EMPLOYMENT TRIBUNALS

Claimant: Mr Muhammad Karmani

Respondent: Spire Healthcare Limited

Heard at: London South (by video)

On: 10 to 25 February 2025

Before: Employment Judge Evans

Representation
Claimant: Ms C D'Souza, counsel
Respondent: Mr D Tatton Brown, KC

JUDGMENT

1. The complaints of direct race discrimination are not well-founded and are dismissed.

2. The complaints of being subjected to detriments for making protected disclosures are not well-founded and are dismissed.

REASONS

Index

Preamble

1. These are the Tribunal's reasons for its reserved judgment.

2. The claimant worked at the respondent's Montefiore hospital in Brighton as a consultant surgeon with practising privileges from 2014 until his practising privileges were permanently withdrawn on 28 October 2022.

3. Early conciliation began on 10 March 2023 and ended on 13 April 2023. The claimant presented his claim on 11 May 2023. It included complaints of direct race discrimination, harassment related to race and of having been subjected to detriments for making protected disclosures. The complaint of harassment related to race was subsequently withdrawn.

4. The claim came before the Tribunal between 10 and 25 February 2025. The parties had agreed a bundle of 3926 pages prior to the Hearing to which additional pages 3927 to 3966 were added by agreement during the Hearing. All references to page numbers are to the pagination of the bundle.

5. The claimant gave evidence by reference to a witness statement. So too did:

   5.1. Mr Marsh ("GM"), a retired orthopaedic surgeon;

   5.2. Mr Hatrick ("CH"), the medical director of the Montefiore hospital from November 2014 until 30 June 2023 and an orthopaedic surgeon;

   5.3. Mr White ("BW"), a hospital director of the respondent;

   5.4. Mr Bloomer ("MB"), the finance director at the Montefiore hospital;

   5.5. Ms Clarke ("AC"), the clinical governance & risk manager at the Montefiore hospital and a registered nurse;

5.6. Ms Dixon ("RD"), the managing director of the Montefiore hospital and its registered manager for the purposes of the CQC;

5.7. Ms Awdry ("LA"), the director of clinical services ("DOCS") at the Montefiore hospital from December 2011 to August 2022. The role had the job title of "Matron" until 2019;

5.8. Mr Cass ("MC"), a consultant spinal orthopaedic surgeon who practised at the Montefiore hospital;

5.9. Dr Cale ("CC"), the group medical director and responsible officer of the respondent.

6. The parties provided me with the following further documents at the beginning, or during the course, of the Hearing: an agreed, and then an agreed amended, timetable, an agreed cast list, an agreed chronology, opening submissions, an agreed reading list (by email on 10 February 2025), a revised agreed list of issues (by email on 10 February 2025), further particulars of the respondent's position in relation to the claimant's protected disclosures (by email on 14 February 2025), further particulars of the respondent's position in relation to the claimed detriments (by email on 17 February 2025), and written closing submissions.

7. All references to page numbers are to the page numbers of the bundle unless otherwise stated. References to paragraphs in witness statements are as follows: [*initials*] WS [x], where the initials used are as set out above and the claimant is referred to as "C", and [x] is the paragraph number of the witness statement. Various matters were dealt with at the beginning of the Hearing as set out below. Otherwise, the first two days of the Hearing were reading days. I heard evidence between days 3 and 10, oral submissions were on day 11 and I began to deliberate on day 12. I deliberated further on 26 February 2025, 4 to 7 March 2025, 31 March 2025 and 2 April 2025.

Glossary and defined terms

8. Some of these terms are also defined in the text of these reasons but it is convenient to set out a glossary and table of defined terms here. To the extent that this explains medical terms, the explanation is intended only to explain what I mean by the term when it is used in these reasons.

2019 PRC	The Professional Review Committee process which considered the claimant's treatment of patient CD in 2018.
2022 PRC	The Professional Review Committee process in 2022 which considered the claimant's treatment of patients KW and MB and resulted in the permanent suspension of his practising privileges.
Coding Complaint	The anonymous complaint to the NHS Fraud Team made in January 2018
GDG	The Guideline Development Group

GDG document	The National Guideline Centre document commissioned by NICE and produced by the Guideline Development Group in relation to “Low back pain and sciatica in over 16s: assessment and management – Invasive treatments”
Index Procedure	The first operation carried out in relation to a particular complaint.
Low back pain	“Low back pain that is not associated with serious or potentially serious causes has been described in the literature as 'non-specific', 'mechanical', 'musculoskeletal' or 'simple' low back pain.” (The NICE guidance) Or “'low back pain’ is used to include any non-specific low back pain which is not due to cancer, fracture, infection or an inflammatory disease process.” (The GDG document)
MDT	Used to refer both to the Spinal Multidisciplinary Team and, because this is how witnesses used the term, to meetings of that team.
MED06 policy	The Managing Consultant Performance Concerns Policy
Never Event	A patient safety event which is wholly preventable.
NICE guidance	The guideline “Low back pain and sciatica in over 16s: assessment and management” which was given a NICE reference number of “ng59”
Operating loupes	A bulky device which mounts magnifying glasses onto the forehead/in front of the eyes of the wearer
PRC	Professional Review Committee – the body constituted under the MED06 policy to consider what if any action should be taken against a consultant after concerns have been investigated.
RCA	Root Cause Analysis.
SIRI	Serious Incident Requiring Investigation

Matters dealt with at the beginning of the Hearing

Hearing to be held by CVP

9. The parties had jointly applied shortly before the Hearing for it to be held by CVP in light of the size of the bundle and for the convenience of the witnesses. I told the parties at the beginning of the Hearing on 10 February 2025 that their application

had been successful. I did not realise until the Hearing began that they had not already been informed of that.

Panel composition

10. I then explained to the parties that the Regional Employment Judge had made a decision pursuant to [28] of the Presidential Guidance on Panel composition that the Hearing should take place before an employment judge sitting alone because there had been a material changes in circumstances. That change was that (1) one of the Non-Legal Members assigned to the case could not in fact sit on the first Thursday and there was no other Non-Legal Member in London South who was available for the whole of the Hearing; (2) it was not a case where a day could simply be cut from the Hearing. Indeed, since the preliminary hearing at which the length of the Hearing had been agreed, the bundle had increased vastly to nearly 4000 pages and it was therefore likely in any event that the Tribunal would need more deliberation time than that permitted by the agreed timetable; (3) the need for additional deliberation time was easier to accommodate in a case where an employment judge sits alone; (4) the parties had jointly applied for the Hearing to be held by CVP. The other Non-Legal Member habitually works with a hard copy bundle and always sits in person, which would have resulted in a hybrid hearing which would have affected the speed at which the Hearing would progress; (5) at the preliminary hearing the parties had initially suggested a 15-day hearing giving an indication of the scale of the bundle from the parties' perspective.

11. I asked the parties whether there was anything they wished to say about the REJ's decision on panel composition and there was a short adjournment so that both counsel could take instructions.

12. After the adjournment Mr Tatton Brown indicated that the respondent had no objection to the claim proceeding before an employment judge sitting alone. Ms D'Souza queried whether the claimant could challenge the REJ's decision and, if they did so successfully, the likely delay that would result. I said that my understanding was that the decision was one which could be challenged by an application or an appeal and that I did not know what the likely delay would be, but could make enquiries if the claimant wished me to. I asked Ms D'Souza whether the claimant wished me to make enquiries so that the claimant could decide whether to ask the REJ to reconsider their decision or, indeed, to appeal. Ms D'Souza replied that, weighing all relevant factors, the claimant did not wish me to make enquiries about the extent of the delay which would ensue if the claimant sought to challenge the REJ's decision on panel composition and was content to proceed before an employment judge sitting alone.

Third party disclosure application

13. The claimant had made an application for a third-party disclosure order in respect of Mr Cass and for a specific disclosure order on 19 November 2024. This had not been dealt with before the beginning of the Hearing, but it had been reduced in scope so that it related only to text messages exchanged between Mr Cass and Ms Awdry between 2013 and 2022.

14. I dealt with the application on Tuesday 11 February 2025. I refused the order sought for reasons given orally on the day. I note that Ms D'Souza was unable to attend on 11 February 2025 as a result of a domestic emergency. I indicated to the claimant's solicitor, Ms Shawcross, that we could postpone the hearing of the application to the following day so that Ms D'Souza could deal with it but Ms Shawcross said that the claimant preferred to proceed.

The Issues

15. The issues arising in this case were agreed between the parties prior to the Hearing. A revised list of issues was produced on the first day of the Hearing and then, as noted above, the respondent provided further particulars of its position in relation to the claimed protected disclosures and the claimed detriments. The further particulars were provided at my request in light of the scantily pleaded response. I made this request so as to avoid time being spent on matters which were in fact not in dispute.

16. The amended list of issues together with the further particulars provided by the respondent is contained in Appendix One.

The Law

Protected disclosure detriment

17. Section 47B(1) of the Employment Rights Act ("the 1996 Act") provides that a worker has the right not to be subjected to a detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a "protected disclosure".

18. A worker also has the right under section 47B(1A) of the 1996 Act not to be subjected to a detriment by any act, or any deliberate failure to act, by a co-worker done on the ground that the worker has made a "protected disclosure". Section 47B(1B) provides that the employer will be vicariously liable for the acts of the co-worker.

What is a protected disclosure?

19. A "protected disclosure" is defined by section 43A of the 1996 Act as a "qualifying disclosure" made in accordance with any of sections 43C to H. Section 43C states that a qualifying disclosure is made in accordance with it if the worker makes the disclosure to their employer.

20. A "qualifying disclosure" is defined in section 43B(1) of the 1996 Act as follows (with sub-sections irrelevant to this claim omitted):

> *…any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show one or more of the following—*
> *…*

(b) that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,

…

(d) that the health or safety of any individual has been, is being or is likely to be endangered,…

21. An employee wanting to rely on the whistleblowing protection bears the burden of proof of establishing the relevant failure referred to in 43B(1)(b). In Boulding v Land Securities Trillium (Media Services) Ltd UKEAT/0023/06 Judge McMullen said:

As to any of the alleged failures, the burden of the proof is upon the Claimant to establish upon the balance of probabilities any of the following:

(a) there was in fact and as a matter of law, a legal obligation (or other relevant obligation) on the employer (or other relevant person) in each of the circumstances relied on.

(b) the information disclosed tends to show that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject.

22. Several communications may when taken together amount to a qualifying disclosure even though each individual communication itself is not (Simpson v Cantor Fitzgerald [2020] EWCA Civ 1601.

The approach of the Tribunal to deciding whether there has been a protected disclosure

23. The approach that a Tribunal should take when deciding whether there has been a protected disclosure was set out by the EAT in Williams v Michelle Brown AM UKEAT/00/44/19:

23.1. Is there a disclosure of information?

23.2. Does the worker believe the disclosure to have been made in the public interest?

23.3. If so, is that belief reasonably held?

23.4. Does the worker believe that the disclosure tends to show one of the six specified matters in s.43B of the 1996 Act?

23.5. If the worker holds such a belief, is it reasonably held?

24. The Court of Appeal considered when there has been a disclosure of information in Kilraine v London Borough of Wandsworth [2018] IRLR 846. It concluded that there was no "rigid dichotomy" between "information" and an "allegation" (at [32]). It went on to state at [35]: "In order for a statement or disclosure to be qualifying disclosure according to this language, it has to have a sufficient factual content and specificity such as is capable of tending to show one of the matters listed in sub-section [43B](1)". Then at [36] "Whether an identified statement or disclosure in

any particular case does meet that standard will be a matter for evaluative judgment by a tribunal in the light of all the facts of the case".

25. In Chesterton Global v Nurmohamed (PCAW Intervening) [2017] All ER 947 the Court of Appeal considered the second and third questions. The following principles were identified:

    25.1. Did the worker believe at the time they made the disclosure that making it was in the public interest (at [27])?

    25.2. If so, was that belief reasonable? The Tribunal is required to recognise that there may be more than one reasonable view as to whether a particular disclosure was in the public interest (at [28]);

    25.3. The necessary belief is simply that the disclosure is in the public interest. The particular reasons why the worker believes that to be so are not of the essence (at [29]);

    25.4. While the worker must have a genuine and reasonable belief that the disclosure is in the public interest, that does not have to be the predominant motive in making it (at [30]);

    25.5. Parliament chose not to define the phrase "in the public interest" and so the intention was to leave it to employments tribunals to "apply it as a matter of educated impression". The essential distinction is between disclosures which serve the private or personal interest of the worker making the disclosure and those that serve a wider interest.

