EMPLOYMENT TRIBUNALS

Claimant **Respondent**

Dr Anthony Adams **v** General Medical Council

Heard at: Cambridge

On: 1, 2, 3 and 4 July 2024
Discussion in Chambers: 4 July 2024

Before: Employment Judge Tynan

Members: Ms E Deem and Mr S Holford

Appearances
For the Claimant: Mr Liam Varnam, Counsel
For the Respondent: Mr Ivan Hare KC

RESERVED JUDGMENT

The Claimant's claims that he was indirectly discriminated against in relation to the protected characteristic of race and victimised are not well founded and are dismissed.

REASONS

Background

1. Dr Adams brings claims of indirect discrimination and victimisation against the General Medical Council ("GMC").

2. The GMC is the regulator of doctors in the UK. Its statutory purpose, governance and responsibilities are prescribed by the Medical Act 1983. Amongst other things, the GMC investigates concerns regarding doctors' conduct and performance. Its procedures in that regard are laid down in the General Medical Council (Fitness to Practice) Rules 2004 ("the FTP Rules") which have been approved by Order of the Privy Council (SI 2004 / 2608).

3. The GMC is independent of government and the medical profession, and accountable to Parliament. It is a registered charity and is regulated by the

Professional Standards Authority, which scrutinises and oversees its work, together with other health and social care professional bodies in the UK. Dr Adams does not challenge the GMC's evidence that it has never failed to meet any of the PSA's standards for good regulation.

4. Dr Adams' claims against the GMC are brought pursuant to section 53 of the Equality Act 2010 ("EqA") which applies to qualification bodies.

5. Section 53(2) of the EqA 2010 provides,

> "A qualifications body (A) must not discriminate against a person (B) upon whom A has conferred a relevant qualification-
>
> …
>
> (c) by subjecting B to any other detriment."

6. Section 53(5) of the EqA 2010 provides,

> "A qualifications body (A) must not victimise a person (B) upon whom A has conferred a relevant qualification-
>
> …
>
> (c) by subjecting B to any other detriment."

7. Dr Adams is a British citizen of Afro-Caribbean heritage. He qualified as a doctor in 1988 from St. George's Medical School, University of London. In September 2004 he joined the GMC's Specialist Register in Emergency Medicine, having obtained his Certificate of Completion of Training in 1999. He continues to be registered with the GMC but is no longer licenced to practise. He says that he decided to relinquish his licence to practise with effect from March 2020 because he had not been able to keep up to date with the requirements for a successful re-validation. In September 2020 he enrolled in the Master's of Science in Psychology online programme at the University of Derby with a view to becoming registered with the Health and Care Professions Council as a Counselling Psychologist, again something we shall come back to. There is reference in the Hearing Bundle to Dr Adams having also studied for a Master's in Law.

8. We heard evidence from Dr Adams and on behalf of the GMC from:-

   - Joanna Farrell, Assistant Direct of Investigations within the Fitness to Practise Directorate;

   - Courtney Brucato, Information Governance Manager and Archivist within the Information Policy Team; and

   - Michael Keegan, Senior Case Examiner.

9. The Respondent was proposing to call Claire Light, Head of Equality, Diversity and Inclusion ("ED&I") at the GMC to give evidence. A witness statement had been served for her. However, on the basis that Mr Varnam confirmed he would not be asking any questions of Ms Light, we were able to excuse her attendance at Tribunal. Her evidence as to the GMC's approach to ED&I, both as an employer and regulator is therefore unchallenged, as indeed was the other witnesses' evidence regarding ED&I. Ms Light states that ED&I is embedded within the GMC's corporate strategy and that it utilises its data to help inform its understanding of the impact of regulation on different groups. The GMC also commissions research and analysis to provide wider insight on these issues. Later in this judgment, we refer to a 2014 report by Plymouth University's Peninsula Schools of Medicine & Dentistry entitled 'Review of decision-making in the General Medical Council's Fitness to Practise procedures': the "Plymouth Review" led to changes in guidance and practices within the Fitness to Practise Directorate. We accept Ms Light's evidence that the GMC strives to understand the impact of its regulatory functions and also, more broadly, any inequalities experienced by the profession within their working, educational and training environments, and that when developing strategies, policies, guidance and procedures the GMC considers ED&I by undertaking equality impact assessments. It also monitors the representation of doctors within the fitness to practise process and has a separate team which audits the GMC's fitness to practise work independently. Ms Farrell, Ms Brucato and Mr Keegan's evidence corroborates Ms Light's evidence that the GMC takes a robust approach to training on ED&I, starting with induction. Case examiners are part of this training regime.

10. In his closing written submissions, Mr Hare highlights what he says are a number of aspects of Dr Adams' case and the way in which it has been advanced which lack credibility. We identify below certain difficulties in Dr Adams' case, certain of which led him to withdraw what we would describe as the central plank of his claim, namely that information held by the GMC has been made available or disclosed to prospective employers of his. Whilst we have not specifically addressed Dr Adams' credibility, we place on record that we have been greatly assisted in this matter by Ms Farrell and Mr Keegan's evidence. They brought particular clarity to the issues and we were struck by their insights, their thoughtful and measured approach, and their ability to frame their evidence within the broader policy and regulatory context.

11. There was an agreed electronic Bundle comprising eight sections, A – H. Any page references in the course of this Judgment correspond to the Bundle. We were additionally provided with 33 pages of additional documents, a 2022 BMA report entitled 'Racism in medicine', and extracts from the Medical Act 1993 in their amended and unamended form.

The Law

12. Mr Hare has set out the relevant law in some detail in his written submissions. Accordingly, we do not repeat the law here, save to note that indirect discrimination is defined in section 19 of the EqA 2010 as follows:

> (1) A person (A) discriminates against another (B) if A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B's.
>
> (2) For the purposes of subsection (1), a provision, criterion or practice 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.
>
> (3) The relevant protected characteristics are—
>
> - …
> - race;

Victimisation is defined in section 27 of the EqA 2010 as follows:

> (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.
>
> (3) Giving false evidence or information, or making a false allegation, is not a protected act if the evidence or information is given, or the allegation is made, in bad faith.
>
> (4) This section applies only where the person subjected to a detriment is an individual.

(5) The reference to contravening this Act includes a reference to committing a breach of an equality clause or rule.

13. Mr Hare has also helpfully set out relevant provisions of the Medical Act 1983 and of the FTP Rules. He highlights that the statutory over-arching objective of the GMC is the protection of the public (section 1 of 1983 Act). The GMC does not have statutory duties towards doctors in that capacity.

14. Provided that a complaint or referral to the GMC is within the GMC's remit and that the Registrar does not consider it to be vexatious, it will be referred in the first instance to a medical and a lay case examiner for their consideration. The steps then available to them are set out in Rule 8(2) of the FTP Rules, as set out more fully in Mr Hare's written submissions.

Introduction

15. Dr Adams was dismissed from his employment as a Consultant in Emergency Medicine at Kettering General Hospital NHS Foundation Trust ("KGH") on 9 February 2012. He appealed against his dismissal but his appeal was not upheld. On 12 May 2012, the Medical Staffing Manager at KGH wrote to the GMC notifying it of Dr Adams' dismissal. They wrote,

> "In view of the serious allegations raised and the fact Dr Adams was dismiss-ed from his role at the Trust it was felt appropriate to refer this matter to the GMC for further consideration/investigation."

