Case number: 2602063/2022

EMPLOYMENT TRIBUNALS

BETWEEN:

Claimant		**Respondent**
Dr Mona Hosni	And	Nottingham University Hospitals NHS Trust

AT A FINAL HEARING

Held at : Nottingham

On: 16-23 April 2024 (attended in person),
12 June 2024 (remotely, by CVP),
18,19 & 23 - 25 July 2024 (attended in person)
In Chambers for reading in on 15 April 2024, and re-reading on 11 June & 17 July 2024.
In Chambers for deliberations on 29 - 30 July 2024

Before: Employment Judge R Clark
Mr J Akhtar
Mr C Goldson

REPRESENTATION
For the Claimant: Dr Hosni in person
For the Respondent: Miss S Firth of Counsel

RESERVED JUDGMENT

The unanimous decision of the tribunal is that: -

1. The claims of harassment related to race **fail and are dismissed.**

2. The claims of direct race discrimination **fail and are dismissed.**

REASONS

1. Introduction

1.1 This claim arises from the respondent's decision to invoke performance assessment procedures early in Dr Hosni's short spell of employment as a locum consultant anaesthetist. There is little dispute that Dr Hosni had a bad experience, and aspects of the procedures adopted by the respondent to satisfy itself of her level of clinical competence would be criticised at the later independent appeal. The question for us, however, is only whether any of the treatment alleged amounts to either of the two forms of prohibited conduct alleged under the Equality Act 2010 ("the Act").

1.2 We apologise to the parties for the delay in promulgating this judgment. This has taken longer than originally anticipated due, principally, to it not being possible to write up all the necessary elements before an extended period of sickness absence of the Judge.

2. The Issues

2.1 The case had been considered at several case management hearings. Through those, 17 discrete acts or omissions are identified which are alleged to amount to either harassment or less favourable treatment. There was some further refinement of that list as the case progressed which we allowed. Other claims have been dismissed at earlier stages on withdrawal or because of lack of jurisdiction.

2.2 The final list of issues before us is set out in appendix I. This judgment answers the questions that poses. Whilst we adopt it, we have chosen to analyse each allegation first as harassment and then direct discrimination. In that order, we overcome any issues arising from the technical and exclusionary definitions of detriment and harassment contained in section 212 of the Act.

3. Preliminary issues

3.1 This final hearing has been subject to what in our experience was an unpresented number of case management issues arising on a daily basis, some quite unusual. Ordinarily, we would have summarised those matters within the body of these reasons. We have set it out separately in Appendix II.

3.2 We also had to give repeated and increasingly firm directions to Dr Hosni in the conduct of how her evidence was given and her examination of witnesses. Whilst our interventions were, in part, out of a concern about the way in which the case was being conducted, in the main our interventions were with a view to discharging our duty to ensure a fair hearing. Dr Hosni's speed of thought, and expression of those thoughts, was unusually fast. Witnesses could not keep up. We could not keep up. We were concerned that

potentially important aspects of Dr Hosni's case could be lost and had to repeatedly ask her to slow down.

4. The evidence

4.1 For the claimant we heard from Dr Hosni herself.

4.2 For the respondent we heard from: -

a) Dr Navinder Bhandal. Associate Medical Director for Professional Standards.

b) Dr Adam Carney. Head of Service, Theatres and Anaesthesia at Nottingham City Hospital.

c) Dr Mark Ehlers. Consultant in Critical Care and Anaesthesia and Director of Postgraduate Medical Education.

d) Dr Andrew Matthews. Consultant Anaesthetist.

e) Dr William Rattenbury, Consultant Anaesthetist.

4.3 We received a substantial bundle of contemporaneous documentation. After being added to at various stages of the final hearing by both parties, this ran to 1789 pages. We considered the documents we were taken to in evidence as well as specific reading lists provided by both parties.

4.4 All witnesses gave evidence on oath or affirmation and were questioned save for Dr Matthews. His evidence was adduced as hearsay. We refused an application for a postponement which would have led to a fourth final hearing. At different times, this application had been intimated by both parties. The respondent then altered its position and sought to conclude the evidence during the third hearing, relying on Dr Matthews' statement as hearsay evidence. The claimant maintained the application for a fourth listing for him to be cross examined. We had to balance the competing applications and, in particular, have regard to any prejudice to the claimant of not being able to test his evidence. All had to be considered within the context of the overriding objective, proportionality and fairness, and a fair allocation of limited resources to meet the needs of justice. We declined the claimant's application for a fourth listing to cross examine Dr Matthews. A significant factor in that decision was that the medical evidence meant we could not be confident that his ill health would improve sufficient to make that possible at a future date. We agreed to consider Dr Matthews evidence as hearsay and to give it such weight as was appropriate in the circumstances, recognising it had not been challenged.

4.5 That necessarily leads to consideration of what weight we should give to it. In this case, we considered the weight we should give to his hearsay evidence to be substantial. Applying the factors in section 4 of the Civil Evidence Act 1994, the following stood out to us:-

a) Dr Matthews had prepared a witness statement, signed it under an old-style CPR statement of truth and we are satisfied that, at all times until he was incapacitated, intended attend to face questions on it.

b) He had been present in person at the original 7-day listing when, but for the time that was lost during that hearing in the numerous applications and speed of evidence, he would have given evidence and been questioned.

c) At that time, he was facing serious health issues that required imminent surgery. Even then he was content to be made subject to separate orders for a remote hearing to give his evidence, only for that to be scuppered by the date for his surgery coinciding with that second listing.

d) We are satisfied that he would, but for his ongoing ill health, have been in attendance at the third reconvened hearing.

e) The evidence he would give engages little dispute of fact. In his witness statement he accepts the thrust of the more significant factual matters he is said to have said or done, albeit the motivation remains in dispute.

f) His evidence is his own first-hand evidence. There was no apparent reason for his evidence to be an attempt to conceal or misrepresent when it was consistent with the contemporaneous evidence before us in the bundle.

g) We were satisfied there was no basis at all for concluding his non-attendance was an attempt to avoid his evidence being tested.

h) His evidence is consistent with other aspects of the respondent's case which has been tested and challenged.

4.6 We extended the listing to sit on Thursday, 25 October for closing submissions. Both parties made closing submissions in writing and orally. Both had initially provided opening written submissions, in substance if not in name.

5. The Facts

5.1 It is not the purpose of the tribunal to resolve each and every last dispute of fact between the parties. Our function is to make such findings of fact as are required to answer the issues in the case and to put them in their proper context. On that basis, and on the balance of probabilities, we make the following findings of fact.

5.2 The respondent is a large acute hospitals trust running two main hospital sites. They are the City Hospital and the Queen's Medical Centre, or QMC. The anaesthetic department is large with approximately 100 consultant anaesthetists.

5.3 Dr Adam Carney is a consultant anaesthetist. At the material time he was one of two Heads of Service for Theatres and Anaesthesia. He was based at the City Hospital Campus.

A colleague held a similar role based at the QMC. That role is a leadership role, managing the clinicians in the anaesthetic department. It meant he was involved in the strategic planning of the service and all aspects of the management and delivery of clinical and safety standards expected of the consultant anaesthetists employed.

5.4 Following the initial restrictions arising from the Covid-19 pandemic, hospitals across the UK began taking steps to increase their surgical resources as part of the drive to tackle the consequential growth in waiting lists. This respondent was no different. During the summer of 2021, Dr Carney had set about recruiting an additional consultant anaesthetist to support these additional general surgical lists. The plan was to recruit on an extended locum contract of 6 months. We find the role did not require any specialism, although if a candidate had experience of any of the specialist anaesthetic lists, that would obviously be an advantage. A job description and person specification were prepared for the role. The person specification identified essential and desirable qualities of the candidates.

5.5 We find the fact that the entire health system in the UK, if not worldwide, was facing the same challenges created both an urgency to this recruitment and a consequential labour shortage. It is quite common for locum appointments to be made through agencies. One such agency is called Remedium. A potential candidate had been identified by Remedium and Dr Carney made the arrangements for that candidate to be interviewed. Just before the interview date, that candidate withdrew. Remedium then offered an alternative candidate for the post and provided Dr Hosni's CV. We find the CV in the bundle is the one that was before Dr Carney at the time. As an interview date of 15 July 2021 was already in the diary, he proceeded to interview Dr Hosni, albeit at short notice and on an informal basis

5.6 Dr Hosni's application appeared to provide a good fit for the role. The claimant is a consultant anaesthetist. She did not undertake her medical training in the UK. In June 2005, the Specialist Training Authority of the Medical Royal Colleges had issued her with a certificate of equivalence to the certificate of completion of specialist training (CCST), that is the certificate that would be issued to a doctor in training in the UK making them eligible to work as a consultant, now termed a certificate of completion of training (CTT). She was registered with the General Medical Council on the specialist register with a licence to practice in the UK from 3 February 2006.

5.7 Her clinical training, and her recent practice, was principally in Egypt with some contracts in Kuwait, Dubai and British Virgin Islands. Prior to her appointment to the respondent in 2021, her CV showed she occupied the post of Consultant and Professor in Anaesthetics at Ain Shams University Hospital in Cairo. In that role she described conducting anaesthesia for to ENT, Obstetrics and Gynae, ICU and Orthopaedic lists. Her CV also stated that she was now: -

> ***conducting anaesthesia for cardiothoracic in our huge cardiothoracic academy where we do any and all kinds of cardiac and thoracic surgeries for adults and PAEDS and we are in continuous communication with the royal Brompton hospital where we were privileged of their visit on multiple occasions and did mutual good and productive work together via skype to discuss different case scenarios we both came across.***

5.8 Her CV also records her earlier time in the UK. She has worked in the UK at various hospitals in short term locum positions between 2006 and 2010. Dr Carney did not know at the time of the recruitment that many of these locum consultant appointments listed were not in fact consultant level posts. They were more junior positions. Her own employment history shows that. Dr Carney was also unaware that quite soon after she started working at consultant level, in 2010 she faced a General Medical Council ("GMC") fitness to practice investigation and was made subject to an interim suspension, and then later an erasure from the register. We find Dr Carney did not know because he was not told and, as will become clear, did not conduct the degree of scrutiny in the appointment process expected by the Trust's own procedures and did not cause any checks, or any adequate and timely checks, to be completed.

5.9 The earlier GMC matters had arisen in relation to two areas of concern. One was in respect of Dr Hosni's honesty in that she had submitted an employment reference purporting to be from a consultant she had been working with, but which was in fact written by herself on headed paper from that trust. The second was in respect of clinical practice which, in part, involved the administration of medication in circumstances that led to a patient becoming aware during surgery. She exercised her right to a statutory appeal against the first interim decision which the High Court dismissed. Whilst that decision was pending, she faced a second fitness to practice investigation due to making further applications for employment to UK hospitals without disclosing that she was subject to an interim suspension. This led to a further interim suspension before the outcome of the final hearing which, in April 2012, decided to erase her from the GMC register. That decision was further appealed to the High Court, again unsuccessfully. Thereafter Dr Hosni returned to work in Egypt although she did some work in Kuwait and Dubai. In 2018, Dr Hosni applied to be restored to the register but was refused, in part because of the lack of evidence that she had kept her knowledge of clinical practice in the UK up to date. She renewed that application in 2020 and this time it was granted by the Medical Practitioners Tribunal. At the hearing of that renewed application, the GMC took a neutral position. The tribunal assessed the history of repeated dishonesty and concerns about the currency of her UK medical skills, knowledge and practice and determined on the evidence that she was a fit and proper person to be restored to the register.

5.10 We find that recruitment into this type of longer-term locum position was expected to follow an established and formal internal recruitment process. We don't doubt that is informed by various HR objectives aimed at achieving a fair, transparent and effective appointment. We do not need to go into great detail about the deficiencies that would later be identified in the process that selected Dr Hosni for the post, beyond recording that there is no dispute that this appointment missed some important aspects of the expected process. Instead of having a panel including an HR representative, Dr Carney conducted an informal remote interview alone with Dr Hosni, although someone from the agency sat in. There was no exploration of the claimant's GMC registration history which normally forms part of the standard interview questions. There was no testing about her practice and some aspects of

the “essential” criteria on the job description were not satisfied. There were also issues identified later with the generic references provided but these did not come to light as potential concerns until around the time the claimant had started work.

5.11 Ignorant of the full history, we find Dr Carney was impressed with Dr Hosni’s application. Whilst the role did not require a cardiothoracic specialism, he felt having experience of that area of work would certainly be an advantage to provide some flexibility and additional cover where needed. We accept the discussions during that interview, however informal, left Dr Carney with the understanding that this was work the claimant was doing in addition to general surgical lists and that she was a very good candidate with experience across the areas he needed and beyond. We find his conclusion to be wholly consistent with how her CV reads. He concluded that she was a good candidate to appoint.

5.12 In fact, the claimant accepts that aspects of her CV are not accurate and correct. She says that is because it had been written by someone at the agency, Remedium. Whilst it has been printed on a document carrying Remedium branding, we reject the claimant’s contention that the agency had modified her CV to make it look like she was more qualified or experienced that in fact she was. On the balance of probabilities, she provided the agency with the information. That finding is supported by her own remodelled CV also before us. The prospect of an agency exaggerating a candidate’s skill is a less likely explanation. To do so would risk being exposed so easily. Agencies require repeat business with hospitals and doing so would destroy the trust any healthcare provider could have in the agency going forward.

5.13 We find that Dr Carney was aware from the outset that the Claimant’s nationality was Egyptian. He knew that she had trained in Egypt and that much of her professional career had been in Hospitals in Egypt. He believed she had not worked in the UK for about 10 years or so but before then had spent 5 or 6 years in various NHS hospitals at consultant level. We find her nationality was in no way whatsoever an issue or concern in the recruitment process. We find the Trust employs people of many nationalities, including Egyptian. He was also persuaded there were no concerns to be found in the fact she had a lot of short-term job changes by her explanation that she was taking up development opportunities before returning to her post in Cairo.

5.14 An argument was put to us that Dr Carney was desperate to appoint. Whilst the surrounding circumstances of the employment market and the deficiencies in the selection process support that to some degree, we do not accept that Dr Carney would have taken any applicant. The fact is Dr Hosni’s application appeared to meet what he was looking for and, in any event, nothing changed about the surrounding circumstances, job market or need for additional anaesthetists. There is nothing in the evidence which explains why it was that Dr Carney’s knowledge of Dr Hosni’s Egyptian nationality was irrelevant to his decisions at the time of appointment in July 2021 but, on her case, became so relevant and negative towards her 3 months later. We find it was never relevant to Dr Carney.

5.15 We find as a fact that had this recruitment been conducted in accordance with the respondent's expected procedures, Dr Hosni's application would have been unsuccessful. We do not accept that there is any basis for concluding Dr Carney was in some way seeking to disadvantage the claimant by adopting this informal procedure in order to appoint her in circumstances that she otherwise would not have been appointed.

5.16 Dr Carney then goes to on to make further favourable decisions about Dr Hosni's terms of appointment at a time when Dr Carney was clearly aware of her nationality. They all related to the convenience and practicality of her relocating to the UK to take up the role. They included financial assistance and, more particularly, agreement to change the initial contract from one of 6 months, with potential to extend, to one of 12 months duration from the outset. He also agreed to put back the start date at the claimant's request. These discussions resulted in a formal offer being made and accepted.

5.17 Dr Hosni moved to the UK and took a 12-month tenancy on a property. She started work for the respondent on 18 October 2021. She also managed to fit in some additional locum appointments between arriving in the UK and starting with the respondent. We find Dr Carney would not learn of that until much later in the chronology and, at the later material time, he believed she had not worked in the Uk for about 10 or 11 years.

5.18 One consequence of that delayed start date was that it coincided with a period when Dr Carney was himself absent on annual leave. He did not return to work until 1 November 2021 and was not, therefore, at work during the first 2 weeks or so of her employment. We find Dr Carney made arrangements for the claimant to undergo the standard induction for a long-term locum appointment. We find it is usual for a newly appointed consultant to undergo a familiarisation induction period for a couple of weeks and that was arranged for Dr Hosni. In accordance with that usual practice, she was not given lists of her own but instead doubled up with fellow consultant anaesthetists on their list, working alongside them scrubbed and performing aspects of the procedures as part of this familiarisation. We should add, there was no intention to undergo any induction training on the clinical work itself. This was a consultant appointment and like any consultant appointment, Dr Hosni was expected to be working at that level and able to lead and direct anaesthetic practice to the level expected of a consultant in the UK. This induction was more about how the local systems and procedures worked, meeting colleagues from all associated disciplines and orientation to the physical environment and local practices.

5.19 Upon starting work, we find the claimant me with Vanessa Bacon in the anaesthetic department administration office to work through an induction checklist. The checklist we have seen was completed by Ms Bacon in her handwriting. The claimant says she did not fill it in and that it was completed in her absence and not fulfilled. We do not accept that this checklist was completed without Dr Hosni's input. We find Dr Hosni gave information to Ms Bacon in order for her to fill it out and many of the topics covered are there as prompts to the person conducting the orientation. It is a fairly typical of many day-1 onboarding processes including practical matters such as obtaining ID badges, security passes and email accounts.

One aspect that we were specifically taken to is in respect of life support or resuscitation training which is ticked with the entry “up to date, MLS booked for 21/10/21”. MLS is short for medical life support training. Dr Hosni says had she filled in the form she would have said she was not up to date as she had not undertaken Advanced Life Support (ALS). We do not accept that, on balance, the anaesthetic secretary would not guess or make up an answer to a question such as this. On balance, the answer came from information provided by Dr Hosni. That entry is also consistent with the contemporaneous records of Dr Hosni’s initial attempts to secure this training, and we return to the significance of this later.

5.20 We find very early on, literally over the first week of the claimant starting work, a number of colleagues began to express concerns that Dr Hosni did not seem to be demonstrating the sort of knowledge, skills and competencies that they would expect to see in a consultant. The gravity of these concerns can be expressed at four levels. First, the concerns were being voiced by various professional disciplines present in operating theatres. That is, not just fellow consultant anaesthetists but including key junior colleagues such as ODP staff that support the operating theatre. Secondly, the nature of the concerns included both technical and no-technical matters and some even commented that the claimant’s skills were more consistent with that of an S.H.O. (a junior doctor at the second stage of foundation training). Thirdly, they questioned whether Dr Hosni should be supervising trainee doctors, an inherent aspect of the consultant role. Finally, and most importantly, the concerns were framed in the context of patient safety.

5.21 Dr Hosni does not accept that these people may have had a genuine concern about her skills and competencies. She says there was a conspiracy to set her up to fail, orchestrated by Dr Carney. She says he sent an email in early October referring to the claimant as Egyptian and that they should “keep an eye on her” as she worked differently. The fact no such email exists was put to Dr Hosni in evidence who then resiled from the allegation of an email communication, but maintained Dr Carney was nonetheless instrumental in a conspiracy to undermine her. She stated she was *“Not sure of time, but whispering everywhere and Carney behind everything, even when on leave”*.

5.22 Whilst there is a later email from Dr Carney which does refer to her nationality, to which we will return, we find as a fact that Dr Carney did not contact colleagues in the way suggested and did not conduct a whispering campaign to discredit the claimant or influence his colleagues before she started in the role, or at any time. We reject the claimant’s contention that those expressing views, apparently independently of each other, were part of a conspiracy to undermine her from day one. There are a number of reasons for that. We have already referred to Dr Carney treating the claimant more favourably in the selection process and the contractual negotiations. His indifference to her nationality is consistent with the fact that the Trust and the anaesthetic department already employed a number of clinicians from many nationalities and, specifically, of Egyptian nationality. There is no logical basis for Dr Carney going from appointing her and accommodating her contractual wishes, to then taking against her for no reason. The Trust had a pressing need for qualified anaesthetists to tackle its theatre lists and the idea of undermining someone in those

circumstances is so at odds with the interests of those colleagues in theatres that we would require clear evidence to support it. We do not have that evidence. The most that could be said is that it is perfectly natural that colleagues would know in advance that Dr Hosni was joining them and, if for no other than the context of her relocation delay, it is equally natural that they would know she was relocating from Egypt.

5.23 During Dr Carney's annual leave, his colleague Dr Sycamore was covering for him. The concerns of clinical colleagues found their way to her. At some stage during this same period, she and others in the Trust came to learn of the claimant had previously been erased from the GMC register. Dr Sycamore felt the situation was sufficiently serious for her to take steps even before Dr Carney had returned from annual leave. She asked HR if there was any sort of "cooling off" period to an appointment, which there was not. She then sought advice from the medical director's office on how to handle the situation.

5.24 Pausing there, we need to deal briefly with how Dr Hosni advanced her challenge to Dr Sycamore's motivation for acting as she did. Dr Hosni took the view that she was seeking to get her out of the organisation or force her to resign. She supported this contention by purporting to quote an email from her that stated: -

> ***we cant beat her with the stick now, she is someone who is good to go***

5.25 We find there is no such quote from Dr Sycamore at all. This is not the only example of Dr Hosni conflating various communications to create a quote that does not exist. When the actual communications are read in totality, they show a different picture. One part of the constructed quote is not in fact authored by Dr Sycamore at all. It was HR writing <u>*to*</u> Dr Sycamore in connection with her enquiries about the previous erasure from the GMC register which states: -

> ***I thought so… I do think we need to make sure she has had a proper induction and can evidence that… we weren't aware that she had been removed from the register but in fairness to her she has now been re-instated so we can't use that as a stick to beat her with….***

5.26 This was in response to Dr Sycamore writing: -

> ***The feedback that I had this this lady isn't someone who needs 2 weeks supervision and will be good to go unfortunately…..***

5.27 We are satisfied the last extract has been misunderstood by Dr Hosni. The phrase good to go is not a direction to terminate. It reflects the nature of the concerns being raised. It is in the context of the amount of supervision and support that would be needed before being confident Dr Hosni was able to undertake independent practice at consultant level, or as she phrased it, would be "good to go". Dr Sycamore's concerns are also to be viewed in the context of her email to Dr Carney on 27 October in which she sets out the issues prior to his return from annual leave. She recounted the flavour of the concerns other consultants were raising. She also raised the fact that Dr Hosni's session doubling up with the specialist anaesthetists had evidently shown she was <u>not</u> skilled in cardio thoracic anaesthesia to such an extent that she should not work in that field at all. Dr Sycamore set out some initial

thoughts on managing the situation including suggesting that Dr Carney work alongside Dr Hosni on his return from leave to assess her level of work himself. Despite all the grounds for concern, we find Dr Sycamore concluded with an observation favourable to the claimant in all the circumstances, stating: -

> ***It might just be very early days and if she hasn't worked in the UK for 10 years she will just need a longer induction.***

5.28 We find that Dr Sycamore's actions were motivated solely by the concerns being relayed to her by the various clinical colleagues. We find there is no reasonable basis for her to do anything other than act on them and explore them further. We find recognition that Dr Hosni's practice in the UK was some time ago further reinforces our conclusions that the picture before Dr Sycamore was genuinely the motivating factor in the decisions she took. The possibility that the apparent deficiencies in the claimant's practice might be simply due to her being unfamiliar with the local equipment, practices and systems was something we find Dr Carney would also keep hold of when he would later come to implement the initial plan to assess and address these initial concerns. We find he was equally at pains to explore and rule out whether they arose merely from her being unfamiliar with UK and local practice and did so clearly in the hope that concerns might resolve in a short time. That proved not to be the case.