26. The EAT considered the fourth and fifth questions posed by Williams in Twist DX Limited v Armes UKEAT/0030/20/JOJ. It stated that:

    26.1. The fourth question is a subjective question to be decided on the evidence as to the claimant's beliefs at the time of the alleged disclosure [64]. The belief must be as to what the information "tends to show", which is a lower hurdle than having to believe that it "does show" [66].

    26.2. The fifth question has both a subjective element and an objective element. Importing the test from Chesterton Global, the subjective element is that the worker must believe that the information disclosed tends to show one of the six matters listed. The objective element is that that belief must be reasonable". The worker's view may be wrong but nevertheless reasonable ([67] to [70] of Twist DX).

27. Insider knowledge is relevant to the reasonableness of the belief in what the disclosure "tends to show" (Simpson v Cantor Fitzgerald Europe [2020] EWCA Civ 1601 and Korashi v Abertawe Bro Morgannwg University Local Health Board [2012] IRLR. In the latter, at [62] the EAT noted

    To take a simple example: a healthy young man who is taken into hospital for an orthopaedic athletic injury should not die on the operating table. A

whistleblower who says that that tends to show a breach of duty is required to demonstrate that such belief is reasonable. On the other hand, a surgeon who knows the risk of such procedure and possibly the results of meta-analysis of such procedure is in a good position to evaluate whether there has been such a breach. While it might be reasonable for our lay observer to believe that such death from a simple procedure was the product of a breach of duty, an experienced surgeon might take an entirely different view of what was reasonable given what further information he or she knows about what happened at the table. So in our judgment what is reasonable in s43B involves of course an objective standard - that is the whole point of the use of the adjective reasonable – and its application to the personal circumstances of the discloser. It works both ways. Our lay observer must expect to be tested on the reasonableness of his belief that some surgical procedure has gone wrong is a breach of duty. Our consultant surgeon is entitled to respect for his view, knowing what he does from his experience and training, but is expected to look at all the material including the records before making such a disclosure. To bring this back to our own case, many whistleblowers are insiders. That means that they are so much more informed about the goings-on of the organisation of which they make complaint than outsiders, and that that insight entitles their views to respect. Since the test is their "reasonable" belief, that belief must be subject to what a person in their position would reasonably believe to be wrong-doing.

28. An employer's belief that a disclosure is not protected is not relevant to the assessment of whether it is (Beatt v Croydon Health Services NHS Trust [2017] IRLR 748).

What is a detriment?

29. The 1996 Act does not define "detriment" but "detriment" is a familiar concept in discrimination law. In Jesudason v Alder Hay Children's NHS Foundation Trust IRLR 374 the Court of Appeal confirmed that it should be construed in a similar fashion in the context of whistleblowing. A detriment will be established if a reasonable worker would or might take the view that the treatment accorded to them had in all the circumstances been to their detriment.

The burden or proof

30. Section 48(2) of the 1996 Act provides that:

On a complaint under section …(1A) it is for the employer to show the ground on which any act, or deliberate failure to act, was done.

31. In a claim that a worker has been subject to a detriment in breach of section 47B, the worker must prove on the balance of probabilities that they made a protected disclosure and suffered a detriment. Under section 48(2) it is then for the employer to show the ground on which the detriment was done. If the employer does not, the Tribunal may (but is not required to) infer that the detriment was on the ground that the worker made a protected disclosure (Ibekwe v Sussex Partnership NHS Foundation Trust UKEAT/0072/14/MC the EAT).

Causation

32. The question of causation requires an analysis of the mental processes (conscious or unconscious) which caused the employer to act as it did and the test is not a "but for" test (Harrow London Borough v Knight [2003] IRLR 140 EAT).There will be a breach of section 47B if the protected disclosure materially influenced (in the sense of being more than a trivial influence) the employer's treatment of the whistleblower (NHS Manchester v Fecitt [2012] IRLR CA).

Knowledge of disclosures

33. In Nicol v World Travel and Tourism Council and others [2024] EAT 42 the EAT considered the question of what level of detail of knowledge is required of a protected disclosure by person B when the actual disclosure is made to person A. Is it sufficient that person B merely knows that a disclosure has been made to person A, or does person B have to know at least some of the content of the disclosure that has been made? At [82] the EAT concluded that: "For employers to be fixed with liability, therefore, they ought to know at least something about the substance of what has been made [sic]: that is, they ought to have some knowledge of what the employee is complaining or expressing concerns about". It is not enough that person B simply knows that the worker has made a disclosure to person A.

Multiple disclosures

34. If multiple protected disclosures have been made and the Tribunal finds that they operated cumulatively, the Tribunal should in an unfair dismissal claim consider whether cumulatively they were the principal reason for the dismissal (El-Megrisi v Aza University (IR) in Oxford UKEAT/0448/08 at [19]).

Time limits for a claim for breach of section 47B of the 1996 Act

35. Section 48(3) of the 1996 Act provides:

(3) An employment tribunal shall not consider a complaint under this section unless it is presented—

(a) before the end of the period of three months beginning with the date of the act or failure to act to which the complaint relates or, where that act or failure is part of a series of similar acts or failures, the last of them, or

(b) within such further period as the tribunal considers reasonable in a case where it is satisfied that it was not reasonably practicable for the complaint to be presented before the end of that period of three months.

(4) For the purposes of subsection (3)—

(a) where an act extends over a period, the "date of the act" means the last day of that period, and

(b) a deliberate failure to act shall be treated as done when it was decided on; and, in the absence of evidence establishing the contrary, an employer, a temporary work agency or a hirer shall be taken to decide on a failure to act when he does an act inconsistent with doing the failed act or, if he has done no such inconsistent act, when the period expires within which he might reasonably have been expected do the failed act if it was to be done.

36. In Arthur v London Eastern Railway [2006] EWCA Civ 1358 LJ Mummery considered what "a series of similar acts or failures" meant and at [35] concluded:

> *In order to determine whether the acts are part of a series some evidence is needed to determine what link, if any, there is between the acts in the three-month period and the acts outside the three-month period. … It is necessary to look at all the circumstances surrounding the acts. Were they all committed by fellow employees? If not, what connection, if any, was there between the alleged perpetrators? Were their actions organised or concerted in some way? It would also be relevant to inquire why they did what is alleged. I do not find 'motive' a helpful departure from the legislative language according to which the determining factor is whether the act was done 'on the ground' that the employee had made a protected disclosure. Depending on the facts I would not rule out the possibility of a series of apparently disparate acts being shown to be part of a series or to be similar to one another in a relevant way by reason of them all being on the ground of a protected disclosure*

37. The Tribunal must therefore consider two things if a claim is presented outside the three-month time limit. First, whether it was not reasonably practicable for the claim to be presented within the (the burden of proof is on the claimant). Secondly, if it was not, the Tribunal must be satisfied that the further period within which the claim was presented was reasonable.

38. The Tribunal must determine as a matter of fact the substantial cause of the claimant's failure to comply with the primary time limit. The whole of the limitation period should be considered but "attention will in the ordinary way focus upon the closing rather than the early stages" (Schultz v Esso Petroleum Ltd [1999] IRLR 488.

39. The leading case in relation to reasonable practicability remains Palmer and Saunders v. Southend-on-Sea Borough Council [1984] IRLR 119. In this case, May LJ stated that the test was one of reasonable feasibility: '

> *We think that one can say that to construe the words "reasonably practicable" as the equivalent of "reasonable" is to take a view that is too favourable to the employee. On the other hand, "reasonably practicable" means more than merely what is reasonably capable physically of being done - different, for instance, from its construction in the context of the legislation relating to factories: compare Marshall v Gotham Co Ltd [1954] AC 360, HL. In the context in which the words are used in the 1978 Consolidation Act, however ineptly as we think, they mean something between these two. Perhaps to read the word "practicable" as the equivalent of "feasible" as Sir John Brightman did in [Singh*

v Post Office [1973] ICR 437, NIRC] and to ask colloquially and untrammelled by too much legal logic - "was it reasonably feasible to present the complaint to the [employment] tribunal within the relevant three months?" - is the best approach to the correct application of the relevant subsection.

40. The question of what is or is not reasonably practicable is essentially one of fact for the Tribunal to decide.

Direct race discrimination

Detriments

41. Section 39(2) of the Equality Act 2010 ("the Equality Act") provides that an employer must not discriminate against an employee by, *inter alia*, dismissing the employee or subjecting the employee to any other detriment.

42. A "detriment" is something that a reasonable worker would or might view as a disadvantage in the circumstances. An unjustified sense of grievance cannot amount to 'detriment', but it is not necessary to demonstrate some physical or economic consequence (Shamoon v Chief Constable of RUC [2003] UKHL 11).

Direct discrimination

43. One of the forms of discrimination prohibited by the Equality Act is direct discrimination. This occurs where "because of a protected characteristic, A treats B less favourably than A treats or would treat others" (section 13(1) of the Equality Act).

44. The question, therefore, is whether A treated B less favourably than A treated or would treat an actual or hypothetical comparator and whether the less favourable treatment is because of a protected characteristic – in this case race. On such a comparison, there must be no material difference between the circumstances relating to each case (section 23 of the Equality Act).

45. The relevant circumstances are those taken into account by the employer when deciding to treat the claimant as they did. All the characteristics of the claimant with are relevant to the way the case was dealt with must be found also in the comparator. They do not have to be precisely the same but they must not be materially different (MacDonald v Advocate General of Scotland and TSB Governing Body of Mayfield Secondary School [2003] ICR 937 at [63]) . The comparator does not have to be a clone in every respect bar the protected characteristic (Madden v Preferred Technical Group CHA Limited [2005] IRLR 46) and so differences that are not material can be ignored. The existence of a different decision-maker will not necessarily amount to a material difference but may do so (Olalekan v Serco Limited UKEAT/0189/19 at [31]).

46. Deciding whether there has been direct discrimination is therefore a comparative exercise. However, in many cases the claimant does not rely on a comparison between their treatment and that of another person. Rather they rely on other types of evidence from which it is contended that an inference can be drawn. The

comparison is with how the claimant would have been treated if they had had some other protected characteristic.

47. In other cases, the claimant compares their treatment with that of one or more other people. Such a comparison may be relevant in two ways. First, if there are no material differences between the circumstances of the claimant and the person with whom the comparison is made, this may provide significant evidence that there could have been discrimination. The person with whom the comparison is made in such cases is often referred to as an "actual comparator".

48. Secondly, where the circumstances of the person with whom the comparison is made are similar, but not sufficiently alike for the person to be an "actual comparator", the treatment of that person may provide evidence that supports the drawing of an inference of discrimination, sometimes by helping to consider how a hypothetical person whose circumstances did not materially differ from those of the claimant would have been treated – such a hypothetical person usually being referred to as a "hypothetical comparator".

Causation

49. There can be more than one reason for the treatment. If the Tribunal is satisfied that the protected characteristic is one of the reasons for the treatment, and that it had a significant or material influence on the detrimental treatment, then discrimination is established (Nagarajan v. London Regional Transport [1999] IRLR 572).

50. 'Significant' means more than trivial (Igen Ltd v Wong [2005] IR 931, Villalba v Merrill Lynch & Co Inc [2006] IRLR 437, EAT).

The shifting burden of proof

51. Section 136 of the Equality Act provides for a shifting burden of proof:

> *(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*.

52. The correct approach to the shifting burden of proof remains that set out in the guidance contained in Barton v Investec Securities ltd [2003] IRLR 332 approved by the Court of Appeal in Igen Ltd v Wong and further approved recently in Royal Mail Group Limited v Efobi [2021] ICR 1263.The Barton guidance is as set out below. The references are to sex discrimination because it was a sex discrimination claim, but the guidance applies equally to a claim of direct race discrimination:

> *(1) Pursuant to s 63A of the SDA 1975, it is for the claimant who complains of sex discrimination to prove on the balance of probabilities facts from which the tribunal could conclude, in the absence of an adequate explanation, that the*

respondent has committed an act of discrimination against the claimant which is unlawful by virtue of Part II or which by virtue of s 41 or s 42 of the SDA 1975 is to be treated as having been committed against the claimant. These are referred to below as "such facts".

(2) If the claimant does not prove such facts he or she will fail.

