine and factual assessment by Mr Kumar of Dr Challis's training. There is nothing that is negative or critical, but what is apparent is a serious lack of evidence for Mr Kumar to draw on in making his assessment in respect of various parts of the form. In box HLO 3 Mr Kumar has written "*Grace has managed some of her learning. She could have done better had it not been for her difficult precious pregnancy, shielding and now maternity leave."*

78. Dr Challis views this as a critical comment and takes particular exception to the use of the term 'precious pregnancy'. We heard a lot of evidence about this term. It is not a medical term in a technical or scientific sense. We find it is a term used in medical settings to denote a pregnancy which is high-risk and/or hard won. This would include situations such as where there have been previous miscarriages or, as in Dr Challis's case, pregnancies resulting from IVF. Different views may be taken on the appropriateness of that usage, but we find, as a matter of fact, that the usage is common and well-known in the medical world. Whilst not every junior doctor might have come across it, we find Dr Challis certainly would have been aware of it given both her own situation as a woman who had pregnant through IVF and the fact that her first FY2 rotation had been on a neonatal ward. She has continued to maintain that the reference to "precious pregnancy" was some sort of slight to her, rather than a descriptive shorthand and, again, we find that an unsustainable argument which makes it more difficult to accept Dr Challis's interpretation of other events.

79. More generally, we find that any reasonable person reading the comment made by Mr Kumar in full would conclude that he has mentioned Dr Challis's pregnancy in order to explain that there are extenuating circumstances which prevented her from evidencing the competencies, and not to criticise her.

80. At the time of the 6 May meeting, Dr Challis had not completed the audit projects she had started. She complains that Mr Kumar told her she had until "the end of the week" to complete them and that this put her under pressure. We accept, firstly, that Mr Kumar had no personal interest in having Dr Challis complete the audit projects. This was non-urgent work and he could arrange to have it taken forward by the next trainee from whatever point Dr Challis managed to get to. The point was that if she completed the work it could be recorded on her ePortfolio and used to support her competencies. The key date for this was ARCP which was due to take place on 7 June. (In other circumstances, Dr Challis's ARCP could

have been delayed, but she needed an ARCP outcome in order to progress with her application to transfer her training to London).

81. The Clinical Supervisor report actually records that the QI audit projects will be forwarded to Mr Kumar "in a few weeks" which is in line with the ARCP timetable and not the "end of this week" deadline which Dr Challis had asserted in her evidence.

82. Subsequently, Dr Challis did a significant amount of work in completing her ePortfolio before her ARCP. She received an ARCP outcome of '5' which indicates that she had not yet evidenced all competencies. Although Dr Challis initially appeared to be complaining about that outcome, that complaint was not pursued. She was able to transfer to London and has now successfully passed her FY2 stage and proceed to the next stage of her career. She was required to do a short extension to her final placement, but we find that this equated to the time she had 'lost' due to working less than full-time hours. Therefore, the fact that she had not been able to successfully evidence all of her competencies at the end of her second rotation did not delay her completion of her training overall.

83. On 3 August 2022 Dr Challis raised a grievance (in Trust terms, a 'resolution'), broadly about the matters which form the basis to this claim. The grievance was investigated by Jamie Swales, an Acting Consultant Nurse within the Acute Care team, who had experience of investigations. A determination was made on the grievance by Dr Stanley, who gave evidence. Dr Stanley communicated his outcome in March 2023 and did not uphold any of Dr Challis's complaints. Dr Stanley did find areas where improvements could be made, for example around the process of making occupational health referrals.

84. Dr Challis appealed the outcome on 11 March 2024 and, at the point when this hearing took place, the appeal hearing had still not taken place. Making a claim to the Tribunal, progressing through case management and waiting for a multi-day full hearing to take place is far from a quick process. We have to question what use is served to anyone by an employer appeal process which takes longer than the Tribunal process itself. By the time the appeal has concluded the parties will have the outcome of this case, Dr Challis will be at a completely different stage in her career and her son will most likely be walking and talking.

Relevant Legal Principles

Pregnancy and maternity discrimination

85. Section 18 Equality Act 2010 provides as follows:

Pregnancy and maternity discrimination: work cases

(1) This section has effect for the purposes of the application of Part 5 (work) to the protected characteristic of pregnancy and maternity.
(2) A person (A) discriminates against a woman if, in the protected period in relation to a pregnancy of hers, A treats her unfavourably—
(a) because of the pregnancy, or

(b) because of illness suffered by her as a result of it.

(3) A person (A) discriminates against a woman if A treats her unfavourably because she is on compulsory maternity leave.

(4) A person (A) discriminates against a woman if A treats her unfavourably because she is exercising or seeking to exercise, or has exercised or sought to exercise, the right to ordinary or additional maternity leave.

(5) For the purposes of subsection (2), if the treatment of a woman is in implementation of a decision taken in the protected period, the treatment is to be regarded as occurring in that period (even if the implementation is not until after the end of that period).

(6) The protected period, in relation to a woman's pregnancy, begins when the pregnancy begins, and ends—

(a) if she has the right to ordinary and additional maternity leave, at the end of the additional maternity leave period or (if earlier) when she returns to work after the pregnancy;

(b) if she does not have that right, at the end of the period of 2 weeks beginning with the end of the pregnancy.

(7) …

86. S.39(2) EA provides that an employer must not discriminate against an employee by dismissing her or by subjecting her to any other detriment.

87. A "detriment" occurs when a reasonable worker would or might take the view that she had thereby been disadvantaged in the circumstances in which she had thereafter to work. See **Shamoon v Chief Constable of the Royal Ulster Constabulary 2003 ICR 337, HL**.

88. The effect of these provisions are that a woman can succeed in a claim of discrimination on grounds of pregnancy or maternity by demonstrating that in dismissing her or subjecting her to a detriment her employer has treated her unfavourably on the grounds of pregnancy or maternity. If she establishes this, the claim will succeed and she need not compare herself to a man (real of hypothetical) who has received (or would receive) more favourable treatment.