5.29 The Deputy Medical Director for Professional Standards at the time was Dr Carol Roberts. Her response to Dr Sycamore acknowledged the difficulty of the situation and that unless Dr Hosni had misrepresented her qualifications/experience/skills that the situation would need to be managed through the capability or conduct route. We find central to Dr Roberts' response was that patient safety was paramount. In fact, we find that was the driving force behind all who made decisions concerning the assessment of Dr Hosni. Dr Roberts advised that a fact-finding process would be needed which, hopefully, Dr Hosni would cooperate with. In that regard, we find Dr Sycamore had already been exploring how these concerns could be assessed and measured fairly including using the sort of objective and evidence-based assessment tools that were used to assess the clinical competence of junior doctors in training. In this field of clinical practice, assessments were routinely done using the Anaesthetic List Management Assessment Tool. ("ALMAT").

5.30 In a separate area of concern, the respondent's HR set about verifying the references they had originally received. Having now learned not only of the fact of the erasure from the register, but that the underlying issues related in part to providing false references, that is entirely understandable. By late November 2021, the attempts to verify the generic references provided by Dr Hosni remained unfulfilled. Telephone contact proved difficult as HR said they were unable to verify who they were speaking to in Egypt and had sought email addresses for making contact. In the event, specific up to date references proved difficult to obtain

5.31 Dr Carney returned from leave on 1 November 2021. It is unfortunate to say the least that on his first day back from leave, he was unable to work alongside the claimant as had been planned. The reason was that she was absent from work. Dr Hosni had in fact been

working over the weekend as a locum at a distant private hospital in the UK. We find her absence was because she was unable to get a train back to Nottingham in time. In fact, she phoned in sick saying she had pain in her knee but that she would make up the lost day working on another day. She accepts she did not tell him the full story.

5.32 In the meantime, Dr Carney wrote to those consultants who had doubled up with Dr Hosni over the previous two weeks. We find he sought written feedback from them so that he could better understand their concerns. We find he did this to inform himself how best to deal with the matter. He asked them to structure their comments using the headings used in the GMC "Good Medical Practice" standards. He concluded his request with a final line equally supportive of Dr Hosni saying: -

> ***This issue has already been raised to the medical director's office by Hannah, so please rest assured we will do all we can to help Dr Hosni, if that is what is required, but also protect our patients and staff.***

5.33 When the initial responses arrive, we find they were balanced. Some identified areas of positive and competent practice, some contextualised their concerns by the fact they had spent very little time with her. Most, however, identified potentially serious deficiencies. The overall impression was of a level of concern that needed to be investigated further, of concern about supervising trainees, of a doctor whose skills and performance were not at consultant level and, to quote one, a doctor who would "definitely need further supported working to get her up to speed". We find nothing in those responses indicated any connection with the claimant's nationality. We do not accept Dr Hosni's contention that it was wrong to put her on a "doubled up" thoracic list with Dr Chikkabbaiah. Dr Hosni says that was unfair as she was employed as a generalist, not a specialist thoracic anaesthetist. We agree that, as a matter of fact, she is not a specialist anaesthetist but find the motivation was not to set her up to fail, but because her application gave the impression she was able to work in those lists.

5.34 Dr Hosni's case alleges every colleague she dealt with referred to her as Egyptian in their dealings with her. We reject that. In answering questions on the point, Dr Hosni explained how some had mentioned her nationality in their initial introductions to each other and had done it in a nice way. We find in the face-to-face dealings with colleagues, there was no reference to her nationality or use of the word Egyptian in any other context than this friendly, getting to know each other sense.

5.35 In respect of the feedback itself, Dr Hosni sought to split those commentating between those who made positive comments, who were honest, and those who gave negative comments, who were dishonest. We find Dr Carney's closing remarks in his email were genuine. The respondent was justifiably concerned about patient safety but needed an additional consultant anaesthetist, and these concerns might have been merely unfamiliarity. It was in its interest to understand the problem fully before deciding what action was needed.

5.36 On 2 November 2021 Dr Carney emailed the claimant. We find this was in response to her absence on the Monday when they would otherwise have worked together. He invited her to work alongside him in addition to the planned day on Wednesday 3rd. He wrote: -

Mona - if you want to join me in Day surgery on Thursday, that would be a good list for you to potentially be in charge of for you to get used to 'running' lists here (I gather you are finding things slightly different to Egypt)

5.37 This is the first comment that could be described, indirectly at least, as referring to the claimant's national origins. We find that, in its proper context, it was based on Dr Carney's genuine understanding that Dr Hosni had been working in Egypt for much of the previous 10 years and that there was likely to be differences in various aspects of practice which could be the explanation for the apparent differences in practice.

5.38 The two worked together on Wednesday 3 November 2021. We find Dr Carney deliberately framed his later discussions about the work that day in as positive a tone as he could, and his contemporaneous note reflects that. We accept that meeting would have been a difficult meeting as Dr Carney was the person raising the issue with Dr Hosni for the first time when he shared the nature of the negative feedback he had received. He goes on to give some initial options for support. Some of the themes arising from the initial feedback were that she didn't seem to listen to feedback, that she was chaotic, that the record keeping was poor and that there had been two instances of turning anaesthetic gasses off earlier than a colleague observing felt was appropriate. He revisited the basis of his understanding gained at the interview concerning whether she was working in cardio thoracic lists. Feedback had shown her technical abilities in thoracic work was not at a level to take charge of such lists. The initial action was a decision to remove Dr Hosni from any on-call or emergency work and to set up an extended period of induction after which they would review how to proceed and to deploy Dr Hosni on appropriate work. We accept his motivation to do this was patient safety.

5.39 The two worked together again the following day, Thursday 4 November 2021. Dr Hosni took the lead as planned with Dr Carney observing. We find during that day, Dr Carney observed a number of aspects of practice that gave him first hand cause for concern. He documented them at the time and discussed them with Dr Hosni. The concerns related to practice, including not recognising and responding to adverse clinical indications, failing to prescribe medication and a 'near miss' drug error. Aspects of these concerns were compounded by the fact that Dr Carney understood from colleagues' earlier feedback that errors that were initially identified and were now being repeated. During the day itself an incident arose with one patient who, in the time Dr Hosni had been attending to him, should by then have been asleep but the patient was still moving. We accept Dr Carney had a genuine clinical concern about why the anaesthetic was not taking effect, that the patient might still be "aware" and risked suffering a laryngospasm (an involuntary contraction of the vocal cords) if they had not received the correct dose. Dr Carney stepped in to ensure the patient remained safe. He denies the counter accusation that he performed the procedure incorrectly. We accept the issue was not whether in fact the canula was incorrectly inserted, it was that there was a risk it wasn't because of the indications. He denies shouting but does accept in the moment of intervening he raised his voice for which he would later apologise.

5.40 We find in these two days of working together, Dr Carney witnessed first-hand the same sorts of issues that had been reported by his colleagues. We find the picture looked worse than we are sure he had hoped. In the meeting afterwards, we find Dr Carney shared his views of what he had seen. The next steps were crystalising further from the previous day. Dr Hosni would be treated as supernumerary. She would double up with colleagues on simple lists and be observed by those colleagues who would adopt the ALMAT assessment tool.

5.41 It is understandable that Dr Hosni would be upset by what she was hearing. We readily accept that Dr Hosni was working in Egypt in a senior position. For anyone in any professional field to be told that one's skills and abilities fall below the expected standard is inevitably going to hurt. We find even with the level of the evidence now before him, perhaps even because of that level of concern, Dr Carney was alert to that. We find he was in a position to know what the next stage of the process of formal assessment was likely to entail and he could see that this was going to be a difficult period for the claimant. It is against that background that we find he explored with Dr Hosni whether she wanted to remain within the Trust or, if she wanted, to leave its employment at that stage. Dr Hosni declined, and it is equally understandable why. Her position was that all aspects of her clinical skills, knowledge and decision making were excellent, and she would seek to demonstrate that.

5.42 The claimant also alleges that during this meeting Dr Carney threatened to report her to the GMC and the Medical director. We do not accept he did. We find Dr Hosni was told that the Medical Director had been approached for advice. We accept the contemporaneous notes summarise the things that were put to her, including the discussion about options to leave the Trust but not this. Whilst that is not conclusive, the fact is reporting to the GMC does not fit with the plan to undergo some form of internal assessment of her skills and competence. It may be that it was obvious to the claimant from the nature of the issues being raised that this could be something that could happen in the future. We do not consider there would have been problem with the topic being covered in this context. We find it is the sort of matter that, had it been discussed would have been recorded and we find it would not have been something Dr Carney would seek to deny for any reason other than he did not say it.

5.43 Dr Carney and Dr Hosni were scheduled to work together again on Monday 8 November 2021. The morning had started without incident. We reject Dr Hosni's contention that Dr Carney greeted Dr Hosni with the words "oh you again". We find he knew he was working with her that day and it would not have come as a surprise. We also find the fact the situation was so difficult, and that Dr Carney was otherwise alert to that sensitive dynamic, makes it less likely than more likely he would have done anything to add to the difficulty.

5.44 We find the two were in the process of completing the pre-operative work when Dr Carney received a call to say his daughter had tested positive for Covid. That necessarily meant he could not remain present in theatre. He made arrangements for a colleague to be the named consultant doubling up and supervising Dr Hosni. That was Dr Webster. In line with all other doubling up, we find it is a matter of judgment for the supervising consultant

what level of proximity that supervision needs to take. That will depend no doubt on the nature of the procedure, the patient and the risks. It is in the context of having to make that last minute change, that Dr Carney is alleged to have said to Dr Webster to "keep an eye on her", referring to Dr Hosni. Dr Carney said he could not recall using those words but, in the context of what was happening, accepts it is entirely possible he could have.

5.45 The allegation of directing Dr Webster to keep an eye on the claimant was originally put as happening on 10 November 2021. It evolved in the course of the case to happening during this oral exchange on 8 November.

5.46 On 10 November 2021 Dr Carney met with Dr Webster, Dr Roberts and Dr Davies to decide the best way to assess the claimant's competency. This meeting confirmed the use of the ALMAT approach. There is no dispute that ALMAT's are a tool for assessing doctors in training and not consultants. We find, by the very nature of the qualification route, there is no equivalent assessment tool for consultants. The nearest process for that would be an independent assessment under the guise of the "MHPS" scheme (Managing High Professional Standards in the NHS). Although the internal assessments mirrored aspects of MHPS, the Trust was not yet at a stage to engage MHPS, and certainly not the independent assessor option, but the evidence gathered would inform, at a later stage, whether that process might be engaged. Another alternative of developing a tool specifically for this purpose would take considerable time and probably have to involve a royal college. We find the advantages of, and therefore the motivation for use of, the ALMAT was to provide some form of structured assessment of the claimant's anaesthetic skills and behaviours. It was a tool that the assessing consultants were used to in their everyday role of supervising trainees, and it provided a degree of standardisation and consistency, making the assessment more objective. We can see obvious good reasons why Dr Carney and the medical director's office would not want the assessments to be made up of entirely free form unstructured opinions. We find they could anticipate that the outcome of the assessment would need to provide an evidential basis to justify either why Dr Hosni could work independently without compromising patient safety or could not. Indeed, at the end of the relevant chronology in this case, the independent appeal panel would accept that the use of ALMAT was not inappropriate for this unusual case.

5.47 The ALMAT form describes the activity being observed. It includes a summary of a reflective discussion between the assessor and subject about the management of the list and a section explicitly identifying suggestions for development. From this format we find Dr Hosni and the assessors would have been expected to engage with the issues arising in the assessment at the time. Even if she did not receive a copy of the form, there should be discussion and feedback about the assessment. Key to the ALMAT is an overall assessment score of one of five categories. Each broadly reflects the level of supervision that would be required of the key stages of doctors in training. Level 1 is a stage 1 trainee requiring direct supervisor involvement with them being physically present in theatre throughout. Levels 2A, 2B and 3 progress through the training stages through to level 4, which reflects a doctor who is able to manage independently with no supervisor involvement. We find the essence of the

scores is not to provide an overarching or generalised assessment of that doctor's competence overall, but an assessment of what level of supervision would apply for the performance observed on that particular day. In other words, if the subject were to repeat the procedure or list, what supervision they would need. Level 4 is what final stage trainees will be expecting to consistently score as they approach the final stage of training before obtaining their CCST/CCT. Obviously, it is the level one would expect any consultant to be assessed at.

5.48 Dr Carney implemented the process. Dr's Dawson and French were the first consultants asked to perform an assessment. Dr Carney wrote to them on 10 November 2021, copying in those deciding on the process. This email is a significant part of the claimant's case. We set it out in full, as it was written.

> ***Thank you for supervising Dr Hosni over the next two days.***
>
> ***The situation is as follows:***
>
> ***1. She is an Egyptian consultant anaesthetist***
> ***2. She is working a locum consultant anaesthetist here for 12 months***
> ***3. In the first three weeks we have found some significant safety issues***
> ***4. We have declared that she is currently supernumerary - is cannot take responsibility for patients.***
> ***a. It is up to you how you run the list - I try to let her take as much responsibility as I dare (watching through anaesthetic room windows etc)***
> ***5. She will be doubled up with consultants for the next 4-6 weeks.***
> ***6. During that time, we will be assessing her for something akin to the RCOA IAC. (Vicki & Mel will be helping)***
> ***7. To help with that - we would ideally like an ALMAT (attached) discussed and filled in at the end / during each list, and sent back to me.***
>
> ***Sorry about this burden…***

5.49 We find Dr Carney was aware of the risk of bias in this process. We find the nature of medical training means consultants simply do not assess the clinical skills of other consultants, at least not outside any independent assessment conducted under the MHPS. Asking anyone to do that would inevitably raise suspicion as to why, and we find it simply could not be done without signalling that there was some sort of existing concern about that consultant's practice. We find the process may not, therefore, lead to an entirely neutral assessment. The risk is that assessors are subconsciously drawn to observe evidence of deficiencies. There is no way to avoid that. We find Dr Carney recognised that. He chose to set out a brief summary of the background behind his request to Drs Dawson and French. It is, consequently and inevitably, a negatively loaded communication both implicitly and, in parts, explicitly so. We find it was not done deliberately to bring about or influence a negative assessment. It was done as the least-worst way of putting the request into context.

5.50 Dr Hosni took issue with the use of the word "burden", which she interpreted to be referring to her. We disagree. We find Dr Carney was referring to the burden placed on the recipients of his email arising from the task of undertaking the assessment and it was not used in a pejorative sense directed at the claimant.

5.51 The obvious significance of Dr Carney's email in the context of this case is that it explicitly refers to the claimant by reference to her nationality. We accept Dr Carney's explanation that this was a shorthand for where the claimant had trained and had recently worked. In the context of what the issues were, and how Dr Carney originally came to recruit her into the role, we accept that explanation, but we acknowledge it allows a difference between what was in his mind, and how what was said might be interpreted. We do accept, however, that evidence of the feedback and discussions put before us does engage directly with those differences in training and practice between the two nations' health systems and which we accept supports the notion that different health systems in different parts of the world may go about things differently for any number of reasons. There are numerous references by various individuals to how that remained a potential explanation for the apparent concerns about Dr Hosni's clinical practice. We equally accept, therefore, that had the concerns arose about a doctor who had trained in any other country other than Egypt, a similar shorthand would have been used for them. We also find that as the assessments widened later in the chronology, Dr Carney would write similar emails requesting colleagues assist with an assessment. Those said essentially the same thing but did not refer to the claimant as an Egyptian consultant in this way.

5.52 Dr's French and Dawson completed their assessments on 10 and 11 November respectively. They each gave generally positive reports within a theme of unfamiliarity with equipment and techniques. They identified a need for better communication with theatre colleagues. Suggestions for the future were encouraging and supportive. However, they both scored 2B, the middle band, meaning the level of supervision required to repeat that activity was "Supervisor within hospital for queries, able to provide prompt direction/assistance". That is two steps below that expected of a consultant.

5.53 Dr Bhandal was the Associate Medical Director for Professional Standards. She led the decision-making group, or DMG, that would oversee the assessment process that was now to take place in a more formal way.

5.54 On 16 November 2021, Dr Carney emailed the claimant. He enclosed the feedback that had been received so far and set up a further, and more formal, meeting to manage the capability issues the following day. Dr Carney proposed an agenda to discuss an overview of current situation, the concerns that have been raised; the assessment and supervision plan over the next 4 weeks. It included discussion about the possible outcomes and other relevant issues. It included a link to join the teams meeting the following day. For reasons that become relevant later, this appears to have been sent to the claimant at her NHS email address, as one might expect it to be. The invite was obviously received as the two met as planned on 17 November 2021. This was a more formal meeting with HR in attendance to set out the plan for assessment. Within the meeting they discussed how some may have been attributable to the fact that having worked predominantly in Egypt where procedures may work in a different way compared to how a UK consultant might practise, some of the issues raised were relating to patient safety. Dr Carney shared that he had raised concerns with the Medical Directors office and the decision reached to double up the claimant for a

period of assessment on the less complex lists, that she would not undertake unsupervised lists and that she would undergo a process of assessment, taking into account that she would need some time to adapt to different ways of working in the UK and at Nottingham University Hospitals. They set out the plan to use the Royal College of Anaesthetists ALMAT procedure over a period of 4 weeks.

5.55 We find it of significance that Dr Carney was again alert to the risk of bias in the process. Dr Hosni's circumstances were becoming known to the consultant anaesthetists working at the City Hospital campus. There was less risk of that at the QMC. Dr Carney wrote: -

> ***all of your lists so far had been at the City campus with colleagues who are aware of the performance concerns and I wanted to ensure that this process would be conducted with impartiality, objectivity and free from bias. To facilitate this I advised you that I proposed that you moved to the Treatment Centre at the QMC campus as I felt this would offer you a more independent assessment of your technical and non-technical skills and competencies.***

5.56 We acknowledge that even then, the same implicit risk of bias was unavoidable for the reasons we set out above. We find whilst Dr Carney could not eliminate the risk, he was genuinely taking steps to make the assessment as objective as possible. He identified appropriate lists at QMC for her to be able to demonstrate her skills, the appropriate consultants and asked them to complete an ALMAT.

5.57 Within the meeting Dr Hosni attributed the issues simply to her lack of familiarity. She considered the concern about competence stemmed from her working in Cairo where they may work differently. It is significant that her observation at this stage seems to be echoing that of Dr Carney and others. She agreed to go to the QMC and work in the treatment centre. She asked to be given unsupervised lists. She referred to Dr Dawson's observation in which he had let her run things, and it had gone smoothly. We accept that there may be some force in the contention that the very fact of being supervised and observed may well put further pressure on the person observed. Others, however, would take that into account at the time in their assessment of the claimant's performance and counter with the fact that, if being observed, one should be at one's best. In any event, Dr Carney explained that the nature of the patient safety concerns was such that he could not give her unsupervised lists until the assessment process was concluded and demonstrated that was appropriate.

5.58 He again stressed the same point that some of the concerns may be no more than different working practices and that he hoped she would pass the assessments with "flying colours", but he had to explain that if it was determined that she was not working at the level of a consultant in the UK, that it would need to be formally addressed. As previously, we find there was no threat to report the claimant to the GMC.

5.59 The letter was sent to the claimant on 19 November as an attachment. The covering email gave details of the arrangements for a separate part of the assessment process, namely a simulation day although it seems that was not explicitly discussed at the earlier meeting. That was to take place on 16 December 2021. The email was sent to Dr Hosni at

two email addresses, both of which shows only the identity of the recipient ("*Hosni Mona (Anaesthetics):")* and neither therefore shows us the underlying email address. In isolation we would infer the explanation for apparently sending it to the same person twice is that it was actually sent to both the claimant's NHS and Hotmail accounts.

5.60 We need to say something about means of communications between Dr Hosni and others. As is to be expected, on her appointment Dr Hosni was issued with an organisational NHS email address. For reasons we did not entirely understand, for the most part she chose not to use it in favour of her "Hotmail" account. In part, that seems to have been explained on a practical level. The Trust was not able to source a laptop for the claimant due to a worldwide shortage in supplies following the Covid pandemic. We accept that might have accounted for some difficulty at certain times, but we find there were terminals throughout the hospital and theatres that any member of staff could use to log into their accounts. We would, however, also accept that the claimant did not have a computer at home with which to log into the Trusts intranet. Again, that does not explain why or how she was still able to access a Hotmail email account, presumably on a smart phone, but not her NHS one. We expected more to be said about how using a Hotmail account might be inappropriate as the communications were likely to at some stage to involve sensitive patient information but whilst that is the case, no issue is taken by the respondent about use of Hotmail for other purposes, as long as confidential patient information was not sent. In that respect, we note on 18 November 2021 the claimant emailed the anaesthetics rota administrator to ask her to send her details of her list for the following Monday to her Hotmail account and gave the email address. This was a legitimate and helpful request by Dr Hosni in order to respond to a request to help cover other lists. However, it could not be done due to patient confidentiality. Dr Carney replied on this occasion, to the claimant's NHS account, explaining that patient details could not be sent to a Hotmail account. Nonetheless, the claimant used her Hotmail email for most, but not all, of her outgoing communications. The relevance of this is that we can see in the contemporaneous documents that from time to time, correspondence of significance was sent to the claimant at her NHS email address as was to be expected. Indeed, on one occasion Dr Carney consciously felt it was more appropriate to send it to that address because of its formality. It is only in that latter respect that we find there was any conscious decision on how to address emails. We reject as a fact that Dr Carney or anyone was choosing to send emails to her NHS account with the deliberate intention that she would not see them. That simply does not make sense.

5.61 So far as there is any dispute as to why the claimant says she had not seen a document, we find that is the reason and not because it was not sent. The respondent consequently was reasonably entitled to proceed on the basis that she had seen the correspondence including the record the meeting on 17 November and did not raise any issues or chase any missing outcome. Similarly, the covering email adds notice of arranging a critical incident simulation day. Perhaps the greatest indication supporting the finding that the claimant did receive her emails, at least during this period, is the fact that the link to join

the teams meeting on 17 November 2021 was sent to her in the email the day before which was also sent only to her NHS account.

5.62 From 17 November 2021, Dr Carney began identifying and contacting the first of the Consultant Anaesthetists at QMC with whom the claimant would be doubling up and who were asked to complete an ALMAT. Soon after, he began to receive those completed ALMAT's. Assessments were undertaken up to 16 December. As is to be expected, the assessments vary as they cover different lists involving different patients and being assessed by different consultants. There are many positive observations. Some assess the claimant as working at a level 4 supervision which is what would be expected of a consultant. The overwhelming picture, however, was that the Dr Hosni could not repeat that work independently of supervision. In other words, she was not working at consultant level. Of the 19 ALMAT assessments, 17 of them scored her at a level below that necessary and to raise matters which did not resolve the concerns about patient safety. We should make clear two issues with the ALMATS. First, the ALMAT's before the respondent were undertaken both before and after this formal assessment period. The fact that the decisions that follow were based on all the ALMAT's was a procedural issue which the independent appeal panel would criticise in due course. They took the view that those earlier ones should be disregarded. That may well be an entirely proper approach when considering the procedural fairness of a process, but we address this at this point as our concern is to discern the reason why things happened. For our part we consider the total picture containing both the positive and negative observations, informs that. The second issue is that some of the assessments did not date the ALMAT form, and some chose not to use the form at all in favour of sending narrative email with varying degrees of consistency with the expected content of the ALMAT form. Again, the independent appeal panel would in due course exclude consideration of those. Again, for our part they remain evidence that is relevant to discerning the reason why things happened.

5.63 We do not need to address the detail of each theatre list in respect of which the claimant was assessed. However, some of them give rise to separate allegations that we do need to reach findings on. The first such occasion was on 1 December when the claimant worked alongside Dr Matthews.