(3) It is important to bear in mind in deciding whether the claimant has proved such facts that it is unusual to find direct evidence of sex discrimination. Few employers would be prepared to admit such discrimination, even to themselves. In some cases the discrimination will not be an intention but merely based on the assumption that "he or she would not have fitted in".

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

(5) It is important to note the word "could" in SDA 1975 s 63A(2). At this stage the tribunal does not have to reach a definitive determination that such facts would lead it to the conclusion that there was an act of unlawful discrimination. At this stage a tribunal is looking at the primary facts before it to see what inferences of secondary fact could be drawn from them.

(6) In considering what inferences or conclusions can be drawn from the primary facts, the tribunal must assume that there is no adequate explanation for those facts.

(7) These inferences can include, in appropriate cases, any inferences that it is just and equitable to draw in accordance with s 74(2)(b) of the SDA 1975 from an evasive or equivocal reply to a questionnaire or any other questions that fall within s 74(2) of the SDA 1975.

(8) Likewise, the tribunal must decide whether any provision of any relevant code of practice is relevant and if so, take it into account in determining, such facts pursuant to s 56A(10) of the SDA. This means that inferences may also be drawn from any failure to comply with any relevant code of practice.

(9) Where the claimant has proved facts from which conclusions could be drawn that the respondent has treated the claimant less favourably on the ground of sex, then the burden of proof moves to the respondent.

(10) It is then for the respondent to prove that he did not commit, or as the case may be, is not to be treated as having committed, that act.

(11) To discharge that burden it is necessary for the respondent to prove, on the balance of probabilities, that the treatment was in no sense whatsoever on the grounds of sex, since "no discrimination whatsoever" is compatible with the Burden of Proof Directive.

(12) That requires a tribunal to assess not merely whether the respondent has proved an explanation for the facts from which such inferences can be drawn, but further that it is adequate to discharge the burden of proof on the balance of probabilities that sex was not a ground for the treatment in question.

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

53. There is therefore a two-stage process to the drawing of inferences of direct discrimination. In the first place, the claimant must prove facts from which the tribunal could conclude in the absence of any other explanation that the respondent had committed an act of discrimination against the complainant. If the burden does shift, then the employer is required to show a non-discriminatory reason for the treatment in question.

54. In Efobi the Supreme Court confirmed the point that a Tribunal cannot conclude that "there are facts from which the court could decide" unless on the balance of probability from the evidence it is more likely than not that those facts are true. All the evidence as to the facts before the Tribunal should be considered, not just that of the claimant.

55. In Madarassy v Nomura International plc [2007] ICR 867 the Court of Appeal stated that "could conclude" must mean "a reasonable Tribunal could properly conclude" from all the evidence before it. However, that does not include evidence of the reason for any less favourable treatment (Efobi). Consequently, a Tribunal may have to draw a distinction between primary facts (which can include facts which might be an alternative reason for the treatment) and evidence about the mental processes of the decision maker (Edwards v Unite the Union [2024] EAT 151).

56. The Court of Appeal in Madarassy also pointed out that the burden of proof does not shift simply on proof of a difference in treatment and the difference in status. This was because it was not sufficient to prove facts from which a Tribunal could conclude that a respondent could have committed an act of discrimination.

57. In deciding whether there is enough to shift the burden of proof to the respondent, it will always be necessary to have regard to the choice of comparator, actual or hypothetical, and to ensure that they have relevant circumstances which are the same or not materially different as those of the claimant having regard to section 23 of the Equality Act. Evidence of the treatment of a person whose circumstances materially differ to those of the claimant is inherently less persuasive than that of a person whose circumstances do not materially differ. If anything more is required to shift the burden of proof when there is an actual comparator, it will be less than would be the case if a claimant compares their treatment with a person whose circumstances are similar, but materially different, so that there is not an actual comparator.

58. If the burden of proof shifts, the respondent must show a non-discriminatory explanation but that need not be a good explanation.

Time limits for a direct race discrimination claim

59. Section 123 of the Equality Act provides where relevant as follows.

> *(1) Subject to sections 140B, proceedings on a complaint within section 120 may not be brought after the end of –*
>
> *(a) the period of 3 months starting with the date of the act to which the complaint relates, or*
>
> *(b) such other period as the employment tribunal thinks just and equitable…*
>
> *…*
>
> *(3) For the purposes of this section –*
>
> *(a) conduct extending over a period is to be treated as done at the end of the period;*
>
> *(b) failure to do something is to be treated as occurring when the person in question decided on it.*
>
> *(4) In the absence of evidence to the contrary, a person (P) is to be taken to decide on failure to do something—*
>
> *(a) when P does an act inconsistent with doing it, or*
>
> *(b) if P does no inconsistent act, on the expiry of the period in which P might reasonably have been expected to do it.*

60. Turning first to the question of whether there is a "continuing act" (i.e. conduct extending over a period of time), there is a continuing act when the employer is responsible for an "an ongoing situation or a continuing state of affairs" in which the acts of discrimination occurred, as opposed to a series of unconnected or isolated incidents (Hendricks v Metropolitan Police Commissioner [2002] EWCA Civ 1686). The focus of the Tribunal should be on the substance of the complaint not on whether there was a discriminatory policy, rule, practice, scheme or regime – these are just examples given in the authorities of when an act extends over a period of time.

61. Turning secondly to the “just and equitable” extension, it is for the claimant to show that it would be just and equitable to extend time. However, the discretion given to the Tribunal to extend time is a wide discretion to do what it thinks is just and equitable in the circumstances. The Tribunal should assess all the factors in the particular case which it considers relevant to whether it is just and equitable to extend time.

62. In Jones v Secretary of State for Health and Social Care [2024] EAT 2, HHJ Tayler deprecated reliance on the comments of Auld LJ in Robertson v Bexley Community Centre (t/a Leisure Link) [2003] EWCA Civ 576 that time limits are to be "exercised strictly" and that a decision to extend time is the "exception rather than the rule" as though they were "principles of law" and noted at [31] that "the propositions of law for which Robertson is authority are that the Employment Tribunal has a wide discretion to extend time on just and equitable grounds and that appellate courts should be slow to interfere". HHJ Tayler suggested that the Court of Appeal's decision in Abertawe Bro Morgannwg University Local Health Board v Morgan [2018] IRLR 1050 at [17] to [19] was a more useful source for a judicial self-direction:

> *[17]. The board's other grounds of appeal all seek to challenge the decisions of the employment tribunal that it was just and equitable to extend the time for bringing (a) the claim based on a failure to make adjustments and (b) the claim alleging harassment by Ms Keighan. Before turning to those grounds, the following points may be noted about the power of a tribunal to allow proceedings to be brought within such period as it thinks just and equitable pursuant to s 123 of the Equality Act 2010.*
>
> *[18] First, it is plain from the language used ("such other period as the employment tribunal thinks just and equitable") that Parliament has chosen to give the employment tribunal the widest possible discretion. Unlike s 33 of the Limitation Act 1980, s 123(1) of the Equality Act does not specify any list of factors to which the tribunal is instructed to have regard, and it would be wrong in these circumstances to put a gloss on the words of the provision or to interpret it as if it contains such a list. Thus, although it has been suggested that it may be useful for a tribunal in exercising its discretion to consider the list of factors specified in s 33(3) of the Limitation Act 1980 (see British Coal Corpn v Keeble [1997] IRLR 336), the Court of Appeal has made it clear that the tribunal is not required to go through such a list, the only requirement being that it does not leave a significant factor out of account: see London Borough of Southwark v Afolabi [2003] EWCA Civ 15, [2003] IRLR 220, [2003] ICR 800, para [33]. The position is analogous to that where a court or tribunal is exercising the similarly worded discretion to extend the time for bringing proceedings under s 7(5) of the Human Rights Act 1998: see Dunn v Parole Board [2008] EWCA Civ 374, [2009] 1 WLR 728,paras [30]–[32], [43], [48]; and Rabone v Pennine Care NHS Trust [2012] UKSC 2, [2012] 2 All ER 381,para [75].*
>
> *[19] That said, factors which are almost always relevant to consider when exercising any discretion whether to extend time are: (a) the length of, and reasons for, the delay and (b) whether the delay has prejudiced the respondent (for example, by preventing or inhibiting it from investigating the claim while matters were fresh).'*

63. LJ Leggatt then stated at [25]:

> *As discussed above, the discretion given by section 123(1) of the Equality Act 2010 to the employment tribunal to decide what it "thinks just and equitable" is clearly intended to be broad and unfettered. There is no justification for reading*

into the statutory language any requirement that the tribunal must be satisfied that there was a good reason for the delay, let alone that time cannot be extended in the absence of an explanation of the delay from the claimant. The most that can be said is that whether there is any explanation or apparent reason for the delay and the nature of any such reason are relevant matters to which the tribunal ought to have regard.

The nature of memory

64. The claim involves events which took place up to 8 years ago. The witnesses have given oral evidence lasting eight days. In these circumstances, the comments of Mr Justice Leggatt (as he then was) in Gestmin SGPS SA v. Credit Suisse (UK) Ltd [2013] EWHC 2560 (Comm) between [15] and [22] on "Evidence based on recollection" are of considerable relevance:

[15] An obvious difficulty which affects allegations and oral evidence based on recollection of events which occurred several years ago is the unreliability of human memory.

[16] While everyone knows that memory is fallible, I do not believe that the legal system has sufficiently absorbed the lessons of a century of psychological research into the nature of memory and the unreliability of eyewitness testimony. One of the most important lessons of such research is that in everyday life we are not aware of the extent to which our own and other people's memories are unreliable and believe our memories to be more faithful than they are. Two common (and related) errors are to suppose: (1) that the stronger and more vivid is our feeling or experience of recollection, the more likely the recollection is to be accurate; and (2) that the more confident another person is in their recollection, the more likely their recollection is to be accurate.

[17] Underlying both these errors is a faulty model of memory as a mental record which is fixed at the time of experience of an event and then fades (more or less slowly) over time. In fact, psychological research has demonstrated that memories are fluid and malleable, being constantly rewritten whenever they are retrieved. This is true even of so-called 'flashbulb' memories, that is memories of experiencing or learning of a particularly shocking or traumatic event.

[18] Memory is especially unreliable when it comes to recalling past beliefs. Our memories of past beliefs are revised to make them more consistent with our present beliefs. Studies have also shown that memory is particularly vulnerable to interference and alteration when a person is presented with new information or suggestions about an event in circumstances where his or her memory of it is already weak due to the passage of time.

[19] The process of civil litigation itself subjects the memories of witnesses to powerful biases. The nature of litigation is such that witnesses often have a stake in a particular version of events. This is obvious where the witness is a party or has a tie of loyalty (such as an employment relationship) to a party to the proceedings. Other, more subtle influences include allegiances created by the process of preparing a witness statement and of coming to court to give

evidence for one side in the dispute. A desire to assist, or at least not to prejudice, the party who has called the witness or that party's lawyers, as well as a natural desire to give a good impression in a public forum, can be significant motivating forces.

[20] Considerable interference with memory is also introduced in civil litigation by the procedure of preparing for trial. A witness is asked to make a statement, often (as in the present case) when a long time has already elapsed since the relevant events. The statement is usually drafted for the witness by a lawyer who is inevitably conscious of the significance for the issues in the case of what the witness does nor does not say. The statement is made after the witness's memory has been "refreshed" by reading documents. The documents considered often include statements of case and other argumentative material as well as documents which the witness did not see at the time or which came into existence after the events which he or she is being asked to recall. The statement may go through several iterations before it is finalised. Then, usually months later, the witness will be asked to re-read his or her statement and review documents again before giving evidence in court. The effect of this process is to establish in the mind of the witness the matters recorded in his or her own statement and other written material, whether they be true or false, and to cause the witness's memory of events to be based increasingly on this material and later interpretations of it rather than on the original experience of the events.

[21] It is not uncommon (and the present case was no exception) for witnesses to be asked in cross-examination if they understand the difference between recollection and reconstruction or whether their evidence is a genuine recollection or a reconstruction of events. Such questions are misguided in at least two ways. First, they erroneously presuppose that there is a clear distinction between recollection and reconstruction, when all remembering of distant events involves reconstructive processes. Second, such questions disregard the fact that such processes are largely unconscious and that the strength, vividness and apparent authenticity of memories is not a reliable measure of their truth.