For convenience we shall refer to this email from KGH as the "Referral". Whether or not it was a referral as that (undefined) term is generally understood by the GMC, is not material in terms of our decision. Pursuant to section 35B(1)(b) of the Medical Act 1983, the GMC was required to notify the Referral to Dr Adams' new employer, North Lincolnshire and Goole Hospitals NHS Foundation Trust ("NLAG"), which it duly did on 12 September 2012. Dr Adams was made aware this would happen. NLAG subsequently provided certain information about Dr Adams which, together with the information already provided by KGH, was considered by the appointed case examiners, Professor Taylor and Mr Davis (the "Case Examiners"). Their decision was that the Referral should not proceed further. They did not, as Dr Adams asserts in his Amended Particulars of Claim, determine that the information that had been provided to the GMC by KGH and NLAG was vexatious. The Case Examiners' decision, as notified to Dr Adams and recorded on 'Siebel', the GMC's electronic storage system, was "to conclude the matter with no further action". There is an issue between the parties as to whether the case was concluded with or without advice being given to Dr Adams. In recording the reasons for their decision (which are set out in a document referred to as "Annex A" appended to the GMC's letter to Dr Adams dated 15 February 2013 – pages B312 and B313), the Case Examiners made certain observations to which Dr Adams objects and which he has unsuccessfully sought to have removed from his GMC record.

16. Dr Adams brought an Employment Tribunal claim against KGH in May 2012 complaining of unfair dismissal, race discrimination and victimisation. The claim was settled by agreement.

17. In the years following his dismissal from KGH, Dr Adams says that he experienced numerous setbacks in his career. We summarise them briefly as follows:-

    a. In 2012, he was interviewed for, but not appointed to, a Consultant post at the Pilgrim Hospital in Boston.

    b. In 2014, notwithstanding he was the only candidate for the role and had been working as a Locum Consultant at the Hospital for six months, he was unsuccessful in his application for a Consultant post at Lincoln County Hospital.

    c. In 2015, he was unsuccessful in his application for a Consultant post at Northwick Park Hospital, where he had trained as a Registrar.

    d. In the same year, he was unsuccessful following an interview at York Training Hospital for a Consultant post in Emergency Medicine, notwithstanding he says he had been encouraged by the Hospital's Clinical Director to apply for the role.

    e. In 2016, he was unsuccessful for a Consultant post at Hinchingbrooke Hospital despite being the sole candidate and having had a satisfactory appraisal just ten days earlier with the Deputy Medical Director of Lincoln County Hospital.

    f. In 2017, he was put forward for a Locum position at Peterborough Hospital but was unsuccessful and two months later received no response from the Hospital when he applied for a substantive post. We understand that Dr Adams had sued Peterborough Hospital in 2003.

    g. Later in 2017, he was put forward for a Locum position at Hinchingbrooke Hospital but claims that the Emergency Medicine Consultants at Peterborough Hospital, which is part of the same Trust, blocked his appointment.

    h. In January 2018, Kings Mill Hospital stopped booking Dr Adams for shifts, apparently without explanation.

    i. In April 2018, he received no response to his further application for a Consultant post in Emergency Medicine at Hinchingbrooke Hospital, notwithstanding he had worked there for two months as an Agency Locum Consultant, apparently without issue.

    j. Later in 2018, Dr Adams' CV did not attract interest from Consultants at the Lister Hospital in Hertfordshire, notwithstanding

the Hospital was said by his Agency to be short staffed and desperate to recruit.

k. He alleges that the following month his application for a 12 month fixed term post at Stoke Mandeville Hospital, with the potential to become substantive, was unexpectedly limited to 3 months with the possibility of only a further 3 month extension.

18. Dr Adams states that he became “curious” in late 2019 as to whether his professional record at the GMC had been shared with anyone, as a possible explanation for his difficulties in securing positions as a Consultant. However, on his own account, as he sets out in some detail in his witness statement and as also documented in a Judgment of Employment Judge Kurrein dated 10 April 2020, a number of the hospitals in question explained at the time why he had been unsuccessful in his application: none of them made reference to his GMC record or to having been provided with information about him from the GMC. Having first submitted a Data Subject Access Request to the GMC in September 2019, Dr Adams made further enquiries of the GMC on 20 November 2019, asking for information about who had accessed his ‘non-public personal data’ (page C7). The GMC treated his enquiry as an Article 15 GDPR Right of Access Request. Sadie Jones, an Information Access Officer with the GMC wrote to him on 2 December 2019,

> “I have looked at the information that we hold on record and have not been able to identify that we have disclosed your non-public personal data to a third party.” (page C8)

In order to assuage any concerns he might have had, Ms Jones provided Dr Adams with a copy of his online register profile so that he could see for himself the limited information that was publicly available about him.

19. Dr Adams states that he had previously made a number of Data Subject Access Requests in June and July 2018 to various Hospitals and NHS Trusts. It may reasonably be assumed that these had not yielded any evidence that non-public personal data of his held by the GMC had been disclosed to any current or prospective employer, save to NLAG in 2012 as detailed above.

20. Against that background, it is unclear to us on what basis Dr Adams might have remained curious, or suspicious, after December 2019 that the Respondent was, or might be, in the practice of making available his non-public personal data to third parties, specifically to prospective employers. The Respondent’s position in the matter, namely as communicated to Dr Adams by Ms Jones, has been reiterated throughout these proceedings, including in quite some detail in the GMC’s witness statements. Nevertheless, Dr Adams pursued the matter through to final hearing. In his closing submissions Mr Varnam acknowledged on behalf of Dr Adams, as we think he was bound to, that the evidence did not establish that the Respondent had disclosed the contents of Annex A (or, it seems to us, any other information about Dr Adams) to any prospective employer of his.

21. It thereby having been accepted that the PCP identified in paragraph 7.2.1 of the List of Issues had not been established, Dr Adams' claim of indirect discrimination proceeds with reference to a single claimed PCP, recorded in paragraph 7.2.2 of the List of Issues as being an alleged provision, criterion or practice of,

> "Failing to remove the advice and details of the Employer Referral from the accessible information on his Professional Record under Rule 12".

The reference to Rule 12 is to Rule 12 of the FTP Rules.

The List of Issues

22. On the third day of the final hearing, towards the end of Mr Keegan's evidence, an issue arose as to the ambit of the claim, namely whether the victimisation claim includes a complaint that the Case Examiners' decision to conclude the matter with no further action (or more accurately, the inclusion of certain comments within Annex A, including reiterating the GMC's guidance to doctors in paragraphs 46 and 47 of *Good Medical Practice*), was an alleged detrimental act within §.27(1) and 53(5)(c) of the EqA 2010. We had proceeded, and had stated a number of times in the course of the hearing without being corrected in the matter, that we were proceeding on the understanding that the two claimed detriments recorded in the List of Issues did not extend to the Case Examiners' decision itself (including the reasons for their decision), even if Dr Adams fundamentally disagreed with certain comments within their reasons. However, in the course of Mr Keegan's evidence, Mr Varnam clarified that the victimisation claim does extend to the contents of Annex A. He relies in that regard upon paragraphs 59 – 62 of the Amended Particulars of Claim, paragraph 19.1 of Employment Judge L Brown's Judgment of 2 February 2024 (following a Public Preliminary Hearing on 15 January 2024 to determine a jurisdiction issue) and a Skeleton Argument submitted at that hearing by previous Counsel instructed for the GMC, in which it had been contended on behalf of the GMC that 'any claim/action in relation to the content of Annex A crystallised in February 2013 when it was disclosed to the Claimant'. Mr Varnam says this confirms that the GMC understood the complaint to be about the content of Annex A and not simply what was done with it.