5.64 We find Dr Matthews' first awareness of this matter was when, on 26 November 2021, he received the same email from Dr Carney that Dr Carney was sending to all the consultant anaesthetists at QMC identified as appropriate to undertake and assessment. There was nothing materially different about the email Dr Matthews received compared to the others undertaking assessments, but it is convenient to set it out here. It said: -

> ***I am writing to ask for your help over the next two weeks:***
> ***You will notice in your list at the TC over the next two weeks that you are working alongside Dr Hosni. Dr Hosni is a Locum Consultant Anaesthetist recently employed at NUH. We (The Trust, as asked for by the Medical Directors Office) need to independently assess her competency level. For the past month she has been working at City Campus, but I now need to broaden the area of lists and consultant colleagues she is exposed to, to strengthen the assessment process.***

> ***To this end, I am asking you to allow her to run the your TC list in the same way a trainee may ask you to run a list, as independently as you feel is appropriate / safe with your supervision. At the end of the list, please could you complete the attached ALMAT assessment form together (i.e you and Dr Hosni) and send back to me. I appreciate that this is a form designed for trainees, but it is the most robust form we have immediately available to us.***
> ***Thank you very much for your help in this matter - your independent expert views will help us greatly.***

5.65 As before we repeat our observation that whatever lengths might be attempted to present a neutral request, the very fact of asking one consultant to assess another inevitably imports and inference of some underlying issue. Dr Matthews would himself observe that whilst he had done many ALMAT assessments for trainee's, he had never undertaken one of a fellow consultant.

5.66 We find Dr Matthews and Dr Hosni met for the first time on 1 December. We find they exchanged typical small talk introductions. We do not accept he stated "you are from Egypt" or that he referred to her throughout their time together as Egyptian. We do accept during their initial introductions he asked about her nationality in response to which Dr Hosni told him she was Egyptian. They worked on a gynaecology list including both simple and more challenging cases which Dr Matthews considered relatively straight forward for a consultant. He recorded various issues about record keeping including wrongly noting an absence of allergy in one patient, use of "Train of Four" monitoring, choice of drugs to administer, clinical decision making, choice of Laryngeal mask airway tube size and a failure to label syringes which Dr Matthews reported as prompting a response from Dr Hosni that "she didn't think she needed to".

5.67 While working together that day, the claimant alleges Dr Matthews rudely and aggressively told her that she should leave the room and look in a mirror at her hair and nose. He does not dispute that he had to ask her to rearrange her hair in her surgical hat three times as her hair was not properly tied up. He accepts that on the third occasion he suggested she look in the mirror as her hair was still showing. Similarly, he recalls having to ask her to pull up her face mask on two occasions because it was not covering her nose, a matter that the claimant disputed would cause any risk, thereby supporting the accuracy of Dr Matthews' observations.

5.68 Dr Matthews described never having to remind a colleague to wear PPE correctly, especially in the context of this being post Covid-19. Even though we have not heard from Dr Matthews, we prefer his account of the explanation for his actions. We reach that conclusion because it is consistent with the contemporaneous feedback he wrote, and largely because Dr Hosni's response was focused on justifying that it didn't matter if she wore her mask in a way to expose her nose; that people often don't wear them correctly, albeit she was not saying they were correct, only that it was common place; that there was a lack of infection control risk.

5.69 Dr Matthews did not complete the ALMAT form. He sent an email following his supervised list on 1 December. Whilst not applying an ALMAT supervision score, he gave a narrative conclusion that: -

> ***"I had to keep a very close eye on her and don't think she is safe to leave in theatre unsupervised. In conclusion I really don't think she is suitable candidate for a (locum) consultant anaesthetist post in a teaching hospital"***

5.70 The second specific interaction on which we need to record findings of fact occurs on 7 December when the claimant worked alongside Dr Rattenberry.

5.71 We find the two met for the first time on this day that they were rostered to work on the same list. We find they were not known to each other before hand. Dr Rattenberry received the same email from Dr Carney asking him to perform the assessment. We find that Dr Rattenberry faced the same concern about why he was being asked to assess a fellow consultant. In his case, this was perhaps more related to the fact that he was only relatively recently appointed as a consultant anaesthetist and questioned whether he was best placed to perform such an exercise. He and Dr Carney were well known to each other and, indeed, Dr Carney had supervised much of his training when a Junior Doctor.

5.72 We find he and Dr Hosni met in the theatre corridor and engaged in the usual introductions and small talk. That included the post she had with the respondent and where she had worked previously. We find that natural conversation inevitably disclosed that she was Egyptian and had worked mainly in Egypt. Two things flowed from that which we find to be entirely natural. The first was that Dr Rattenberry shared his experience of a visit to Egypt which we find was in positive terms, save for one experience he shared of being pressed by street vendors. We accept he did not use the term beggars. We accept and find that the conversation at the time did not appear to him to have caused any issue for Dr Hosni. We also accept his evidence that this is a feature of visits to certain countries that the Foreign Office and tour guide specifically warn tourists to prepare for. In summary, we do not accept there was anything detrimental or offensive in this conversation.

5.73 We find the mention of the claimant's nationality also prompted Dr Rattenberry to introduce her to another Egyptian consultant anaesthetist in the department who happened to be present that day. We heard much argument about the facts of this exchange as the claimant could not recall any such introduction. Dr Hassan himself was not called but other evidence was adduced to show he was listed in a neighbouring theatre on that day. We consider it less likely that Dr Rattenberry would fabricate an encounter against the claimant simply not recalling what might have been a fleeting introduction. There is supporting evidence of Dr Hassan being in theatre that day. It supports a finding that the day started in a good place with the sort of friendly collegiate relations one would expect. Outside the context of the introduction to Dr Hassan, we do not accept that Dr Rattenberry thereafter referred to the claimant by her nationality.

5.74 We find the assessment that followed during that list flagged several concerns for Dr Rattenberry. One concerned the way Dr Hosni repeatedly attempted a spinal anaesthesia.

We find Dr Rattenberry was slow to intervene because of the fact both were consultants but he was eventually forced to “scrub” and intervene to perform the procedure himself. This in turn would lead to explanation by Dr Hosni that the operating table was not working properly in that it was not lifting or lowering as it should. She supported this by reference to Dr Rattenberry having to crouch down to perform the procedure himself. In fact, Dr Rattenberry is very tall, well over 6’, and described often having to kneel to perform some procedures. We find the theatre equipment was working within normal parameters.

5.75 We heard disputed evidence about whether the claimant had been pressurised to perform this spinal procedure on this patient against his consent. We reject that. We find the patient was anxious because of an unpleasant experience on a previous occasion. The pre-op process dealt with that. We find Dr Rattenberry explained the factors to weigh and the options and reassured the patient. We are satisfied consent was given by the patient. We do not accept that had any bearing on the later concerns about the way in which the procedure was performed.

5.76 We find how during the day, the two discussed how the patients being seen that day should be cared for during their anaesthesia. We do not find that Dr Rattenberry or other of them raised their voices. We do not accept these discussions could be described as arguing, even at the points where there was a difference of opinion and even on the occasion that Dr Rattenberry stepped in to perform a procedure,

5.77 During the theatre list that they shared, we find Dr Rattenberry became concerned about the illegible state of the anaesthetic record that Dr Hosni had made. For obvious reasons, it is rare for an anaesthetic record to be re-written. Doing so could lead to problems with accuracy and later implications with patient care for any other with good reason to reflect on what happened during the procedure. It is not, however, unheard of. The obvious example of needing to do so would be when a record became soiled because of being completed in the theatre environment. On this day, we find the charts completed by Dr Hosni contained several words that had been scribbled out and were difficult to read. Scribbling out is contrary to the Royal College of Physicians guide which requires amendments to be crossed through and countersigned. He decided to rewrite the anaesthetic record legibly. The problem then is that there cannot be two live documents in theatre. We accept that is why Dr Rattenberry then tore the original in two and left the original on a bench in theatre as there was no confidential waste bin in theatre. We do not accept he ripped it into multiple pieces and left it on the floor for Dr Hosni to see. It may be that Dr Hosni’ suspicion about Dr Rattenberry’s motives arises from the fact this was rewritten whilst she was out of theatre on a coffee break, but we find he explained to her why he had felt the need to re-write the form and that he then put the two halves of the original in confidential waste when he left theatre.

5.78 The ALMAT he completed applied a score for the level of supervision of 1. We find Dr Rattenberry did give oral feedback to the claimant about how he had assessed the day. The claimant says she didn’t take all of it in.

5.79 After the assessment, Dr Rattenberry messaged Dr Carney saying: -

Doctor Hosni a concern. Major concern technical skills. Poor and dangerous spinal technique. Gave feedback but second attempt just as dangerous and also a failure. Many other concerns. I will complete ALMAT but wanted to let you know.

5.80 Dr Carney replied with: -

Thanks Will. Yes we will review all the ALMATS. Feedback has been very variable. Sorry to give you a tricky day!

5.81 And Dr Rattenberry responded with: -

Surprised by variable. What I witnessed was poor. I have had to be honest and I think she is disappointed with me and said I could have been more supportive.
ALMAT sent.

5.82 In the same way that we do not need to recount the detail of every assessment, it is equally unnecessary to recount the detail of each challenge to a number of clinical decisions made by the claimant. We heard much evidence during the claimant's cross examination of the respondent's witnesses challenging the basis on which others had formed critical views of her clinical decision making. Whilst we were concerned not to get too drawn into differences in clinical practice, we allowed this questioning, at times at length, on this basis. If the respondent's witnesses stated reasons for acting as they did was undermined, namely the interest of patient safety arising from the claimant's clinical practice, that would be a relevant and important fact to inform the inferences we might draw from the evidential landscape. In the event, each challenge to clinical practice fell flat. Moreover, the process of challenging the witness meant their explanations of how and why they held the concerns they did in the context of the particular area of clinical practice was reinforced. The challenges covered technical aspects of how medication is administered; the choice of medication; the medical equipment used; how records should be kept; the requirement for how PPE was worn; the decision making at pre-op stage. All were all challenged in many cases by reference to the anaesthetic notes disclosed during the hearing of particular patients that the claimant encountered. We found faced with those challenges the respondent's witnesses maintained and their views about the clinical decision made by the claimant which only served to give us confidence in the legitimacy of their clinical concerns. Whilst some of those differences were in the nature of variations in acceptable clinical approaches, which might be explained by unfamiliarity in the differences in local or national preferred practices or techniques, others were more fundamental to patient safety.

5.83 On the evening of 7 December 2021, Dr Hosni emailed Dr Carney to raise her own concerns about the clinical competence of Dr Rattenberry. She referred to the spinal anaesthetic procedure that both she and Dr Rattenberry had performed and identified various aspects of what she had observed about Dr Rattenberry's practice that she considered to be surprising and worrying in contrast to how she was accustomed to practicing, especially in the context of the anxious patient they dealt with. She concluded with the line: -

I hope Sir you would take my comments in consideration as you take his.

5.84 The claims of direct discrimination rely on a hypothetical comparator save in one respect where the claimant says she was treated less favourably than Dr Rattenberry because she raised concerns about his clinical competence, but nothing happened to him. We do not accept that he is a comparator in materially similar circumstances. First and foremost, it is not the case that nothing happened because of her complaint. We accept that Dr Carney did contact Dr Rattenberry to raise this with him and explored the various aspects of clinical decision making that were alleged. In each case, and after understanding the context of the patient's circumstances, Dr Carney was satisfied that the clinical decisions and actions were in the nature of what was clinically justified. In short, there was not the body and breadth of clinical concern about Dr Rattenberry. Dr Rattenberry was also someone who had undertaken his training within the Trust including with Dr Carney. That is not to say he benefitted from favourable treatment simply for that reason, the fact is he had a long history of having his clinical skills assessed and Dr Carney could draw on that knowledge in a way that he could not in assessing Dr Hosni's skills.

5.85 On 8 December 2021, Ms McCracken sent a further email to the Claimant requesting that she provide her with the necessary email addresses to verify her references. It is not entirely clear whether HR were ever satisfied in the references they eventually received. We were shown various other documents from the alleged referees. We do not need to go any further in respect of those documents, and we certainly do not reach any findings of fact of substance, save to say there appeared to be discrepancies in the handwritten signature of one referee which would at least give any lay person contemplating their authenticity reasonable grounds for further enquiry.

5.86 Arrangements were put in place for the claimant to undertake a critical incident 'simulation' day. These are artificial simulations to test responses to various high-risk scenarios as a means of safely assessing the doctor in question on how they responded to them. They are performed on mannequins, not live patients. We find trainees are required to pass a simulation test. We accept, as with the ALMAT assessment, it is all but unheard of to require a consultant to undergo a simulation test, but they are used for training purposes for all grades of doctors, especially when trialling a new technique. We accept that simulation is less about the technical execution of a task and more about how the person reacts to the changing clinical situation in a pressure. It is as much about planning, communication and involving others in the team. We accept the artificial nature of simulations means they are not easy.

5.87 We find Dr Carney has arranged for other doctors to facilitate the simulation day. In the event, one of them had a domestic emergency which meant they could not so another had to be found. Dr Carney initially considered doing so but decided against it due to his wider and previous involvement in the process. Dr French stepped in and although he had previous involvement, we accept it was the least-worse option to go ahead with him rather than reschedule.

5.88 At some stage of arranging the day ahead, Dr Carney and Dr Hosni spoke about the simulation day and whether she had experienced a simulation exercise before. It is alleged that Dr Carney said, in a mocking manner, “do you have simulation days in your country? We find Dr Carney did want to know whether the claimant had experience of it. If not, we find it likely the process would have had to be moderated, or at least the assessment factor in the additional factor of unfamiliarity of the process. It seems to us therefore, that the enquiry itself was entirely legitimate. As there is no dispute that an enquiry broadly of this nature was made, it is entirely possible, as Dr Carney readily concedes, that the words alleged may well have been how he posed that enquiry. However, we do not accept that Dr Carney conducted himself at any stage that could be described as “mocking” or otherwise with a purpose to humiliate the claimant. In making that finding we have regard to Dr Carney’s acknowledgement from the very first meetings with the claimant that this was a difficult process for her, that he had done what he could to make the assessment process as independent as was possible and we therefore simply do not accept that he would engage with Dr Hosni in a way that would make that more difficult than it was already. We do not accept as a fact that Dr Carney asking this question caused her to feel humiliated or offended in any way.

5.89 The simulation exercise itself resulted in Dr French and Dr Munford concluding there were concerns about the Claimant practicing independently because it was felt she did not meet the standard expected of a Consultant in the NHS. Again, we heard a great deal of evidence about the actual scenarios being tested in the simulation and the clinical procedures that the claimant sought to deploy in response. For some time during evidence, we focused on whether a needle or scalpel front of neck procedure was appropriate or not. We found the position of the assessors was that whilst there was a preferred technique advocated within the UK, the claimant’s approach was not an improper technique. To that extent there was clear evidence of those assessing the claimant recognising a range of clinical approaches. Their concern was, mainly, about her decision making and communication with others in theatre, rather than choice, or execution, of a particular technique. We also accept that the concerns were not focused on ALS skills. Only one of the simulations engaged with that specifically. The concerns raised related to decision making steps and of signposting of concerns. They included communication the need to be prompted and the assessors were concerned about the claimant’s failure to ask for assistance. For our part we can understand why someone unfamiliar with the simulation process, in the circumstances that the claimant was then in, may well have felt that asking for assistance was itself a sign of deficiency as opposed to pressing on independently but that only goes so far. Apparently, there was feedback between each scenario and this concern can only be militated on that basis for the first exercise, not the subsequent once where it was apparently repeated. One of the main concerns was what was described as task fixation. The feedback concluded with an opinion that: -

> ***Practice demonstrated today in an actual patient would significantly concern any team member she would work with at NUH and could lead to patient harm.***

5.90 This process of doubling up lists, the ALMAT assessments and the simulation were all part of the initial fact finding. In other words, the Claimant was not in a formal process at that time. The results of these assessments were what would inform whether the claimant could be given her own independent lists or whether the matter progressed to the formal capability process.

5.91 The way Dr Bhandal and the decision-making group went about that assessment was to convene a panel of three other experienced consultant anaesthetists to review the assessments and arrive at a recommendation. In late December 2021, Dr Sally Hancock, Dr Deborah Hinchliffe and Dr Vicky Webster were asked to perform this task. All had a background of education and training. They reviewed the assessments and the evidence gathered.

5.92 Dr Hinchcliffe provided her feedback on 21 December 2021. She took the view that Dr Hosni was not functioning at consultant level and that, at best, she required supervision from a consultant who was immediately available within the theatre suite. From a patient safety perspective, there was a risk that the Claimant needed a level of support that was not available. Perhaps of greater concern was the conclusion that Dr Hosni appeared to have a "lack of insight into her own limitations", and without some insight from the Claimant that she might need assistance in certain situations, she may not ask for timely assistance. On 24 December 2021, Dr Webster provided her feedback. She concluded that the Claimant was not functioning at consultant level and that she failed to show adequate knowledge of ALS and failed airway management which needed to be addressed before the Claimant could work without supervision, but that she could function if there was immediate Consultant supervision. She felt that Dr Hosni was a patient safety risk and not at the national standard expected of an NHS Consultant. On 4 January 2022, Dr Hancock provided her feedback. She concluded that the Claimant was not working at the level of a consultant. She felt the comments provided by the assessors were akin to a struggling junior doctor in training. Dr Hancock advised that the Claimant should not work with trainees and would benefit from a 'buddy' (i.e. a consultant colleague that can provide support in and out of theatre), and there was at that stage a risk to patient safety.

5.93 The result of this panel assessment was that the question now had to be asked whether this case required referral for a MHPS capability investigation. Management of the process then transferred from Dr Carney to the Medical Director's office and in particular, Dr Bhandal. Initially, Dr Carney had made arrangements to meet with the claimant to feedback on the assessments overall. Dr Bhandal took the view that the Medical Directors Office should now take over. As there appeared to be a need to formalise the investigation, we find Dr Bhandal advised that the assessments were not shared with the claimant at that stage. We find the reason for that decision was because she was conscious of the risk of it having an impact on the formal process. Of course, although Dr Hosni did not have copies of the ALMAT forms, in most cases the individual assessments had been discussed with her on the day, or at least the assessing consultant had attempted to engage in feedback. We find that Dr Hosni was not always well disposed to listen to other's opinions.

5.94 On 6 January 2022, we find Dr Bhandal sought advice from the GMC Employment Liaison Officer for this employer ("ELA") about making a referral to the GMC. At that stage, considering the extent of the concerns raised so far, she was minded to make a referral but wanted his input.

5.95 Around mid-January further concerning feedback appears to have been given by an operating department practitioner (ODP) to Dr Dawson who had conducted both an ALMAT and was present at the simulation day. He forwarded the concerns to Dr Carney. In short, the ODP had described Dr Hosni's technique with patient's airways as "awful", lacking finesse and observing that it resulted in a small cut to the lip. It was also framed in balance that, like many of us, this ODP found her to be a very pleasant person but not someone functioning at the level of a consultant. Dr Carney shared this with Dr Bhandal. It seems there was now a growing concern that some colleagues might refuse to work alongside Dr Hosni.

5.96 We find Dr Bhandal maintained the course to refer the case and repeated the need for the Claimant to work only with supervision. Within her communications with Dr Carney, she agreed with the risk of colleagues taking their own action and used the phrase "but our hands are tied". We do not accept there is anything hidden or sinister in that phrase. It is simply reflecting the fact that the matter was now proceeding to a formal referral and that had to run its course.

5.97 Pausing there, we need to touch briefly on the issue of ALS that Dr Webster mentioned as part of her feedback.

5.98 We heard there are two levels of training. Namely medical life support and advanced life support. We remained in some uncertainty as to the exact distinction between ALS and MLS. Whilst a distinction was drawn and explained, we did not find everyone referred to the differences consistently. Perhaps ALS gets used in a generic sense in some contexts. In any event, the claimant's life support training was stale, in that it needed refreshing, but the point was not about training per se and where the responsibility lay for arranging that training. The point was simply whether the claimant displayed the skills and competencies in life support that would be expected of a consultant in the UK which Dr Webster had concluded she did not

5.99 Insofar as the surrounding circumstances for updating her ALS skills is relevant, we find and accept that around this time Dr Hosni undertook some independent study, borrowing a practice text on the subject from the Medical Education library. We find taking this approach was largely due to the fact that she had failed to book onto the ALS course she had identified as requiring when starting in October. We also find that Dr Carney was extremely supportive of her attending that ALS course and, in late November when corresponding about other matters, he impressed on her how "*the ALS course is an excellent idea and very necessary - you should definitely attend this course and ensure you pass!!*". Dr Hosni had been prompt in engaging with the training department to try and obtain a place on the next course but failed to secure a place because she didn't respond to their subsequent booking invitation and, by the time she did, the course was full.

5.100 Returning to the chronology, on 19 January 2022, Dr Bhandal met with Dr Hosni. The purpose was to discuss the result of the assessments. We accept it was a difficult meeting for all. In part that was because there was a direct conflict in the respective views of Dr Hosni's performance. She felt she had performed well. Dr Bhandal was conveying evidence of many others to the contrary. Dr Hosni did not always maintain her argument that was performing well. An alternative argument arose in this meeting that was advanced before us, namely that there were difficulties for her performing in unfamiliar environment alongside fellow consultants whom she did not know whilst being observed. The contention was repeated that she should be allowed to work alone. As before, we accept that the state of the opinion about the risk to patient safety was such that we accept the Trust could not permit that.

5.101 Dr Hosni was told most of the assessments showed serious concerns and that she was not working to the standard of a Consultant in the UK. The meeting explored the detail. Dr Hosni pointed to the fact that no patients had suffered serious harm. That, too, was a line maintained in the evidence before us. We accept that no patients are known to have died or be injured under the care of Dr Hosni. We also accept the respondent's position that the need for action to preserve patient safety is engaged when there is a reasonable basis for it to be at risk. It is not left until there actually is a serious clinical adverse incident. We also accept that those assessing Dr Hosni were concerned that that was such a risk, were observing and supervising to various degrees of physical proximity and, at times intervening when things appeared to be going wrong. Dr Hosni was told the situation would be referred to a formal investigation.

5.102 During the meeting the claimant was told that the GMC had been informed of the outcome as, we find, the Trust was bound to do. The GMC position was that the situation did not require a referral because the patient safety risk was being mitigated by the respondent only permitting the claimant to work under supervision. However, if the claimant were to work outside the Trust, this would become a concern for the GMC and pass its threshold for formal referral. We find this was not considered to be an issue because during the meeting Dr Bhandal had asked Dr Hosni to reflect on where things had got to. We find she was asked not to engage in clinical practice as an anaesthetist. We find that Dr Bhandal had understood that the claimant agreed, or at least did not object, to restrict clinical practice including in respect of work for other health care providers. We find the Trust's internal procedure in respect of "Conduct Capability and Ill-Health for Medical Practitioners" deals explicitly with the two forms of restriction on practice in section 7. Firstly, there is a difference between voluntary restriction and one imposed when a doctor does not agree. Secondly, the doctor has a duty to inform the Case Manager conducting the investigation of any other organisations they work for. We find this procedure was guiding Dr Bhandal's decisions. Under the voluntary restriction, the doctor in question agrees not to undertake any work in their area of practice unless the third-party organisation has confirmed they are aware of the restrictions and are still prepared to engage them. We find failure to comply could lead to disciplinary action, as well as a GMC referral.