[22] In the light of these considerations, the best approach for a judge to adopt in the trial of a commercial case is, in my view, to place little if any reliance at all on witnesses' recollections of what was said in meetings and conversations, and to base factual findings on inferences drawn from the documentary evidence and known or probable facts. This does not mean that oral testimony serves no useful purpose – though its utility is often disproportionate to its length. But its value lies largely, as I see it, in the opportunity which cross-examination affords to subject the documentary record to critical scrutiny and to gauge the personality, motivations and working practices of a witness, rather than in testimony of what the witness recalls of particular conversations and events. Above all, it is important to avoid the fallacy of supposing that, because a witness has confidence in his or her recollection and is honest, evidence based on that recollection provides any reliable guide to the truth.

Submissions

65. The parties both provided written closing submissions for which I am grateful. These were supplemented by oral closing submissions. Given their length, I do not summarise them here. However, I have where appropriate focused findings of fact on particular submissions.

Findings of fact

66. These findings of fact do not of necessity refer to all of the evidence that was before me. I explained to the parties during the Hearing that in reaching my decision I would take account only of documents: (1) listed in the agreed reading list; (2) referred to during oral evidence in chief or cross-examination; (3) referred to during written or oral opening or closing submissions; (4) other documents I came across when looking at documents in the first three categories. I explained that I did not propose to read all of the documents that were referred to in the parties' witness statements because it was clear to me that many were irrelevant to the issues that I was required to decide and to do so would substantially extend the time that would be required for the Hearing.

67. I said that, if either party wished to take issue with this approach, they should do so by no later than Monday 17 February 2025. Neither party did so.

Introduction to findings of fact

68. The claimant is a consultant orthopaedic spinal surgeon. He graduated from King's College Medical School in 1997 and completed postgraduate training in surgery in 1999. His first consultant post was at the Royal Sussex County Hospital in Brighton where he practised as a consultant from 2007 to 2017.

69. The claimant participated in the joint venture to establish Montefiore hospital from around 2011 and it became operational in 2012. The claimant began to practise there as a consultant orthopaedic spinal surgeon from 2013.

Credibility of the witnesses

70. The determination of the claimant's complaints requires me to make a very considerable range of findings of fact. To assist me in this task, I have a vast amount of documentation, to which the parties have assiduously referred me. The number of findings which depend exclusively or to a very considerable extent on my assessment of the credibility of the witnesses is fairly limited. Nevertheless, and in light of how the parties chose to make their submissions, I have concluded that it is appropriate for me to make some limited findings in relation to the credibility of the witnesses.

The credibility of the claimant

71. Turning first to the claimant, Mr Tatton-Brown's credibility submissions were more limited than those of Ms D'Souza. Taking them into account I make the following findings in relation to the claimant's credibility:

    71.1. **His belief that he was whistleblowing:** in cross-examination the claimant contended that he had believed that he was whistleblowing *when he made* the various alleged protected disclosures. It is difficult to see how he could have had such a belief in relation to, for example, disclosures 1 and 2 when the purpose of the communications in which disclosures 1 and 2 were made was so obviously not to blow the whistle. This is a matter which does a little damage to his credibility.

    71.2. **The withdrawal of part of protected disclosure 6:** at the beginning of the hearing the claimant withdrew, in effect, disclosure 6i. That is to say, he no longer contended that he had had a phone call with Ms Dixon on 24 December 2021. The respondent contended that he was either mistaken or had invented the telephone call to build a case and that either of these possibilities damaged his credibility. I find that in fact this is not a matter which damages the claimant's credibility. In particular, any false recollection may well have arisen as a result of the litigation process, as discussed in particular at [19] to [20] of Gestmin.

    71.3. **Patients RO and JB**: there was a tension between the claimant's contention that surgery was not appropriate for patients RO and JB and his referring them to Mr Cass, which is considered at [112] to [114] below. I find that the claimant's explanation of this tension was not satisfactory and this is a matter which does some damage to the claimant's credibility.

72. Bringing these various points together, and taking account of the fact that the claimant's oral evidence lasted for two days, I found the claimant to be a generally credible witness. By that I mean that I find that he was, overall, recounting events as best he remembered them. However, and again bearing in mind Gestmin, and given the passage of time, it is inevitable that in fact his recollections will not in every respect have been accurate and, in some respects, may well have been significantly inaccurate.

The credibility of Mr Cass

73. Turning secondly to Mr Cass, Ms D'Souza put forward a number of points in her closing submissions which she said damaged his credibility.

    73.1. **His recollection of the claimant being in attendance at the GIRFT visit:** This took place in 2019. Mr Cass accepted that his recollection was faulty. However, I find that it was the case that during the visit Professor Briggs made forceful comments about the fact that at the time the claimant had not complied with British spinal registry requirements. This is an obvious reason for the false recollection. This, given what is said about the nature of memory in Gestmin, results, I find, in the false recollection not damaging Mr Cass's credibility in any significant way.

73.2. **The JD MDT minutes of 26 November 2019:** The claimant contends that Mr Cass recollection that a SPECT-CT scan was available at the meeting was demonstrably false in light of his own clinic letter of 21 June 2021 (nearly two years later). That gave rise to the possibility that the MDT minutes which referred to a SPECT-CT scan had been doctored. In cross-examination Mr Cass accepted that "there is a variance on [the MDT minute of 26 November 2019], which warrants me to look at it further if you wish". It was not put to Mr Cass that he or somebody on his behalf had doctored the minute. I find that this is not a matter which damages Mr Cass's credibility in any significant way. This is because there are a variety of possible explanations for the discrepancy and what *may be* a false recollection on the part of Mr Cass, given the meeting took place more than 5 years ago. In particular, any false recollection may well have arisen as a result of the litigation process, as discussed in particular at [19] to [20] of Gestmin.

73.3. **The Medtronik representative issue:** This concerns an event which took place in 2018, over 6 years ago. The evidence of Mr Cass and the short email of 2 December 2024 from the Medtronik representative at page 3712 setting out his recollections are inconsistent. However, a short email written 6 years after the event does not constitute "overwhelming evidence" against Mr Cass's position. Again, in light of what is said in Gestmin about the effect of the litigation process on memory, I find that this is not a matter which damages Mr Cass' credibility in any significant way. In making this assessment I have taken into account the conflicting recollections of Ms Clarke and Ms Awdry about what Mr Cass said to them on the day. Ms Clarke did not recall any discussion of the Medtronik representative, Ms Awdry did, but not with any great certainty. I attach very little weight to the conflicting recollections given that they are in relation to a detail of a conversation which took place over 6 years ago which would not have seemed very important to them at the time.

73.4. **His account of the joint operation on CD:** This again took place more than 6 years ago. Ms D'Souza relies on differences between the contemporaneous accounts of Mr Cass and the scrub nurse (at pages 383 and 899) and the contents of the witness statement of Mr Cass. Taking careful account of what Mr Cass said in cross-examination, I note that the most significant fact – that the claimant had begun the operation before Mr Cass had arrived despite it having been agreed that it would be a joint operation – is not in dispute. Overall, I find that the differences were above all differences in emphases which reflected the different reasons for which the contemporaneous notes, on the one hand, and Mr Cass' witness statement on the other were prepared. In other words, and taking into account what is said about the effect of the litigation process on memory in Gestmin, I conclude that the differences do not point to dishonesty on the part of Mr Cass which would damage his credibility.

73.5. **The casting vote point:** this was too much of a lawyer's point to damage Mr Cass' credibility. His explanation that he was effectively allowed to decide whether to appoint the claimant or not, because he would have to work with him, was entirely consistent with what many would understand a "casting vote" to be.

73.6. **The PT letter at page 3892:** Patient PT wrote the letter in response to an email from the claimant dated 16 January 2025 which began: "It seems your solicitors wrote the complaint letter. Please can I ask did Mr Cass prompt/provide you with the information to complain" (page 3893). Patient PT replied on 21 January 2025:

> *Good morning Shuaib*
> *1. Yes Mr Cass prompt me. nor sure if he proved information. i can't remember wote happened between Mr Cass an solicitors .All I remember was the spring fell out and he said it was the wrong thing he wouldn't do that and he operated to take it out and then later operation on my back again and said this shouldn't have happened.*
> [Errors reproduced from the original.]

73.7. When asked in cross-examination why patient PT would have said that he had prompted him to complain if he had not, Mr Cass said that "he may have been coerced by someone". I find that the context for this answer was that Mr Cass was genuinely very surprised that the claimant had been writing to former patients such as PT as he had to gather evidence to support his Tribunal claim. I find that in this context the suggestion of coercion by Mr Cass does not do any real damage to his credibility.

73.8. **His interpretation of the text message at page 3435 and what is wife said in the email at page 1534:** The text message was sent by Ms Awdry to the claimant just after the claimant was suspended on 19 February 2022. In somewhat gushing terms Ms Awdry expresses thanks to Mr Cass and then says "Hopefully this is the last time now… I can't see how it won't be. Although I would never wish harm on anyone he has to be held to account fir [sic] what he has and equally what he hasn't done". Ms D'Souza contended that Mr Cass's refusal to accept that the only sensible interpretation of this was that Ms Awdry was hoping that the claimant would exit the Montefiore hospital. Mr Cass disagreed saying "I have no idea, her message not mine, can be interpreted in a number of ways, I think it was more about the whole situation". I find that this was not an answer that damaged Mr Cass credibility because I find that the construction contended for by the claimant is not the only sensible one. In particular I note that the words "Hopefully this is the last time…" may well refer back to what Ms Awdry at least saw as Mr Cass coming to the rescue of the patient concerned. The claimant being "held to account" for what he had (in Ms Awdry's view) done wrong was not inevitably a reference to a hope that the claimant would exit Montefiore hospital, given her comment "I would never wish harm on anyone".

73.9. Turning to the email at page 1534 sent by Mrs Cass on 17 September 2021, Ms D'Souza argued that the references to "the real problem" and to the "concerns" that both she and Ms Awdry had, were references to the claimant. In cross-examination Ms D'Souza contended that these were "veiled" references to the claimant. Mr Cass answered that the references were to issues surrounding the MDT meetings, including the fact that discussions between himself and the claimant were often "tetchy", the hospital failing to

provide administrative support to the MDT, and the difficulties in getting radiologists to attend. This is an entirely plausible explanation, given that Mrs Cass' email begins "I can't tell you how frustrating this whole situation is becoming; British spinal registry, the MDT etc etc". As such Mr Cass' refusal to accept what Ms D'Souza put to him did not damage his credibility.

73.10. **Why he did not tell Mr White about his Nuffield MDT attendances:** Mr Cass asserted that he did not tell Mr White about his attendances at the Nuffield MDT because "he did not believe that the Nuffield was a functioning MDT that he was prepared to put his patients through". The Nuffield MDT minutes showed the claimant attending 5 of its meetings in 2021 and putting forward 8 of his cases for discussion. As such, Mr Cass's explanation of why he did not tell Mr White about his attendance is unsatisfactory because it is implausible. This is a matter which does a little damage to the Mr Cass's credibility.

74. Bringing these various points together, and taking account of the fact that Mr Cass oral evidence began at midday on Thursday 20 February and ended at 1.30pm on Friday 21 February, I found Mr Cass to be a generally credible witness. By that I mean that I find that, overall, he was recounting events as best he remembered them. However, and again bearing in mind Gestmin, and given the passage of time, it is inevitable that in fact his recollections will not in every respect have been accurate and, in some respects, may well have been significantly inaccurate.

The credibility of Ms Dixon

75. The claimant attacked Ms Dixon's credibility primarily on the basis of how she had approached the withdrawal of practising privileges (claimant's submissions [71]) and, in particular, on a comparison of how Ms Dixon had on the one hand approached the 2022 PRC and on the other hand how she had approached Mr Cass' MED06 process (claimant's submissions [222] to 224]).
[
76. I make findings below at [238] to [247] below in relation to the approach of Ms Dixon to the MED06 investigation concerning Mr Cass. I have also made detailed findings below in relation to Ms Dixon's conduct of the 2022 PRC and the decision taken. In light of those findings, I find that the way in which Ms Dixon dealt with the MED06 investigation concerning Mr Cass on the one hand, and the 2022 PRC concerning the claimant on the other, and her evidence in relation to those matters, are not matters which damage her credibility.

77. Generally, I found Ms Dixon to be a witness who was doing her best to recall sometimes complex events which had taken place some considerably time ago. I found her oral evidence to be generally consistent with the documentation. However, I have no doubt that the accuracy of her recollections was at times affected by the litigation process, in the way described at [19] to [21] of Gestmin. Nevertheless, taking matters in the round, I found her to be a generally credible witness.