89. The statute does not define "unfavourable" treatment. By analogy with the same term used in s.15 (discrimination arising from disability) it may be taken to mean something which puts the employee "at a disadvantage" (Para 5.7 EHRC Code of Practice on Employment). Para 8.22 of the Code gives specific examples of matters likely to amount to unfavourable treatment in the context of pregnancy.

90. In our view, the concept of unfavourable treatment aligns closely with the concept of detriment as explained in **Shamoon**. We note that Simler P in **Interserve FM Limited v Tuleikyte UKEAT/0267/16** stated that it was "a question of fact to be left to the good sense of tribunals" but also referenced the discussion in paragraph 29 of Langstaff P's decision in the s.15 case of **Trustees of Swansea University Pension & Assurance Scheme v Williams UKEAT/0415/14** as providing helpful guidance. We have had regard to that discussion, although do not reproduce the paragraph here for reasons of brevity.

91. If the claimant shows that she has been subjected to unfavourable treatment, we will have to consider the reason for that treatment.

92. Miss Martin made submissions about certain types of cases where the mindset of the discriminator is irrelevant because there is something about the act itself which is inherently discriminatory. In this regard, she placed reliance on the Judgment of Underhill J (as he then was) in **Amnesty International v Ahmed 2009 ICR 1450**. That case arose from unusual facts - the claimant was denied promotion to a role related to Sudan, because she was herself Sudanese and it was felt that appointing her as opposed to a non-Sudanese worker may give rise to additional risks for the claimant and colleagues. The EAT confirmed that this was direct discrimination in terms of the law, even where the motives were laudable. Mis May relied particularly on an example given in the Judgment that if an owner of a premises put up a sign say "no blacks permitted" that act would be inherently discriminatory and no further enquiry is necessary.

93. The distinction between "criterion" cases, where a blanket policy or criterion is applied which is inherently discriminatory and "reason why" cases where the focus of the Tribunal's enquiry will be on the decision-makers (conscious or unconscious) motive is recognised across the authorities. Criterion cases are, however, relatively rare. The **Interserve** case, mentioned above, is an example of where a Tribunal fell into error by incorrectly identifying a case as a criterion case. For the avoidance of doubt, we did not consider that any of the impugned treatment in this case amounted to the application of an inherently discriminatory criterion, although we do not rehearse that conclusion separately in respect of each allegation discussed below.

94. In considering the connection that must otherwise be established to demonstrate that pregnancy or maternity was the reason for the unfavourable treatment, Miss Martin accepted that the test is not a 'but for' test but nonetheless submitted that the ambit of s.18 is wider than s.13. She argued that s.18 does not simply look at the characteristic of pregnancy/maternity, but also everything that comes with it. She relied on the well-known case of **O'Neill v Governors of St Thomas More Roman Catholic Voluntary Aided Upper School 1997 ICR 33, EAT.** In that case, the claimant's dismissal from a teaching post when she fell pregnant in scandalous circumstances was held to be discriminatory. The school's argument that it was not the pregnancy itself, but rather the particular circumstances of the pregnancy, which left it with no option but to dismiss, was rejected. Miss Martin emphasised the following passage from the Judgment:

"Pregnancy always has surrounding circumstances, some arising prior to the state of pregnancy, some accompanying it, some consequential on it. The critical question is whether, on an objective consideration of all the surrounding circumstances, the dismissal or other treatment complained of by the Applicant is on the ground of pregnancy. It need not be only on that ground. It need not even be mainly on that ground. Thus, the fact that the employer's ground for dismissal is that the pregnant woman will become unavailable for work because of her pregnancy does not make it any the less a dismissal on the ground of pregnancy. She is not available because she is pregnant. Similarly, in the present case, the other factors in the circumstances surrounding the pregnancy relied upon as the "dominant motive" are all causally related to the fact that the Applicant was pregnant -

the paternity of the child, the publicity of that fact and the consequent untenability of the Applicant's position as a religious education teacher are all pregnancy based or pregnancy related grounds. Her pregnancy precipitated and permeated the decision to dismiss her."

95. Miss Martin developed this argument with reference to other authorities, as outlined in her written submissions.

96. Mr Williams disagreed with Miss Martin's submission. He said that the "because of" test is that same in s.13 and s.18 and that this was confirmed by the EAT in **Interserve**. He also relied on the explanation of causation provided by HHJ Richardson in **Indigo Design Build & Management v Martinez UKEAT/0020/14** at paragraphs 29 to 36. Those passages draw, in particular, on the Court of appeal decision in **Onu v Akwiwu [2014] EWCA Civ 279** in pointing out that the "grounds" for a particular act will vary according to the type of case. The Tribunal in the **Indigo** case had found that various acts were 'based on the premise' that the claimant was pregnant. The EAT found that this was, in effect, a 'but for' test and the Tribunal had strayed into error.

97. Mr Williams developed his position by drawing attention to the EAT case of **SW Yorkshire Partnership NHS Foundation Trust v Jackson UKEAT/0090/18/BA** where, again, the Tribunal had fallen into error by applying a 'but for' test. He submitted that if this Tribunal accepted Miss Martin's submissions, we would be in danger of doing the same.

98. Broadly, we accepted Mr Williams' submissions and note that this approach is reinforced by the very recent EAT decision of **Blackdown Hill Management Limited v Tuchkova [2023] EAT 156** (published a few weeks before this hearing, and not cited by the parties). At paragraph 40 of that decision, HHJ Auerbach provides the following helpful guidance:

> ***"It is an error to apply a "but for" test. Nor would it be sufficient that the fact that the complainant took maternity leave provides the context of, or background to, the impugned conduct. The conduct must be because she exercised that right, in the sense that this must have materially influenced the decision, by operating, whether consciously or not, on the mind of the decision-maker."***

Again, in that case the Tribunal was found to have applied an incorrect test, by asking if the unfavourable treatment was related to the claimant having taken maternity leave.

99. Section 136 EqA contains the burden of proof provisions namely that if there are facts from which a Tribunal could decide, in the absence of any other explanation, that a person (A) contravened the provisions concerned, the tribunal must hold that the contravention occurred. Section 136 applies to s.18 cases.