5.103 The meeting was reconvened on 21 January 2022 to discuss arrangements in relation to the formal investigation and options for the work she might do until then. Dr Hosni was invited to bring a colleague or BMA representative. Dr Hosni wished to see the assessments. That is quite understandable. Dr Bhandal declined to release them at that stage, consistent with her earlier advice to Dr Carney on the same point. We find the reason for that was that the matter was now proceeding to a formal process, this was the first formal MHPS that Dr Bhandal had led in her position of Associate Medical Director, and she was concerned not to compromise that formal process. One purpose of the meeting was to consider options for redeployment and next steps. Two areas of work were potentially available. One was working in the Covid-19 Medicines Delivery Unit. We accept that work was serious and important clinical work, and it was entirely reasonable for the Trust to offer it. Equally, it is not clinical anaesthetic work, and we make no criticism of the claimant's concerns when declining it. The other area was in research or audit work. We find Dr Hosni was at least prepared to consider that, albeit in due course it would come to nothing as Dr Hosni considered she would have been treated as a student researcher, as opposed to a co-author on any research undertaken.

5.104 Within her challenge to the basis for the investigation, Dr Hosni asserted examples of poor practice of other Consultants. We find Dr Bhandal genuinely took the view this was not raising safety concerns about those other doctors, but was being used to demonstrate and support Dr Hosni's view that she did not agree that there were significant differences between them and her own practice. We find those present discussed the formal process and parted on terms that Dr Hosni would consider the alternatives let Dr Bhandal know. The outcome and summary of both meetings was recorded in writing and sent to the claimant in a letter dated on 24 January 2022. Whilst Dr Hosni agreed the content summarised the topics they had discussed, some aspects of those meetings led to disputes of fact before us. Dr Hosni said originally in her list of issues that Dr Bhandal told all consultants that she was not happy with her work despite the Claimant performing well. We find Dr Bhandal did not say and do that. There was no need for her to tell consultants that she was not happy with the claimant's work. There was no evidence of that and, in any event, it was a number of those consultant colleagues who were themselves consistently informing Bhandal through the ALMAT assessments that *they* had concerns about Dr Hosni's work. For that reason, we accept Bhandal did not at any time state that the claimant was "working well". We find Dr Bhandal did express to Dr Hosni that many of the consultants that had worked with her were not happy with her clinical performance. The allegation in the list of issues was varied during the hearing to reflect this variation in the complaint.

5.105 One of the most significant aspects of this meeting was to consider and action a restriction on the claimant's clinical practice. The restriction to practice is a significant step and we might have expected to see it referred to a little more prominently than it was. There is no doubt the outcome letter summarises discussions about GMC and the advice from Practitioner Performance Adviser ("PPA"). Equally it records a discussion on the point in terms that says Dr Hosni: -

> ***"would be required to step out of clinical anaesthetic practice whilst the investigation takes place.***
>
> ***You asked me to reconsider this as you believe your practise to be safe; However, I explained to you that given the wealth of information received trust has an obligation to fully investigate and ask you to step away from clinical practise until the investigation has been concluded.***

5.106 We are sure that, at the time, this appeared to convey all that was needed. In hindsight, and particularly viewed from the current view point, it might have been better if the record made the restriction more explicit, perhaps by reference to the procedure, the understanding that it was a voluntary agreement as opposed to an enforced restriction which, at times, it seems to be conveying, and perhaps most importantly that the restriction applied to any clinical practice in the UK, not just in the Trust. It is perfectly possible that in this communication, the exchanges during the meeting and even in some of the subsequent communications on this point that Dr Hosni's understanding was not the same as Dr Bhandal's understanding about what was being agreed to. However, there were several other factors and statements around this time that lead us to accept Dr Bhandal's evidence of both her explaining the voluntary restriction to practice and her understanding that Dr Hosni had agreed to it, even if they were not entirely as one.

5.107 The restriction to clinical duties is referred to explicitly in an email from Dr Bhandal on 26 January 2022 confirming it was discussed at the meeting. The content is also consistent with emails from HR after the meeting following up the alternative work as well as the advice from the GMC ELA that a fitness to practice restriction was not necessary whilst the claimant was voluntarily agreeing to restrict her practice. We find had Dr Bhandal in any way believed that Dr Hosni was not in agreement with the voluntary restriction, we are satisfied she would have imposed the restriction formally under the policy which would then have led to a different response from the GMC. Moreover, the claimant's subsequent actions in at least giving consideration to the research alternative only served to reinforce Dr Bhandal's belief that the claimant agreed with the voluntary restriction to clinical practice. The Claimant remained on full pay throughout.

5.108 Around the time of Dr Bhandal's decision, it came to light the claimant had erroneously been booked to run a surgical list of her own. We find Dr Bhandal forwarded the email to Dr Carney who took steps to remove her from the list. He contacted Dr Hosni to correct the error informing her that as a decision had been made to restrict her clinical practice, she should not be working in theatres until the investigation concluded. Dr Bhandal corrected Dr Carney's wording which suggested the restriction was imposed and explained she had voluntarily agreed. He then rewrote the email to Dr Hosni saying:-

> ***Sorry Mona***
>
> ***Please can I reword that email.***
>
> ***I have been informed that you agreed to step back from patient facing clinical activity whilst the investigation is ongoing.***

5.109 This did not prompt any challenge or correction to revisit the understanding that this was a voluntary restriction.

5.110 We find that Dr Bhandal did not tell the claimant that she would be reported to the General Medical Council. She was told of the interactions with the GMC which, at that stage, was not felt required any action. Again, the reason for that was the understanding that the claimant was consenting to a voluntary restriction.

5.111 Our understanding is that the voluntary restriction would be a viewed by the GMC as positive factor in any subsequent fitness to practice hearing. It demonstrated awareness of a potential patient safety and showed insight and reflection, even if the basis for the underlying concerns were themselves challenged. We did not follow Dr Hosni's contention that she would have been in a better place to have had an enforced restriction to her clinical practice placed upon her.

5.112 Through February, as the formal investigation was set up and an investigating panel assembled, Dr Hosni began contacting doctors she had worked alongside asking for feedback. We can understand why she would want to collate evidence of what she felt were examples of clinical competence. Some were uncomfortable about being drawn into the formal process. That is not to undermine the evidence they had given in their assessments. We find it was largely a result of the fact that this employer had recent experience of extreme responses to investigations of clinical practice. Whilst there is no suggestion that Dr Hosni was in anyway threatening to these other doctors, it is understandable why some did not want the contact at this stage or as things progressed to the hearings themselves.

5.113 Dr Carney emailed Dr Hosni on 9 February 2022. The matters raised included revisiting her decision on working in the covid medicines delivery unity. It included identifying and offering Dr Philips as a mentor or "buddy" to support her during the upcoming process, which the claimant subsequently declined. It also included the concerns expressed by colleagues about Dr Hosni contacting them seeking feedback and he asked her not to do that and restating that the current investigation may share the ALMATS but until then, he was not able to do so. The final point was in respect of the restriction to clinical practice. This was the foundation for seeking to find alternative work for her but, more significantly, Dr Carney made the following request: -

> ***Finally, please can I ask you to provide Dr Bhandal and I assurance that you are not seeking any further short term locum work in any other Trusts / UK hospitals currently, because this would be inappropriate until the formal MHPS process had been completed.***

5.114 One might think that if there had been any ambiguity about whether the restriction to clinical practice, whether voluntary or otherwise, was limited to the respondent's hospitals or to all clinical practice, that Dr Carney's request would make things clear. As will be seen below, Dr Hosni did not interpret this with the clarity we might think it provides.

5.115 Initial arrangements for setting up the formal investigation were made in February 2022. Dr Andrew Marshall, an ENT consultant, was appointed as the investigation case

manager. His task was to set the terms of reference. Dr Mark Ehlers, another consultant anaesthetist, was appointed to conduct the formal investigation with supporting from Mr Wooley in HR. The policy defines how those terms of reference are set and by whom. We do not accept the claimant was treated differently or with any unfairness in not being able to contribute to the terms of reference of the employer's investigation into her own capability. The procedure defines that is for the employer, and particularly the case manager. The terms of reference identified 8 discrete points of investigation, within some wider considerations. They were –

> ***TOR 1***
> ***The circumstances around recruitment in particular whether the remit of the role at NUH was discussed, to explore the skills and experience outlined by Dr Hosni and whether any development needs were identified.***
>
> ***TOR 2***
> ***To review the systems and processes in place regarding induction into the Anaesthetic Department. Specifically, to establish what induction and ongoing support Dr Hosni received at both Nottingham City Hospital and The Treatment Centre when she commenced her post, and whether this was adequate.***
>
> ***TOR 3***
> ***The circumstances around a meeting on 03/11/21 attended by Dr Carney and Dr Hosni to explore concerns that Dr Hosni was not working at the level expected of a UK Consultant Anaesthetist. In particular to explore how the concerns had arisen and what was discussed relating to initial feedback obtained from colleagues. In addition, was Dr Hosni made aware of these performance concerns and was any evidence provided.***
>
> ***TOR 4***
> ***The circumstances around a meeting held on 17/11/21 attended by Dr Carney, Dr Hosni and Tina Bull which led to Dr Hosni agreeing to transfer to The Treatment Centre for a period of formal assessment as a supernumerary trainee. In particular what was Dr Hosni told about her performance, the assessment process and the reasons for the transfer.***
>
> ***Explore the process relating to the period of assessment at The Treatment Centre. In particular:***
>
> ***TOR 5***
> ***To explore which assessment tools were used to assess competency and were these valid tools and appropriately applied by assessors experienced in their use to determine an Initial level of competency in Anaesthesia.***
>
> ***TOR 6***
> ***To explore the circumstances related to assessments at a critical incident simulation session held on 16/12/21 by Dr Munford and Dr French. In particular, were the simulation scenarios appropriate for a Consultant Anaesthetist and conducted using a recognised form of assessment by assessors familiar with simulation training. In addition what feedback did Dr Hosni receive after each scenario to allow for learning.***
>
> ***TOR 7***
> ***To explore the review of the assessments and feedback gathered by 3 Consultant Anaesthetists (Dr Hancock, Dr Hinchliffe, Dr Webster) during the assessment period. In particular, were the reviewers adequately qualified to review the assessments and were their conclusions objective and free of bias. Was it reasonable for the reviewers to conclude that Dr Hosni was functioning well below the level expected of a UK Consultant Anaesthetist.***
>
> ***TOR 8***

> ***To explore if the assessment process was robust, impartial, objective and free from bias. In particular were there adequate numbers of independent consultant assessors and assessments to fairly and thoroughly assess competence. In addition what feedback did Dr Hosni receive during this assessment period.***

5.116 On 22 February the claimant commenced a period of sickness absence, or at least the circumstances to her absence from work were understood to relate to her health. Consequently, by March Dr Bhandal was exploring an occupational health referral. Dr Marshall decided to pause the investigation due to Dr Hosni's absence. A referral was made to Occupational health. The claimant would in due course attend an occupational health appointment on 25 March but declined to consent to any report being shared with the respondent. In part, the claimant's position has been that she was not unwell but was simply forced out from her work.

5.117 In any event, on 21 February 2022 the claimant did submit written response to the Terms of Reference which was before the investigation. At this stage in the chronology, we need to touch on one aspect of the claimant's response to those terms of reference, specifically TOR 7. Within that is a line which reads (with our emphasis added): -

> ***Hence all objective conclusions were biased and wasn't reasonable to reflect after all these years of experience in so many different countries that I was functioning in any way below the level of a UK Consultant. I had 15 years ago <u>and at present</u> references from UK Consultants praising my Consultant practice .I would send you a sample should you wish.***

5.118 Whilst Dr Hosni did not respond to Dr Carney's request for assurance that she was not working at other hospitals, she relies on this as a disclosure to her employer that since being restricted from clinical practice, she had undertaken clinical work for other trusts on other locum contracts. She says her use of "and at present" was a reference to that current alternative work she was by then undertaking. We can readily understand why no one reading this at the time would have thought to themselves that this was a disclosure by her of actually working in contravention of what they all understood to be a voluntary restriction.

5.119 In fact, by the time of Dr Carney's request for that assurance, the claimant had undertaken clinical anaesthetic work at another trust on 4 & 5 February. Not only did she not give Dr Carney the assurance he sought, but she worked again at that other trust between 11 and 14 February and then, again at a different trust on 24 and 25 February and then again, at a different trust in March and May. The claimant explanation to us for apparently ignoring Dr Carney was because she considered that his use of the word "inappropriate" conveyed a level of curtailment which might be something that some would think should not happen but was short of an absolute restriction or prohibition. Her evidence was at times inconsistent between not being told and that the restriction was imposed on her and being told but not agreeing to it voluntarily. She said if she was told she would argue against it. We find she was told, but she did not argue against it.

5.120 Her intention to undertake this work was not only to continue to practice, but in doing so to obtain positive evidence and references of her clinical skills. In that regard we do accept

that she obtained favourable, or at least uncritical, references of sorts. These were gained using the agency reference form conventionally used at the end of any short-term locum contract. They are typically completed by the surgeons with whom the claimant worked, not a fellow anaesthetist. We understand the claimant was keen to demonstrate positive clinical practice. However, we were concerned that in her desire to produce evidence, she appeared to have obtained patient medical records during those locum placements which she had retained for that purpose.

5.121 Whilst the focus of the Trust's later concerns was conducting clinical practice during a period of restriction, it is right to say Dr Hosni was also being paid by the respondent at the time, whilst not taking up any of the alternative work offered to her.

5.122 Dr Ehlers then set about gathering the documentary evidence and arranging interviews with the relevant witnesses. There was delay in this process. Much of the initial delay was due to the claimant's ongoing absence either for sickness reasons or, generally, because of her restriction. On that point, we find efforts were made by HR to engage with the claimant during her absence as much for wellbeing checks as anything. Dr Carney continued to contact the claimant and attempt to secure some non-clinical alternative employment. On 11 February 2022 Dr Carney emailed colleagues with a view to identifying alternative work. It is another communication that potentially has implications for the claimant's case, and we therefore set it out in full. It was not seen by Dr Hosni until disclosed in the course of preparing the bundle for these proceedings. It reads: -

> ***Mona Hosni is a locum consultant from Egypt. Unfortunately, we are currently unable to accommodate her in a theatre setting. However, we do need to offer her some alternative work within the hospital.***
>
> ***I have been asked if she can sit in on some pre-op clinics.***
>
> ***Next week I have slotted her in to your clinics. This should be in an observer role only initially. In time, we may be able to allow her to review notes etc, but for next week, please allow her to observe how the clinic process works.***
>
> ***Many thanks for your help***

5.123 It also looked at one stage as if the research work with Professor Moppett may happen. On 3 March there appeared to be agreement that Dr Hosni would make contact with him. There was some contact, but the work did not take place. On 20 April 2022, Dr Hannah Sycamore asked the claimant about this in correspondence that asked Dr Hosni to confirm what work, if any, she had been doing. The Claimant explained that she had not commenced any research project work because in her view it did not make sense to do so whilst restricted from practice, that the pre-op clinics were humiliating and that there had been some miscommunication with Professor Moppett. The Claimant also said that she had been undertaking her own research work outside of her responsibilities with the Trust.

5.124 Through March the issues with confirming the claimant's references raised the question of honesty or probity and consideration was given to whether to amend the terms of

reference for the formal investigation beyond the extent to which they already formed part of the enquiry. The Medical Director's decision-making group decided not to, principally because the risk of delay that would cause to the investigation.

5.125 The date of 20 May 2022 is a significant day in the chronology for three reasons. The first is that, in a letter of that date but attached to an email to HR sent late on 19 May, Dr Hosni resigned giving one month's notice. Her resignation said: -

> ***Please accept this letter of my resignation from my position as a Locum Consultant Anaesthetist***
>
> ***As you are well aware and as I had reflected on multiple occasions that I was unfairly treated and was subject to serious misbehaviour and unlawful attitude even from the very first day of starting and this was for no obvious reasons. Still if there were reasons this won't ever justify that.***
>
> ***It was really extremely upsetting and had countereffects on the whole team and on myself thereafter***
>
> ***Being that detrimental till this moment of time. you can see that the working environment is no longer comfortable for all parties***
>
> ***As a result, I apologize for any inconvenience I might have unlikely caused***
>
> ***However, as you well know I incurred huge expenses for relocation next to the hospital and had been subject to tenancy agreements which can't be broken***
>
> ***So, I presume for all fairness I need to be paid the salary till the end of the contract as a compensation for what took and is still unfairly taking place***
>
> ***Please look into that with serios consideration***
>
> ***May I finally take the opportunity to thank you for your support all way through***

5.126 The second event of significance on 20 May 2022 is that it was the day Dr Ehlers interviewed Dr Hosni as part of his investigation. Dr Hosni was supported by Dr Oni, BMA chair of the Trusts LNC. She provided a detailed statement. They explored matters relevant to the terms of reference. The claimant did not disclose to Dr Ehlers that she had resigned. He learned this a few days later when the statements arising from the investigation were shared with her. At that stage, she said she had resigned as she felt she could no longer engage in the process.

5.127 The ALMAT forms that Dr Hosni had previously requested had by now been made available to her in preparation for this interview. Dr Bhandal's previous stance had been that they would be disclosed as part of formal process at the appropriate time. This was that time and, curiously, the claimant then said that she chose not to read them, saying that was because the consultants have been told what negative and unfair comments to write.

5.128 The third event of significance on 20 May 2022 is that it was on this day that the Trust became aware of the claimant undertaking the clinical work for other hospitals in breach of what was understood to be the voluntary restriction. This appears arose through Dr Ehler's

investigation. He passed on the information but did not himself take the action that followed in consequence. The first of which was a decision on whether this warranted a counter fraud investigation on the basis that the locum work took place during the time the claimant was notionally available and being paid by the respondent. An urgent meeting was arranged with Dr Roberts and Dr Keith Girling, Medical Director. Dr Roberts was unable to identify at that stage whether Dr Hosni carried out shifts in her own time or not. Steps were then taken to contact the Claimant's recruitment agency for clarification. At this stage the agency was called Holt, not Remedium through which she had initially been appointed. Dr Bhandal wrote to the claimant on 20 May. She said: -

> ***Dr Ehlers has also brought to my attention your disclosure to him today that you worked clinically as a locum in Leeds and Doncaster in February. This was after you had accepted a voluntary restriction on 21.1.22 to non-patient facing duties, and I understand was booked through Holt agency.***
>
> ***I have discussed these issues with Dr Girling, who is the Medical Director and your Responsible Officer. We have agreed that a senior member of the Medical Director's office and HR department need to meet you to discuss these two issues early next week. We will write again with arrangements for the meeting. In the meantime, you must not undertake any clinical work for any organisation given your voluntary restriction to non-patient facing duties. If you have any locum work booked, this must be cancelled. Please provide me with details of all the agencies you are registered with. We will be contacting Holt Agency early next week, but you also have a personal responsibility to notify any locum agencies you are registered with of your restriction.***

5.129 A decision was taken not to add this matter to the agenda for a pre-planned meeting with Dr Hosni as it would give insufficient notice to her to prepare. In the event, the meeting planned for 25 May did not happen as Dr Hosni said she was too unwell to attend. By the end of May, enquiries with the claimant's agency had confirmed she had performed the shifts we referred to earlier in February but, it is only during disclosure for this case that the respondent obtained the knowledge of the later shifts at the third alternative trust.

5.130 The second significant decision concerned the regulatory issues. We have already noted the original GMC advice to Dr Bhandal was that a fitness to practice referral was not necessary as the risk to patient safety was being managed by the voluntary restriction. In terms, as long as the claimant was not working elsewhere it was not required. That had now changed. Further advice was sought from the PPA which invited a referral for there to be consideration of issuing a Healthcare Professional Alert notice (known as a HPAN). Dr Bhandal made that referral on 24 May 2022. The HPAN itself is a notice issued by an independent organisation called NHS Resolution. We find whether it responds to a referral is its decision. In this case it did, and it issued a notice concerning Dr Hosni. The practical effect of such a notice is that she would not pass any pre-employment checks for other clinical work.

5.131 We should add whilst referring to NHS Resolution that it is also the agency with a responsibility to support the independent assessment of a doctor's clinical capabilities under the MHPS. Enquiries around this time on that aspect of their work showed it was no longer something it could support as the claimant had resigned.

5.132 At the same time the Trust also revisited the advice of its GMC ELA. For similar reasons, he also advised that the respondent should now make a referral to the GMC. An emergency meeting of the DMG was convened which decided to make the referral. We find the reason was the belief that the claimant had been working elsewhere in a clinical role whilst subject to a restriction to her clinical practice. Subsequently, a GMC restriction was imposed. It appears to have been delayed. That delay seems to us to have been due to the appeal process.

5.133 On 9 June 2022, the Claimant emailed Dr Girling in his capacity as Medical Director. Her concerns were broadly about her sense of unfair and inappropriate treatment by her employer. We find this complaint was a repeat of concerns she had attempted to raise with him in February 2022 and part of this renewed complaint was the fact that he had not replied to at all to that earlier complaint. We find the single and determinative reason why she did not receive a response is because she incorrectly addressed the original email, and he had simply not received it. Arrangements were then made for Dr Girling to meet her on return from his annual leave.

5.134 Within those complaints, the claimant did not suggest the unfair or inappropriate treatment related to her nationality.

5.135 Two days before Dr Hosni's notice was due to expire, on 17 June 2022, the Claimant asked to withdraw her resignation. She simply wrote

> ***I am writing to withdraw my letter of resignation, submitted on 19.05.2022 I no longer wish to resign***
> ***I sincerely apologize for any inconvenience caused by my withdrawal. I think all matters needs to be resolved***

5.136 Dr Hosni also then raised her concerns about her treatment through the Trust's Freedom to Speak-up Guardian. The guardian discussed them and put a summary to the Chief People Office on 17 June 2022. The summary concludes with 11 specific questions broadly raising similar points to the allegations in the case before us. They do not appear to reference her Egyptian nationality although the covering email does state how Dr Hosni "strongly feels she has been discriminated against". The respondent, through its HR department, responded to her offer to withdraw her resignation declining to agree to the withdrawal but did agree to explore the issues raised by her in the meeting planned with Dr Girling.

5.137 The claimant's employment with the respondent terminated on 19 June 2022 on the expiry of her notice. Notwithstanding this, the investigation continued.

5.138 On 9 July 2022, Dr Ehlers concluded his investigation report. Before then, Dr Hosni raised some challenges to the process, in particular to Dr Ehlers' independence. Dr Marshall responded assuring her of his appropriateness to conduct the process. So far as anyone within a single organisation can be said to be independent, we are entirely satisfied that Dr Ehlers' went about his task prepared to reach whatever conclusion was justified by the

evidence before him. His report is detailed and the analysis thorough and balanced. It addresses each of the matters raised in the terms of reference and the wider recommendations. We find it fairly acknowledges various aspects of the case that might have put Dr Hosni in a difficult position or otherwise disadvantaged her. One example is that she was unfamiliar with ALMAT's as they were not used during her training or, it would seem by her when supervising trainees as a consultant. Indeed, whilst he would eventually conclude the ALMAT's were a credible basis to assess competence, it's use as a tool to assess a consultant was something Dr Ehlers did not agree with as being the best approach, although he did conclude the claimant had agreed and, as a consultant, she should have easily passed. His view was that it would have been better to ask the Royal College of Anaesthetists to design a tool for the assessment although, even then, he acknowledged the delay that would have caused even if it had been feasible.