The credibility of Dr Cale

78. The claimant attacked Dr Cale's credibility primarily on the basis of her oral evidence in relation to the extent of any investigation into the question raised by the claimant in his appeal that he had been treated less favourably than Mr Cass. I have made findings in relation to this issue at [293] to [295] (concerning the investigative steps taken or not taken by Ms Dixon and Mr Price) and at [410] to [412] below (concerning the steps taken by Dr Cale herself).

79. Dr Cale did not give straightforward answers in relation to these matters during cross-examination. She was extremely defensive about what, I have found, was in fact a very limited investigation of the matters raised prior to the MED06 process concerning Mr Cass. She did not answer questions concerning these matters directly.

80. I have no doubt that the accuracy of her recollections was at times affected by the litigation process, in the way described at [19] to [21] of Gestmin. However, I find that what was in effect prevarication did not extend to her being deliberately untruthful. As such, notwithstanding these deficiencies in how she gave her evidence, I found her to be a generally credible witness.

The credibility of Mr Hatrick

81. The claimant attacked Mr Hatrick's credibility primarily on the basis of his explanation of a comment attributed to him in an email from Ms Dixon. I have made findings in relation to the email and Mr Hatrick's evidence in relation to it at [136] to [140] below. In light of those findings, I find that Mr Hatrick's explanation of a comment attributed to him in the email did not damage his credibility.

82. Overall, I found Mr Hatrick to be a generally credible witness, although I have no doubt that the accuracy of his recollections was at times affected by the litigation process, in the way described at [19] to [21] of Gestmin.

The Managing Consultant Performance Concerns Policy - MED06

83. The title of his policy is self explanatory. It is often referred to as the "MED06 policy". The September 2021 version of it was at page 225.

84. The MED06 policy sets out the respondent's approach to managing performance concerns of self-employed Consultants. It is relevant to the claim because the application of the policy resulted in the permanent withdrawal of the claimant's practising privileges. I set out here some of its provisions which I turn to in more detail below.

Section 3: Responsibilities

85. Mr Hatrick was the Medical Advisory Committee Chair during the relevant period. Section 4.4 under this heading ("MAC Chair") provides:

> *The MAC Chair provides advice to the HD [hospital director]. The MAC chair and/or HD may nominate one of the MAC members (or another member of the medical society) to provide advice on their behalf if specialty specific advice is*

sought. The MAC Chair is a member of any PRC, and is responsible for declaring any perceived or actual conflicts of interests in individual cases. The MAC chair is responsible for raising any concerns that he is made aware of with the HD to ensure that appropriate consideration of these is undertaken. The MAC chair may also escalate concerns to the RMD should they perceive that appropriate action is not being taken, or there is a conflict of interest.

Section 5 – Concerns about practitioner performance

86. The MED06 policy explains that concerns may be addressed informally or formally. They may require investigation and action to restrict of remove practising privileges ([5.1]).

Sections 6 and 9: The procedure to investigate concerns under the MED06 policy

87. Section 6 provides, amongst other things, for a "Preliminary Review of Concerns", when a concern is received.

88. There is a flowchart in section 6 (page 235) which shows the how concerns are dealt with and how they may reach the Formal Investigation stage.

89. One of the outcomes of a Preliminary Review is a Formal Investigation. The purpose of the Formal Investigation is to collect evidence and to produce a report for consideration at any subsequent PRC hearing (section 9.1). The flowchart at page 240 shows how a decision whether to proceed to a PRC hearing is taken.

90. The procedure for a Formal Investigation is set out at section 9 (page 237). This includes that the "LI" (Lead Investigator) will:

9.7 The LI will carry out an unbiased investigation into the allegations and collect and document evidence to establish the relevant facts.

In carrying out the investigation, the LI should: …

9.7.3 Interview the Practitioner (who should be given the opportunity to be accompanied by a friend, relative, colleague or representative from a Professional Body) and give the Practitioner the opportunity to put forward his or her view of events

.

Section 10: Outcome of the Investigation

91. Once the hospital director has received the report resulting from the Formal Investigation they must review and decide how to proceed. Perhaps most significantly, they must decide whether "There are concerns about the Practitioner's conduct or capability that should be dealt with at a professional review committee hearing" (MED06 [10.2.1].

Section 11: The Professional Review Committee

92. Sub-section A of section 11 deals with the constitution of the PRC panel. Where relevant, it provides:

> *11.1 The PRC panel will be chaired by the HD ("the Chair") unless this is not possible due to illness or incapacity or a conflict of interest. In these circumstances, another HD will act as Chair.*
>
> *11.2. The PRC must comprise of, as a minimum, 3 individuals including the RMD, MAC Chair and/or an MAC specialty representative and the HD.*
>
> *11.3. The MAC Chair/MAC Speciality Representative and RMD will sit as panel members for the PRC, unless this is not possible due to illness or incapacity or a conflict of interest. A conflict of interest may arise in cases where the relationship between the Practitioner and a proposed PRC panel member has become damaged or has deteriorated, or the proposed PRC panel members have given evidence as part of the investigation. In these circumstances, another RMD and/or another MAC Chair/MAC Speciality Representative will act as a PRC panel member.*

93. Sub-section B deals with the role and function of the PRC. It provides at its [11.5]:

> *The role of the PRC is to consider the evidence of the investigation report and any comments and/or evidence put forward by the Practitioner, and consider whether, in their view, this warrants any action being taken to restrict or withdraw the Practitioner's PPs and/or such other remedial action is required by the Practitioner.*

94. However, the decision maker is the hospital director "advised by other members of the PRC panel".

Section 12: Possible PRC Recommendations and Actions

95. The actions that the PRC may consider if allegations are upheld include:

95.1. No change to practising privileges but training or personal development is required;

95.2. Recommendations for improvement;

95.3. Practising privileges being subject to conditions, restricted for a defined period, permanently restricted or permanently withdrawn.

96. The MED06 policy provides for a right of appeal to the group medical director (its [14]).

The NICE guidance and the GDG document

97. On 30 November 2016 the National Institute for Health and Care Excellence ("NICE") published the guideline "Low back pain and sciatica in over 16s: assessment and management" which was given a NICE reference number of

"ng59" ("the NICE guidance") (page168). The NICE guidance featured prominently during the Hearing.

98. Under the heading "Your responsibility" the NICE guidance explains its status as follows:

> *The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.*

99. The "Overview" section at page 170 explains:

> *This guideline covers assessing and managing low back pain and sciatica in people aged 16 and over. It outlines physical, psychological, pharmacological and surgical treatments to help people manage their low back pain and sciatica in their daily life. The guideline aims to improve people's quality of life by promoting the most effective forms of care for low back pain and sciatica.*

100. The intended audience for the NICE guidance is wide and includes healthcare professionals, commissioners and providers of healthcare and people with low back pain or sciatica (page 170).

101. The parts of the NICE guidance to which reference was most often made during the Hearing were contained in the section "Invasive treatments for low back pain and sciatica" (page175). Under the sub-heading "Surgical interventions" this included the following:

> ***Spinal decompression***
> *1.3.8 Consider spinal decompression for people with sciatica when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms.*
>
> ***Spinal fusion***
> *1.3.9 Do not offer spinal fusion for people with low back pain unless as part of a randomised controlled trial.*
>
> ***Disc replacement***
> *1.3.10 Do not offer disc replacement in people with low back pain.*

102. References to "low back pain" are taken to exclude back pain which has specific causes (section 1.1.1 and the "Context" section at page 179). Other NICE guidance is identified as applying to at least some back pain with specific causes.

103. Considering the complexity of the matters with which it deals, the NICE guidance has to be seen as a high-level document, which does not deal with its

subject in any great detail. More detail was included in the National Guideline Centre document commissioned by NICE and produced by the Guideline Development Group ("the GDG") in relation to "Low back pain and sciatica in over 16s: assessment and management – Invasive treatments" ("the GDG document"). "Low back pain" is used in the GDG document to include "any non-specific back pain which is not due to cancer, fracture, infection or an inflammatory disease process". References to "low back pain" in these reasons are to "low back pain" as defined by the NICE guidance and GDG document.

104. The GDG document contains, amongst other things, what in the GDG's view is the evidence underpinning the NICE guidance. Its summary in relation to spinal fusion surgery is at page 3656 and is as follows:

> *Overall the GDG considered that there was no consistent benefit of spinal fusion over comparator treatments and evidence of potential harm. Given this and the limited number of studies from which data could be evaluated, the GDG agreed that there was a lack of evidence of clinical effectiveness to recommend spinal fusion for people with low back pain other than in the context of a randomised controlled trial.*

105. However, under the heading "Other considerations" (page 3658) the GDG document notes:

> *The GDG agreed there were causes of low back pain for which spinal fusion might be an appropriate treatment which were beyond the scope of this guideline.*

106. In relation to disc replacement surgery, the CDG document's summary at page 3648 states:

> *The GDG noted that there were some signs of benefit from disc replacement compared to other interventions, but this evidence was very limited and not consistent across outcomes. Furthermore the GDG felt the risk of harms associated with disc replacement outweighed the potential benefits…*

107. However, again under the heading other considerations, the GDG document states (page 3649):

> *The GDG agreed there may be specific causes of low back pain for which disc replacement might be an appropriate treatment which are beyond the scope of this guideline.*

108. In relation to the risks presented by both spinal fusion surgery and disc replacement surgery, the GDG document noted at page 3656 that:

> *The GDG noted that there was a high rate of serious complications associated with both treatments, for example 1 study reported that 345 out of 405 people experienced adverse events at 2 years following fusion surgery. However, it was noted that intraoperative rates of serious complications differed at 14.6% for disc replacement compared to 8.7% for spinal fusion; the higher rate in disc*

replacement possibly attributed to its more invasive nature. The GDG understood there to be a roughly 10–20% rate of complications across trials, with approximately 4-5% serious complications.

109. It is clear that the conclusion of the GDG was that in general terms the risks of harm outweighed the potential benefits of spinal fusion and disc replacement surgery – and therefore that such surgery *might* endanger the safety of *some* patients who underwent it. However, the following points must also be born in mind:

109.1. First, this conclusion relates to "low back pain" as defined or described at [102] and [103] above. The conclusions of the GDG and the NICE guidance itself both suggested that there were circumstances in which spinal fusion or disc replacement surgery might be appropriate.

109.2. Secondly, I find that the contents of the NICE guidance and the GDG document were in some professional quarters controversial. I find in light in particular of the evidence of Mr Cass that spinal surgeons were divided over them. This was reflected in Mr Cass organising a debate on the subject (C WS [63]) in 2018.

109.3. Thirdly, I find that there has never been any suggestion that disc replacement surgery was simply something that should not be done at all. If it were, then Mr Cass would not, I find, have been advertising his ability to do it on his own website (page 3707) or preparing detailed information about his "anterior lumber surgery" practice ahead of the GIFT visit to the Montefiore hospital in 2019 (page 3320).

The claimant's view of the NICE guidance, spinal fusion surgery and disc replacement surgery, and the practice of Mr Cass

110. I find in light of the claimant's evidence that he accepted the NICE guidance and believed that the overwhelming majority of spinal surgeons followed it. I find in accordance with his oral evidence that he believed that spinal fusion surgery and disc replacement surgery were of unproven scientific benefit and would not *generally* be an appropriate treatment for low back pain (as defined in the NICE guidance) unless, in the case of lumber fusion surgery, it was part of a randomised control trial. I find that he believed that in *some* cases spinal fusion surgery and disc replacement surgery for low back pain *might* endanger patient safety and that consequently the same was true of Mr Cass' spinal fusion surgery and disc replacement surgery practice (notwithstanding Mr Cass' undoubted expertise).

111. I also find, however, that the claimant did not believe that spinal fusion surgery and disc replacement surgery for low back pain was, or was likely to, endanger patient safety *generally*. I make this finding for various reasons. First, because if he had had that belief, he would not have referred patient RO or patient JB to Mr Cass.

112. In relation to patient RO, the claimant contended that he did this only because he was obliged to respect the wishes of the patient to have an opinion about surgery for his back pain but that he himself did not think that surgery was

appropriate. However, this is not reflected in his letter to Mr Cass of 19 October 2018 copied to patient RO in which he wrote "RO is keen to explore the idea of surgery for his back pain and I would be grateful for your advice" (page 3946).