100. In **Igen Ltd V Wong 2005 ICR 931 CA** the Court of Appeal considered and amended the guidance contained in **Barton v Henderson Crosthwaite Securities Ltd 2003 IRLR 332** on how to the previous similar provisions concerning the burden of proof should be applied:

100.1 It is for the claimant who complains of discrimination to prove on the balance of probabilities facts from which the Tribunal could conclude, in the absence of an adequate explanation, that the respondent has committed an act of discrimination against the claimant which is unlawful .These are referred to as " such facts"

100.2 If the claimant does not prove such facts the claim fails.

100.3 It is important to bear in mind in deciding whether the claimant has proved such facts that it is unusual to find direct evidence of discrimination. Few employers would be prepared to admit such discrimination, even to themselves.

100.4 In deciding whether the claimant has proved such facts it is important to remember that the outcome at this stage of the analysis by the tribunal will therefore usually depend on what inference it is proper to draw from the primary facts found by the tribunal.

100.5 It is important to notice the word "could". At this stage the tribunal does not have to reach a definitive determination that such facts would lead it to the conclusion that there was an act of unlawful discrimination. At this stage the tribunal is looking at the primary facts proved by the claimant to see what inferences of secondary fact could be drawn from them and must assume that there is no adequate explanation for those facts. These inferences can include any inferences that may be drawn from any failure to reply to a questionnaire or to comply with any relevant code of practice. It is also necessary for the tribunal at this stage to consider not simply each particular allegation but also to stand back to look at the totality of the circumstances to consider whether, taken together, they may represent an ongoing regime of discrimination.

100.6 Where the claimant has proved facts from which inferences could be drawn that the respondent has treated the claimant less favourably on the proscribed ground, then the burden of proof shifts to the respondent and it is for the respondent then to prove that it did not commit, or as the case may be, is not to be treated as having committed that act.

100.7 To discharge that burden it is necessary for the respondent to prove, on the balance of probabilities that the treatment was in so sense whatsoever on the proscribed ground. This requires a tribunal to assess not merely whether the respondent has proved an explanation for such facts, but further that it is adequate to discharge the burden of proof on the balance of probabilities that the proscribed ground was not a ground for the treatment in question.

100.8 Since the facts necessary to prove an explanation will normally be in the possession of the respondent, a tribunal will normally expect cogent evidence to discharge that burden of proof. In particular a tribunal will need to examine carefully explanations for failure to deal with the questionnaire procedure and/or any relevant code of practice.

101. The guidance has been approved in subsequent cases including, significantly, **Hewage v Grampian Health Board [2012] IRLR 870, SC** and **Royal Mail Group v Efobi 2021 ICR 1263, SC**. The case law makes it clear that the tribunal is not expected to split its hearing into two parts, but instead conducts the two-stage exercise during its deliberations, having heard all of the evidence. Secondly, in conducting this exercise the tribunal may take account of all relevant evidence at stage 1, without artificially excluding

evidence which comes from the respondent at this stage of the decision-making process.

Indirect sex discrimination

102. Section 19 EqA provides that a person (A) discriminates against another (B) if A applies to B a provision, criterion or practice ('PCP') which is discriminatory in relation to a relevant protected characteristic of B's. Subsection (2) goes on to explain that a PCP is discriminatory in relation to a relevant protected characteristic of B's if—

(a) A applies, or would apply it to persons with whom B does not share the characteristic,
(b) it puts or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it,
(c) it puts, or would put, B at that disadvantage, and
(d) A cannot show it to be a proportionate means of achieving a legitimate aim.

103. Neither party referred to any authorities in their submissions on indirect discrimination. We have, however, had regard to the helpful guidance set out by the Court of Appeal in **Ishola v Transport for London [2020] EWCA Civ 112** as to what will constitute a PCP.

Harassment

104. Section 26 of the Equality Act 2010 provides (as relevant) as follows:

(1) A person (A) harasses another (B) if—

(a) A engages in unwanted conduct related to a relevant protected characteristic, and
(b) 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

105. In determining whether conduct has the effect of violating B's dignity or creating the relevant environment for the purposes of EqA 2010, s 26(1)(b) the Tribunal must take into account: B's perception; the other circumstances of the case; and whether it is reasonable for the conduct to have that effect (EqA 2010, s 26(4)).

106. Mr Williams made reference to the case of **Land Registry v Grant [2011] EWCA Civ** and the comments of Elias LJ in relation to the words "intimidating, hostile, degrading, humiliating or offensive" that:

> ***"Tribunals must not cheapen the significance of these words. They are an important control to prevent trivial acts causing minor upsets being caught by the concept of harassment."***

A similar point was made in paragraph 22 of the Judgment in **Richmond Pharmacology v Dhaliwal [2009] IRLR 336**.

107. Pregnancy/maternity is not a relevant protected characteristic for the purposes of a harassment claim, so this part of the case is put forward on the basis of the claimant's sex.

Victimisation

108. Section 27 EqA provides (so far as is relevant):

(1) A person (A) victimises another person (B) if A subjects B to a detriment because—
(a)B does a protected act, or
(b)A believes that B has done, or may do, a protected act.

(2) Each of the following is a protected act—
(a)bringing proceedings under this Act;
(b)giving evidence or information in connection with proceedings under this Act;
(c)doing any other thing for the purposes of or in connection with this Act;
(d)making an allegation (whether or not express) that A or another person has contravened this Act.

109. In terms of establishing the "reason why" the respondent acted in a particular way, the same principles apply as in cases of direct discrimination. Victimisation claims are also subject to the shifting burden of proof set out in s.136 EqA.

Submissions

110. The parties each made detailed submissions in writing, which we do not attempt to summarise here. In their oral submissions the representatives elaborated on certain points and addressed the submissions of the other side. As we have already noted, the submissions were of high quality and we were grateful for them. Specific points are referred to within this Judgment, but we paid careful attention to the full content of the submissions.