23. If Mr Hare had been labouring under the same understanding as the Tribunal, he did not actively resist Mr Varnam's submissions in closing, but instead sought to highlight that even if there is a complaint regarding the content of Annex A, the main focus of the claim has been on how Dr Adams' career prospects are alleged to have been damaged by the information in Annex A being disclosed to prospective employers. As we have observed already, that was undoubtedly the central plank of Dr Adam's claim until it was conceded in closing.

24. Regrettably, the List of Issues is not drafted as clearly as it might have been. It was originally filed as an agreed document for a case management preliminary hearing before Employment Judge Ord on 1 September 2023. The first of the two claimed detriments was stated to be:

> "That the Respondent published and retained prejudicial comments on the Claimant's Professional Record since 2013…"

This formulation reflects the wording of the Amended Particulars of Claim, seemingly drafted with legal input, in which the detriment is pleaded at paragraph 5.1 in the following terms:

> "Ongoing publication on the Claimant's professional record of that Advice, prejudicial comments and details of the employer referral in Annex A, which are accessible to prospective employers and regulators for 20 years." (page A31)

In that context and pleaded in those terms, we understood the detriment in the List of Issues to relate to the alleged *ongoing* availability to the public of the details of the Referral, including as set out in Annex A. We remain of the view that this is the ordinary and natural meaning of paragraph 5.1 of the Amended Particulars of Claim. Our understanding in this regard is reinforced, or at least compounded by the List of Issues having been structured with reference to two rather than three claimed detriments.

25. In the course of her judgment on the jurisdiction issue, Employment Judge L Brown had referred to three detriments, namely:-

    a. the creation of Annex A;

    b. its maintenance as a record; and

    c. the GMC's refusal to amend it on 6 September 2022.

    Unfortunately, the List of Issues was not updated to reflect this clarification or formulation.

26. Be that as it may, and notwithstanding as we shall return to, the List of Issues has bedevilled the proceedings in other ways, the claims are ultimately to be found in the Amended Particulars of Claim rather than in the List of Issues. Notwithstanding the pleading in paragraph 5.1 of the Amended Particulars of Claim, the amendment did not remove what were originally paragraphs 34 – 37 of the Particulars of Claim (now paragraphs 59 to 62 of the Amended Particulars of Claim). Although the detriments are pleaded more narrowly in paragraph 5.1 of the Amended Particulars of Claim, and putting aside for a moment that the Case Examiners' alleged victimisation of Dr Adams is seemingly not addressed in his witness statement, we are satisfied by reason of paragraphs 59 to 62 of the Amended Particulars of Claim that there is an extant complaint in respect of the content of Annex A and accordingly that the victimisation claim is not limited to what was done with the information in Annex A after it had been created and communicated to Dr Adams on 15 February 2013.

27. We shall deal with the victimisation complaints first, before going on to consider Dr Adams' claim that he was indirectly discriminated against .

Victimisation – s.27 of the Equality Act 2010

28. The Respondent accepts that Dr Adams did the two protected acts relied upon by him, namely in 2011 he made complaints to KGH of race discrimination and victimisation (as well as being party to a collective grievance) and in May 2012 he presented a claim to the Employment Tribunals complaining amongst other things that KGH had racially discriminated against him and victimised him.

29. Whilst we do not recall being taken to evidence that the Case Examiners were aware before they made their decision (and provided their reasons for their decision) that Dr Adams had done the second protected act – the only potential evidence in that regard to our knowledge being a later telephone record from 1 March 2003 when Dr Chilton of KGH had contacted Ms Uppal of the GMC to say that they were "going to Tribunal soon about Dr Adams unfair dismissal claim against them" – Mr Hare has conceded on behalf of the GMC that the Case Examiners were aware of both protected acts at the time they made their decision, a concession we obviously do not go behind.

30. We shall deal with the detriments on the basis of how they were formulated by Employment Judge L Brown.

31. On the basis that a "detriment" means "putting under a disadvantage" and, in the employment context, that a detriment will exist "if a reasonable worker would or might take the view that the action of the employer was in all the circumstances to his detriment" (<u>Ministry of Defence v Jeremiah</u> [1980] ICR 13 per Brandon LJ and Bright LJ respectively), we are inclined to the view that the first of the three detriments could arguably be regarded as being to a registered practitioner's detriment. Whilst Dr Adam's was plainly not disadvantaged in so far as any concerns notified by KGH or NLAG were concluded with no further action, in our judgement a practitioner might consider that being reminded of their professional obligations in the context of a complaint or referral is to their detriment, regardless of whether or not such reminder, or 'reiteration', is issued as advice within the fitness to practise process. We have come to this view notwithstanding, as we shall return to, the GMC itself does not regard advice, let alone a reminder, as an admonition. The issue is not clear cut, since most, if not all, professionals, including the judiciary, are subject to professional review and continuing professional development, including regular reminders of the standards of professional conduct expected of them. However, as we shall come to in a moment, Mr Keegan told the Tribunal that he understood why Dr Adams perceives Annex A to include findings of fact. In which case, we think a reasonable practitioner might equally perceive Annex A in that way and accordingly might regard it as being to their detriment in circumstances where the provisions of *Good Medical Practice* are being reiterated in the context of an investigation rather than, for example in the more neutral setting of a training event or as part of a routine communication to practitioners.

32. By contrast, and as we shall explore further in the context of the claim of indirect discrimination, we do not consider that Dr Adams was put at a disadvantage because Annex A was maintained as a record or because the GMC refused to amend it in 2022 at his request. In our judgement, even though they might disagree with the case examiners' reasoning in their case, a reasonable practitioner would accept both that it is appropriate, indeed necessary, for the GMC to maintain complete and accurate records of case examiners' decisions, and that they are not disadvantaged by being denied the ability to require changes to be made to the case examiners' reasons at a later date in circumstances where they were afforded an opportunity to make representations at the time, but failed to avail themselves of that opportunity.

33. In case we are wrong, we have gone on to consider whether Dr Adams was subjected to the claimed detriments because he did the protected acts. We shall address the detriments in turn.

<u>Annex A</u>

34. Mr Varnam submits that there is sufficient evidence to shift the burden to the Respondent pursuant to s.136 of EqA 2010. In paragraph 20 of his written submissions he identifies three specific matters that he says support an adverse inference, namely:

    34.1. Comments of the Case Examiners which suggest they made findings of fact, notwithstanding this was not within their remit;

    34.2. The unusual wording of Annex A; and

    34.3. The GMC's failure to call the Case Examiners to give evidence and indeed to identify them by name.

35. As Dr Adams seeks to rely upon the contents of Annex A to support the requisite inference, we must necessarily address the offending passages in this judgment even though this may result in information that hitherto has not been publicly available now being placed in the public domain. However, given Dr Adams' concerns in the matter, we have decided against setting out the offending passages in full: for the avoidance of doubt, they are the seventh, eighth, eleventh, twelfth and thirteenth paragraphs of Annex A.