113. In relation to patient JB, the claimant in his oral evidence said that he did not believe the treatment was appropriate but that he referred the patient because he wanted a surgery referral. However, this is again not reflected in the letter the claimant sent to JB's GP on 5 April 2018 (page 3960).

114. I accept that in both cases the claimant, because of his general views in relation to spinal fusion surgery and disc replacement surgery for low back pain, did not believe that surgery was *likely* to produce any significant benefit. But believing that is not at all the same as believing that the surgery was *inappropriate* if that was what the patient wanted or that it would endanger their safety. I find that if he had had such belief, he would have declined to make the referral.

115. Secondly, if he had had believed that spinal fusion surgery and disc replacement surgery for low back pain was likely to endanger patient safety *generally*, he would have complained when the respondent did nothing in relation to his earlier alleged protected disclosures and would have pursued the matter more formally than he did.

116. Thirdly, if the claimant had really believed that surgery conducted by Mr Cass, that in his view was or might have been in breach of the NICE guidance, was endangering patient safety generally, he would have raised this more clearly than he ever did.

Mr Cass' view of the NICE guidance and the GDG document

117. I find that Mr Cass's view of the NICE guidance was reflected in his oral evidence. He accepted that a variety of specialist associations endorsed (or were "affiliated to") it and that in general terms the guidance was "excellent". However, he was critical of it in that his view was that it left a significant percentage of patients with "nowhere to go". By this he meant that, if surgery was ruled out to the extent suggested by the NICE guidance, there was a significant percentage of patients who would exhaust treatment options that might cure their back pain and so be left with no option beyond increasingly strong painkillers.

118. I find that in Mr Cass's view the NICE guidance and the GDG document were excessively biased against surgery for back pain and that this reflected what in his view was the unbalanced make up of the GDG: he believed that of its 2020 "version" none of the 14 members was a spinal surgeon.

The MDT's terms of reference

119. In broad terms the purpose of the Spinal Multidisciplinary Team ("MDT") was for spinal surgeons to exchange views and seek the agreement of one another on proposed courses of treatment, with a radiologist also being present to provide their expertise.

120. The MDT terms of reference from November 2021 are at page 1933. This replaced previous MDT terms of reference from 2019. In relation to frequency of meetings, section 3 provides:

> *3. The Spinal MDT shall meet every 4 weeks. Extraordinary meetings may be requested if considered clinically necessary via the Designated Consultant Chair or Matron.*

121. In terms of its duties, section 5 states that it shall:

> *5.1 Ensure honest and open discussion regarding individual case management and treatment plans, challenging and agreeing pathways to reflect best national pathways and agree where variation is necessary.*
>
> *5.2 Review all spinal patients where it is planned that instrumentation will be used during surgery (i.e. insertion of metalwork or hardware of any type).*
>
> *5.3 Review all spinal patients who have made an unplanned return to theatre or experienced any other kind of post-operative complication, including surgical site infection, and determine the need for any adjustment to clinical practice.*
>
> *5.4 Review all spinal patients requiring revision surgery or any other case generating concern or interest as identified by any member of MDT.*
>
> *5.5 Ensure that all relevant patients are enrolled on The British Spine Register (BSR).*
>
> *5.6 Assist the hospital with any clinically related adverse event or near miss, claim, complaint or other patient feedback.*

122. In terms of the conduct of its business, section 6 includes the following:

> *6.1 Each group member shall ensure that ALL relevant patients (as detailed in section 5) are listed for discussion at the next Spinal MDT meeting. The Group Coordinator shall be informed of all relevant patients by 13:00hrs the Monday prior to the scheduled meeting; by full completion and submission of the designated patient referral form. …*
>
> *6.3 Only in exceptional (clinically urgent) instances may surgery be undertaken in relevant patients without prior consideration by the Spinal MDT and, in these instances, the responsible surgeon must alert the Designated Consultant Chair or Matron and request an extraordinary meeting. …*
>
> *6.7 At the discretion of the Designated Consultant Chair, business may be transacted through a teleconference provided all parties are able to hear all other parties and where imaging can be reviewed by necessary parties (radiologists and surgeons) and where an agenda has been issued in advance.*

The MDT meetings

123. Meetings of the MDT at the Montefiore hospital were sporadic between 2017 and the 2019 PRC. Mr Cass and Ms Awdry were instrumental in trying to set it up but it was difficult to secure the attendance of a radiologist and, as there were for a time just two spinal surgeons (the claimant and Mr Cass), both needed to attend for the MDT to be functional. Mrs Cass acted as an unpaid coordinator. Part of the problem was that participants had to attend in their own unpaid time.

124. The need for a fully functioning MDT was identified in the recommendations from the 2019 PRC concerning the claimant's treatment of patient CD (see [171] to [178] below).

125. Following the 2019 PRC report, the MDT met several times before its meetings ceased during the pandemic. Monthly meetings of the MDT at Montefiore hospital resumed in November 2021 and then ran monthly. During 2021 there were, however, meetings of an MDT at the Nuffield hospital, where both the claimant and Mr Cass performed surgery.

126. In light of the difficulties the respondent experienced in arranging regular MDT meetings, a virtual WhatsApp MDT also functioned from time to time. An example of the virtual WhatsApp MDT is considered in relation to detriment 6 and patient KW below.

The relationship between Mr Cass and the claimant

127. The claimant and Mr Cass worked together for a long time. Mr Cass was on the panel that appointed the claimant to his position as a consultant at the Royal Sussex County Hospital in 2007. I accept the evidence of Mr Cass that he supported the appointment of the claimant.

128. I find that, whilst not close, Mr Cass and the claimant had a more than satisfactory working relationship for a number of years marked by mutual respect. This was reflected in, for example, the claimant taking over a lot of Mr Cass's private patients between 2012 and 2014 when he took a prolonged leave of absence as the result of the terminal illness of his wife. I find Mr Cass was satisfied with the treatment that the claimant had provided to his private patients in this period. It was also reflected in them, together with another surgeon Mr El Sayed, discussing a possible business project together, both in person and in an email trail headed "3 Amigos" in 2016 (page 3860). It was further reflected in them both working for the Brighton Orthopaedic Sports Injury Clinic and both being involved from a very early stage with the Montefiore hospital. In summary, if Mr Cass had had a poor view of the claimant's professional abilities then, given his seniority, it is unlikely that the claimant's professional life would have developed as it did from 2007.

129. I do not accept that the claimant going "fully private" in 2017 was a problem for Mr Cass "as I ate into his practice significantly", as the claimant contended. Rather, I find that there was plenty of work to go around – as the claimant himself admitted in cross-examination (I refer to my findings at [338] in this respect).

130. I do find, however, that the events concerning patient CD, considered in particular at [171] to [178] below, had a very significant effect on the way in which Mr Cass viewed the claimant professionally. The long and short of the events concerning patient CD was that surgery conducted by the claimant had catastrophic results for the patient and Mr Cass had seen first hand what he regarded as poor professional conduct by the claimant – including the claimant beginning the third operation which was planned as a joint operation before Mr Cass was present. I find that their relationship deteriorated significantly from around the time of the events concerning patient CD because Mr Cass had, following those events, substantially less respect for the claimant's professional abilities and conduct than he had had previously.

The relationships between Ms Awdry and the claimant and Ms Awdry and Mr Cass

131. I find that Ms Awdry had a closer relationship with Mr Cass than she had with the claimant. I find that this was reflected in the fact that when she had needed back surgery, she had asked Mr Cass to perform it. I find that the origins of her relationship being closer with Mr Cass than with the claimant are probably the fact that, when Mr Cass' first wife was an inpatient being treated for cancer, Ms Awdry was involved in her care.

132. I find that Ms Awdry also had a higher professional regard for Mr Cass than for the claimant. Ms Awdry had seen the problems that had arisen in the treatment of patient CD (considered in more detail from [171] below) and, I find, this had caused her to have doubts which did not disappear with the passage of time in relation to the claimant's professional competence.

MDT meetings and the relationship between Mr Cass and the claimant

133. The question of how the relationship between Mr Cass and the claimant affected MDT meetings featured significantly in oral evidence and I make the following findings in relation to it:

133.1. The claimant and Mr Cass had differing views of the NICE guidance, as set out above. This meant that there were at times differences of view between them at MDTs in relation to whether surgery was or was not an appropriate treatment for some patients.

133.2. I find that this, together with the deterioration of their relationship following the events concerning patient CD, resulted in MDT meetings becoming at times difficult and "tetchy" and "nearly dysfunctional" (to adopt words used by Mr Cass).

133.3. I find that the poor relationship between Mr Cass and the claimant was also negatively affected by administrative matters – such as the fact that Mr and Mrs Cass believed that the claimant was not registering patients as regularly as he should with the British spinal registry (see for example the emails between pages 1531 and 1534).

134. However, I find that the MDT had not ceased to function properly by February 2022 (when the claimant was suspended) or generally become borderline dysfunctional. Rather I find that *particular* MDT meetings were difficult, and could become borderline dysfunctional, if the only surgeons in attendance were Mr Cass and the claimant. That is the picture given, for example, when the "outcomes" document at page 3417 for the meeting on 9 December 2021 is read together with the minutes document at page 2996 for the meeting on 31 January 2022.

Group think and the claimant

135. In his oral evidence the claimant referred on multiple occasions to the email from Ms Dixon to Dr Philips and Dr Cale dated 11 June 2021 at page 1446 as evidence of negative group think and affinity bias about him led by Mr Cass (there may have been further addressees, but this is not clear form page 1446). The claimant spoke of an "inner clique" comprising Dr Cale, Ms Dixon, Ms Awdry, Mr Cass and Mr Hatrick. The group think concerned his conduct and concerns were escalated inappropriately by Mr Cass whose judgment was "clouded". He also referred to the "gelling of an inner clique based on prejudice against me". He said in cross-examination that the email was his best evidence that Dr Cale treated him less favourably because of race. He also referred to it when asked to explain why anybody other than Mr Cass might wish to penalise him for raising the alleged protected disclosures and, also, as evidence pointing to Ms Awdry subjecting him do a detriment because he had made a protected disclosure.

136. Overall, the claimant's witness evidence strongly suggested that he believe the email as being the strongest piece of evidence showing that he was subjected to detriments because of his race or because he had made protected disclosures. It is therefore appropriate to set it out in full:

> *Dear all*
>
> *I have attached the screening form for Mr Karmani, hopefully completed.*
> *Following our earlier discussions, I met again with Cameron (MAC Chair).*
> *He is not now supporting suspension unless advised by yourselves. He feels clinically Mr Karmani acted appropriately with regard to the clinical management of the patient but the main issue, is his lack of open communication with himself and DoCS, and not evidenced to patient.*
>
> ***He also feels the information given to us by the MAC spine rep is clouded by professional conflict.***
>
> *We all agree an independent review of this case and going wider into his use of BSR, audit of number of dural tears etc must be done but we do not currently have evidence of this as a concern without the audit to back this up.*
>
> *Happy to proceed on advice*
> *Many thanks*
>
> [Emphasis added.]

137. The underlying issue that had led to the email was the claimant's treatment of patient RM and a meeting with Mr Hatrick at which Mr Hatrick had told the claimant that he should write a letter to RM as a result of the duty of candour. Mr Hatrick had also told the claimant that he should have informed Ms Awdrey of the incident sooner than he had (claimant's email at page 1449).

138. When Mr Hatrick gave evidence, he said that the email did not record a direct quote. His position, essentially, was that he was recommending getting external opinions on complications suffered by patients of the claimant because Mr Cass was unhappy at the prospect of having to sort out complications suffered by the claimant's patients. This was because Mr Cass was concerned that the claimant would accuse him of having a vendetta against him, and that Mr Cass felt there was a conflict between his desire to help patients and his desire not to cause difficulties for the claimant who was a colleague. Mr Hatrick denied that he was suggesting that Mr Cass's advice in relation to matters concerning the claimant was in some way unreliable or biased. He was clear that he did not doubt the sincerity or accuracy of Mr Cass' advice.

139. When Ms Dixon gave evidence**,** her recollection was that Mr Hatrick had told her that the claimant and Mr Cass had different clinical views and so it was better to have facts looked at independently. She emphasised that she understood that the claimant and Mr Cass had differing professional views.