Discussion and conclusions

111. We structured our discussions around the agreed List of Issues, parts of which are reproduced as headings below. The full List of Issues appears as an Annex to the Judgment.

Pregnancy and maternity discrimination (Equality Act 2010, section 18)

112. We deal with each separate allegation in turn below. Although the List of Issues identified the question of whether, in each case, the alleged discrimination took place in a protected period, the parties agree that each allegation advanced in this case did take place in a protected period and so that element of the test is satisfied. On that basis, we have not separately addressed that point in respect of the allegations set out below.

Allegation 1: Failing to request a laptop to enable the claimant to work from home

113. In the light of the findings of fact set out above, we found that this was not "unfavourable treatment". The individual respondents, like the

others in the Breast team, had no channel to make such a request, save to the Foundation Programme, which also had no laptops. Ideally, this position would have been established earlier and discussed with the Dr Challis but in the changing circumstances and short timescales we have outlined we find that such an expectation, whilst ideal, would be unrealistic. We find that the respondents' conduct towards the claimant in terms of making arrangements for the laptop is not something which she could reasonably perceive to be unfavourable given the circumstances of the case as she must now understand them to be.

114. If, contrary to our findings, the respondents' 'failure' to request a laptop did amount to unfavourable treatment then we are satisfied that it was not because of the claimant's pregnancy. The claimant's pregnancy provided the context for the requirement for a laptop – because she was pregnant she needed to shield at home and her ability to work meaningfully from home was inhibited by her lack of a hospital laptop with VPN connection. However, the *reason* the laptop was not provided was nothing to do with her pregnancy. The reason the laptop was not provided arose entirely from the difficulties in securing such equipment across the Trust (and the NHS as a whole) amidst the pandemic, as elaborated above. The fact that Dr Challis was quickly allocated a laptop when she took up covid-specific remote triaging work underlines the fact that it was the work that she was doing (and resultant access to funding streams) which dictated whether or not there was any route for Dr Challis to access a laptop, and not her pregnancy.

115. It was not suggested by Dr Challis that the issues in respect of the laptop arose either because of her pregnancy related illness, or because she was seeking her right to exercise maternity leave. In any event, the reasoning set out above would apply equally to those propositions.

Allegation 2: The second respondent suggesting that the claimant would fail her rotation (specifically, that in a Teams meeting with the claimant on 12 January 2022, that the claimant would not pass her rotation as a result of being removed from 'on calls' following a pregnancy-related illness suffered by the claimant on 10 January 2022, namely a loss of vision)

116. We refer to our findings of fact about this meeting. Although we have broadly accepted the respondent's account, we are satisfied that there were comments made to the effect that Mr Kumar would have difficulty in passing Dr Challis as meeting all of the required competencies, given the situation as at it stood at the time of this meeting.

117. It is obvious that that news was very unwelcome to Dr Challis. Her distress was genuine. However, as the **Williams** case itself demonstrates, treatment which is unwelcome is not necessarily treatment which is unfavourable. Plainly, if Mr Kumar informed Dr Challis that he would fail her (or not pass her) as a threat to make her agree to resume on-calls, or as a retaliatory act resulting from her being unable to do on-calls, then that would be unfavourable treatment i.e. she could reasonably take the view that she was being put at a disadvantage. Where, however, Mr Kumar was simply making a genuine assessment of where Dr Challis stood in relation to the

training requirements, we have difficulty in seeing that it is unfavourable, or detrimental, or placing her at a disadvantage, to have this communicated to her. In this instance, therefore, the question of whether the treatment is "unfavourable" is bound up with both the findings of fact about the meeting, but also the question of the reason for the treatment.

118. Our conclusion is that, in the circumstances of this case, the concerns communicated to Dr Challis by Mr Kumar on 12 January 2022 did not amount to unfavourable treatment. Further (and if we are wrong) we are satisfied that Mr Kumar's reason for communicating those concerns arose entirely from the fact that he genuinely held those concerns and wished to alert Dr Challis so that she could take such steps as she was able to in order to evidence her competencies as much as possible given the various constraints she faced. Again, her pregnancy provided the context for this treatment but was not (other than in a "but for" sense) the reason for it.

Allegation 3: Failure to act promptly to ensure that the claimant would be able to complete her rotation notwithstanding her need to shield or take maternity leave

119. This allegation, as framed in the List of Issues, lacks clarity and specifity. In Miss Martin's submissions she refers to Dr Coutt's failure to make the occupational health referral after saying that she would do so. But that was a complaint that emerged from counsel's forensic examination of the documents and chronology. It was not something which exercised Dr Challis at the time and not something about which a specific complaint is discernable, either within the List of Issues or, importantly, in the claim form itself, which makes no mention of the OH process at all. It is also notable that Dr Coutts is neither named as an individual respondent, nor as the person whom this allegation is directed towards and so the submission appears opportunistic.

120. The reality is that there were probably things that all of the individuals involved, including Dr Challis, could have done to provide more opportunity for Dr Challis to evidence her competencies. The circumstances in which things were not done, or were delayed, or could have been done more quickly or otherwise better are enumerated in our findings of fact. Those represent, in the view of the Tribunal, the vicissitudes of working life and, in particular, the vicissitudes of working life within this respondent at the particular time question. Again, there is an apt comparison with the **Williams** case, the fact that Dr Challis could (arguably) have been treated more advantageously does not mean that she has been subject to unfavourable treatment. In our Judgment she has not been.

121. Again (and this will be unsurprising given our comments above) to the extent that there was any unfavourable treatment we find that the reason for it was not Dr Challis's pregnancy, pregnancy-related illness or maternity. The reason was, instead, the competing pressures on the medics involved in Dr Challis's training, a degree of miscommunication (which Dr Challis herself did not assist with), for example in relation to the OH referral, and the challenging and frequently changing circumstances in which everyone was operating as a result of the pandemic.