36. We do not agree that the Case Examiners made findings of fact, even if that is how their comments are perceived by Dr Adams and notwithstanding Mr Keegan understood why he perceives them in that way. In the first of the five paragraphs objected to, the Case Examiners summarised certain alleged behaviours that had been identified by KGH within an investigation report: the Case Examiners' observations in the matter are expressed in terms that Dr Adams was "seemingly" unaware of how his behaviour could be perceived by others. In the second of the five paragraphs objected to the Case Examiners again used the word "seems" to indicate their understanding as to the reasons given by KGH for

dismissing Dr Adams. In our judgement, in neither paragraph do they offer a view as to whether the allegations were well founded. In the third of the five paragraphs objected to the Case Examiners state, "the repetition of very similar problems in his current employment following his recent dismissal suggests he has not taken steps to address the criticisms of his behaviour and that there has been no mitigation or insight." In the overall context, we read "suggests" as "could indicate". We agree with Mr Hare that the word "suggests" extends to the Case Examiners' further comments about there being no mitigation or insight. In the fourth of the five paragraphs objected to the Case Examiners refer twice to it being "said" in relation to Dr Adams, namely they are recording what was reported in relation to him rather than expressing their own personal views or conclusions in the matter. Finally, in the last of the five paragraphs objected to they again use the expression "suggests" in the context of potential concerns. They go on to refer to the "possibility" (but in our judgement, no more than the possibility) that Dr Adams had failed to recognise the impact of his actions and alter his behaviour. In our judgement it was on the basis of that *possibility* that the guidance in paragraphs 46 and 47 of *Good Medical Practice* was reiterated to Dr Adams.

37. Mr Keegan is an experienced Senior Case Examiner. His unchallenged evidence is that he has completed approximately 4,000 decisions since 2011. He explained in detail why he does not read the decision in the way that is contended for by Dr Adams. We are confident in his explanation and why he says other case examiners would not construe the Case Examiners' decision as involving findings of fact. We are satisfied that it is clearly understood by case examiners that theirs is not a fact finding role, something that is instead reserved to the Medical Practitioners Tribunal on referral from the Investigation Committee. The GMC's 2016 guidance for decision makers on giving written advice at the end of fitness to practise investigations is explicit:

> "Advice should provide guidance for future practice and is not an admonition in relation to past actions."

38. Mr Keegan acknowledged that he might not have expressed himself in the matter quite as the Case Examiners did, but case examiners inevitably have their own particular style and turns of expression. Moreover, as Mr Keegan pointed out, he was being asked to comment upon a decision from nearly ten years ago: over the intervening years practices have continued to evolve within the Directorate and revised templates are in place to document decisions by case examiners.

39. Mr Varnam submits that the wording of Annex A is unusual. Although we were not provided with other decisions for comparison purposes, the wording does not obviously strike us as unusual. We refer again to our comments in paragraph 36 above.

40. Annex A makes no reference to Dr Adams' protected acts or to him raising concerns more generally with KGH or NLAG. Accordingly, there is no indication on the face of Annex A that the Case Examiners even had those

facts in mind when they reached their decision and drafted their reasons, even if information pertaining to the protected acts may have been contained within the 273 pages of documents submitted by KGH.

41. We did not, of course, hear from the Case Examiners, both of whom have since retired. In that sense they are unavailable. But in any event it is difficult to see what additional evidence they might have provided in the matter over and above that which has been gleaned from the case file on Siebel, particularly given that eleven or more years have passed since they made their decision in a case which, although of great importance to Dr Adams, has no obvious distinguishing features to it. Whilst the Case Examiners might of course have been asked about their understanding of and commitment to ED&I, it is not an issue in respect of which any of the Respondent's witnesses were challenged. In any event, we agree with Mr Hare, having regard to Lord Leggatt's comments in Efobi v Royal Mail Group Limited [2021] UK SC33, that the significance of the Case Examiners' evidence has to be seen in the overall context of the case as a whole, particularly before Dr Adams withdrew the central plank of his claim. Dr Adams has provisionally assessed the value of his claim, excluding stigma damages, at just under £1.7 million. His claim for compensation is pursued in very large part with reference to losses he attributes to the contents of Annex A having been made available to prospective employers, something he now accepts cannot be established. His claim in that respect is no longer pursued and with it much of the value of his claim has fallen away. In our judgement it is entirely understandable that the GMC has focused its attention and resources on that aspect of his claim, not least in circumstances where Dr Adams' pleaded case in relation to the Case Examiners is expressed in terms that they "might" have victimised him and it was "possible" they were seeking to deter him from making further complaints (see paragraphs 61 and 62 respectively of the Amended Particulars of Claim). In his April 2020 Judgment, Employment Judge Kurrein said that many of the claims then being pursued by Adams were "based on nothing more than mere assertion". Whilst we might not express the matter in the same terms, the pleading is certainly not indicative of a claimant who is confident in his assertion that he has been victimised.

42. We should add that there is no evidence to suggest that the GMC withheld the Case Examiners' names other than in accordance with its normal practices around the processing of personal data. Certainly, we were not referred to any correspondence in which Dr Adams had requested the names or personal characteristics of the Case Examiners. We attach no significance to the fact their names only emerged in the course of cross examination.

43. We have noted already that Dr Adams does not set out in his witness statement why he believes the Case Examiners victimised him. Mr Varnam rightly points out that witness statements are for matters of evidence rather than a platform for submissions. Nevertheless, given that Dr Adams identifies certain alleged "victimising" acts by third parties in his

witness statement and indeed advances various submissions and arguments, it is not entirely beside the point that he does not expand upon or indeed even repeat his pleaded case in his witness statement.

44. In our judgement there would need to be something more in order for us to conclude that there are facts from which we could conclude, in the absence of an adequate explanation, that the 'advice' and disputed comments in Annex A were because Dr Adams did protected acts, not least in circumstances where those protected acts were directed not at the GMC but at a third party and where the GMC's overarching objective is the protection of the public. Mr Keegan has drawn the Tribunal's attention to paragraphs 7, 9 and 10 of *Good Medical Practice* in which the GMC actively encourages doctors to raise concerns. Indeed, paragraph 7 of *Good Medical Practice* states that all doctors have a duty to raise concerns where they believe that patient safety or care is being compromised. Given that duty, the GMC's statutory overarching remit already referred to, and its robust approach to ED&I, Dr Adams has offered no explanation or theory as to why the Case Examiners may both have taken against him or at least reacted at some subconscious level to the fact that he had done protected acts within his workplace. Dr Adams has not challenged Ms Light's evidence regarding the GMC's approach to ED&I. Nor did he challenge Ms Farrell, Ms Brucato and Mr Keegan's evidence regarding their extensive training and awareness in the matter. There is an abundance of evidence that the GMC takes its responsibilities particularly seriously and has done for many years, which begs the question why, within such a culture and environment two Case Examiners nevertheless victimised Dr Adams.