140. Taking the evidence in the round, and bearing in mind (1) what is said about the nature of memory in Gestmin, particularly its [19] as set out above; (2) what is being considered is wording reflecting Ms Dixon's one sentence summary of a conversation with Mr Hatrick, I find that Mr Hatrick was referring to various matters, including both these set out at [138] above and also his awareness of some tension between the claimant and Mr Cass. Mr Hatrick would inevitably have been aware of such tension given his own involvement in the 2019 PRC and so his knowledge of how Mr Cass felt about the claimant having begun the third operation on patient CD before Mr Cass had arrived.

141. Turning to the extent that the email can be said to be evidence of "negative group think and affinity bias about him led by Mr Cass" or of an "inner clique" comprising Dr Cale, Ms Dixon, Ms Awdry, Mr Cass and Mr Hatrick or the "gelling of an inner clique based on prejudice against me", I make the following findings:

141.1. The fact that Mr Hatrick is actually recorded as being against suspension of the claimant points away from there being "group think" about him;

141.2. Although Dr Philips suggests a "temporary pause" on the claimant's practice, he was, I find, a gynaecologist based in Hull who had little day to day contact with the claimant or others based in Brighton. There is no good reason for thinking that his response reflected "group think" rather than his own honest professional opinion of what should be done in light of the facts known to him;

141.3. Equally, Dr Cale worked at group level as Group Medical Director, was not based in Brighton, and was not involved in the day-to-day running of the Montefiore hospital. There is scant evidence that she would have been either

a contributor to or infected by any group think in Brighton concerning the claimant.

141.4. Further, Ms Dixon's response to Dr Cale's response agrees with the partial restriction to practice proposed by Dr Cale adding "so we hopefully don't impact too greatly on his practice" (page 1446). She is not dogmatically pursuing a particular outcome and is demonstrating concern for the claimant's professional practice. Again, this does not suggest that she is party to "group think" relating to the claimant.

142. Overall, the only notable aspect of the email is the comment attributed to Mr Hatrick, in relation to which I have reached conclusions at [140] above. I find that the email does not contain evidence which support the claimant's assertion of "negative group think", "affinity bias", or an "inner clique based on prejudice".

Patient safety issues

143. The claimant contends that the respondent's approach to patient safety issues was inconsistent and that this is a matter of significance because the respondent contends that its treatment of the claimant resulted from patient safety concerns. I make the following findings in relation to this.

The treatment of clinical incidents involving Mr Cass

Patient AS

144. Patient AS was a patient of Mr Cass. He developed the condition of footdrop and was discussed in the MDT on 19 November 2019 (page 1188). At Mr Morassi's suggestion an endoscopic decompression – that is to say a less invasive procedure - was first attempted on 23 November 2019 by Mr Morassi. That was unsuccessful because it could not identify the cause of the footdrop. Mr Cass then operated again on 3 December 2019. He placed a message in the virtual WhatsApp MDT on the following day (page 587) explaining the patient's MRC (a measure of muscle contraction) had gone up from 0 to 2 immediately and 3 overnight. In answer to supplementary questions, Mr Cass gave detailed evidence about the treatment of patient AS. He explained that on follow up in clinic the foot drop had completely resolved.

145. Ms Awdry accepted that two returns to theatre should have resulted in the patient AS being entered into Datix. Mr Cass said he thought Ms Awdry as the DOCs would have done the Datix because she had been at the MDT meeting 3 days after the complication came to light and noted he had hardly ever done Datix entries himself. Ms Clarke thought that the matter would have been investigated if a report had been made.

146. So far as patient AS is concerned, I find that Mr Cass dealt promptly with a footdrop that appeared around 2 weeks after the initial surgery. I find patient AS was discussed at an MDT before the second surgery and that, when the minimally invasive endoscopic decompression carried out by Mr Morassi could not identify the problem, it was resolved by a third surgery carried out by Mr Cass. I find that

there was no complaint by the patient and no failure on the part of Mr Cass to discuss the patient appropriately at the MDT. The point of note is that no Datix entry was made and so, I find, no investigation took place. I find that this occurred because Mr Cass assumed that Ms Awdry would make the necessary entry but she did not.

Patients RM and JS

147. The comparison relied on by the claimant refers to one patient's treatment resulting in an RCA and the other in a Local Review Report. I find that the question of whether a SIRI resulted in an RCA or a Local Review Report was a matter decided upon by centrally by the respondent's IRWG, not at the Montefiore hospital. In broad terms, an RCA was a more serious investigation that a Local Review Report.

148. Patient RM was a patient of the claimant. Patient JS was a patient of Mr Cass. They both developed caudi equina syndrome. A SIRI was made in respect of patient RM (page 1442) and an RCA conducted by Ms Clarke resulted (page 1657). Its conclusions were at pages 1705-6. A SIRI was also made in respect of patient JS. This resulted in a Local Review Report (page 3777), again conducted by Ms Clarke.

149. The claimant contends that whilst considerable attention was paid in the RCA conducted by Ms Clarke in relation to patient RM to whether an earlier examination should have been carried out, the question was apparently not considered in the case of JS.

150. I accept the evidence of Ms Clarke that the intensity of an investigation would reflect to some extent the level of harm suffered by a patient as a result of the incident. The more serious the harm, the more serious the investigation. I also accept her evidence that the level of residual harm suffered by RM was higher than that suffered by JS. The background to the RCA in relation to RM as found at [137] above is also relevant.

Annual leave cover

151. The Practice Review Document (the nature of which is explained at [354] below) showed that Mr Cass had failed to organise holiday cover for a holiday beginning on 6 April 2023 after operating on 5 April 2023. It shows post operative events relating to three patients. The claimant submits that it is significant that there is no record of in investigation into the emergency readmission of one patient to another hospital or of outcomes for that patient.

152. Ms Clarke accepted that the readmission should have triggered a SIRI and that the IRWG would have determined the level of investigation required. She accepted that the Practice Review Document did not show that there had been an investigation but noted that it would be "very unusual for a patient readmission not to be investigated". I accept that evidence as true, given Ms Clarke's undisputed expertise in investigations. However, there is no evidence in the bundle that there was such an investigation.

Mr Cass' SIRIs

153. When Ms Dobson interviewed Ms Clarke as part of the MED06 process concerning Mr Cass (considered in more detail at [230] to [251] below), she said that there had been 4 SIRIs for him in the period October 2023 to March 2024 (with the figure from August 2020 to the date of the interview being 7 in total) (page 3256). Very brief details are given at page 3256. The evidence of Ms Dixon, which I accept, was that she had taken no action in the form, for example, of a MED06 against Mr Cass in relation to them. I have no evidence before me in relation to the question of whether they were investigated.

Wrong site injections

154. I make findings of fact below at [354] to [358] in relation to the question of wrong site injections in the context of detriment 15.

Patient HO and the question of incivility

155. On 2 September 2021 the claimant operated on patient HO. After carrying out kyphoplasty, he requested to undertake lumber facet joint injections, but the patient had not consented to these. Ms Awdry became involved. After discussion with Mr Hatrick and Ms Dixon, a decision was taken not to go ahead with the injections. Ms Awdry subsequently raised an issue about how the claimant had spoken to her. The issue was initially considered through an RCA (page 2234) but in the event Ms Dixon decided to "close off" the matter after a discussion with the claimant in October 2021 (RD WS [47]). The formal process followed in relation to the incident was very limited. It was not dealt with through the MED06 process.

156. I find that the claimant did speak rudely to Ms Awdry in front of other staff. To the extent that this requires me to prefer the evidence of Ms Awdry to that of the claimant, I do so because I find it improbable that she would have made up an event which she said had been witnessed by a number of members of staff, the details of which could easily be checked. I find that it is of note that the circumstances of the claimant speaking rudely to Ms Awdry included a patient who was under anaesthetic and the claimant wishing to carry out a procedure to which the patient had not consented.

157. Turning to the comparison made with the way in which Mr Cass was treated when allegations of incivility arose, I find that it is not the case that these were simply ignored. I accept the evidence of Ms Awdry that she spoke to Mr Cass on more than one occasion following allegations of incivility or rudeness by members of staff and that on one occasion she had arranged a meeting between Mr Cass and the whole theatre team, which she had attended, so that members of the team could give Mr Cass feedback on how on occasion his behaviour made them feel.

158. Remaining with the comparison, I refer to my findings at [131] and [132] above about the relationships that Ms Awdry had with the claimant on the one hand and Mr Cass on the other. I find that, although allegations of incivility against Mr Cass were not ignored, the fact that Ms Awdry had a closer personal

relationship with, and great professional regard for, Mr Cass than the claimant affected her approach to issues of incivility which arose in relation to them to some extent. This was because she found it easier to speak to Mr Cass about such issues and to seek to resolve them in a relatively informal way.

Mr Cass' lumbar practice and the claimant raising concerns in relation to it and the NICE guidance

159. The claimant contends that there was a "consistent failure" to subject Mr Cass' surgical output to any form of audit or scrutiny (paragraph 11 of the claimant's closing submissions). Various examples are given which are said to illustrate this. I make findings of fact in relation to some of these and related matters here.

160. The context for my findings in relation to this issue is my findings at [97] to [118] above in relation to the view of the claimant and Mr Cass in relation to the NICE guidance and my conclusion at [286] below that their respective positions in relation to it reflected a difference in professional opinions.

161. In light of this, I find that the fact that the respondent did not investigate the claimant's concerns following his response to PT's complaint letter of 6 September 2017 (alleged protected disclosure 1) is of no real significance, particularly in light of my findings and conclusions at [428] below.

162. So far as the claimant's email of 14 May 2021 (alleged protected disclosure 4) (page 1427) is concerned, I find at [287] below that this did represent the claimant raising a wider concern and at [288] that the respondent did not at the time take any action in relation to Mr Cass about it. However, notwithstanding my conclusion at below that this was a protected disclosure, as found at [437] the email in which the protected disclosure was made was in fact an email which was primarily complaining about what the claimant saw as restrictions on his practice. He gave no details of who Mr Cass was allegedly carrying out surgery on "against NICE guidance" and I find did not seek to discuss it with Mr Hatrick by, for example, phoning him as he was invited to do in the email of 17 May 2021 (page 1431).

163. So far as the question of a baseline assessment is concerned, I find in light of my findings at [275] to [276] below that no such assessment was ever conducted. However, it should be noted that the recommendation by Ms Clarke was for a baseline assessment of the whole spinal service (see [274] below). Any such assessment would not have focused in particular on the "lumbar practice" of Mr Cass. In the absence of clear contemporaneous concerns about that lumbar practice – in the form, for example, of patient complaints or negligence claims or other concerns raised in relation to his treatment of specific patients – there is no obvious factual link between the failure to conduct the baseline assessment and the lumbar practice of Mr Cass.

164. So far as the fact that the respondent did not review its surgical procedures following the anonymous whistleblower letter of April 2018 is concerned, I refer to my findings at [278] to [280] which reflect the fact that the main thrust of the letter was injections and not surgery.

165. So far as the fact the way in which Dr Cale dealt with the points raised by the claimant about Mr Cass's compliance with NICE guidance in the appeal decision are concerned, I refer to my findings at [410] below, which include that Dr Cale and the appeal panel did not regard deciding the appeal as involving a comparative fairness exercise.

166. So far as Mr White screening out the question of NICE guidance compliance by Mr Cass on the basis that the claimant had not provided evidence, I find that that is reflective of the unparticularised nature of the allegations the claimant made, for example in alleged protective disclosure 4.

167. Generally, in relation to this issue I note that the claimant did not ever pursue what he regarded as Mr Cass' non-compliance with the NICE guidance in a systematic way. I have made detailed findings about the alleged protected disclosures below which reflect that, and which I do not repeat here.

168. Bringing the evidence together, I find that the lack of investigation into what the claimant said about Mr Cass and the NICE guidance reflected not any lack of appetite on the part of the respondent for such an investigation but rather the manner in which the concerns were raised and the fact that there was not other significant evidence – for example negligence claims or complaints – which suggested that such an investigation should be carried out.

Consistency towards the MDT

169. I have made findings in relation to this issue between [256] to [260] in the context of my findings generally about the MED06 policy to which Mr Cass was subject.

The six claimed protected disclosures

170. The findings of fact necessary for my conclusions in relation to whether the six alleged protected disclosures were in fact protected disclosures are for ease of reading included in my conclusions below.