Allegation 4: By implying that it was the claimant's responsibility to ensure that she was able to complete her rotation when she was allegedly unable to do so for reasons connected to her pregnancy or pregnancy-related illness

122. This must be assumed to be an allegation against Mr Kumar. We find that Mr Kumar acted properly, as a clinical and educational supervisor, to support Dr Challis to make the most of her training and to identify to her the legitimate concerns that he had. Further, as an FY2 doctor, Dr Challis did have responsibility for her own training and development. There was no unfavourable treatment.

Allegation 5: the second respondent suggesting that the claimant should stop working, implying that she would be unable to work effectively, while she was pregnant and caring for her new-born, with the implication that the claimant would be unable to effectively complete her role during those periods

123. This allegation (and the subsequent allegations) arise out of the 14 January meeting and we refer to our findings of fact about that meeting.

124. Employers must be very careful about making suggestions around when a pregnant employee might be best to start, or return from, maternity leave. Putting pressure on employees to commence maternity leave rather than making appropriate arrangements to accommodate them continuing to work if they wish to do so may well amount to unfavourable treatment. Contrary to what appears to be suggested by Mr William's submissions, we consider unfavourable treatment of that nature may well be because of pregnancy (at least in part), rather than merely in the context of pregnancy. The circumstances which make it awkward or problematic for the employee to continue working are almost certainly circumstances which arise out of her pregnancy and are part of the "surrounding circumstances" of the pregnancy as explained in **O'Neill**. Equally, however, merely informing employees of the various options available to them, and discussing the practicalities of each one, is not unfavourable treatment and is not discriminatory. It is probably sensible that such discussions are properly minuted and, at least in large organisations, that there is input from HR to ensure that the information given is accurate.

125. Despite the fact that Mr Kumar was clumsy in his approach (e.g. the maternity/career break confusion) we find that this is a case which fell on the latter side of that line, and that there was no unfavourable treatment. We take account of the particular circumstances of this employment relationship. The priority, for both sides, was how Dr Challis could most effectively progress with her training, not her contribution to the 'business' of the hospital. Mr Kumar was providing guidance and advice in his role as a supervisor, rather than as a conventional line manager. We reject, as we have said, the idea that he presented Dr Challis with an ultimatum that was false or unfair. Dr Challis understandably, did not like the fact that her training was being compromised by the combined effects of her pregnancy, her pregnancy-related illness and the covid situation, but that was the result of the situation that she found herself in, not the result of unfavourable treatment by Mr Kumar.

Allegation 6: the second respondent failing to consider the impact that a career break would have on the claimant's training, maternity leave entitlement and pension

126. As above, we are satisfied that Mr Kumar was guilty only of a misunderstanding of terminology. In confusing the term 'career break' and 'maternity leave' he did not turn his attention to the distinction between the two concepts and the disadvantage that would have resulted to Dr Challis had she actually given up her maternity leave and instead taken a career break without maternity protections. (It seems highly likely, in any event, that if she had decided to choose this 'option' then once she began to make arrangements with the Foundation Programme and the Trust's HR team, it would have quickly become apparent that the appropriate route was an early start to maternity leave.)

127. Nonetheless, we are persuaded (just) that by setting out to discuss Dr Challis's options with her, at a difficult time and in sensitive circumstances, and not making sure that he was sufficiently well-informed to provide an accurate summary of those options Mr Kumar can be said, in a limited way, to have subjected Dr Challis to unfavourable treatment. A pregnant employee who is involved in a discussion with a senior supervisor about their pregnancy and the implications for their training and progress is entitled to assume that the supervisor will be able to discuss their options, rights and entitlements in an accurate way, or else will secure appropriate support to do so or signpost the employee to appropriate support, rather than make statements which are confusing and potentially misleading. For that not to be the case can reasonably be seen as being put at a disadvantage.

128. The context of this unfavourable treatment is pregnancy. This is not a criterion case. This is a specific misinformed comment that Mr Kumar made to one pregnant employee on one occasion. The reason for him making the comment, we find, is that he simply didn't know any better. He had not turned his mind to the intricacies of the law, or the respondent's policies, in respect of maternity leave. That is unfortunate but, in our view, it is not discriminatory. Whilst pregnancy is the context it cannot realistically be said to be the reason, or any part of the reason.

Allegation 7: the second respondent making a comment on how the claimant should care for her baby while working which was insensitive, unrequited, and ignorant of her personal circumstances

129. We repeat the discussion relating to allegation 5, above. In some contexts, such comments will constitute unfavourable treatment and may well be discriminatory, in other contexts, they will not be. Given the findings of fact we have made in this case we do not find that there was unfavourable treatment here.

Allegation 8: the second respondent suggesting that the claimant could continue her rotation while shielding but the outcomes would not be favourable for her and she would fail

130. This allegation is the other side of the 'ultimatum' that Dr Challis claims was put to her by Mr Kumar (see allegation 5 above). We reject her interpretation and characterisation as already explained. We find that Mr Kumar had a frank discussion with Dr Challis about the limitations there were in her ability to evidence the relevant competences on the strength of the work she had done in the unit. That discussion was legitimate and necessary. It was not unfavourable treatment, and, even if it was, pregnancy was only the context of the treatment, not the reason for it.

Allegation 9: during a Teams call on 6 May 2022, the second respondent refusing to allow the claimant to speak with her obstetric consultant

131. We have found it likely that Mr Kumar did indicate that Dr Challis was not permitted to take a personal call during this meeting, albeit that he did so on the spur of the moment and without a full appreciation of how important the call was to Dr Challis. We find that Dr Challis could legitimately view that as unfavourable treatment, albeit that it was, in view of the circumstances we have set out, a minor matter.

132. We are not persuaded that the reason for the unfavourable treatment had anything to do with pregnancy. Pregnancy provided the context for the telephone call. It could just as easily have been an important call about another personal matter. Mr Kumar indicated that Dr Challis should not take the call because the meeting was important and he (justifiably) considered his time to be important. We are not satisfied that he knew the call was connected to Dr Challis's pregnancy and, even if she had communicated this, we are certain that that did not affect his approach. He would have taken the same approach if a junior doctor asked to personal call during a similar meeting for any other reason. There is room for argument as to whether he ought to have been more accommodating, but that does not mean that his failure to be accommodating was caused, in any part, by the fact that Dr Challis was pregnant. We are satisfied it was not.