45. It is also relevant, we think, that Dr Adams has not satisfactorily explained why he came to believe that he had been victimised by the Case Examiners. All relevant facts were before him in 2013 when he received the Case Examiners' decision. He suggests that he was influenced by comments made by Employment Judge Kurrein at a hearing in January 2020 following which his 2018 claim against KGH, NLAG and Lincoln County Hospital was struck out as having no reasonable prospect of success. The Judge apparently noted that the 2013 decision was "not an exoneration by the GMC". Firstly, that much was apparent at the time on the face of the Case Examiners' decision, the Case Examiners having specifically stated that their task was simply to decide whether the evidence demonstrated a realistic prospect of establishing that Dr Adams' fitness to practise was sufficiently impaired to justify action on registration. Dr Adams is an articulate, highly intelligent individual and we think it unlikely that he would have read Annex A in 2013 as an exoneration. In any event, if he is saying that he believed at the time that he had been exonerated, that sits uneasily with his various contentions in these proceedings that the Case Examiners' comments in Annex A portray him in a bad light. If he thinks their comments portray him in a bad light he must have thought the same in 2013. We are unpersuaded by his explanation that a single alleged comment by Employment Judge Kurrein in January 2020 led to a fundamental reappraisal by him of the Case

Examiners' decision and comments. Indeed, we note in this regard that when Dr Adams wrote to the GMC two years later on 24 January 2022 (page C10) to request that his record be amended, he made no reference to the Case Examiners' comments now objected to or that he had come to understand that the 2013 decision was not an exoneration. Instead, he was seeking to have KGH and NLAG's allegations expunged from his record. That does not reflect the case he now pursues within these proceedings. If, as he claims, Employment Judge Kurrein's alleged comment in January 2020 generated concerns in his mind that he had been victimised by the Case Examiners, he did not give expression to those concerns on 24 January 2022. His focus only seems to have begun to shift to the Case Examiners in summer 2022, when of course he had reached the end of the road in relation to KGH and NLAG by virtue of his claim against them having been struck out.

46. Dr Adams wrote to the GMC on 5 August 2022 to say that he was trying to better understand their decision making procedures. Even then, he said that his interest in the matter was "an academic one", as professional registration was his dissertation topic for his LLM (page C20). Subsequently, on 2 September 2022 he wrote,

> "… because of the information that I have provided, it is for the GMC to put on record just reasons for the decision to close the case and amend its comments on my conduct and attitude."

Having therefore had over two and a half years in which to reflect on Employment Judge Kurrein's alleged comment, there is still no suggestion there that the Case Examiners had victimised him, including by seeking to deter him from raising further concerns. Instead, Dr Adams was asking for the reasons for the Case Examiners' decision to be revisited in light of the extensive information he was then putting forward about his case some nine years after he had first been afforded, but had failed to take up, an opportunity to comment on concerns that had been expressed by KGH and NLAG.

47. For all these reasons, we consider there is no proper basis for us to infer that the Case Examiners' decision or their reasons for it, including their 'reiteration' of paragraphs 46 and 47 of *Good Medical Practice* was because Dr Adams had done protected acts. His claim that he was victimised in that regard is not well founded.

The maintenance of the decision in Annex A on Siebel

48. In paragraph 22 of his written submissions, Mr Varnam concedes that if there is no victimisation claim in respect of the content of Annex A, the claim in respect of its publication / retention on Siebel is unlikely to succeed. In his oral submissions he accepted that this would also be the case if the Tribunal were to conclude (as indeed it has done) that there was such a claim but the claim was not well founded.

49. The publication and retention on Siebel of the 2013 decision was plainly not because Dr Adams did protected acts in 2011 and 2012, it was simply an administrative act on the part of the GMC in accordance with its comprehensive Records Retention and Disposal Policy that cases such as Dr Adams', which are concluded with no further action because the relevant threshold test has not been met, are retained for 20 years from 'closure', after which only a summary record is kept (page G221). The second victimisation complaint is not well founded.

The GMC's refusal on 6 September 2022 to amend Annex A

50. Dr Adams' third victimisation complaint is also not well founded. The detriment is pleaded in paragraph 5.2 of the Amended Particulars of Claim as "a continuing failure to remove the Advice and prejudicial information in Annex A following a Rule 12 application by Dr Adams in 2022".

51. In his written submissions Mr Varnam acknowledges that if the Tribunal concludes (as it does) that there was a PCP of not removing material from Case Examiners' decisions, then it is likely that the non-amendment of Annex A was as a result of the implementation of that PCP rather than a response to Dr Adams' protected acts.

52. Notwithstanding that concession, for the avoidance of doubt, in our judgement there are no facts from which we might infer that the decision not to amend Annex A was because Dr Adams had done protected acts. There are potentially two elements to the complaint, namely how his request was dealt with respectively by the Rule 12 Team and the Information Policy Team. When Dr Adams initially made his request to the GMC he did so without specific reference to Rule 12 of the FTP Rules. It was only following further correspondence with the GMC in the course of which the GMC stated that his request was being treated as a rectification request pursuant to Article 16 of the GDPR, that Dr Adams wrote,

> "For the avoidance of doubt my request was made subject to Rule 12 of the GMC's Fitness to Practice Rules and it is my expectation under paragraph (6), to receive a letter with a decision and the reasons for that decision." (page C30)

53. There is a clear, indeed obvious, explanation for why Annex A was not amended by the GMC pursuant to Rule 12, namely Rule 12 confers no such power of amendment upon the Registrar. The circumstances in which a decision, as distinct from the reasons underlying it, may be reviewed are set out in Rule 12(1)(a) to (d). Sub-paragraphs (a), (c) and (d) are not relevant for these purposes. As regards sub-paragraph (b), which enables the Registrar to review a decision not to refer an allegation to the Investigation Committee or to the MPTS for consideration by the Medical Practitioners Tribunal, Dr Adams confirmed in writing on 2 September 2022 (page C28) that he agreed the case should have been closed. Whilst that is effectively determinative of his complaint, we would add that there is no power under Rule 12(1)(b) for the Registrar to review case examiners' reasons for their decision independently of the decision

itself. It seems to us that the Registrar would have been acting outside the powers conferred upon them by the FTP Rules had they purported to review the Case Examiners' reasoning alone or altered the record of their decision.

54. As regards Ms Brucato, Mr Varnam submits that she failed to engage with the substance of Dr Adams' request. In so far as he seeks to criticise Ms Brucato for being inflexible or process driven in her approach, what emerged very clearly from her evidence at Tribunal is that she genuinely believes she cannot alter case examiners' decisions unless perhaps directed to do so by the GMC's Data Protection Officer, the Information Commissioner or a Court. Indeed, her understanding as to the limits of her authority extended to being unable to correct the name of a hospital or a doctor where these details have been recorded incorrectly by case examiners. Whilst we do not think that necessarily accords with Article 16 of the GDPR, it has no bearing upon the issues in this case since we are satisfied that the GMC's processing of his data in the particular circumstances here was in accordance with Article 6(1)(e) of the GDPR and consistent also with guidance issued by the ICO in respect of the documenting of opinions, including mistaken opinions (pages G231 to G244).

55. We find that the fact Dr Adams had done protected acts ten or eleven years earlier simply never entered Ms Brucato's mind, who instead diligently adhered to what she genuinely understood to be the need to preserve a complete and accurate record of the Case Examiners' decision in relation to Dr Adams.

Indirect Discrimination – s.19 of the Equality Act 2010

56. We return then to Dr Adams' complaint that he was indirectly discriminated against by reason of the claimed PCP of,

> "Failing to remove the advice and details of the Employer Referral from the accessible information on his Professional Record under Rule 12."

57. We have referred already to the difficulties that have arisen because of how the List of Issues has been drafted. These difficulties extend to the complaint of indirect discrimination.