5.139 He was also critical of the induction she received when familiarity with local systems was a potential issue. We do not need to cover each and every aspect of Dr Ehlers' sometimes scathing conclusions. It suffices to say that, after what we are satisfied was a detailed examination of the evidence before him, he was absolute in his view that the claimant was not able to work at consultant anaesthetist level. Moreover, he was certain that had the deficiencies in the selection process not occurred, the claimant would not have been appointed to the role in the first place. The detail of his final recommendations was that Dr Hosni: -

- ***should not have been shortlisted for this position as she did not meet the personal specification and submitted a misleading CV in support of her application.***
- ***should not have commenced employment as her reference was inadequate and of a dubious nature.***
- ***was not capable of fulfilling the required role of a consultant anaesthetist at NUH who could work safely and independently.***
- ***From the feedback and assessments, it seems unlikely that after a period of training, [Dr Hosni] would be able to work independently as there was no demonstrable learning during the time that she was at NUH.***
- ***Therefore, the recommendation would be to terminate MH's contract. [had she not already resigned]***

5.140 Specifically, Dr Ehlers concluded that, whether she was aware of it or not, she had submitted a misleading CV, and her reference was dubious.

5.141 The claimant was sent the investigation report on 2 September 2022. On 5 September 2022, Dr Marshall explained in an email to the Claimant the role he had as the Case Manager in deciding what action to take amongst the various options. He invited comments from the claimant. She sought an extension of time to responded which was granted to 30 September 2022.

5.142 Based on the report and the recommendations made by Dr Ehlers, Dr Marshall prepared a report in October 2022. Dr Ehlers' conclusions were accepted, and he concluded both that there were significant shortcomings in the recruitment process, but that there were significant concerns regarding the Claimant's practice. Although the claimant was no longer

employed, the nature of them was such that it was not appropriate for the respondent to simply take no action. His recommendation to convene a formal capability hearing under the Trust's internal policy was accepted was adopted.

5.143 Alison Wynne, the respondent's Director of Strategy was appointed to chair the panel making the decision. Also on the panel were Dr Walsh, Deputy Medical Director, Dr Lirkbride, a consultant anaesthetist from another trust, Dr Gill the Associate Medical Director for Equality and Diversity and Inclusion and Ms Nunn, HR Business partner. The hearing took place on 11 January 2023. The claimant attended and was again represented by Dr Oni. The hearing took the form of a quasi-adversarial process with the "management" case being presented by Dr Marshall and the evidence being challenged by questions. Aspects of the case put in that hearing did raise discrimination. It was also put that Dr Carney's deficient recruitment process led to what Dr Oni termed "buyer's remorse' and that upon discovering issues that had not been explored at the time, he then wanted the claimant to leave which was denied, and Dr Carney stressed the desire for her to show her skills and succeed in the role. We note, however, that there were others in those early days when the claimant's competence was coming into question, at the same time as her GMC history became known and her references were being questioned, who did want to bring the appointment to an early termination. In that context we could see some force in what we understand Dr Oni's term 'buyer's remorse' to mean but, as a potential reason for the events that follow, that points to something other than her nationality.

5.144 The decision was given on the day and confirmed in a detailed letter dated 27 January 2023. In short, Ms Wynne on behalf of the panel said: -

> ***I feel that the case presented shows that you have failed to demonstrate a satisfactory level of performance and, had you still been employed by the Trust, you would have been dismissed on the grounds of capability. This information will be included in any employment reference provided by the Trust. The GMC will also be informed.***

5.145 The letter concluded with details of the right of appeal. The claimant lodged her appeal against that decision on 12 February 2023 citing 21 discrete challenges to the events that had happened. They included generalised referenced to bullying harassment and discrimination.

5.146 The appeal was acknowledged and set down for 16 June 2023 then postponed for a short time to 6 July 2023. Such an appeal is heard before an independent appeals panel convened under the very prescribed procedure applicable to doctors. The independent appeal panel was chaired by Mr Paul Archer appointed by the NHS Employers from an approved list of chairs of independent panels. Joining him were Mr Craig Wilcockson, a non-executive director of the Trust and Dr Ralph Leighton, a consultant anaesthetist from another hospital. As with the capability hearing, the process adopts a form of quasi-adversarial approach, with Ms Wynne this time presenting the management response to the appeal.

5.147 The appeal outcome was sent in writing on 16 August 2023. The claimant has relied on much of the conclusions reached by that independent appeal panel in support of her case before this tribunal. They key elements are that ultimately, the appeal was upheld. It found

shortcomings in the capability procedure and transparency with Dr Hosni and her representative about the process. It found that her recruitment and induction were both flawed, on which Dr Hosni founded a proposition that everything else that then followed (that is about her capability) could not be relied on. Significantly, it found procedural problems in the way some ALMATS were completed and that many of them should be disregarded. Similarly, it considered that there had been a lack of transparency and reasonable preparation about the simulation day.

5.148 The ultimate conclusions were put in these terms.

> ***As Dr Hosny resigned from the Trust with effect from 19 June 2022 and before the Capability Hearing on 11 January 2023 any of the other outcome options available under the Trust's Appeal Procedure cannot be applied. The Panel does not make any finding in relation to the capability of Dr Hosny and is aware that any potential patient safety concerns will be addressed by the status of her registration with GMC. The Panel notes that her current registration is subject to Interim Conditions.***

5.149 We do not accept Dr Hosni's contention that the result of this appeal is such that, but for her resignation, she would still be working for the Trust today. On the balance of probabilities, but for her resignation the original 12-month fixed term locum appointment would have ended without being renewed.

5.150 We also consider the support Dr Hosni seeks to draw from the independent appeal panel outcome to be of very little relevance to the case before us. The criticisms it makes are not materially in dispute and are in the nature of procedural concerns which offend the fairness of the process, not necessarily the substance, truth or accuracy of the evidence gathered. In summarising its outcome, the independent appeal panel identified aggravating features as: -

> ***Irrespective of a flawed induction process only 2 of the 10 ALMATS examined by the Panel stated that MH was capable of operating as a Consultant Anaesthetist without supervision and 8 ALMATS declared that supervision (at different levels) was required.***
> ***• 4 ALMAT assessments provided red flag warnings of poor practice, which had potential to result in patient harm.***
> ***• The review of the simulation exercises by 3 senior Consultants concluded that there were potential patient safety concerns.***

5.151 In the context of the flawed recruitment process, it concluded, as Dr Ehlers had done previously, that: -

> ***although the Trust admits their performance in this regard did not meet their own standards, the Panel is of the view that Dr Hosny is unlikely to have been offered the position of Locum Consultant Anaesthetist had Trust practice been properly followed.***

5.152 And: -

> ***Although the Panel considers these processes to have been unfairly conducted, the Panel cannot ignore the patient safety concerns which have emerged as a result. Multiple and varied assessments concluded that Dr Hosny is not currently performing at the standard required for independent consultant practice in the UK***

5.153 The overwhelming evidence before us reinforces that the numerous assessments of the claimant's clinical skills, and the numerous other doctors that have considered the totality of that evidence, all points to substantial grounds for a genuine belief that the claimant's clinical skills showed deficiencies for her to be working at consultant level.

6. The law

6.1 The direct discrimination claim is brought under subsections 39(2)(c) and (d). The claimant resigned following a series of alleged detriments which she says entitled her to resign without notice thus amounting to a dismissal in law in accordance with section 39(7)(b).

6.2 Section 13 of the Act provides, so far as is relevant to this claim: -

> ***(1) A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others."***

6.3 Section 9(1) of the Act defines race as including –

> ***(a) colour;***
> ***(b) nationality;***
> ***(c) ethnic or national origins.***

6.4 Section 13 provides a painfully simply prohibition. It requires the claimant to show some treatment towards her amounting to less favourable treatment, and that the reason why that happens is in some way motivated by a protected characteristic. The treatment will usually be detrimental or adverse to the claimant when seen in context in order to be *less* favourable, even though in isolation it need not be negative in quality to amount to a detriment. The protected characteristic will usually be possessed by the claimant but need not be for it to motivate the less favourable treatment towards her.

6.5 The simplicity of this form of prohibited conduct can be contrasted with the evidential complexity of establishing a claim. Discriminators tend not to announce their private, discriminatory motivation for acting. Often, they will not be aware of it themselves (See **Glasgow City Council v Zafar [1997] 1 WLR 1659**). For that reason, the forensic process of analysing whether the protected characteristic is, in any sense at all, part of the reason why the treatment occurred can be assisted by the provisions of section 136 of the Act which provides: -

> ***(1) This section applies to any proceedings relating to a contravention of this Act.***
>
> ***(2) If there are facts from which the court could decide, in the absence of any other explanation, that a person (A) contravened the provision concerned, the court must hold that the contravention occurred.***
>
> ***(3) But subsection (2) does not apply if A shows that A did not contravene the provision."***

6.6 The connotes two stages of analysis. The first is whether the claimant has shown facts from which the tribunal could conclude there has been discrimination, which will include

such inferences arising from the primary facts as are appropriate to draw. The second, if the first stage is satisfied, is for the employer then to show that the treatment was in no way whatsoever because of the protected characteristic.

6.7 To understand how that works, and what evidence should and should not be considered at each stage, regard must be had to **Efobi v Royal Mail 2021 UKSC33**, which confirmed the subsequent decision on the same point in **Ayodele v Citylink Ltd [2017] EWCA Civ 1913**. It confirmed the long-standing approach in **Igen v Wong [2005] EWCA Civ 142, [2005] ICR 931**, and **Laing v Manchester City Council & Anor [2006] ICR 1519** and the further explanation provided by Elias J, as he then was. Drawing on other high authority in this area including **Shamoon v Chief Constable of the Royal Ulster Constabulary [2003] ICR 337** and **Madarassy v Nomura International [2007] EWCA Civ 33**, the ultimate question remains whether or not the respondent has committed an act of discrimination and section 136 simply overcomes the obstacle that there are real evidential problems for an employee in evidencing the motivating factors found only in someone else's mind. We approach this task with the following propositions in mind: -

6.8 The legal burden on the claimant to prove at least a prima-facie case, flows from sections 39 and 13. Section 136 provides a forensic device for analysing whether the claimant has discharged it. The neutral language of s.136 (compared to the legacy statutes) does not alter the burden, it merely confirms the existing caselaw that evidence of the facts relevant to the first stage of the analysis can be adduced by all parties.

6.9 The two stages of the shifting burden are a forensic tool. It is sensible to begin the analysis expecting that tool to be used and it will usually be appropriate to deploy it. It is not, however, obligatory to use it in every case. There may be good reason why use of that forensic tool is not needed in a particular case.

6.10 There may be a sound basis to draw inferences that, in the absence of an explanation, would require the tribunal to conclude that discrimination has occurred. There may equally be explanations that go directly to the "reason why", especially where the analysis is based on a hypothetical comparator and the construction of the circumstances of how that hypothetical comparator would have been treated are inextricably linked to the reason why question.

6.11 The tribunal may be satisfied on cogent evidence of a genuine and non-discriminatory reason for acting and where that does not disclose either conscious or unconscious discrimination, that is the end of the matter.

6.12 Of course, going straight to the second stage may disadvantage both the claimant in that the first stage evidence is not adequately analysed and can also risk placing a legal burden on the respondent to discharge that the law had not yet placed on it.

6.13 How the evidence, and the respective parties' contentions, is to be treated at each of the two stages was the focus of the analysis in **Efobi** and whether the "could conclude" threshold has been met to shift the burden. We approach that issue on this basis: -

6.14 At the first stage, “could conclude’ means that a reasonable tribunal could properly conclude from all the evidence before it. This would include evidence adduced by the complainant in support of the allegations of discrimination, such as evidence of a difference in status, a difference in treatment and the reason for the differential treatment. It would also include evidence adduced by the respondent contesting the complaint, subject only to the statutory restriction to exclude any exculpatory explanation for the treatment.

6.15 Other than the respondent’s explanation for the treatment, the tribunal should consider all the evidence relevant to the complaint.

6.16 Analysis of the first stage contemplated by [section 136] does not expressly or impliedly prevent the tribunal from hearing, accepting or drawing inferences from evidence adduced by the respondent disputing and rebutting the complainant’s evidence of discrimination. The respondent may adduce evidence at the first stage to show that the acts which are alleged to be discriminatory never happened; or that, if they did, they were not less favourable treatment of the complainant; or that the comparators chosen by the complainant or the situations with which comparisons are made are not truly like the complainant or the situation of the complainant; or that, even if there has been less favourable treatment of the complainant, it was not on the ground of her sex or pregnancy (**Madarassy** at para 71)

6.17 All that must be ignored at the first stage is any exculpatory explanation for the treatment itself.

6.18 We also remind ourselves that whilst we should not ignore evidence which suggests discrimination, we should equally not ignore evidence that suggests there has not been discrimination. (**Field v Steve Pye & Co (KL) Ltd and Others [2022] EAT 68**)

6.19 The harassment claim is brought under section 40(1)(a). Harassment is defined in section 26 of the Act and, so far as is relevant to this case arises where:-

> ***(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.***
>
> ***(2)...***
> ***(3)…***
> ***(4)In deciding whether conduct has the effect referred to in subsection (1)(b), each of the following must be taken into account—***
>
> > ***(a)the perception of B;***
> > ***(b)the other circumstances of the case;***
> > ***(c)whether it is reasonable for the conduct to have that effect.***
>
> ***(5)The relevant protected characteristics are—***
> > ***…***
> > ***race;***
> > ***…***

6.20 We are required to consider the discrete elements of this provision in turn, namely whether any conduct found to have taken place was unwanted; whether it was related to the relevant protected characteristic; whether it had the prescribed purpose (in which case it matters not whether it was actually achieved); and if it was not done with that purpose, whether it nonetheless had the effect, in which case it must actually be achieved and must be reasonable that it did. (see ***Richmond Pharmacology v Dhaliwal [2009] IRLR 336***). This case is also relevant to the threshold of when conduct amounts to harassment under the act. Underhill P, as he then was, said at para 22: -

> ***"We accept that not every racially slanted adverse comment or conduct may constitute the violation of a person's dignity. Dignity is not necessarily violated by things said or done which are trivial or transitory, particularly if it should have been clear that any offence was unintended. While it is very important that employers, and tribunals, are sensitive to the hurt that can be caused by racially offensive comments or conduct (or indeed comments or conduct on other grounds covered by the cognate legislation to which we have referred), it is also important not to encourage a culture of hypersensitivity or the imposition of legal liability in respect of every unfortunate phrase."***

6.21 Whilst that passage focused on dignity as a proscribed purpose or effect within s.26(1)(b)(i), we take the view the essence of a threshold applies similarly to the words used to define the other proscribed consequences or environment in s.26(1)(b)(ii) and that threshold is regulated by the concept of the reasonableness or not of the conduct having the prohibited effect as set out in in s.26(4)(c). Similarly, the meaning of the statutory words is itself a measure of the threshold and, as the Court of Appeal stated in ***Grant v HM Land Registry & Another [2011] IRLR 748***, the significance of the words must not be cheapened. They are an important control to prevent trivial acts causing minor upsets being caught by the concept of harassment.

6.22 Sections 15(4) of the Equality Act 2006 requires a tribunal to take into account any code of practice issued under section 14 which appears to be relevant. We have had regard to the Employment Code of Practice issued by the Equality and Human Rights Commission. Chapter 15 deals with enforcement. Paragraph 15.32 onwards provides guidance on the burden of proof. Chapter 3 provides guidance and examples on direct discrimination. Chapter 7 does the same with harassment.

6.23 Finally, a discriminatory act cannot amount to both a detriment and be an act of harassment. That is because of section 212(1) which provides, so far as is relevant: -

> ***"detriment" does not, …., include conduct which amounts to harassment.***

7. Discussion and Conclusions

7.1 Before analysing the discrete allegations, we start by considering the primary findings of fact and whether there are any inferences that can properly be drawn. There are five broad headings under which the claimant's case, and the evidence in totality, can be considered to approach the question of inferences. They are: -

a) The claimant's clinical competence.

b) The unfairness in the assessment procedures adopted.

c) Covering up the deficient aspects of her recruitment and appointment

d) Bias.

e) Explicit references to Dr Hosni's Egyptian nationality.

The claimant's clinical competence.

7.2 We allowed much questioning on the differing clinical opinions about numerous aspects of Dr Hosni's patient care. Whilst we made clear that our judgment was not a vehicle to make a determination about clinical skills and competence, that was the respondent's single line of defence to the allegations that its decision makers were motivated that, and not by her nationality. As such, it was a proper approach for the claimant to take to seek to undermine that reasoning.

7.3 We should start by noting Dr Hosni's position in her own level of performance fluctuated in the course of giving evidence. At times, her case was put with conviction that her level of skills, abilities and performance generally was excellent, and the observers were wrong to conclude as they did that she was not performing at the level of a consultant. Otherwise, her case was put on the basis of explaining and justifying why her performance fell below that which would be expected. That was also a perfectly proper argument, and one that we found all parties were alert to. The claimant's unfamiliarity with the local systems and procedures was explicit in the respondent's thinking throughout. For our part, trying to discern the reason why things happened as they did against those matters served to reinforce the veracity of the respondent's evidence of those who had undertaken assessments of the claimant. That is not to say that there are not ranges of clinical opinion on how to approach certain situations, or that some of the assessments were in artificial and strained situations that did not show Dr Hosni off to her best, but we are satisfied that those expressing their opinion of the clinical skills and competence of the claimant did so genuinely and based on what they saw.

7.4 Indeed, as to certain of the specific clinical decision making that the respondent's witnesses were challenged on in questioning, the responses and analysis provided in answer to those questions only served to reinforce the genuine and rational basis for the respondent's belief. Most of the challenges fell flat. Even where the respondent's witnesses made concessions about ranges of opinion or acknowledged distinctions between clinically appropriate techniques and clinically preferred ones, it served to demonstrate the assessments had been made with a reasonable consideration of varying clinical practice.

7.5 Dr Hosni point in her case that no patient's came to harm may be true in a literal sense but takes this allegation no further and there were times when the witnesses commenting on it were not so black and white. Moreover, the respondent makes the point that Dr Hosni was

doubled up with another consultant and in some cases interventions by that supervising consultant may have prevented issues getting that far.

7.6 We have not been able to accept the claimant's specific challenge that the Trust was looking only for inculpatory evidence and ignoring exculpatory evidence, including by considering those ALMATs obtained outside the period when the claimant was subject to the assessment period. We have found Dr Ehlers considered matters with a critical eye from both perspectives. Indeed, he was critical of the respondent at times. It cannot be said that he ignored exculpatory evidence. There was evidence within the ALMAT's of positive clinical practice. However, the overall picture was broad enough and consistent enough for it to be entirely reasonable conclusions that the claimant's clinical skills fell below what was safe for her to operate as an independent consultant. Frankly, Dr Ehlers was bound to reach that conclusion.

7.7 It follows that the claimant has not undermined the respondent's stated reason for acting to any degree, and certainly not to form a proper basis for us to draw adverse inferences.

Unfairness in the assessment process

7.8 For understandable reasons the claimant relies significantly on the critical findings of the independent appeal panel. She says her initial induction was not adequately structured, as was found, and she didn't have any real opportunity to familiarise herself with her new surroundings before concerns about her competency emerged. Equipment and systems were different to what she was used to in Egypt.

7.9 The independent appeal panel did indeed express a number of concerns about the process conducted to assess the claimant's clinical skills. It excluded a number of the assessments due to their timing or formality of completing the ALMAT form. It was critical of the induction and opportunity to familiarise herself with local practices and at times the process should have been more transparent.

7.10 However, the induction was the induction that would normally be applied to such an appointment. Whilst in hindsight, the claimant's recent clinical practice may well have justified a bespoke induction, we do not accept that the plans for induction engaged anyone at the Trust in any specific consideration of doing anything other than their normal induction for such a post. Equally, no one consciously decided ***not*** to arrange a bespoke induction. In the absence of any apparent conscious decision specific to the claimant's case, still less is there any basis for concluding her nationality played any part.

7.11 Significantly, the independent appeal panel did not set aside the underlying concern about the claimant's clinical skills, describing the presence of a "number of red flag warnings of poor practice which had the potential to result in patient harm". It is also significant that the panel recorded that it was not provided with material evidence on which to formulate an

opinion on the allegation of harassment and discrimination either way. It also rejected that use of the ALMAT tool as being inappropriate.

7.12 That is significant as the catalyst for all the events that then followed were the initial concerns during that induction. Even if it was unfair for those colleagues to express concerns about the claimant's clinical competence in those early days before she had chance to familiarise herself, we are still faced with an operative reason for all the events that followed being a concern about her clinical skills and patient safety. One might have expected over the weeks of assessment that followed, that any initial unfamiliarity would have been overcome. The ALMAT assessments do not show that was the case.

7.13 Whilst the independent appeal panel concluded there was sufficient unfairness in the process to uphold the appeal, for our purposes in this claim we can see no basis on which to say that process undermined the genuineness of the beliefs held by those numerous clinical colleagues who assessed the claimant or expressed concerns about her clinical performance. The fairness of the formal procedure does not in this case provide any basis for us to properly draw adverse inferences

Covering up the deficient aspects of her recruitment and appointment

7.14 This was put by the Claimant as a reason for wanting her out of the organisation. It is consistent with the argument run on her behalf by Dr Oni at her appeal in what he terms "buyer's remorse". This all flowed from the undisputed fact that the recruitment process was insufficiently rigorous.

7.15 We were at a loss, however, to understand how the events that in fact happened could be part of a cover up of those deficiencies in the recruitment process. It is an illogical argument. If Dr Carney was concerned that he would come under scrutiny for the way in which he conducted the recruitment and was minded to try to take steps to 'cover up' those facts, we consider it becomes less likely and not more likely that he would do things to highlight the deficiency in Dr Hosni's clinical practice. Doing so would only serve to draw attention to his own deficiencies in the recruitment process. We found as a fact that Dr Carney was acting in the interest of patient safety. Against that finding, we do not accept he would compromise that patient safety in order to cover up the recruitment process. The conscientious response to the realisation that the deficient recruitment process had let someone be appointed who otherwise would not have been, was to grasp the nettle and deal with the consequences. That is what Dr Carney did.

7.16 In any event, not only have we rejected the factual basis on which this argument is put, we cannot see how it provides a proper basis to draw inference that the claimant's nationality played any part in the decision making. It necessarily requires there still to be concerns about the claimant's clinical practice. Otherwise, there would be no concern about the deficient recruitment and the assessments that were put in place would have shown her to be practicing at an appropriate level. Hypothetically, if we had accepted as a fact that Dr Carney became anxious that he would be censured in some way for not following the Trust's

expected recruitment procedures, and for that reason embarked on the assessment of the claimant's clinical skills, it would also provide the reason why those events then happened. The hypothetical comparator would have faced the same events. It does not support the idea that the claimant's nationality played some part.

Bias

7.17 We do accept that it is likely that some bias has operated on some of the decisions and clinical assessments.

7.18 The first thing to note is that Dr Hosni's GMC history and the concern about the references provided to the respondent, all came to light around the time she started work in mid-October 2021. Both issues are more than capable of influencing decision makers and there is more than a suggestion that the GMC history, if not both issues, was colouring Dr Sycamore's initial assessment of the claimant's suitability to be working at consultant level during those initial days. However, bias is not simply allowing a factor to influence a decision or action, it is an improper factor which leads to an unjust outcome. We do not consider that the information before Dr Sycamore or her initial conclusions to be that. In any event, whilst it may have influenced her decisions, it was information that was not known to the colleagues who expressed their first-hand concerns. In any event, we can construct no basis whatsoever to connect this with her nationality so as to support drawing any adverse inferences.

7.19 We also note that this arose independent of Dr Carney, who was on leave at the time, and learned of them only on his return. Significantly, this was after the initial concerns about Dr Hosni's clinical skills had crystalised.