Allegation 10: During a Teams call on 6 May 2022, the second respondent failing or refusing to ensure that the claimant had sufficient time to breastfeed and to prepare her four-week-old son for his hospital appointments, despite being aware of her son's appointments and the need for her to breastfeed

133. As regards this allegation, we reject Dr Challis's case on the facts. We find that Mr Kumar did not know of any restrictions to the claimant's ability to attend the meeting other than that she had to be free by 1.30pm, nor did he know that she needed (or wanted) to feed her son. There was therefore no unreasonable treatment.

Allegation 11: during a Teams call on 6 May 2022, the second respondent informing the claimant that he was failing her on her rotation and accusing her of performing poorly because she was pregnant because she needed to shield for reasons related to pregnancy, and because she was on maternity leave

134. We reject this allegation in the terms that it has been put by Dr Challis. We find that Mr Kumar did not tell Dr Challis that he "was failing her" nor did he "accuse her of performing poorly". That was Dr Challis's

interpretation which was not justified based on Mr Kumar's actual comments, either spoken in the meeting or completed on the supervisor's report form.

135. It is a matter of fact that Mr Kumar recorded in various parts of the form that there were areas of "some concern". We find that that was unfavourable treatment. Dr Challis would have wanted the form to record "no concern" in respect of each area, which would support her in demonstrating to the ARCP that she had met all of her competencies.

136. We find, however, that this unfavourable treatment was not by reason of Dr Challis's pregnancy (nor her pregnancy-related illness nor maternity leave). We fully accept the respondents' position that Mr Kumar made a genuine assessment in good faith of the extent to which Dr Challis had been able to evidence her abilities in different areas. To have done anything else would have been a dereliction of his duties not only to Dr Challis, but also to training programme and, ultimately, to patients. Again, the pregnancy was merely the context for the unfavourable treatment, and not its cause.

Allegation 12: during a Teams call on 6 May 2022, the second respondent requiring the claimant to complete work during her maternity leave and by setting a deadline for the completion of that work which was unreasonable

137. Again, we reject this allegation on the facts. Mr Kumar gave Dr Challis opportunity to complete the QI projects in order for them to be considered as further evidence for her ARCP. There was no requirement that she do them. The deadline that was set was not as short as suggested by Dr Challis but, in any event, it reflected the timeline for the ARCP. Dr Challis would need to complete the work within this timeframe to benefit from it in terms of what she could show she had done as part of her second rotation. Again, critically, there was an agreement, rather than a requirement, that Dr Challis would do within a particular timeframe because it was in her interests to do so.

Conclusion - Discrimination of grounds of pregnancy or maternity

138. For the reasons set out above we find that none of Dr Challis's complaints of discrimination on the grounds of pregnancy or maternity are well-founded.

Indirect sex discrimination (Equality Act, section 19)

PCP1: The first respondent applied a provision, criterion or practice (PCP) or failing or refusing to provide laptops to its staff members who need to work from home

139. The respondent points out that there was no refusal to provide a laptop and, indeed, in Miss Martin's submissions, the PCP is framed simply as a "failure to provide laptops to its staff members who need to work from home". We are unable to accept that the Trust applied a PCP as alleged, not least because Dr Challis was supplied with a laptop from 7th February. It is certainly the case that there was a shortage of laptops (and VPN

connections) and that not everyone who could potentially benefit from having one was able to access one. It is equally clear, however, that there was no blanket failure to provide them. Miss Rusius talked at one point of the VPN facility "breaking" due to too many lines having been issued, and the fact that Dr Challis received a laptop when she was engaged in covid-related work, along with other staff engaged in that work, shows that there was no such policy.

140. Arguably a more focussed case could have been presented around a practice of not providing laptops for Foundation Stage doctors, or those working in particular departments. Had the case been run in that way then Dr Challis may well have been able to establish a disadvantage for female staff, although it is likely that the focus would then have turned to justification and the respondent may well have been able to justify whatever prioritisation was given to the allocation of whatever laptops and VPNs it did have at its disposal.

141. All that, however, is speculation, the case was put forward on the basis of a blanket failure, and the evidence simply does not support a conclusion that any such PCP was applied.

142. The being the case, we did not go on to analyse the other parts of the indirect discrimination test.

PCP2: the first respondent applied a PCP or failing or refusing to ensure that its staff members could complete rotations when a need to work remotely arose, and or putting service provision demands ahead of the training needs of its staff

143. We accept the respondent's submission that this PCP has been constructed to meet the claimant's circumstances, rather than being a true reflection of any real policy. Dr Challis did complete her rotation, albeit that she was unable to evidence every competency. We agree that there was no evidence of the respondent putting service provision demands ahead of training needs and, in any event, such an assertion is, in the view of the Tribunal, too vague to amount to a PCP in any event.

144. The being the case, we did not go on to analyse the other parts of the indirect discrimination test.

PCP3: The second respondent applied a PCP of holding long meetings

145. Mis Martin withdrew from reliance on this alleged PCP in her written submissions. We need not consider it further.

Harassment (section 26 Equality Act 2010)

146. We note that the List of Issues agreed by the parties and annexed to this Judgment is incomplete in terms of the statutory test. As well as asking whether, in each instance relied upon, the respondent subjected the claimant to unwanted conduct relating to her sex, we must also ask whether that conduct had the purpose or effect proscribed by s.26 (see above).

Allegation 1: On 12 January 2022, did the second respondent suggest that the claimant would fail her rotation for reasons related to a pregnancy related illness?

147. We repeat the findings above. Whilst Mr Kumar expressed concerns about Dr Challis's ability to evidence all the required competencies we find that his conduct in doing so was not related to the claimant's sex and did not have the purpose, nor the effect, proscribed by s.26. It was not harassment.

Allegation 2: On 14 January 2022, did the second respondent suggest that the claimant should stop working while she was pregnant and caring for her new-born?