<u>The claimed PCP</u>

58. As recorded in the List of Issues, the PCP reads in terms that the provisions of Rule 12 of the FTP Rules mean that information is not removed from case examiners' decisions. If so, for the reasons just set out, that is indeed the effect of Rule 12(1). But if that were to be the PCP relied upon, it seems to us the GMC would be able to justify its practice on the grounds that it is required to operate within the ambit of Rules that have been approved by Order of the Privy Council. Mr Varnam advocates a simpler construction, namely a practice of not removing any material from case examiners' decisions. Whilst we cannot re-write the PCP, we

are not required to construe its meaning in an overly mechanistic, literal or limiting way, particularly if this flies in the face of what was clearly intended by Dr Adams and we think reasonably understood by the Respondent.

59. In our judgement the words, "under Rule 12" add nothing to the PCP, rather they were simply intended to signify that Dr Adams had (incorrectly, as it transpires) originally identified to the GMC that his request for rectification was made pursuant to Rule 12 of the FTP Rules. What of the formulation of the PCP by reference to the "accessible information" on Dr Adams' record? We do not construe this as being limited to information held in relation to Dr Adams that is publicly accessible on the medical register, but instead that it extends to information held on Siebel that is capable of being accessed by authorised individuals at the GMC or, in certain circumstances, that might be made available to third parties even if it is not generally available to the public.

60. So construed and understood, and as identified by Mr Varnam, the PCP is plainly established, since Ms Brucato and Mr Keegan essentially accepted that it is the GMC's practice not to edit case examiners' decisions or to remove the information contained in their decisions from Siebel. Ms Brucato denied the existence of any rigid policy in this regard but accepted that it was certainly the practice within the Information Policy Team not to amend case examiners' decisions, even if she could not speak to any wider practice within the GMC. At paragraph 32 of her witness statement for example, she refers to the decision not to rectify the Case Examiners' decision as being the only one reasonably available to her. At paragraph 33 of her witness statement she states that to date she had never made a decision to amend a case examiners' decision. Her evidence in this regard was reinforced by Mr Keegan who went on to explain why certain practical considerations render it difficult to amend decisions, as opposed to issuing updated versions of them or noting obvious factual errors, and recording doctors' objections on Siebel.

<u>Disadvantage</u>

61. Once again, the List of Issues has thrown up difficulties in this regard.

62. The pleaded position at paragraph 8.3 of the Amended Particulars of Claim is that the PCP "put the Claimant under a particular disadvantage as more BAME Doctors are likely to get into a dispute about race discrimination culminating in the Respondent's involvement by way of an employer referral". However, whilst this identifies that BME doctors are disadvantaged in so far as they are the subject of a disproportionate number of complaints and referrals to the GMC (something over which the GMC ultimately has no control), that disadvantage results from the actions of those who make complaints and referrals to the GMC rather than any practices on the part of the GMC. The pleading does not obviously identify the particular disadvantage that is said to result from the practice of not amending case examiners' decisions. At paragraph 79.5 of the Amended Particulars of Claim, reference is made to Dr Adams having been disadvantaged and continuing to be disadvantaged in obtaining future employment by the comments made by

the GMC on his professional record. Whilst that clearly relates to the Case Examiners' decision, it is in the context of a pleaded PCP of "issuing Advice following a workplace dispute about alleged discrimination and victimisation", a PCP which has not been advanced before us and is not reflected in the List of Issues.

63. The claimed disadvantage caused by the PCP relied upon is recorded within the List of Issues as follows:

> "7.3.1 puts BME Doctors at a disadvantage in the circumstances; and
>
> 7.3.2 that the Claimant has suffered that disadvantage and continuing disadvantage to his prospects of obtaining future employment by the comments made by the Respondent on his Professional Record and that the comments on the Claimant's record which are alleged to be based on untested, inaccurate and misleading information."

64. As drafted, paragraph 7.3.1 of the List of Issues fails to identify the group disadvantage, so that we can only infer that it is the disadvantage described in paragraph 7.3.2 in relation to Dr Adams himself, namely that BME doctors' future employment prospects are harmed by unsubstantiated comments being held by the GMC on its records in relation to them. In which case, as formulated, Dr Adams' indirect discrimination claim would be bound to fail given Dr Adams' acceptance by the close of the hearing that the evidence does not establish that the GMC disclosed (or, in our judgement, would disclose) the contents of Annex A to any prospective employer of his or that its practice is to disclose closure decisions to prospective employers of doctors on the register.

65. However, Mr Varnam sought to advance the claim in a different way in closing. In his closing written submissions, he states that so long as the comments in Case Examiners' decisions remain on a doctor's GMC record, those comments may be taken into account if the doctor is subject to a further complaint to the GMC. He develops this further in paragraphs 7(2) and (3) of his written submissions, in which he notes that BME doctors are more likely to be subject to complaints to the GMC, and are more likely, if complained about, to be referred to what is known as 'stream 1'. As such, he submits, if adverse material remains on their record, they are at greater risk of that being taken into account against them.

66. Mr Varnam initially suggested that this claimed disadvantage could somehow be read into paragraph 7.3 of the List of Issues. Even on the most generous reading of the List of Issues, we cannot agree. We invited Mr Varnam to identify where within the Amended Particulars of Claim Dr Adams had referred to being disadvantaged in the event of any further complaint to the GMC. He was unable to pinpoint anything in the Amended Particulars of Claim. We have since gone back through the Amended Particulars of Claim to see whether these might reveal anything further of assistance. Aside from paragraph 8.3 of the Amended Particulars of Claim, which we have addressed above, the only other

potential references to Dr Adams having been disadvantaged are at paragraphs 5.1 and 59 of the Amended Particulars of Claim, in which reference is made to Annex A remaining accessible to regulators as well as to potential employers.

67. We have re-read Dr Adams' witness statement in case this might shed some further light on the matter. It is clear from paragraph 59 of his witness statement that his concern is not that the GMC might revisit his record in the event of further complaints, rather that other regulators would have access to the information held by the GMC. He states that when he wrote to the GMC on 24 January 2022,

> "I was particularly concerned about the untrue and prejudicial comments that the Medical Director of KGH had sent to the GMC, which, together with the comments in Annex A would portray me in a bad light to external bodies, such as the GMDC, the HCPC with regards a career in psychology."

His references to the GMDC and HCPC are respectively to the Grenada Medical and Dental Council and the UK Health and Care Professionals Council.

68. Dr Adams goes on to say that his concerns in this regard derive from the GMC's Publication and Disclosure Policy in respect of Fitness to Practise. He refers to pages G200 and G18 of the Hearing Bundle. Page G18 sets out Rule 11 of the FTP Rules Page, regarding warnings and has no bearing on his situation as he was not issued with a warning. Page G200 likewise has no bearing upon his situation as it concerns those cases where information originally included on the medical register as a result of action having been taken on a complaint has been removed from the medical register at a later date but may nevertheless still be made available to a third party, including an overseas medical regulator. The relevant Policy does not apply to Dr Adams' situation since the decision in 2013 to conclude the case without further action was never placed on the medical register, so would not be made available to a third party, including an overseas regulator, in the circumstances described in the Policy.

69. During the hearing Dr Adams drew our attention to the section at page G201 of the Hearing Bundle headed,

> "What information do we disclose while we are considering concerns about a Doctor?"

It provides as follows:

> "The fact that a doctor is the subject of an investigation will not be routinely disclosed to general enquirers (apart from current or new employers / responsible Officers or the media) unless and until a warning is issued, undertakings are agreed or a hearing takes place. The exception to this is where it is necessary for the MPTS to impose an Interim Order to restrict the Doctor's practice as a precautionary measure."