7.20 Bias is also a factor in the assessment process itself. Many of the witnesses we heard from maintained they, and the wider assessment process, had been unbiased. We consider that simply means they did their best to approach the assessments in as neutral and objective a way as is possible. However, we found Dr Carney's evidence to be insightful. He recognised and accepted at the time that there would inevitably be some risk of bias. That stems from the very fact what was happening does not happen at consultant level. Outside the MHPS independent assessment process, consultant's do not get asked to assess the clinical competence of a fellow consultant. The very fact of doing so is loaded. It necessarily conveys the fact that someone somewhere has questioned that consultant's clinical skills. That is especially so when the person asking for the assessment occupies a senior leadership role and is held in high regard for his own clinical skills, as was Dr Carney. Any assessment that then takes place cannot be entirely neutral; it invokes a form of confirmation bias where the assessment is at risk of being undertaken with the aim of looking for the sort of evidence that might support the underlying proposition that there may be a deficiency with the subject's clinical skills. There is a real risk that this sort of bias will operate subconsciously, hence why we accept those witnesses who denied bias were being truthful, even though we remain alert to the prospect, as Dr Carney recognised, of the risk of bias.

7.21 Once again, we are unable to see any basis on which this can be used to infer that the claimant's nationality was in any way material to the decisions and actions that then happened. That is especially so as this sits against our rejection of the first point about clinical competence. We are satisfied there was a wide body of opinion that there were deficiencies with the claimant' clinical skills to be working at consultant level. There is also no suggestion that those who expressed the initial concerns during the first days of working with Dr Hosni were in any way influenced by her nationality.

7.22 We therefore conclude that, whilst Dr Carney was taking all the steps he reasonably could to minimise the risk of any bias, some may have still operated in some of the assessments. Some assessors, perhaps unconsciously, may have spotted aspects of clinical practice that they felt warranted singling out in circumstances that might not have happened if it were ever possible to undertake a truly objective assessment. However, we simply cannot accept that the margin or degree to which this would operate on the assessments or scores could be such as to alter the overall impression. The assessments were identifying genuine concerns. Some were very minor. Some were in the nature of red flag warnings of patient harm. There is nothing in the evidence which permits us to draw on the risk of this bias to draw any adverse inference that the claimant's nationality was material. Had she been of a nationality other than Egyptian, the exact same risk of bias would have arisen.

7.23 Dr Carney's approach to the risk of bias was to confront it and minimise it. We found the decisions about moving Dr Hosni to the Treatment Centre at QMC was itself part of minimising the contact with those that might have already become aware of the issues at the City Campus. He recognised he could not avoid it altogether and recognised he would have to tell his colleagues something about why the request for an assessment was happening in order to provide the necessary context. He consciously tried to give only as much as satisfied that. In part, it is that attempt to contextualise the situation in shorthand which leads to the final consideration.

References to her nationality

7.24 There are a handful of direct or indirect references to the claimant's protected characteristic, namely her Egyptian nationality. They require careful consideration as they are the principal basis on which the claimant's claim is advanced.

7.25 We have rejected as a fact the claimant's contention that everyone referred to her by reference to her nationality in every conversation. Not only is that at odds with the other evidence, but it also proved to be something the claimant herself resiled from in most of her oral evidence referring to the occasions when reference was made to her nationality being in the context of polite, interested small talk during introductions when finding out about a new colleague.

7.26 There are, however, references to nationality in the contemporaneous documentation. The claimant relies on Dr Carney's email dated 10 November 2021 asking them to assist by undertaking an assessment which starts with "She is an Egyptian consultant"; to his email of

February 2022 looking to secure alternative work referring to the claimant as a “locum consultant from Egypt”; and the question Dr Carney asked of the claimant on 16 December 2021 at the simulation day along the lines of “do you have simulations in your country”.

7.27 We also note another less direct reference in the email dated 2 November from Dr Carney to the claimant stating, “I gather you have been finding things rather different to working in Egypt”.

7.28 There was also a reference to Egypt in an email from HR when chasing the claimant’s references saying, “We were sent a reference from Egypt that indicated she was a Consultant in Egypt from 2001”. We are satisfied these references were matter of fact communications the context of the matter being discussed.

7.29 We recognise that seen in isolation, and without regard to the surrounding context, Dr Carney’s references make a direct or indirect reference to the protected characteristic relied on. The first in time, the opening statement that “she is an Egyptian consultant” is particularly so. However, seen in the surrounding context, we accept these were all used in the way of shorthand to the fundamental issue arising, namely, that the claimant was not recently familiar with working practices in the UK. All three communications arise in that context. We do not, therefore, consider these references provide a basis to draw inferences that the claimant’s nationality could be the reason why the alleged treatment occurred. We are required to have regard to all the evidence in deciding whether to do so. Whilst these references in the evidence are obvious and necessary contenders for our scrutiny, we do not consider it provides a proper basis to draw inference.

7.30 In reaching that conclusion we have reflected on whether we are entitled to have regard to the evidence of that surrounding context at this stage of the analysis. We concluded that it does not stray into the prohibition of the respondent’s explanation for the treatment which section 136 requires to be ignored at the first stage of assessing a prima facie case. The respondent’s evidence of the surrounding facts about why that language was used, is not its explanation for the treatment alleged in the claim. We therefore consider it forms part of the fact finding based on all the evidence that **Jhuti** confirms is appropriate for us to consider at this stage.

7.31 We are further reinforced in not drawing inferences when these references are seen in the wider context of the case, especially in those early stages when Dr Carney was the sole or principal decision maker. The first and most obvious issue for the claimant’s case flows from those other facts and the reasons why the other areas of consideration on which inferences might be drawn have failed. First and foremost, Dr Carney was aware of the claimant’s nationality at the time he interviewed her and then appointed her in what is accepted to have been a deficient and inadequate selection process. Secondly, she was then treated very favourably in response to her requests to delay her start date and extend the period of the fixed term contract. Whilst it would be putting it too high to say the claimant’s nationality led to her being treated favourably, it is right to say that she did benefit from those two decisions at a time when Dr Carney knew of her nationality.

7.32 We also reject the contention that she was somehow penalised for that lax recruitment save in one narrow respect. To the extent that we agree that she would not have been recruited had the process been as robust as the Trust ordinarily expected, it follows the distress the subsequent process then caused her would not have arisen. However, it cannot be said that her nationality was at the root of any adverse motivation. There simply wasn't any adverse motivation. We conclude, as others did in the internal investigation, that there was no logical reason why Dr Carney would agree to an extended contract for Dr Hosni, not to mention the expense of relocation had he not wanted her to succeed in the role at the Trust. We therefore reject Dr Hosni's general assertion that if she had been British, she would have been supported. It is a contention that needs evidence, either directly or indirectly from which we can draw inference. Having ruled out the references to her nationality as providing a basis for that, there is no proper basis for doing so.

7.33 Nothing in these areas of challenge shifts the burden whether we consider them individually or cumulatively, in their totality. Nothing forms a basis for us to properly draw adverse inferences of fact from which we could say that the claimant has shown facts from which we could conclude that her nationality was a material part of the reason why the conduct occurred.

7.34 We then turn to the discrete issues alleged to be either harassment related to race or less favourable treatment because of it. Our findings of fact and our inability to draw inferences that might support the claimant's contentions means that our analysis of each of the discrete allegations that now follows is necessarily brief and somewhat repetitious.

ISSUE "a". *At the start of October 2021, Adam Carney sent an email to people that the Claimant would be working with in which he referred to the Claimant as being "Egyptian" and saying that they should "keep an eye" on her because she might work differently.*

7.35 As put, this allegation fails on the facts. Dr Carney did not send such an email. The claimant has therefore not been subject to this unwanted conduct. She has not been subject to a detriment or less favourable treatment.

7.36 This is an allegation that evolved in the course of hearing evidence, most noticeably when it became apparent the claimant appeared to have conflated other emails at a later stage. He does refer to her as Egyptian on two occasions in November 21 and February 22 to which we have referred. He also accepts that in the supervised session in December 2021 that he had to leave unexpectedly and had to find a colleague to continue supervising the doubled-up list, he could well have asked Dr Webster to keep an eye on the claimant. We see no detriment in that, especially as the concept of "doubling up" lists to work alongside a colleague was a normal part of induction for all new consultants. (This much duplicates allegation "j", below).

7.37 This first allegation presents a fundamental problem for the claim as a whole as this is a necessary foundation to everything else that happened. Without there being some basis to infer the claimant's nationality was a motivating factor, those initial concerns about her clinical

competence, at a time when Dr Carney was not at work, stand out as being just that, genuine concerns about patient safety. As such, they are what starts the events. They are the reason why everything else happened.

7.38 This allegation consequently evolved to one of Dr Carney spreading rumours, of whispers, and of influencing everyone negatively about the claimant. We rejected that as a fact.

7.39 This allegation necessarily fails as both an allegation of harassment and direct discrimination.

***ISSUE b**. In early November 2021, Adam Carney raised concerns about the Claimant's work performance, despite her not having made any errors and there having been no complaints made.*

7.40 Dr Carney did raise concerns about the claimant's work performance. This refers to the claimant and Dr Carney working together on 3 and 4 November. The reason why he did so was because he had returned from annual leave to be met with a number of concerns from colleagues, including both consultants and other theatre staff that had questioned Dr Hosni's ability to work at the level of consultant anaesthetist. To that extent it is not right to say she had not made errors or that there were no complaints. The basis of the initial concerns in late October amount to colleagues' opinions that the claimant's clinical competence was not at the consultant level and the, referring their concerns amounts to complaint.

7.41 We also note Dr Carney's act of raising concerns was not only based on third party accounts. By early November, Dr Carney's actions were also being informed after an opportunity to work alongside the claimant to gauge for himself the nature of her clinical skills.

7.42 We therefore accept the conduct is made out. We accept that being on the receiving end if this sort of criticism is properly characterised as unwanted conduct. We do not accept that it was in any way related to the claimant's protected characteristic. It is not on its face related to nationality. It is not possible to infer some relation to nationality and the context rules it out. The claim of harassment must therefore fail.

7.43 We are satisfied that Dr Carney did not express his concerns with the purpose of causing the claimant to experience the proscribed consequences or environment.

7.44 Further analysis of the elements of section 26 of the Act is at risk of being artificial when the claim fails at an earlier stage. So far as we can do so, we accept the claimant felt humiliated by having her clinical skills challenged. In the context of the surrounding concerns, we would have to conclude that, however deeply that was felt, it was not reasonable that it did for the purposes of section 26.

7.45 As the harassment claim fails, we can turn to analyse this allegation as a claim of direct discrimination. We accept the claimant was subject to a detriment in that a reasonable employee who had their professional skills questioned and was to undergo some form of

assessment after having just been appointed might reasonably conclude they have been put at a disadvantage.

7.46 We do not accept there is a basis for concluding that the claimant was subject to less favourable treatment. There is no actual comparator. We do not accept that Dr Rattenberry is an appropriate comparator in materially similar circumstances as the claimant. We do not accept that a hypothetical comparator would have been treated more favourably. Indeed, the force of the motivation for this treatment is so strong that we are entirely satisfied any hypothetical comparator would have been treated in exactly the same way as the claimant. There is no basis for drawing an inference that would properly allow us to conclude that the claimant's nationality was in some material way a factor in this conduct so as to turn to the respondent to explain the reason why it subjected her to this treatment.

7.47 We acknowledge the independent appeal panel felt there were deficiencies with the quality of the induction Dr Hosni received. It may well be that some of the concern flowed from matters which were simply due to lack of familiarisation with the different systems and equipment and local clinical practices and standards. However, if that is the reason for the concerns those colleagues held, it is still not because of her nationality unless the poor induction was itself done because of her nationality. We can reject that for the same reasons that the Trust was keen to appoint someone that appeared to be a competent consultant anaesthetist from wherever they were in the world, and no specific decision was made about the induction either way other than that the claimant got the standard format that would apply to any long-term locum joining the Trust.

7.48 However, if the respondent were obliged to explain the reason for the treatment, it points firmly to those concerns about patient safety, it is an explanation that we accept and is one which we are satisfied is in no sense whatsoever because of the claimant's nationality.

7.49 These allegations fail.

***ISSUE c**. On 4 November 2021, Adam Carney shouted at the Claimant in front of other members of staff asking her what she was doing and stating that she had put a cannula into a patient incorrectly, even though that was not accurate, and then took over the procedure himself and performed it badly.*

7.50 This relates to the doubling up session when there is no dispute an incident of this nature happened. There is no dispute that Dr Carney raised his voice at the Claimant after he became concerned about patient safety and felt compelled to step in and take over the procedure.

7.51 One person's 'shouting' may be another's 'raising of voice' and we do not draw a distinction. We consider the treatment was therefore made out. We are satisfied being shouted at in this way, on whoever's account, is capable of amounting to unwanted conduct. However, we can see no basis on which this could be said to be related to the claimant's protected characteristic. For that reason, the claim of harassment must fail.

7.52 In any event, we do not accept that this happened with the purpose of causing the proscribed consequences. It was an instinctive response to what Dr Carney considered to be an urgent matter of patient safety and wellbeing. The apology that followed out of the pressure of the moment is not determinative of purpose, but in our judgment undermines it in this case. We would add that we struggle to see why, in the context in which it happened, it should in any event meet the **Dhaliwal** threshold to satisfy the proscribed consequences required by section 26, particularly having regard to the later apology. To the extent that the claimant did in fact experience those consequences, we would not have been satisfied that it was reasonable that this conduct had that effect.

7.53 As the harassment claim fails, we can turn to analyse this allegation as a claim of direct discrimination. We accept the claimant was subject to a detriment in that a reasonable employee who was spoken to in raised voice / shouted at by a colleague in any circumstances might reasonably conclude they have been put at a disadvantage.

7.54 We do not accept the claimant has been treated less favourably. There is no actual comparator. We do not accept that a hypothetical comparator would have been treated more favourably. The instinctive nature of Dr Carney's actions during this event focusing on the patient potentially being aware and the risk of the adverse clinical reaction satisfies us that a hypothetical comparator would have been treated in exactly the same way as the claimant and the claim must fail.

7.55 These allegations fail.

***ISSUE "d**". On 4 November 2021, Adam Carney threatened to report the Claimant to the General Medical Council and the Medical Director of the Respondent and told the Claimant that she should leave the Trust because he did not want her there.*

7.56 We start with the facts as found. We did not find Dr Carney threatened to report the claimant to the medical director or the GMC. We did find the discussions included reference to the Medical Director's involvement and the possibility of a GMC referral. Whilst the allegation may not be made out as it has strictly been put, we proceed with a degree of flexibility because of the essence of what the claimant is alleging is that this was raised with her. Similarly, we did not find Dr Carney said she should leave the Trust 'because he did not want her there', but there was a discussion in which the possibility of the claimant leaving the Trust.

7.57 We accept that being referred internally or to the GMC amounts to unwanted conduct. We accept that even our diluted finding of simply raising the option of leaving the employment the claimant had only just commenced must also be unwanted conduct.

7.58 We cannot see in what way any of this conduct can be said to relate to the claimant's nationality. That necessarily means the allegation of harassment must fail there and further analysis becomes artificial. To the extent we can go on to analyse the situation thereafter, we are entirely satisfied that none of this conduct was not done with the purpose of causing the

proscribed consequences. Indeed, we are again unable to agree that they necessary pass the threshold of amounting to the proscribed consequences in the **Dhaliwal** sense but, to the extent that the claimant did in fact experience them, we would not have concluded that to be reasonable. Even though the emotional effect on the claimant to her clinical skills being challenged was undoubtedly felt, and the section 26(4) evaluation of reasonableness requires consideration of the claimant's perspective, the other circumstances of the case weigh against it being reasonable for the conduct to have that effect. The discussion about leaving the Trust was in the context of the assessment process that would follow. It was early days for the claimant. It might have been that her circumstances were such that she would have rather left than go through that process. To that extent, it was a relevant discussion to have. The fact that she did not want to take that option has only limited effect on colouring the reasonableness and context of raising it with her.

7.59 As the harassment claim fails, we can turn to analyse this allegation as a claim of direct discrimination. We accept the claimant was subject to a detriment in that a reasonable employee who was subject to this treatment might reasonably conclude they have been put at a disadvantage.

7.60 Again, there is no actual material comparator. We are satisfied that the reason why this conversation took place was so inextricably linked to the growing concern about Dr Hosni's clinical skills and patient safety that we must conclude any hypothetical comparator would have been treated in exactly the same way. The question of less favourable is, as is often the case, inextricably linked to the reason why. For reasons already given, there is no basis to infer the claimant's nationality was in any way whatsoever motivating this conduct and the claim of direct discrimination must also fail. There is no legal burden on the respondent to explain the reason why it subjected her to this treatment but, were it in place, we are satisfied that it can show the reason was its concerns about her clinical skills and competence and was therefore in no way whatsoever because of her nationality.

7.61 These allegations fail.

ISSUE "e". *On 17 November 2021, Adam Carney told the Claimant that he was not happy with her in an email and then transferred her to the Treatment Centre and told her that he needed people to monitor her performance.*

7.62 The essence of this allegation is admitted insofar as, on 17 November 2021, Dr Carney informed the Claimant that she would be moved to the Treatment Centre for a period of assessment using the ALMAT assessment. This would be conducted by fellow consultant anaesthetists.

7.63 We accept having to undergo this period of assessment amounts to unwanted conduct. As previously, we are unable to find any basis on which it could be said to be related to the claimant's nationality, and we are entirely satisfied was not done with the purpose of causing the claimant to experience the proscribed consequences. Again, we don't seek to diminish the individual and professional hurt that comes from being told by a

colleague that one's professional skills need to be assessed before she can practice independently. Whilst there are legitimate concerns in this case about the claimant's insight, we do not doubt that she felt humiliated by this whole process. To the extent it is possible to express a view on reasonableness of that in the absence of all the other elements of section 26 being made out, we do not accept it was reasonable the conduct have the effect, in the context of section 26.

7.64 As the harassment claim fails, we turn to direct discrimination. We accept the claimant was subject to a detriment for the same reasons as the previous allegation. Also, for the same reasons, we do not accept there is less favourable treatment or any basis for inferring that her nationality played any part of the motivation for the treatment. There is no legal burden on the respondent to explain the reason why it subjected her to this treatment but, were it in place, we are satisfied that it can show the reason was its concerns about her clinical skills and competence and was therefore in no way whatsoever because of her nationality.

7.65 These allegations fail.

ISSUE "f". *In November 2021, the Claimant was subject to an assessment period whereby Adam Carney selected 19 consultants to monitor her work, told those consultants that she was Egyptian and sent them papers suggesting that she was an anaesthetist in training when she was not and she was a consultant.*

7.66 Again, in the interest of fairness we must interpret the claimant's allegation with a degree of latitude. We did not accept as a fact that Dr Carney told all the consultants that the claimant was Egyptian. In some cases, the fact of her nationality was discussed between the claimant and the consultant in question during introductory small talk, but we firmly rejected the notion of the "whispering campaign" by Dr Carney to that effect. There is no dispute that in November Dr Carney tod the claimant there would be an assessment period. We interpret the reference to "papers suggesting she was an anaesthetist in training" to be a reference to both the use of the ALMAT process and also his email of 26 November to the first of the colleagues at QMC selected to perform the assessment which suggested that they allowed Dr Hosni to "run their lists in the same way as a trainee may ask you to run the list". There were two doctors in this context to whom Dr Carney did refer to the claimant's nationality, they were Drs French and Dawson in the initial request to undertake an ALMAT supervision on 10 November 2021.

7.67 It follows that a large part of the allegation is not made out on the facts, but some is and the essence of that is what we analyse.

7.68 We are satisfied that communicating in those terms to Drs French and Dawson, and referring in the later communications to the assessment being run like a trainee may ask to run it is capable of satisfying the test of unwanted conduct for the purpose of section 26, albeit that did not come to the claimant's knowledge at the time and not for some time later.

7.69 We note the communication that refers to her nationality does not also say 'allow Dr Hosni to run the list as you would a trainee'. The closest it gets is a request that the assessor complete an ALMAT form. Conversely, the communications that do suggest the assessors let Dr Hosni run their lists as they would a trainee, do not refer to her nationality. However much that conduct might be unwanted by Dr Hosni, we do not accept it can be said to be related to her nationality. That part of the allegation must fail.

7.70 The correspondence referring to Dr Hosni as an Egyptian consultant, clearly is related to her nationality. However, we can be absolutely certain that this was not done with the purpose of causing the claimant to experience the proscribed consequences or environment as the communication was not directed to her and nor was it reasonably anticipated would ever be seen by her.

7.71 As to the actual consequences. The claimant did not see this at or near the time. She learned of it some-time later. We do not doubt, in the context of what else she was alleging that it had the effect of causing her to feel offended. Unlike the other allegations, there is here a link to the protected characteristic in that emotional response.

7.72 However, we do not accept it is reasonable that it does have that effect. It does not pass the **Dhaliwal** threshold. The surrounding circumstances of the case give it context and it is not reasonable for it to have that effect.

7.73 These allegations fail.

ISSUE "g". *On 7 December 2021, Adam Carney failed to take any action in response to the Claimant's email complaining about William Rattenbury when she was pressurised to perform spinal anaesthesia even though the patient had difficulties with such a procedure in the past.*

7.74 This allegation is potentially not an allegation at all but, rather, a contention of difference in treatment of her generally compared to Dr Rattenberry. On that basis, he is identified as an actual comparator against the initial decision to commence an assessment process on the back of receiving concerns about her clinical skills and competence.

7.75 In any event, insofar as this is a discrete allegation of conduct or treatment, we do not accept that the underlying proposition is made out as a fact. The claimant did contact Dr Carney to raise issues with how she considered Dr Rattenberry had performed aspects of the procedures that day. We found Dr Carney did take action insofar as he did speak with Dr Rattenberry about the complaints. The result of talking through the issues raised was that he was satisfied that Dr Rattenberry's actions were within the scope of those that were appropriate in the circumstances and decided no further action necessary. We found, the claimant was not pressurised to perform spinal anaesthesia even though the patient had had difficulties with such a procedure in the past. Whilst he had, the pre-op discussion with the patient had led to him consenting to that procedure. As she was also consultant if she genuinely felt that the patient had not given consent, the respondent makes the point that she should not have performed the procedure which itself reflects on her own clinical judgment.

7.76 Dr Rattenbury is not a material comparator.

7.77 Dr Carney's assessment of what Dr Rattenberry had done was also informed by his first-hand knowledge of Dr Rattenberry's clinical skills and competency after having worked with him as a trainee for a number of years. Neither he, nor anyone else at the Trust, had that knowledge of the claimant's clinical skills.

7.78 The act or omission, for the purpose of analysing the conduct under section 26 is Dr Carney's response to the claimant's complaint. Whilst we consider he did "take action" we equally give a wide interpretation to the claimant's allegation and what she means is that Dr Rattenberry was not subject to any form of censure or formal investigation.

7.79 It is not conduct which has any direct effect on her beyond the contrast it provides to her situation under some of her other allegations. We are doubtful it can properly be described as unwanted conduct. To the extent that it can, there is nothing about it which can be said to relate to her nationality. Equally, we do not accept it was done with the purpose of causing the claimant to experience the proscribed consequences or environment as it was not the subject of ongoing exchanges or process in which Dr Carney would have anticipated explaining his decisions to Dr Hosni. Indeed, Dr Hosni only held a belief that nothing happened. If and to the extent that Dr Hosni actually experienced any of the proscribed consequences or environment as a result of this belief, as opposed to any of the other potential causes operating around this time, we do not accept it would be reasonable for it to do so. That is, so far as it is possible to assess reasonableness in the abstract and absence of any conduct being related to the protected characteristic.