Allegation 3: during a Teams meeting on 14 January 2022, did the second respondent comment on how the claimant should care for her baby while working?

148. Again, in respect of both of these allegations we repeat our findings above. We find that the comments made by Mr Kumar about taking a career break and returning at an early stage, perhaps with family support for childcare, are comments relating to her sex as they arise from the fact that she was a pregnant woman. The comments were also unwanted by Dr Challis.

149. We are entirely satisfied that violating Dr Challis's dignity, or creating an environment which was intimidating, hostile, degrading, humiliating or offensive was no part of Mr Kumar's purpose in making these comments. His purpose was to support Dr Challis and provide an illustration of alternative options for her to progress with her FY2 training.

150. We accept that Dr Challis was unhappy about these comments. Being unhappy is not the same as having one's dignity violated or being subjected to the proscribed environment. We find that her unhappiness was not such that she genuinely perceived her dignity to have been violated, or the proscribed environment to have been created. If she did, we find that it is not reasonable for the conduct to have that effect. Either way, we are satisfied that the test is not made out.

Allegation 4: During a Teams meeting on 6 May 2022, did the second respondent fail or refuse to ensure that the claimant had sufficient time to breastfeed and prepare her four-week-old son for his hospital appointment

151. We have rejected Dr Challis's complaints about this meeting. Just as it cannot amount to s.18 discrimination, on the facts as we have found them, it also cannot amount to harassment.

Allegation 5: On 14 January 2022, did the second respondent threaten to fail the claimant on her rotation for the reason that she was shielding or pregnancy-related reasons?

152. No. We reject this claim on the facts and repeat the findings made above.

Allegation 6: Did the second respondent refuse to allow the claimant to speak with her obstetric consultant during a Teams call between the 2nd respondent and the claimant on 9 March 2022?

153. We repeat the facts we have found above. We accept that Mr Kumar's actions in telling Dr Challis she could not take the incoming call during their meeting were unwanted. We do not accept that his actions were related to her sex. Even if they had been, they did not have the purpose proscribed by s.26 and it was not reasonable for them to have that effect.

Allegation 7: During a Teams call on 6 May 2022, did the second respondent fail the claimant on her rotation and accuse her of performing poorly because she was pregnant because she needed to shield for reasons related to her pregnancy and because she was on maternity leave?

154. We repeat the findings we have made above. Specifically, we have rejected the notion that the second respondent "failed" the claimant on her rotation. That assertion arises from a misunderstanding of the Foundation stage process. We also rejected the assertion that he "accused" her of performing poorly. We accept that the Second Respondent assessed the claimant as having some areas of concern, and that that was unwanted conduct. We find that the unwanted conduct was not related to sex, as the claimant's pregnancy merely provided the context for her failure to completely satisfy all of the competencies. However, and in any event, we are entirely satisfied that this conduct did not have the purpose proscribed by s.26, nor did it have that effect (taking into account our conclusion that it would be unreasonable for it to have that effect in all the circumstances of the case.)

Allegation 8: During a Teams call on 6 May 2022, did the second respondent demand that the claimant worked to unreasonable deadlines during her maternity leave?

155. We repeat the findings of fact set out above and reject this allegation on the facts.

Conclusion - Harassment

156. The harassment claim fails for the reasons set out above.

Victimisation

157. It was agreed by the parties that Dr Challis's act of bringing these proceedings was a protected act within the meaning of s.27(1) EqA.

158. There were two inter-related alleged detriments which were said to flow from that protected act, as follows:

Detriment 1: The respondent's failure to properly address the allegations of discrimination made by the claimant.

Detriment 2: The respondent instead focused on the intent of the person who the claimant submits discriminated against her and wrongly directed itself to the current Tribunal proceedings brought by the claimant

159. The evidence we have heard did not focus strongly on the grievance process. The detriments set out above were put to Mr Stanley and he, unsurprisingly, denied that that was the case. Neither party put forward arguments about the victimisation claim in their written submissions and the oral submissions were brief.

160. It is for the claimant to establish her case (at least sufficiently to shift the burden of proof). Whilst there may have been scope within the grievance process for a different manager to reach different conclusions there is no evidence, so far as we can see, that the respondent either failed to properly address the grievance, nor was influenced in its conclusions by the fact that a claim had been brought.

161. If we had found clear and irrefutable evidence of discrimination in the underlying claim that may have raised question marks as to how the respondent could have reached a different conclusion. As will now be clear, however, we did not find discrimination and it is therefore perhaps not surprising that Mr Stanley did not identify discrimination in his investigation either.

162. On the basis that we find Dr Challis was not subjected to the detriments which she has relied upon, the victimisation claim must necessarily fail.

Final words

163. For the reasons set out above, each of Dr Challis's complaints has failed. We appreciate that this conclusion will be upsetting to Dr Challis. We want to record that these claims were in no way cynical, nor was Dr Challis an essentially untruthful witness. The discrepancy in the evidence between the parties was, in the view of the Tribunal panel, much more about perception and interpretation than about the underlying facts. Dr Challis genuinely believes that she was discriminated against. Unfortunately for her, we are unable to reach the same conclusion. It is perhaps also unfortunate that this decision had to be reserved which means that it will result in publicly-available written reasons. We hope that that will not impede Dr Challis in her future medical career which remains at an early stage. It should not do so, and we very much hope, irrespective of our conclusions in this case, that her career will prove to be a long and successful one.