He also referred to an email he had received from Lucy Myatt in the Information Policy Team on 25 October 2019 in which she had referred to disclosures to organisations responsible for healthcare provision and regulation (page D142). However, Ms Myatt had gone on to refer him to the Publication and Disclosure Policy which does not suggest that his situation was one in which a disclosure would be made to another regulator.

70. In any event, there is no evidence that any other regulator was informed in 2013 or has been informed since then that Dr Adams was the subject of an investigation. Certainly, there were no warnings, undertakings or hearing decisions that affected Dr Adams' registration or practise to warrant disclosure; and the MPTS did not impose an Interim Order (and it was never suggested it should do so). The case was simply closed with no further action. Accordingly, having regard to the documented Policy above, no details in relation to Dr Adams would obviously have been disclosed to the GMDC, the HCPC or any other regulator. That is also true of BME doctors more generally whose cases have been concluded with no further action being taken. Even putting aside that this potential aspect of Dr Adams' case was not put to the GMC's witnesses, comprises no more than a bare assertion in his witness statement and was not addressed in closing, in our judgement, there is nothing to support the claimed disadvantage. We have no evidence that investigations which are closed with no further action are routinely, or even occasionally disclosed to other regulators, including overseas regulators or that this impacts BME doctors or other groups disproportionately.

71. In approaching the question of disadvantage, we have been mindful that the Grounds of Response do not identify the legitimate aims relied upon by the GMC as justifying the PCPs contended for by Dr Adams, nor do they set out why the PCPs were a proportionate means of achieving those aims. Instead, these matters have been addressed by Ms Farrell at paragraph 89 onwards of her witness statement, For that reason and in the interests of ensuring the parties are on an equal footing, we have dealt with the claim in Dr Adams' witness statement that he was disadvantaged in terms of information being potentially available to other regulators. We do not consider that fairness or justice require we should afford Dr Adams the same latitude in respect of Mr Varnam's closing submission that the relevant disadvantage is instead that comments in Case Examiners' decisions may be taken into account if a doctor is subject to a further complaint to the GMC. We consider that the GMC would experience significant unfairness and injustice if we were to permit the claim to be altered in this material way in closing without an application to amend having been made and without either party having addressed the matter in evidence, including with statistical evidence if appropriate regarding the numbers and protected characteristics of practitioners who are subject of more than one investigation and the outcomes by group.

72. In any event, even had the claimed disadvantage been advanced in the terms suggested in Mr Varnam's closing submissions, it seems to us

unlikely that the relevant disadvantage would have been established. Firstly, on the issue of whether Dr Adams was put at a particular disadvantage, save that KGH unsuccessfully sought to have the case reviewed in 2013 under Rule 12 of the FTP Rules, no further complaints or referrals were made to the GMC about Dr Adams such that the Case Examiners' 2013 decision was taken into account at a later date in relation to him. Secondly, as we have noted already, case examiners' decisions do not involve findings of fact that disadvantage a doctor in the event of a later complaint or referral. In any event, doctors are always afforded the right to make representations in any investigation: this affords them an opportunity to remind the case examiners in any later investigation, should such reminder be warranted, that any previous advice or observations by case examiners do not amount to findings of fact. In our judgement, if there could be said to be any particular disadvantage, it would flow from the fact that case examiners may have access to the details of previous complaints and referrals, and be influenced by this information rather than the case examiners' decision on them. Dr Adams may have originally wanted the information supplied by KGH and NLAG to be expunged from his records, but he now accepts that this information has legitimately been retained by the GMC. As he wrote to Ms Brucato on 2 September 2022:

> "[I] do not seek to change the fact that my employer chose to complain about me to the GMC."

73. For all these reasons, Dr Adams' remaining complaint that he was indirectly discriminated against is not well founded.

<u>Justification</u>

74. In view of the potential importance of this issue to the GMC given the significant volume of historic decisions held by it, we have gone on to consider whether in the event the disadvantages referred to by Dr Adams in paragraph 59 of his witness statement and additionally contended for by Mr Varnam in paragraph 7 of his written submissions were to have been established, the GMC would be able to justify the PCP.

A. The aims relied upon

75. The legitimate aims relied upon by the GMC as justifying its practice of retaining written closure decisions are as follows:-

    75.1. To identify a potential pattern of conduct;

    75.2. To review closure decisions (where appropriate) under Rule 12 as a result of new information;

    75.3. To co-operate with public enquiries, inquests and law enforcement agencies;

    75.4. To enable the GMC to consider and respond appropriately to any legal challenges it receives; and

75.5. To undertake audits into its decision making.

76. Although Dr Adams accepts, in accordance with the principles in Akerman-Livingstone v Aster Communities Ltd [2015] AC 1399, that these are aims of substantial importance and that there is a connection between them and the disadvantage suffered, he contends that lesser steps than a practice of total non-deletion could have achieved the aims satisfactorily, namely that the GMC could instead have pursued a practice of redacting non-essential elements of case examiners' reasons including in this particular case those elements of Annex A which amount to the apparent drawing of conclusions and the giving of advice, whether or not recorded as such. Whilst we acknowledge the way in which Mr Varnam developed this point in the course of his oral submissions, particularly in response to the Tribunal's various questions, we consider that the suggested approach is impractical and would not achieve the relevant aims satisfactorily. Firstly, it begs the question who would be the arbiter as to which elements of the reasons are essential to the decision, something that is brought into sharp relief in a case such as this where the rectification request has been made some nine years or so after the event and the Case Examiners in question have retired. In any event, as with this Tribunal's reasons, separating out the essential from the non-essential would be a difficult, indeed largely subjective exercise wide open to interpretation.

77. Turning then to whether the GMC's practice was necessary in pursuit of the five identified aims, Mr Hare reminds us of Maurice Kay LJ's observations in Cadman v Health and Safety Executive [2004] IRLR 971, at [31]:

> "The test does not require the employer to establish that the measure complained of was "necessary" in the sense of being the only course open to him. … The difference between "necessary" and "reasonably necessary" is a significant one …"

78. We shall examine the stated aims in turn.

79. Whilst we think that patterns of conduct are more likely to be indicated by the complaints and referrals themselves, the case examiners' decisions provide a helpful precis of the allegations and the information provided in support of them. However drafted or expressed, and regardless of whether the doctor in question might regard it as a fair and complete summary of the alleged concerns that have arisen, there has to be some starting point for case examiners dealing with any further complaints when they are giving consideration to whether a pattern of conduct is potentially indicated. Previous decisions by case examiners provide the obvious starting point in that regard.

80. If, as Dr Adams contends, the Case Examiners gave advice in 2013 by reiterating paragraphs 46 and 47 of *Good Medical Practice* to him, even if their decision was not recorded on Siebel as having involved the giving of advice, it seems to us essential that the GMC should retain a complete record of the reasons why such 'advice' was given. Without such record

the Rule 12 Team would potentially not have all relevant information before it when deciding whether to review a previous closure decision on new information becoming available to it.

81. We can immediately see why the work of public enquiries, inquests and law enforcement agencies could be undermined or at least the GMC's ability to co-operate with them could be undermined, if it was unable to provide a complete picture, which in our judgement would include the reasons why particular advice was given or the provisions of *Good Medical Practice* reiterated, since the giving of 'advice' (understood in its widest sense) and, if relevant a doctor's failure to act upon or their departure from that 'advice' could well inform that other agency's work and conclusions.