7.80 We are bound to proceed to attempt to analyse this against section 13. Again, to the extent we reject the premise of the allegation, there is no detriment. To the extent that there is, we cannot see how the claimant can be said to have been treated any differently to any comparator. We do not accept Dr Rattenberry is an appropriate actual comparator for the reasons given above. A hypothetical comparator in materially similar circumstances to the claimant but not of Egyptian nationality would find the events unfolded in exactly the same way.

7.81 The allegations fail.

ISSUE "h". *On 7 December 2021, William Rattenbury said to the Claimant that he had been to Egypt and that he had "beggars following [him] to get money". William Rattenbury also argued with the Claimant and tore into pieces the Claimant's anaesthetic record that the Claimant had completed in response to William Rattenbury providing a patient with a spinal anaesthetic. William Rattenbury deliberately left the torn pieces of the anaesthetic record in a place where the Claimant would find it.*

7.82 The first part concerns reference beggars. We did not find as a fact that Dr Rattenberry used the word beggars or, to grasp the essence of the allegation more generally,

that his reference to the one negative experience he encountered on a family holiday to Egypt which did happen was critical or disrespectful.

7.83 We have been alert to the fact that English is not the claimant's first language. Nevertheless, her command of English is excellent and there has never been a suggestion of an interpreter being necessary. However, we have been aware of the limits when language is nuanced, as can lead to miswording or misinterpretation with first language speakers. This has potentially manifested in the difference between what was said or written and how it has been understood. There is no dispute that Dr Rattenbury did talk about an experience on holiday in Egypt in respect of street hawkers following him for money. We found that was in the context of a discussion about a very positive experience of Egypt. He did not use the word beggars, but it is entirely possible that that is how it was interpreted. However, what is important is the context of the conversation. This was part of an initial conversation between two doctors who had only met that day and worked only for that one day.

7.84 We are not therefore satisfied that Dr Rattenberry sharing his experience of a visit to Egypt in the context of initial introductions and getting to know each other can amount to unwanted conduct. The context was positive and natural. It is closely linked to the introduction to a fellow anaesthetist who was also of Egyptian nationality. The subject generally, even to the extent that he did share a negative experience, does not materially alter the totality of the exchange. It can only be construed as part of an attempt to welcome her and make her feel relaxed in what all acknowledged was a difficult assessment process.

7.85 To the extent that such conduct as we found to happen could be described as unwanted, it clearly was related to the claimant's protected characteristic as it flows directly from the knowledge of where she was from and where she had worked. That is sufficient to be "related to" for present purposes.

7.86 We have no hesitation in concluding that discussing the holiday, in the generally positive terms that it was, and even focusing on the one negative experience, was not done with the purpose of creating the proscribed consequences for the claimant.

7.87 The question then is whether it did in fact have the effect. We are not satisfied that it did at the time. It is only in reflecting on the case in its totality that this has taken on a particular status. In any event, even if the claimant did in fact experience any of the proscribed consequences, we do not consider it to be reasonable that it did have that effect. This is not the sort of conduct that section 26 is designed for. It falls below the threshold contemplated in **Dhaliwal**. Even taking into account the claimant's perception, the surrounding circumstances and the question of reasonableness does not give this the quality of a statutory tort.

7.88 As it is not harassment, we turn to consider whether it amounts to direct discrimination.

7.89 Dr Rattenbury did not say the words he is alleged to have said, but did say something of broadly similar nature. We do not accept the context of the exchange amounts to a

detriment. However low the threshold, this is not objectively something that ought to be regarded as a detriment when it was a true experience of Dr Rattenberry, was expressed within a surrounding positive context, and where there is no basis for inferring any ulterior motivation for saying what he said.

7.90 To the extent it could be a detriment, the claimant has not been treated less favourably. Dr Rattenbury's experience was factually true. The home office reports on travel to Egypt report it as a fact that tourists have to be alert to when visiting. There is no actual comparator. A proper hypothetical comparator is a person of another nationality, but whose country has a similar known issue for tourists of people approaching for money and which had been visited by Dr Rattenbury and encountered the same experience. On balance, Dr Rattenbury would have said exactly the same to that comparator.

7.91 In any event, the comment was not because of race. It may have been but for her race, in the sense that, but for her race, there would not have been the coincidence of him having visited the country of her nationality and having the experience he did, there would have been no conversation about his holiday experiences. Even then, the true motivating factor is simply the coincidence of an experience in the country of her nationality.

7.92 The second part of this allegation relates to him rewriting the anaesthetic record and, more particularly, ripping up the original part.

7.93 There were substantial differences of recollection of the circumstances and manner in which the claimant observed the anaesthetic record. We preferred Dr Rattenberry's evidence. That necessarily affects the result of the legal analysis that follows.

7.94 We find it hard to accept the facts as found amount to unwanted conduct. It is a matter of fact that a record had to be rewritten. However, we acknowledge that underlying that is the fact that the original was unsatisfactory. As the claimant had been responsible for most if not all of that original record, we can see that another clinician taking a view that it was unsatisfactory must be capable of passing a relatively low threshold of unwanted conduct.

7.95 The conduct, however, is unrelated to race. There is nothing overt or explicitly referencing it. There is nothing in the surrounding circumstances that points to it and there have been no inferences we can draw to support such a conclusion. Conversely, there is a clear explanation as to why Dr Rattenberry did what he did which related entirely to a view that it did not comply with the record keeping guidelines and should be redrawn. As such, the allegation must fail.

7.96 To the extent it is possible to properly analyse the remaining constituent parts of the prohibited conduct, we are satisfied that Dr Rattenberry did not re write and rip up the record with the purpose of causing the claimant to suffer the proscribed consequences. He did it for the reasons found. If the claimant did in fact feel that she had experienced the proscribed consequences, and this is arguably a continuation of the humiliation concerning her clinical practice, we do not accept that it would be reasonable for this conduct to have that effect. As

we have said, analysis in the abstract is artificial. We have not found it to be related to the protected characteristic.

7.97 We then have to analyse those events through the requirements of section 13.

7.98 We are again uncomfortable with a conclusion that this is a detriment in the context in which it happened, especially as the test of detriment itself imports a degree of objective measurement against a reasonable employee. However, for the same reasons as we concluded it was capable of amounting to unwanted conduct, we are satisfied that the relatively low threshold of detriment is made out.

7.99 We then have to consider whether the claimant was treated less favourably. There is no actual comparator. A hypothetical comparator must be in materially similar circumstances but of a different nationality to the claimant. The material circumstances include the need for an assessment as took place in this case, in order to give the same relationship and dynamic. They include the same sort of crossing out and legibility issues that Dr Rattenberry considered warranted re-writing. We are satisfied that that hypothetical comparator would have experienced exactly the same treatment. The claimant has not, therefore been subject to less favourable treatment.

7.100 Finally, and again acknowledging the artificial nature of any analysis once a claim has failed already, we are satisfied that there is nothing in the evidence whether explicit, implicit or arising from any inferences that can properly be drawn, to suggest that the claimant's nationality was in anyway whatsoever part of any motivation for acting as Dr Rattenberry did.

7.101 All these allegations fail.

Issue "i" *All consultants that the Claimant worked with referred to her on all occasions throughout her employment as being "Egyptian" and said the words "you are from Egypt".*

7.102 This fails on the facts. The claimant's case had been that everyone knew she was Egyptian or from Egypt. In cross examination, she limited the offending use and reference to her nationality to Drs Carney and Matthews, which we also rejected. Everyone else who had referred to it she accepted had done so as part of welcoming her, in a friendly manner and were interested in her home country.

7.103 Having rejected as a fact that anyone referred to her nationality or home country in a derogatory way, we must conclude that she has not been subject to unwanted conduct as alleged and has not been subject to a detriment. This allegation also fails.

7.104 Indeed, to the extent that the claimant's evidence accepted that when it was referred to it was done in a friendly and welcoming way, getting to know new colleagues, we are unable to accept it caused as a fact her to experience the proscribed consequences. Not only is there no detriment, but we are not satisfied that the claimant was treated differently. Any other new starter would experience the same welcome, whatever their nationality and

whichever country they were from. Even those from the UK are likely to have similar discussions about where from or the last place they lived and worked.

Issue "j"*. On ~~10~~ 8 November 2021, Adam Carney told Vicky Webster to keep an eye on the Claimant.*

7.105 Do not accept this incident in isolation is sufficient to amount to unwanted conduct. It takes place in the context of a period of doubling up. That was still in the period of what might have been referred to as the extended induction that would later be said to have been needed. In any event, the claimant was being supervised on that day by Dr Carney. She was aware of the circumstances that called Dr Carney away from theatres and the arrangements he made at short notice to provide another anaesthetist to provide the doubling up / supervision. The use of keep an eye on the claimant in that context is not out of place. It is entirely possible that it connotes a limited degree of supervision at a distance, as seems in fact to have then actually happened. We do not accept this amounts to unwanted conduct.

7.106 In any event, there is nothing about this which in any way can be said to be related to the claimant's nationality.

7.107 We do not accept it was said for the purpose of causing the claimant to experience the proscribed consequences. We are not satisfied as a fact that she actually did. To the extent that she did, we do not accept that this conduct is in the nature of what section 26 provides for and does not meet the **Dhaliwal** threshold. If we had found as a fact that the claimant did experience any of the proscribed consequences as a result, we would have concluded that it was not reasonable that they have that effect. The surrounding context does not permit this to amount to harassment.

7.108 For the same reasons, we do not accept this conduct can be said to be a detriment. It was part of the ongoing doubling up supervision that the claimant expected to happen that day in any event. All that changed was the person doing the supervising.

7.109 We do not accept that the claimant was treated less favourably. There is no actual comparator. Any hypothetical new starter in the claimant's circumstances but of a different nationality would have been treated the same. Indeed, the material circumstances may still be material without mirroring the claimant's exact circumstances as a clinician in whom there were concerns about performance. That may not need to be part of the material circumstances as any long-term locum appointment would undergo an initial period of doubling up lists under the supervision of another consultant. Any supervising consultant who was then called away in the way Dr Carney was and required to organise an alternative supervisor at short notice, could quite easily have used comparable language.

7.110 In any event, we are unable to identify any basis on which the claimant's nationality played any part whatsoever in Dr Carney's motivation for acting as he did on that occasion.

7.111 These allegations fail.

***ISSUE "k**". On 10 December 2021, Andrew Matthews rudely and aggressively told the Claimant that she should leave the room and look in a mirror at her hair and nose.*

7.112 We dismiss elements of this allegation as a fact insofar as Dr Matthews was rude and aggressive. Having said that, the essence of the conduct is not in dispute, and we can well imagine an increasing frustration in Dr Matthews having to repeat himself.

7.113 We are not satisfied this conduct can pass even the low threshold of unwanted conduct. We would expect any professional in a theatre setting to expect, and be grateful to, any colleague who pointed out to them to adjust their PPE so that it was effective and properly fitted. Even if we should still conclude that to be unwanted conduct, there is nothing in the evidence that would properly permit us to conclude it was related to Dr Hosni's nationality. As with all of the discrete allegations, Dr Hosni does not advance any particular case beyond the contention that everything that happened was part of a conspiracy orchestrated by Dr Carney due to her race. We have rejected that. In any event, we are satisfied it was not done for the purpose of causing the claimant to experience the proscribe consequences or environment. It was done because this was a post covid period in a clinical setting and Dr Matthews reasonably considered the PPE was not being properly worn. It was done for the purpose of maintaining PPE and clinical hygiene standards. To the extent that Dr Matthews' actions were apparently direct or abrupt, that seems to be in context of having to mention it twice before without success. The reference to the mirror is itself consistent with an apparent difficulty the claimant was experiencing to correctly adjust the cap on those earlier occasions. Consequently, to the extent that the claimant did in fact experience any of the proscribed consequences or environment, we cannot accept it would be reasonable for the conduct to have that effect.

7.114 The alternative claim under section 13 must fail also. We are not satisfied it is properly a detriment to be asked to do something that any consultant should be expected to do without being asked to. In any event, to the extent it is a detriment, we are not satisfied that the claimant was treated less favourably. There is no actual comparator. Any hypothetical Comparator in materially similar circumstances would be treated in exactly same way and for reasons that we have referred to already, there is no basis on which we can construct a situation where that hypothetical comparator could be treated more favourable because of their nationality compared to that of the claimant's.

7.115 These allegations fail.

***Issue "l"** On 16 December 2021, Adam Carney asked in a mocking way whether the Claimant had simulation days in her country.*

7.116 We do not accept that Dr Carney asked the question in a mocking way. That much of the allegations fails on the facts. That part of the allegation, also, appears to us to be the gravamen of it. The question was, however, asked.

7.117 The mockery having been stripped out of the question, we are not satisfied this passes the threshold of unwanted conduct. This was a legitimate enquiry as part of understanding the level of explanation and guidance that might be necessary for the day ahead. The reference is clearly a shorthand for the context of where the claimant had done her clinical training and spent the previous 10 years in practice. It was a legitimate enquiry. The claim of harassment fails for that reason.

7.118 To the extent it is unwanted conduct we can, however, accept there would be a basis for concluding it was related to her nationality by its indirect, but otherwise clear, implication of her nationality. We do not accept that Dr Carney asked the question with the necessary purpose of causing Dr Hosni to experience any of the proscribed consequences or environment. He asked it to find out if she had done a simulation day before during her previous clinical career, the majority of which had been in her home country of Egypt. We do not accept that this question caused the claimant to experience any of the proscribed consequences or environment but, even if she had, we do not accept it would have been reasonable in the circumstances for it to have that effect. This was a legitimate enquiry with the purpose of informing how the day might proceed or at least how the observations might be assessed.

7.119 We reach the same conclusions about whether the question, stripped of the allegation of mockery, can be said to be a detriment. We do not accept it is. However, to the extent that it is, we are satisfied the claimant was not subjected to less favourable treatment. There is no actual comparator relied on. A proper hypothetical comparator would be a locum consultant who was undergoing a first simulation day for the purpose of assessing their clinical skills and competences. They would not be Egyptian, but would be of another non-UK nationality, in respect of which Dr Carney was unfamiliar with the training and practice of doctors. Such a comparator would have been asked the same question. Nothing before us suggests that the fact that the claimant was Egyptian meant she was treated differently, still less that she was treated less favourably because of her nationality.

7.120 These allegations fail.

ISSUE "m". *On 21 January 2022, Navrinder Bhandal all the consultants that she was not happy with the Claimant's work despite the Claimant performing well and told the Claimant that she was restricted from working at the hospital until an investigation had taken place and that she either had to work from home or undertake tasks putting cannulas into oncology patients who also had Covid-19. At the same time Navrinder Bhandal told the Claimant that she was going to be reported to the General Medical Council.*

7.121 This allegation needs unpicking as to the facts. It was amended to one in which Dr Bhandal told the claimant that all the consultants were not happy with her work. We accept the essence of that allegation is what happened when Dr Bhandal gave the feedback of the 3 doctors reviewing the ALMATs. We did not accept as a fact, that this was against the claimant otherwise performing well.

7.122 There is no dispute that Dr Bhandal informed the Claimant that she would be subject to restricted duties until an investigation had taken place. The claimant's reference to cannulas in oncology patients is, we understand, to be a reference to the objective of finding the claimant alternative work and a reference to the Covid-19 Medicines Delivery Unit. Similarly, the prospect of a referral to the GMC and the involvement of the relevant advisers was never hidden. We did not find, however, that Dr Bhandal told the claimant at this meeting that she *was* being reported.

7.123 Even allowing for the changes to the allegation, the nuanced elements of it and taking out those aspects that we did not accept as a fact, we are satisfied that the conduct that did happen can properly be described as unwanted conduct. Dr Hosni has not established, however, that it is in any way related to her nationality. By this stage of the chronology, the evidence of the need for a formal investigation was so overwhelming that it is that which informs this and, frankly, all other steps then taken by the respondent.

7.124 We are satisfied that Dr Bhandal did not do anything with the purpose of causing the claimant to experience the proscribe consequences or environment. In the abstract, we can accept that the fact that the matter was progressing to the next level in this way no doubt added to the claimant's exiting sense of professional humiliation but the steps that the respondent were taking were entirely reasonable. Artificial though it is to evaluate harassment without the conduct being related to a protected characteristic, we cannot see how it could be reasonable for this conduct to cause any proscribed consequences in fact felt.

7.125 We are satisfied the same conduct can be said to amount to a detriment. We are not satisfied the claimant was subjected to less favourable treatment. There is no actual comparator relied on. A proper hypothetical comparator in materially similar circumstances but not Egyptian would have faced exactly the same process at this stage of the chronology. Nothing before us suggests that the fact that the claimant was Egyptian meant she was treated differently, still less that she was treated less favourably because of her nationality.

7.126 These allegations fail.

ISSUE "n". *On 9 February 2022, Adam Carney sent an email to the Claimant asking her not to contact any of the consultants who had been assessing her for feedback.*

7.127 We are satisfied that happened as a fact. It follows the move to the formal investigation and the claimant's understandable desire to obtain a body of positive evidence demonstrating her clinical skills. She had begun to contact those doctors that she had worked alongside during the assessments undertaken in November and December 2021.

7.128 We are satisfied that being told not to contact her colleagues is unwanted conduct. We cannot see how doing so could be said to be related to her nationality and the harassment claim must fail for that reason.

7.129 We are satisfied that Dr Carney did this because the process was now entering a formal stage and Dr Bhandal had advised him of the approach to how the ALMAT forms

would be handled and disclosed to the claimant. It was written in a polite manner, within an email covering other topics, the tone of which throughout was polite. We cannot see any basis for concluding that Dr Carney restricted Dr Hosni contacting the assessing consultants with the purpose of causing the claimant to experience the proscribe consequences or environment. The surrounding explanation given by Dr Carney is such that we cannot accept that, to the extent the claimant did experience the proscribe consequences because of Dr Carny's restriction, it would be reasonable for it to have that effect.

7.130 For the same reasons, we are satisfied that having that restriction imposed amounts to a detriment. We are not satisfied the claimant was subjected to less favourable treatment. There is no actual comparator relied on. A proper hypothetical comparator in materially similar circumstances but not Egyptian, who had been contacting the earlier assessors would have faced exactly the same restriction. Nothing before us suggests that the fact that the claimant was Egyptian meant she was treated differently, still less that she was treated less favourably because of her nationality.

7.131 These allegations fail.

ALLEGATION "o"*. On 22 or 23 May 2022, Mark Ehlers contacted the agency where the Claimant had been recruited from to ask if they had received any feedback about her from other NHS Trusts where she had been placed in the past.*

7.132 This allegation was amended. There was no contact with the agency where the Claimant had been recruited from (Remedium), the contact that did happen was with an agency called Holt. Moreover, we found Dr Ehlers did not do what he is alleged to have done. He played no part in contacting any agency. As discrimination claims must identify the actor, this is potentially fatal to the allegation. Again, however, giving the allegation a broad reading, we do accept that Dr Ehlers passed on what he had learned about the claimant working for other trusts and others in the respondent, in particular Dr Bhandal, made or caused enquiries to be made. Even then, the allegation is not made out. The purpose of Dr Bhandal's actions was to confirm when and where the claimant has been working elsewhere, not as alleged obtaining feedback about her.

7.133 Much of this allegation has fallen away as a fact. The original allegation would have been capable of amounting to unwanted conduct, but we do not accept that which was found can be said to be unwanted conduct. The aspects that remain amount no more than to confirming that the claimant was working elsewhere, albeit the concern was that this was whilst subject to what they believed was her agreement to voluntarily restrict her practice. The reason we do not consider this unwanted conduct is because that alternative work is something the claimant not only disclosed, but it was part of her case at the time that performing that other work provided her with positive evidence of her clinical practice. It was a fact she was wanting to rely on. We don't see how the employer's actions in confirming that, whoever it was that actually caused the enquiry to be made, can be said to be unwanted.

7.134 In any event, to the extent that it was, there is absolutely no basis for concluding that the conduct found to have happened was related to her nationality in any way. Nothing was done for the purpose of causing the claimant to experience the proscribe consequences or environment. It cannot be reasonable for it to have that effect. Not only would conclude it was not reasonable having regard to the surrounding circumstances of the case, but even taking into account the claimant's own perception it points to the same conclusion.

7.135 For similar reasons, we do not accept the claimant was subject to a detriment. We are not satisfied the claimant was treated less favourable. There is no actual comparator relied on. A proper hypothetical comparator in materially similar circumstances but not Egyptian, is someone who the respondent believed had agreed to a voluntary restriction in clinical practice who then disclosed they had been working elsewhere during the currency of that restriction. Nothing before us suggests that the fact that the claimant was Egyptian meant she was treated differently, still less that she was treated less favourably because of her nationality.

7.136 This allegation fails.

Issue "q". *On 1 June 2022, Mark Ehlers and Navrinder Bhandal reported the Claimant to the General Medical Council. Navrinder Bhandal also sent a high alert email about the Claimant to all NHS Trusts in the country which meant that the Claimant was not able to secure a position elsewhere.*

7.137 We found the first part of this allegation concerning the report to the GMC was, in essence, made out insofar as it is directed at Dr Bhandal. We found Dr Ehlers did not report the claimant to the GMC and that much of it fails on the facts. The most that can be said is he referred the initial information relied on by Dr Bhandal which became the foundation of the referral.

7.138 The second part in respect of the "high alert" (that is the HPAN) is similarly made out, at least in its essence. Dr Bhandal did not send the HPAN, but she did instigate the referral to NHS Resolution which then acted on it and caused the HPAN to be issued. Again, we look at the essence of the allegation rather than the strict language used. Both parts of this allegation can be considered together as they are both closely related.

7.139 We have no hesitation in saying the referral to the GMC and the issuing of the HPAN were unwanted conduct. Once again, however, we can see no basis on which it could be said that conduct was related to the claimant's Egyptian nationality.

7.140 In any event, the reason why both acted as they did was because the underlying facts that had informed the earlier advice from the PPA and ELA advisers not to make referrals had fundamentally changed. The patient safety aims of the regulatory landscape was such that referrals were not originally necessary as it was understood the claimant was voluntarily restricting her clinical practice. The fact that had changed was the cause, and the operative reasoning for the action. This is an issue that is explicitly covered in the policy and procedure

on Conduct Capability and Ill-Health for Medical Practitioners. For that reason, although the claim of harassment fails in any event, we can also conclude in the abstract that the referrals were not done with the purpose of causing the claimant to experience the proscribe consequences or environment and, if they had that effect, it would not be reasonable for the purpose of section 26 that they should have that effect.

7.141 For similar reasons, we would accept both referrals are detriments. We do not however, accept that the claimant was treated less favourably at all, still less that her nationality played any part whatsoever in the respondent's actions.

7.142 This allegation fails.

8. Dismissal

8.1 Allegation "p" in the list of issues was the legal effect of the claimant's decision to resign. This is said to be a "constructive" dismissal within the Act. It is an allegation that may have presented little practical consequence to the claim irrespective of which way our conclusions went. The claimant did not have the necessary qualifying service to bring a claim of unfair dismissal, and the statutory compensation for such a claim would not arise. But if the claimant's allegations of discrimination had been made out, it is highly probable that any tribunal would consider a resignation in response to naturally flow from that such that any financial losses would flow.

8.2 As a discrete allegation, it is brought under s.39(2)(d). It is parasitic on those earlier allegations of harassment or discrimination both succeeding and amounting to a breach of contract, in this case offending the implied term of trust and confidence. We do not need to analyse whether that was the case. If they had succeeded, we consider that, whilst it is not automatic as a matter of law (**Amnesty International v Ahmed 2009 ICR 1450, EAT**), in most cases it is likely to all but follow that the acts of discrimination would also amount to a breach of the implied term of trust and confidence on the basis that treating someone less favourably because of a protected characteristic, or subjecting them to unwanted conduct related to it with the proscribed consequences, will amount to conduct that is likely to serious damage trust and confidence. That conduct being breach of the law, we cannot conceive how it could be said that there was reasonable and proper cause for it. Save for consideration of affirmation, we can say that had the claims succeeded, we see no reason why the dismissal claim would not have succeeded also.