164. The provisional remedy hearing date which was agreed with the parties will be vacated.

Employment Judge Dunlop

Date: 29 February 2024

RESERVED JUDGMENT & REASONS SENT TO THE PARTIES ON
11 March 2024

FOR EMPLOYMENT TRIBUNALS

Annex
Agreed List of Issues

1. **Pregnancy and maternity discrimination (Equality Act 2010, section 18)**

1.1 **Did the respondents treat the claimant unfavourably by doing the following things:**

1.1.1 **Failing to request a laptop to enable the claimant to work from home;**

1.1.2 **The second respondent suggesting that the claimant would fail her rotation (specifically, that in a Teams meeting with the claimant on 12 January 2022, that the claimant would not pass her rotation as a result of her being removed from 'on calls' following a pregnancy-related illness suffered by the claimant on 10 January 2022, namely a loss of vision);**

1.1.3 **Failure to act promptly to ensure that the claimant would be able to complete her rotation notwithstanding her need to shield or take maternity leave;**

1.1.4 **By implying that it was the claimant's responsibility to ensure that she was able to complete her rotation when she was allegedly unable to do so for reasons connected to her pregnancy or pregnancy-related illness;**

1.1.5 **The second respondent suggesting that the claimant should stop working, implying that she would be unable to work effectively, while she was pregnant and caring for her new-born, with the implication that the claimant would be unable to effectively complete her role during those periods;**

1.1.6 **The second respondent failing to consider the impact that a career break would have on the claimant's training, maternity leave entitlement and pension;**

1.1.7 **The second respondent making a comment on how the claimant should care for her baby while working which was insensitive, unrequited, and ignorant of her personal circumstances;**

1.1.8 **The second respondent suggesting that the claimant could continue her rotation whilst shielding, but the outcomes would not be favourable for her and she would fail;**

1.1.9 **During a Teams call on 9 March 2022, the second respondent refusing to allow the claimant to speak with her obstetric consultant;**

1.1.10 **During a Teams call on 6 May 2022, the second respondent failing or refusing to ensure that the claimant had sufficient time to breastfeed and to prepare her four-week-old son for his hospital appointment, despite being aware of her son's appointment and the need for her to breastfeed;**

1.1.11 **During a Teams call on 6 May 2022, the second respondent informing the claimant that he was failing her on her rotation and accusing her of performing poorly because she was pregnant because she needed to shield for reasons related to her pregnancy, and because she was on maternity leave; and**

1.1.12 **During a Teams call on 6 May 2022, the second respondent requiring the claimant to complete work during her maternity leave and by setting a deadline for the completion of that work which was unreasonable.**

1.2 **Did the unfavourable treatment take place in a protected period?**

1.3 **If not, did the respondents implement a decision taken in the protected period?**

1.4 **Was the unfavourable treatment because of the claimant's pregnancy?**

1.5 **Was the unfavourable treatment because of illness suffered as a result of the claimant's pregnancy?**

1.6 **Was the unfavourable treatment because the claimant was on compulsory maternity leave/ the claimant was exercising or seeking to exercise, or had exercised or sought to exercise, the right to ordinary or additional maternity leave?**

2. **Indirect sex discrimination (Equality Act 2010, section 19)**

2.1 **Did the respondents apply the following PCP's:**

2.1.1 **The first respondent applied a provision, criterion or practice (PCP) of failing or refusing to provide laptops to its staff members who need to work from home. (PCP1)**

2.1.2 **The first respondent applied a PCP of failing or refusing to ensure that its staff members could complete rotations when a need to work remotely arose, and/or putting service provision demands ahead of the training needs of its staff. (PCP2)**

2.1.3 **The second respondent applied a PCP of holding long meetings. (PCP3)**

2.2 **Did the PCP puts or would put persons with whom she shares her characteristic at a particular disadvantage, namely:**

2.2.1 **In respect of PCP1, being unable to access confidential patient information without a trust laptop with specific software when compared to male members of its staff. The Claimant submits that female members of Respondent 1's staff are more likely to need to work from home for reasons related to, for example, childcare or pregnancy/maternity.**

2.2.2 **In respect of PCP2, difficulty completing rotations, when compared to male members of its staff. The Claimant submits that female members of Respondent 1's staff are more likely to need to work from home for reasons related to, for example, childcare or pregnancy/maternity.**

2.2.3 **In respect of PCP3, the stress of being unable to attend a young child and ensure their needs are met. The Claimant submits that female colleagues are more likely to need to have childcare commitments, to need to breastfeed or to attend appointments related to pregnancy/maternity.**

2.3 **Did the PCP put the Claimant at that disadvantage**

2.4 **Can the Respondent show the PCP to be a proportionate means of achieving a legitimate aim**

3. **Harassment**

3.1 **Did the respondents submit the claimant to unwanted conduct relating to her sex? Specifically:**

3.1.1 **On 12 January 2022. Did the second respondent suggest that the claimant would fail her rotation for reasons related to a pregnancy-related illness?**

3.1.2 **On 14 January 2022, did the second respondent suggest that the claimant should stop working while she was pregnant and caring for her new-born?**

3.1.3 **During a Teams meeting on 14January 2022, did the second respondent comment on how the claimant should care for her baby while working?**

3.1.4 **During a Teams meeting on 6 May 2022, did the second respondent fail or refuse to ensure that the claimant had sufficient time to breastfeed and to prepare her four-week-old son for his hospital appointment.**

3.1.5 **On 14 January 2022, did the second respondent threaten to fail the claimant her on her rotation for the reason that she was shielding for pregnancy-related reasons?**

3.1.6 **Did the second respondent refuse to allow the claimant to speak with her obstetric consultant during a Teams call between the second respondent and the claimant on 9 March 2022?**

3.1.7 **During a Teams call on 6 May 2022, did the second respondent fail the claimant on her rotation and accuse her of performing poorly because she was pregnant because she needed to shield for reasons related to her pregnancy, and because she was on maternity leave?**

3.1.8 **During a Teams call on 6 May 2022, did the second respondent demand that the claimant work to unreasonable deadlines during her maternity leave?**

4. **Victimisation**

5.

5.1 **It is accepted that the Claimant's ET1 claim (the bringing of proceedings) is a protected act as defined under s27(1) Equality Act 2010?**

5.2 **Did the respondents submit the claimant to detriments? Specifically:**

5.2.1 **The Respondent failure to properly address the allegations of discrimination made by the Claimant**

5.2.2 **The Respondent instead focused on the intent of the person who the Claimant submits discriminated against her and wrongly directed itself due to the current Tribunal proceedings brought by the Claimant**