82. If a complete record of case examiners' decisions is not kept, the GMC would potentially be significantly disadvantaged in responding appropriately to legal challenges. This case illustrates the point only too clearly. If only a redacted copy of the Case Examiners' decision had been retained, there would be no explanation for why paragraphs 46 and 47 of *Good Medical Practice* were reiterated to Dr Adams. In our judgement, the GMC would immediately have been on the backfoot in terms of rebutting Dr Adams' claim that the Case Examiners' victimised him. The absence of any explanation for detrimental treatment is commonly a situation in which a Tribunal may draw an adverse inference. As this case illustrates, if the GMC was required to rely upon case examiners to supply the necessary explanation for their decisions, those case examiners would lack critical information to help refresh their memories. We think we would be in the same impossible position if we were asked to explain our judgment eleven years hence without these reasons being available to us and with only the Hearing Bundle available to prompt our recollection. It is not lost on us that Dr Adams relies upon the very passages which he contends should have been redacted in support of his claim that he was victimised by the Case Examiners. Annex A was closely scrutinised during the hearing. The fact that the complete reasons were available to the GMC, and indeed to Dr Adams and the Tribunal, has enabled the GMC to address the inference sought to be drawn by Dr Adams.

83. Finally, the availability of complete records of the reasons for decisions supports effective auditing of the GMC's activities, including the decisions of its Fitness to Practise Directorate. As the Plymouth Review evidences, Plymouth University was able to audit the GMC's practices precisely because complete records were retained. This enabled it to conclude,

> "No evidence of bias or discriminatory practices was identified, either in the GMC's guidance and criteria documentation for decision-makers, or the sampled case files."

It went on to say,

> "The decisions reached in the reviewed case files were found to be in line with the guidance and criteria set out for decision-makers. The review identified a few specific instances which raised further questions: these were

> not about outcomes but about the reasoning behind decisions and the clarity with which they had been expressed and recorded."

These and other observations by Plymouth University ultimately led to revisions in 2015 to the GMC's operational guidance on decisions to case examiners and specific advice in 2016 on giving written advice at the end of fitness to practise investigations. In our judgement, this important review, as well as the changes that resulted from it, might not have happened without data being available to inform the review and support its conclusions.

84. Given that BME doctors, amongst others, are subject to a disproportionately higher volume of complaints and referrals than other doctors, the availability of complete data has supported a change in guidance which we accept is intended to address the difficulties and potential prejudices experienced by BME Doctors within their Practices and workplaces. Whilst the GMC cannot prevent complaints and referrals being made to it, the work done by Plymouth University, on the strength of data maintained by the GMC, is just one example of how effective auditing of the GMC's activities can contribute towards addressing the systemic disadvantages faced by BME doctors and others. According to Mr Keegan, in 2013, which was the year that the investigation concerning Dr Adams concluded, 1,726 investigations concluded in total, with 199 of those cases concluding with advice. In 2023, a total of 467 investigations concluded, with only 39 of those concluding with advice. That can only have benefitted BME doctors and other over represented groups in the process.

B. Proportionality

85. As to whether the GMC's practice strikes a fair balance between its reasonable need to accomplish its stated aims and any disadvantage suffered by Dr Adams and other BME doctors, the disadvantage is not of course the one identified by Dr Adams, namely impaired employment prospects resulting from disclosures to prospective employers or other regulators. Instead, Mr Varnam submits they are disadvantaged in so far as case examiners' decisions are available to other case examiners in the event of further complaints or referrals. Though not explicitly stated, the underlying assumption would seem to be that case examiners will be somehow prejudiced by having access to such decisions (as opposed to the materials underlying them). The implicit disadvantage is seemingly the potential risk of conscious or sub-conscious biases and assumptions operating in the minds of case examiners. Yet, as we have noted already, it seems to us that the greater risk in that regard derives from the details of complaints and referrals, and the materials submitted with them, being retained, something Dr Adams accepts as a legitimate practice. In which case, it might be thought to be in a doctor's interests for the case examiners' reasoning to be available as a counter balance to potentially prejudicial information and materials that may have been provided within or as part of the complaint or referral.

86. In any event, it seems to us that the availability of the case examiners' complete reasons enables doctors, if relevant, to challenge or, as appropriate, rely upon their reasoning in any subsequent investigations. Given that case examiners are aware that their role is not to make findings of fact, a function that is reserved to others, we are satisfied that the GMC's pursuit of the five identified aims is proportionate when balanced against any potential perception by BME doctors or other groups that there is a risk they might be prejudiced in any future investigations because the case examiners' decisions and reasons in respect of past investigations continue to be held on their record at the GMC. If that is their perception in the matter, the 2016 guidance for decision makers on giving written advice at the end of fitness to practise investigations could not be clearer:

> "Advice … is not an admonition in relation to past actions."

87. We have also weighed in the overall balance that the GMC operates a 20-year retention policy, so that information to which a doctor might object or regard as potentially prejudicial is not retained indefinitely. In our judgement, the retention period is proportionate to the aims sought to be achieved by the practice of not removing any material from case examiners' decisions. Again, this case rather illustrates the point, in so far as a claim has been brought against the GMC some ten years after the Case Examiners gave their decision. We can also well understand why patterns of conduct might only emerge over the course of a number of years, and why enquiries, inquests and law enforcement investigations may be as concerned with past or historic events as they are with more recent events. The GMC's retention period is consistent with NHS England's 20-year retention period in respect of information pertaining to concerns and is significantly shorter than the 70-year retention period operated by the Nurse and Midwifery Council in respect of information pertaining to its fitness to practise investigations.

88. Although Dr Adams was afforded more than one opportunity in 2012/13 to comment on the concerns that had been expressed in relation to him, Ms Brucato wrote to him on 8 September 2022:

> "I am happy to save a copy of your comments and/or details of the employment tribunal settlement on the case if you would find that useful. We also have a case retention summary and notes field on our case management system where we can add comments clarifying what happened after your case was closed.
>
> Please let me know if you would like to proceed with any of the above options." (page C32)

Dr Adams did not take up Ms Brucato's offer. Nevertheless a copy of his correspondence was retained in Siebel to provide at least some record of his concerns. Again, this evidences the GMC acting proportionately in the matter by seeking to strike a fair balance between potentially competing interests and taking steps to ensure as far as possible that doctors, or particulars groups of doctors, are not disadvantaged.

89. By way of a final observation in this matter, it seems to us that if we were to accede to Mr Varnam's submissions we would effectively be conferring a right of review upon doctors that is not currently conferred by Rule 12(1) of the FTP Rules. We do not consider it is for this Tribunal to mandate the Rules by refence to which the GMC discharges its statutory responsibilities in respect of doctors' fitness to practise. That is a matter for Parliament, which through the Privy Council has seen fit to approve the Rules in their current form.

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Employment Judge Tynan

Date: 17 July 2024

Sent to the parties on: 9 August 2024

For the Tribunal Office.

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Please note that if a Tribunal Hearing has been recorded you may request a transcript of the recording, for which a charge is likely to be payable in most but not all circumstances. If a transcript is produced it will not include any oral Judgment or reasons given at the Hearing. The transcript will not be checked, approved or verified by a Judge. There is more information in the joint Presidential Practice Direction on the Recording and Transcription of Hearings, and accompanying Guidance, which can be found here:

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