8.3 However, the underlying allegations failed. There was no conduct that was discriminatory. There was conduct which, just as it was unwanted or amounted to a detriment, was likely to seriously damage trust and confidence but, for the same reasons as it was not harassment or discrimination, we would have been bound to say that it was done with reasonable and proper cause.

8.4 For those reasons the dismissal claim also inevitably fails. We should, however, briefly deal with affirmation, although it is academic to the result. The construction of s.39(7)

imports the same common law concepts of acceptance of a repudiatory breach as are found under section 95(1)(c) of the Employment Rights Act 1996. Both modify by permitting an employee the opportunity to resign with notice without the act of giving of notice (the performance of a contractual term) amounting to an affirmation of the contract as it would be at common law. Faced with what they believe to be a fundamental repudiatory breach of their contract of employment, an employee then has a choice to make between accepting the repudiatory conduct or affirming the continuation of the contract. **WE Cox Toner (International) Ltd v Crook [1981] IRLR 443,** at paragraph 13, puts the choices of the innocent party it in these terms: -

> ***he can affirm the contract and insist on its further performance or he can accept the repudiation, in which case the contract is at an end. The innocent party must at some stage elect between these two possible courses: if he once affirms the contract, his right to accept the repudiation is at an end. But he is not bound to elect within a reasonable or any other time. Mere delay by itself (unaccompanied by any express or implied affirmation of the contract) does not constitute affirmation of the contract; but if it is prolonged it may be evidence of an implied affirmation: Allen v Robles (1969) 1 WLR 1193. Affirmation of the contract can be implied. Thus, if the innocent party calls on the guilty party for further performance of the contract, he will normally be taken to have affirmed the contract since his conduct is only consistent with the continued existence of the contractual obligation. Moreover, if the innocent party himself does acts which are only consistent with the continued existence of the contract, such acts will normally show affirmation of the contract.***

8.5 In other words, the right to claim she has been dismissed will be lost where, the continuation of the contract is affirmed. This may arise explicitly. It may arise by implication, often through the effluxion of time. In that sense the passage of time does not, in itself, provide the answer. What is important is what has happened during that time. (**Chindove v William Morrison Supermarkets PLC UKEAT 0201/13**). Events during the employee's notice period are still relevant to affirmation (**Cockram v Air Products Plc [2014] IRLR 672**)

8.6 In this case, during her notice period, the claimant explicitly called for the continued performance of the employment relationship in unambiguous terms, supported by the freedom to speak up guardian. Indeed, it is hard to think of a clearer example of 'calling for the continued performance of the contract' than to seek to rescind the resignation during that period of notice and return to the pre-resignation status quo. Had we got this far in our analysis of the law, we would have concluded that there was no 'constructive' dismissal, as defined by section 39(7). Whether that would have had an effect on remedy is not something we need to explore further.

9. Time limits

9.1 There was an issue of jurisdiction identified in respect of time limits. The claim was presented on 22 August 2022. The ACAS early conciliation was conducted between day A of 26 July 2022 and Day B of 12 August 2022. Any allegations occurring before 27 April 2022 are on the face of it out of time.

9.2 Some allegations were in time. Most were potentially out of time unless they formed part of discriminatory conduct extending over a period for the purpose of section 123(3)(a) of

the Act. In other words, that there was some constant discriminatory state of affairs that sufficiently linked an out of time claim with one that was in time. However, it is not enough to allege a claim that would be in time. That claim must be found to be discriminatory. As we have not found any of the allegations to be made out, there are no acts of discrimination made out and in time to provide that anchor and none that have succeeded but out of time, that require consideration against any later claim.

9.3 We do not consider it is appropriate to consider just and equitable extension in the abstract against a claim that has failed on its merits. Should circumstances arise in the future where any allegations fall to be considered by us again, we will revisit the question of jurisdiction at that stage.

EMPLOYMENT JUDGE R Clark

DATE 25 October 2024

JUDGMENT SENT TO THE PARTIES ON

……28 October 2024……....

AND ENTERED IN THE REGISTER

……....…….

FOR THE TRIBUNALS

Appendix I

Final List of issues

Out of Time – Sections 13 and 26 EqA

1. Are the Claimant's claims under sections 13 and 26 of the Equality Act 2010 ("EqA") brought within the period ending three months less one day from the date of the alleged act or, being a series of acts, within three months less one day of the date of the last act?

2. Do the matters relied upon by the Claimant amount to a continuing course of conduct or a continuing act?

3. If not, would it be just and equitable for the Tribunal to allow the Claimant's claims to be brought out of time? In determining this, the matters that the Tribunal may consider are (this list is not exhaustive):

    a. How far out of time is the claim brought?
    b. What are the reasons for the delay?
    c. When did the Claimant know or suspect that she had a claim for discrimination?
    d. Whether it was reasonable for her to know or suspect that she had a prospective claim earlier?
    e. To what extent the Claimant obtained appropriate professional advice once he knew of the possibility of taking action?
    f. How promptly did the Claimant act in bringing his claim once she knew of the possibility of taking action?
    g. The extent to which the cogency of the evidence is likely to be affected by the delay?
    h. The extent to which the Respondent co-operated with any requests for information?

Direct discrimination because of race (EqA, Section 13)

4. Has the Claimant established that the Respondent treated the Claimant as alleged? The Claimant is alleging:

    a. At the start of October 2021, Adam Carney sent an email to people that the Claimant would be working with in which he referred to the Claimant as being "Egyptian" and saying that they should "keep an eye" on her because she might work differently. (Note: the date of the alleged correspondence later fluctuated in the claimant's case as the evidence unfolded)

    b. In early November 2021, Adam Carney raised concerns about the Claimant's work performance, despite her not having made any errors and there having been no complaints made.

        i) The Respondent has admitted that Adam Carney raised concerns about the Claimant's work performance.

c. On 4 November 2021, Adam Carney shouted at the Claimant in front of other members of staff asking her what she was doing and stating that she had put a cannula into a patient incorrectly, even though that was not accurate, and then took over the procedure himself and performed it badly.

    i) The Respondent has admitted that Adam Carney raised his voice at the Claimant after he became concerned with the Claimant's performance on 4 November 2021 when inserting a cannula into a patient and considered it necessary to step in immediately and take over the procedure himself to ensure patient safety.

d. On 4 November 2021, Adam Carney threatened to report the Claimant to the General Medical Council and the Medical Director of the Respondent and told the Claimant that she should leave the Trust because he did not want her there;

    i) The Respondent has admitted that Adam Carney informed the Claimant that he had discussed the matter with the Medical Director's office and offered the Claimant the opportunity to leave the Respondent if she did not feel it was offering her the job experience she was expecting.

e. On 17 November 2021, Adam Carney told the Claimant that he was not happy with her in an email and then transferred her to the Treatment Centre and told her that he needed people to monitor her performance.

    i) The Respondent has admitted that on 17 November 2021, Adam Carney informed the Claimant that she would be moved to the Treatment Centre for a period of assessment using the ALMAT assessment.

f. In November 2021, the Claimant was subject to an assessment period whereby Adam Carney selected 19 consultants to monitor her work, told those consultants that she was Egyptian and sent them papers suggesting that she was an anaesthetist in training when she was not and she was a consultant.

    i) The Respondent has admitted that in November 2021, Adam Carney agreed with the Claimant that she would undergo an assessment period in which the Claimant would have her work monitored by other consultants and that the assessment period reflected that used for training anaesthetists.

g. On 7 December 2021, Adam Carney failed to take any action in response to the Claimant's email complaining about William Rattenbury when she was pressurised to perform spinal anaesthesia even though the patient had difficulties with such a procedure in the past.

h. On 7 December 2021, William Rattenbury said to the Claimant that he had been to Egypt and that he had "beggars following [him] to get money". William Rattenbury also argued with the Claimant and tore into pieces the Claimant's anaesthetic record that the Claimant had completed in response to William Rattenbury providing a patient with a spinal anaesthetic. William Rattenbury deliberately left the torn pieces of the anaesthetic record in a place where the Claimant would find it.

i. All consultants that the Claimant worked with referred to her on all occasions throughout her employment as being “Egyptian” and said the words “you are from Egypt”.

j. On ~~10~~ 8 November 2021, Adam Carney told Vicky Webster to keep an eye on the Claimant.

k. On 10 December 2021, Andrew Matthews rudely and aggressively told the Claimant that she should leave the room and look in a mirror at her hair and nose.

   i) The Respondent has admitted that at around the start of December 2021, Andrew Matthews asked the Claimant to rearrange her hat on three occasions during surgery because her hair was misplaced and asked the Claimant on two occasions to pull her mask up because it was not covering her nose.

l. On 16 December 2021, Adam Carney asked in a mocking way whether the Claimant had simulation days in her country.

m. On 21 January 2022, Navrinder Bhandal told *the claimant that* all the consultants ~~that she was~~ *were* not happy with the Claimant’s work despite the Claimant performing well and told the Claimant that she was restricted from working at the hospital until an investigation had taken place and that she either had to work from home or undertake tasks putting cannulas into oncology patients who also had Covid- 19. At the same time Navrinder Bhandal told the Claimant that she was going to be reported to the General Medical Council.

   i) The Respondent has admitted that Navrinder Bhandal informed the Claimant that she would be placed on restricted duties until an investigation had taken place. It is admitted that Navrinder Bhandal informed the Claimant that she may be reported to the General Medical Council.

n. On 9 February 2022, Adam Carney sent an email to the Claimant asking her not to contact any of the consultants who had been assessing her for feedback.

   i) The Respondent has admitted this act.

o. On 22 or 23 May 2022, Mark Ehlers contacted the agency ~~where the Claimant had been recruited from~~ *the Holt Agency, not Remedium,* to ask about the secondary employment, not getting the job. ~~if they had received any feedback about her from other NHS Trusts where she had been placed in the past~~.

p. As a result of the allegations at paragraph 4 (a) to (n) the Respondent acted in a way that amounted to a repudiatory breach of contract which rendered the Claimant dismissed and entitled her to resign on 19 May 2022.

q. On 1 June 2022, Mark Ehlers and Navrinder Bhandal reported the Claimant to the General Medical Council. Navrinder Bhandal also sent a high alert email about the Claimant to all NHS Trusts in the country which meant that the Claimant was not able to secure a position elsewhere.

i) The Respondent has admitted that Navrinder Bhandal reported the Claimant to the General Medical Council and submitted a Healthcare Practitioner Alert Notice on or around 7 June 2022.

5. If so, did the Respondent treat the Claimant less favourably than the Respondent treated or would have treated others who do not share the Claimant's protected characteristic?

6. The Claimant is relying on a hypothetical comparator.

7. The Claimant is relying on an actual comparator in the alternative in relation to the allegation at paragraph 4 (g). The Claimant is alleging that William Rattenbury was allowed to complain about the Claimant's practice as part of the ALMAT assessment process, but the Claimant was not allowed to complain about his practice despite being a more senior and experienced Consultant Anaesthetist than him.

8. Was the treatment because of the Claimant's race or for some other reason?

Harassment related to race (EqA, Section 26)

9. Did the Respondent do the things alleged by the Claimant?

    a. The Claimant is relying on the same acts set out at paragraph 4 (a) to (q).

10. If so, was it unwanted conduct?

11. Did it relate to the Claimant's race?

12. Did the conduct have the purpose of violating the Claimant's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for the Claimant?

13. If not, did it have that effect?

14. (Added by the ET) If so, was it reasonable that it had that effect

    a. The Tribunal will take into account the Claimant's perception, the other circumstances of the case and whether it is reasonable for the conduct to have that effect.

REMEDY

15. What is the appropriate award for injury to feelings?

16. Has the Claimant suffered any financial loss due to the discrimination found to have occurred? If so, what is the appropriate award of compensation?

17. What, if any, recommendations ought the Tribunal to make?

Appendix II

Case Management Issues arising

1. We have summarised here the case management issues and challenges that presented during the conduct of the final hearing between April and July

The First Listing - April 2024

2. We started out reading day with an application in respect of one of the Respondent's witnesses, Dr Bhandal, who had suffered a very close bereavement that weekend. We accepted the representations that she was not in position to attend. She was not only a witness for the respondent, but was alleged to have discriminated herself in two matters. Dr Hosni objected, challenging the veracity of the underlying basis for the application and that Dr Bhandal was strong enough to act as she did towards Dr Hosni at the time and that she should attend and be questioned, or the respondent elect not to rely on her evidence.

3. We granted the respondent's application for a relisted hearing. We accepted Dr Bhandal's position, being advanced through two officers of the court. We did not consider it just to deny the respondent her evidence in these circumstances. One issue we did have to settle was that this hearing had been listed as a priority on the basis that Dr Hosni was travelling from Egypt and her travel documentation would shortly expire. In the event, that fell away because, despite that priority listing, the case was still listed as "liability only" meaning we would have to list a further hearing if any of the claims succeeded. Secondly, Dr Hosni confirmed that she anticipated her travel documentation being renewed in the coming months.

4. We contemplated that a reconvened hearing could take place remotely with Dr Hosni Cross examining from Egypt in circumstances that would not offend the diplomatic restrictions on giving evidence from Egypt. In the event, and for reasons set out below, that was not needed.

5. We then dealt with not unusual case management issues concerning disclosure and documents to go into the bundle from both parties, and a similar application by the claimant to remove documents relating to her GMC history. We took a pragmatic and proportionate approach to the issue. To embark on detailed examination of the background to each document would take up valuable hearing time which is already being lost. We admitted them and invited the parties to take us to them in evidence and submissions as appropriate. We declined to exclude documents in respect of the GMC history. It was a live issue in the case and already one that we anticipated arising in the evidence.

6. Dr Hosni also made an application to make a response to the additional documents. We were initially prepared to grant that on the understanding it was in the nature of supplementary evidence in chief going to those documents. In the course of that, we explained the three stages and process generally of giving evidence. It then emerged this was not what the claimant meant and that she was intending to make an introductory statement to her evidence explaining the documents in the bundle. We noted that her witness statement already included a lengthy explanation of the evidence at the outset and the document she wanted to read out had not been served on the respondent. We explained the structure of bundles generally and how the tribunal was used to bundles not always being in the order that it might like. This issue of the bundle order was already something that had been considered by EJ Ahmed at a previous preliminary hearing. We therefore refused the application but did invite her to produce a reading list, as the respondent had done, if there were further documents she felt we should read to provide context.

7. We lost a considerable amount of time on day 2 dealing with these applications

8. On day 3, we lost nearly a further 1 ½ hours of hearing time dealing with further case management applications from the claimant. That included what turned out to be a repeat of the previous day's application, correcting the claimant's page references in her witness statement, in addition to receiving the reading list which we agreed to review and consider those documents.

9. On day 4, Thursday 18 April, we spent the first 2 ½ hours of hearing time dealing with the claimant's overnight repeat application to read out her opening statement and to exclude the respondent's witnesses from the hearing altogether as well as dealing with additional documentation produced by the respondent.

10. We took the same pragmatic approach to permitting documentation to be included in the bundle. We refused the claimant's application to spend time reading out an opening statement for the same reasons as we had given the previous day. It remained a disproportionate use of the increasingly limited time available and has not been served on the respondent. However, as EJ Ahmed had ordered skeleton arguments to be served if relied on, and the respondent had used that to present its opening note, we invited the claimant to serve it on the respondent and file it with us. We would then read it and treat it in exactly the same way as the respondent's.

11. We refused to exclude witnesses. The claimant made two subtly difference applications which were repeated at various stages of the hearing. One was simply to exclude them during their cross-examination. We were not satisfied the point the claimant wanted to advance of different answers outweighed the hardship to the respondent and its representatives getting proper instructions in what was a public hearing. The second strand of this application arose, to our surprise, after being in the same court room as the respondent's witnesses for two days. The claimant indicated she had not realised the

people sat behind her were the respondent's witnesses and sought their exclusion on the ground she did not feel comfortable with them observing her.

12. We refused that application also. After two days in the same room as the witnesses that the claimant says she will never forget, she had realised that they are those people. These are also the same people that she intends to put through cross examination in order to "look them in the eye". Indeed, part of her objection to Dr Bhandal's application for a remote hearing was put on the basis that she needed to be in the same room as her. She had not shown any vulnerability arising from their presence and did not have any disability or obvious need for which any adjustment might be required. That also necessarily meant the witnesses may continue to communicate with their lawyers during the hearing, if it is done discretely.

13. After losing much time dealing with this application, Dr Hosni commented that it was fine as she was a strong person.

14. On day 5, Friday 19 April, we faced two further applications taking up increasingly diminishing and valuable hearing time. We should note here that the timetable had envisaged all 6 witnesses being examined and at least closing submissions being concluded in the 7 days allocated. We were still in the process of hearing Dr Hosni's evidence which was itself a challenge to keep focused and given in a measured manner.

15. One of the applications arose from exchanges during the applications the previous day. Counsel for the respondent had referred to the issues of credibility and that the claimant had "got form" for dishonesty. She was raising that in the context of the applications then before us. At the time we considered it was a submission the respondent was entitled to make on that application, and it did not mean we agreed. We had explained to the claimant that credibility was in issue on some of the allegations and we will have to weigh all the evidence when we make our decision. We may agree or disagree with the party's submissions. We may even be able to determine the facts without regard to concepts such as credibility. That seemed to satisfy the claimant. Today the point has been revisited. We repeated our decision from yesterday.

16. The second application recognised that the claimant had been demonstrably unable to heed our repeated requests during her evidence to slow down in her oral answers. We lost count of the times we had to intervene. She had asked for guidance in her the second email application of the day if she should just say "yes" or "no". We spent time explaining once again that we wanted her answers to be full and in context, in part as there was no advocate to conduct any re-examination, but we had to be able to keep up with what she was saying. The issue behind why we had repeatedly had to stop her over the previous 3 days was not about what she was saying, but the speed at which she was saying it.

17. On day 6, Monday 22 April we received three further emails containing applications which we were thankfully able to deal with quickly. They related to the hard copy bundle, which had been provided by the respondent as ordered. We received the claimant's "opening

note" which we agreed we would read as we had indicated last week. We also received additional documentation which we admitted.

18. We also had also planned to deal with the necessary further listing of a part heard hearing but which we deferred until tomorrow when we would know what the progress was with the witnesses. We were only today turning to the respondent's witnesses. Dr Carney had been estimated to be concluded within the two days remaining.

19. On day, 7 Tuesday 23 April 2024, we were again delayed in starting as new documents were disclosed arising from issues that arose in questioning the day before. That was the anaesthetic charts of the patients on the occasions when the claimant worked alongside Dr Carney and others. These were substantial running to around 70 pages. We facilitated those being printed.

20. In the event, we were unable to conclude Dr Carney's evidence.

Relisting a Part-Heard hearing.

21. The original listing had to go part heard. We discussed time estimates with the parties. Dr Carney was by far the witness likely to take longest in cross examination. The remaining witnesses were estimated to take in the nature of 1 ½ days or less. We were fortunate in being able to coordinate a return date in July which with some minor adjustments, straddling two weeks to avoid complete unavailability and which worked for all participants. However, we then learned of Dr Matthews circumstances. He was anticipating a serious surgical procedure happening in the coming months which would mean he was unlikely to be available in July. We were then able to identify a single date of 12 June 2024 to convene, remotely by CVP, to conclude Dr Carney's evidence and hear that of Dr Matthew's. The case management orders sent at the time set out the circumstances.

22. During the intervening period, Dr Matthews surgery was brought forward to take place on 11 June, the day before the listed hearing. The respondent sought to go ahead, conclude Dr Carney's evidence and substitute Dr Rattenberry for Dr Matthews. Dr Hosni had also discovered problems with the Egyptian civil infrastructure due to the extreme heat in the country. That meant the Egyptian government was imposing planned power cuts of around 2 hours each afternoon. Our case management order at the time sets out the detail of our decision. In short, we directed the hearing to go ahead and make as much progress as possible. We also directed the parties look to arrange an additional day to add to the July hearing, when the claimant would be in the UK, to allow for the possibility we may not make much progress on 12 June 2024.

The Second Listing – June 2024

23. The second remote hearing went ahead as planned. Dr Hosni was able to join in the morning (UK time). We were able to conclude Dr Carney's evidence. Dr Rattenberry was on standby to replace Dr Matthews. He was called but, this coincided with the claimant

losing power and connection. We attempted to make contact with her to establish that that was what had happened. Unfortunately, our clerks were prohibited from telephoning the claimant in Egypt due to a policy restriction we did not understand.

24. In the circumstances we adjourned part heard.

The Third Listing – July 2024

25. The final part heard listing went ahead on 18, 19, 23 & 24. We also had been able to extend it to include Thursday 25 July.

26. We had two applications lodged the day before the hearing. We made directions in advance which, regrettably, had not been actioned by the tribunal and the parties arrived in the dark as to our views. We expressed them orally at the start of the day.

27. The claimant sought an order directing the remaining respondent's witnesses to read certain documents in the bundle in advance of giving evidence with a view to limiting the answers they might give in cross examination. We declined to make such an order as the witnesses can be taken to the documents in cross examination and were entitled to give full answer according to the question asked. We did indicate that it was for the respondent whether it directed the witnesses to those documents in advance as it would seem to indicate the areas of cross examination.

28. The second application was from the respondent in respect of Dr Matthews Attendance. He remained too unwell to attend either in person or remotely. Whilst we did not doubt the veracity of what we were being told we sought some supporting evidence, mainly in respect of his prognosis. Our direction of Wednesday had not been actioned meant the respondent was not on notice of our request. We therefore adjourned the application until the following week for that evidence to be considered.

29. Dr Bhandal attended to give evidence. She could only attend during 18 and 19 July. Her evidence was clearly not going to be completed by then. Dr Hosni applied for her to be required to attend the following week. We refused. That was not in the interest of justice and did not further the overriding objective. We had to look at fairness and justice between parties but also the wider allocation of limited resources. The claimant had had fair opportunity to test evidence and advance her case over nearly 6 hours which we were satisfied covered the two allegations where Dr Bhandal is alleged to have discriminated, the key topics in her witness statement and substantially covered wider issues of other witnesses evidence and the issues of significant importance to the claimant which is the difference of clinical opinion about her competence and skills at the time. The fact there were more questions that could be put to Dr Bhandal did not alter the fact that she was not available, a fact known since April. The prospect of using time vacated by Dr Matthews absence was a relevant practical consideration, but not relevant to the question whether it was necessary or just to allow further time for cross examination.

30. During this third hearing, most of the claimant's questions were put through the Judge as questions to avoid Dr Hosni's sometimes understandable passion turning into aggressive argument. At one stage passion overflowed and we took 20 minutes out to allow her to compose herself.

31. On day 11, Tuesday 23 July, the tribunal was the cause of delay when a fatality on the railway meant one of the non-legal members was unable to join in person. Arrangements were made to facilitate him getting home and attending remotely by CVP with access to the digital bundles.

32. On day 12, Wednesday 24 July, we were further delayed with case management applications. We received further documents from the respondent in respect of the references from 2020 which were said to have been provided to GMC but not in the bundle. We also dealt with an application from the claimant in respect of her intention to play a YouTube video in her closing submission. We invited her to share it with the respondent first and we would reflect. She explained the purpose of the video, the process of which we got her point and asked whether playing it was now necessary. We allowed her to play it in the course of her closing submission.

33. We also dealt with the application regarding Dr Matthews attending in person. We have set out the result of that elsewhere.