Chronological findings

The 2019 PRC concerning patient CD

171. The 2019 PRC took place following an investigation into the claimant's management of patient CD who suffered a neurological injury during spinal surgery. The claimant had operated on patient CD three times in August and September 2018, including on the third occasion jointly with Mr Cass. I consider that third operation briefly at [73.4] above. The Investigation Report prepared in accordance with the MED06 policy (see [89] to [91] above) contained 34 recommendations for the PRC to consider.

172. The 2019 PRC took place on 29 August 2019 and its report was sent to the claimant on 23 September 2019 (page 1107). The PRC comprised Mr Hatrick, Mr Marsh and a consultant anaesthetist.

173. The summary and conclusion of the PRC (page 1113) touched on areas including the following:

173.1. The claimant's consent process which was found "not wholly adequate" (for example, recommendations 4, 5, 6 and7);

173.2. There were issues around communication with the patient, physiotherapists and nursing staff and the recording of that communication in medical records (recommendations 10, 11, 17, 19);

173.3. A "robust" spinal MDT "must be created" (for example, recommendations 2, 3, 12, 13);

173.4. There should have been "an early post operative CT scan" after the second operation;

173.5. The third operation should not have started until there had been a full WHO meeting with the other surgeon present;

173.6. The duty of candour policy was not adequately followed by the claimant (for example, 14, 15 and 16).

174. More generally, the report recommended that the claimant should submit data to the British spinal registry (recommendation 22) and - this being a recommendation of the committee not included in the numbered recommendations from the Investigation Report - that a in future someone should be appointed to support the doctor under investigation.

175. It should be noted that although the recommendations focused on the claimant they also considered matters which the respondent should address.

176. Overall, however, the PRC concluded that the claimant had made the correct diagnosis and offered appropriate treatment to CD. The first operation was "performed adequately" and the second was "carried out appropriately". It concluded:

> *As long as the recommendations listed above are implemented and followed the committee feels that Mr Karmani can resume his full practicing privileges at The Montefiore Hospital with the exception of undertaking major cervical spine surgery.*

177. The restriction in relation to "major cervical spine surgery" reflected the view of the PRC that such surgery should not be conducted at the Montefiore hospital because of its limited facilities.

178. Patient CD had been transferred to the Sussex Rehabilitation Centre and then to Stoke Mandeville for ongoing care and rehabilitation in respect of neurological damage after the operations conducted by the claimant. She had remained at Stoke Mandeville for some considerable period of time The claimant agreed when

it was put to him that the treatment of CD and what followed from it was " a very big deal for you and the hospital". He said that it was something that he reflected on regularly. He also accepted that it had resulted in a clinical negligence claim against the hospital and allegations of negligence against him. He accepted that liability had been admitted but said that the "expert opinion was still in doubt". He also accepted that the 2019 PRC was not tainted by race discrimination or whistleblowing detriment. He said that it had been "a very important investigation".

The 2022 PRC concerning patients KW and MB (Detriment 30)

The 2022 PRC – the process followed

179. The process which resulted in the permanent withdrawal of the claimant's practising privileges began on 16 February 2022 when he was suspended. I have made findings in relation to the events between 11 February and 16 February 2022 in my findings of fact in respect of detriments 6 to 9 below. I have also made findings about the claimant's suspension on 16 February 2022 at [327] to [330] below in the context of detriment 11.

180. Ms Dixon carried out the preliminary case review and wrote to the claimant on 18 February 2022 (page 1776) informing him that Ms Clarke had been appointed as Lead Investigator to investigate his actions in relation to various matters concerning patient KW. I have made findings in relation to Ms Clarke's conduct of the investigation in not interviewing the claimant at [361] to [364] in the context of detriment 17.

181. On 17 March 2022 Mr Cass raised concerns in relation to the treatment of patient MB and I have made findings about that at [348] to [353] below in the context of detriment 15. Then, on 14 April 2022 (see the agreed chronology), Ms Dixon wrote to the claimant adding new allegations in relation to patient MB. Ms Clarke produced the RCA in relation to patient MB and I have made findings of fact in relation to that being sent to patient MB at [372] to [375] in the context of detriment 21.

182. Mr Trevedi was instructed to provide a report in relation to the treatment of patient KW. He provided an initial report (page 1938) and then, on 1 April 2022, a supplementary report (page 2011). Dr Weeks was instructed to provide a report in relation to the treatment of MB which he did on 13 May 2022 (page 2093) supplemented by answers to specific questions on 7 July 2022 (page 2243).

183. Ms Wickwar sent amended terms of reference for the PRC to the claimant on 30 August 2022 (page 2357) and I have made findings about that at [369] to [371] in the context of detriment 20. The amended terms of reference raise 13 allegations for investigation in relation to patient KW (some of which have subsidiary points) and 5 allegations for investigation in relation to patient MB. They also raise 3 conduct concerns and further points under the headed "Trends/Themes of Concern".

184. I have made findings about the claimant's access to patient notes during the investigation at [365] to [366] (in relation to Mr Cass's patient notes relating to KW

in the context of detriment 18). I have also made findings about the extent of Mr Cass' involvement in, and evidence to, the investigation at [335] to [341] (in the context of detriment 13) and [385] to [386] (in the context of detriment 24).

185. On 8 September 2022 Ms Dixon wrote to the claimant (page 3468) setting the PRC hearing date for 27 September 2022. The final investigation report for use at the 2022 PRC was dated 13 September 2022 (page 2443). I have made findings at [398] to [400] about the error Ms Dixon made when she failed to provide the document provided by the claimant to all the allegations to the PRC panel (in the context of detriment 27).

186. The PRC hearing took place on 28 September 2022 (page 2627) and the panel comprised Ms Dixon, Mr Price and Mr Dyson. I have made findings about the fact that Mr Hatrick was not a member of the panel despite being the MAC Chair at [376] to [383] in the context of detriments 22 and 23.

The PRC outcome

187. The PRC outcome letter was sent to the claimant on 28 October 2022 (page 2695). The covering letter confirmed that Ms Dixon was the decision maker and stated that:

> *Having considered all the evidence presented, I have concluded that the only appropriate outcome to this process is the permanent withdrawal of your Practising Privileges at the hospital, in accordance with section 12.2.3.4 of the [MED06 policy].*

188. The PRC outcome document was produced in table form. It indicates which of the allegations were upheld by the "Investigator" (Ms Clarke) and which of them were found to be substantiated following the PRC hearing. There are over 30 allegations and sub-allegations. The investigator recorded no conclusion in relation to 1.12.2, partially upheld 1.12.1, 2.1, 2.2 and 2.10.3, "largely" upheld 2.9, "mostly" upheld 2.11.1, and "possibly" upheld 2.11.2. The Investigator upheld all of the other allegations.

189. Turning to whether the allegations were found substantiated following the PRC, they were all found to be substantiated except for 1.3.4 and 1.12.2 – albeit the perhaps ill-judged use of a tabular format means that at times the document is not entirely clear and is sometimes difficult to read.

190. The allegations which the PRC found substantiated included:

190.1. Failing to submit patient KW to an MDT before her operation on 13 January 2022 (allegation 1.1);

190.2. Inadequate evidence of an informed consent discussion with KW (allegation 1.2);

190.3. Documentation failures (allegations 1.3.1 and 1.3.2), regarding the use of magnification and any discussion with KW of post-operative complications;

190.4. Duty of candour failures (1.5), regarding the lack of any documentation regarding any conversation with KW of post-operative complications or any report of the same to the DOCS;

190.5. Failing to consider more conservative treatment for KW, which might have been offered if her case had been referred to an MDT (1.8) and failing to refer her to a pain management specialist (1.10);

190.6. Failing to inject MB at C1/C2 and injecting her at C6/C7 without her consent (2.1 and 2.2). Also failing to undertake adequate imaging during MB's procedure (2.3) and, in effect, failing to do the procedure with care and reasonable skill because the claimant was working too fast (2.4);

190.7. Failing to record the treatment given to MB accurately and clearly (2.5);

190.8. Failing to "obtain or evidence meaningful dialogue" tailored to a number of patients' individual needs relating to risk and benefits of treatment options (2.9);

190.9. Failing to comply with the terms of his suspension by seeking to access PACs and by writing to a patient (2.6 and 2.7).

191. Themes which emerge from the PRC outcome include:

191.1. Failures to learn from the 2019 PRC, for example, in relation to: MDTs; the consent process (the claimant had not changed his website used as part of the consent process since 2019 and it was inaccurate); the recording of magnification; the duty of candour;

191.2. Specifically (1.13) not complying with recommendations of the 2019 PRC (in particular no.s 2, 5, 7, 10, 11, 12, 15 and 18);

191.3. The lack of insight by the claimant and so the lack of assurance that the claimant understood the seriousness of failures identified and that therefore they would not be repeated (for example, in relation to the consent issue at 1.2 and documentation failures at 1.3.1-2);

191.4. Failures to record work done or conversations held correctly.

192. The following conclusion is recorded at page 2746:

Conclusion:
Spinal surgery is high risk, if it goes wrong the outcome could be catastrophic
SK is not demonstrating good practice with regards to informed consent, MDT and clinical record keeping
He lacks understanding and compliance to explaining risks and benefits of surgery to patients
On the grounds of probability, he failed to inject the main area of concern on patient MB

He performed surgery that the patient had not consented to
He failed to document a post-operative unexpected outcome
He failed to meet policy on duty of candour
The trends identified of concern are across multiple patients
There are no improvements seen in his consent process or learning from the significant incident in 2019
The risk of recurrence therefore remains high
The risk to a future patient is therefore catastrophic
Aware of failings and has been off work for 6 months, no actions taken to make improvements to demonstrate learning.

Detriment 30 – Applying an unfair and disproportionate sanction to the claimant

193. Ms D'Souza for the claimant clarified on Monday 17 February 2025 that alleged detriment 30 was the withdrawal of practising privileges and that points i to vii were not advanced as discreet detriments. My findings of fact in relation to them should be read in light of that clarification.

Point i: The recommendations from the 2019 PRC

194. **The MDT:** I have set out my findings in relation to the MDT at [119] to [134] above. In summary, in the period from September 2019 (when the 2019 PRC report was published) until the events giving rise to the 2022 PRC, the respondent had established a well-structured Spinal MDT (as was reflected in its terms of reference), but it had not met regularly and reliably between early 2020 and the autumn of 2021 because of the pandemic. The relationship of the claimant and Mr Cass and their respective views of the NICE guidance had also had a negative effect on the MDT as set out in particular at [133] to [134] above.

195. **Pathway for cases involving neurological deficit/education campaign on the duty of candour**: I find in accordance with the evidence of Ms Clarke (AC WS [207]) that the former (recommendation 17 of the 2019 PRC) was begun but not completed and that Ms Clarke herself has done some work on the latter (recommendation 30). I find that in neither case had the respondent fully implemented the recommendation as envisaged by the action plan at page 1277.

Point ii: Mr Cass was not held to the same standard in the case of JD and RMc [the patient was previously referred to as RM but the parties changed this to avoid confusion with another patient RM]

196. Allegation 1.1 of the 2022 PRC (page 2699) was that the claimant had not submitted KW to an MDT before surgery. The claimant accepted that he had not done this. The claimant not having discussed CD at an MDT was a feature of the 2019 PRC, but at that time discussion of cases at an MDT was "not a mandatory requirement" (the RCA at page 1256). The CD case had of course led on to a number of recommendations being made in relation to the MDT, including that a meeting of the MDT must review all instrumented cases (its section 5.2 set out at [121] above).

197. So far as the comparison with JD and RMc, who were both patients of Mr Cass, is concerned:

197.1. **JD:** I have made findings about the MDT minutes of 26 November 2019 concerning JD at [73.2] above, and about the treatment of JD by Mr Cass more generally at [291] to [295] below above and reached conclusions in relation to detriment 5 at [498] to [497] below. Taking the evidence in the round, I find that Mr Cass did not get MDT approval for JD before the surgery carried out on 19 October 2021 but that he had expressed the view, agreed with by Mr Morassi, in at an MDT 2019 that JD was a candidate for surgery.

197.2. **RMc:** I have made detailed findings in relation to patient RMc at [342] to [347] above. In light of those, it is clear that Mr Cass did not obtain MDT approval before operating on RMc but did obtain the approval of Mr Hatrick.

Point iii: There was an evident dysfunction in the working relationship between Mr. Cass and the Claimant

198. The claimant contends that such dysfunction plainly undermined the collaborative efficacy of the MDT and of the respondent's spinal surgical unit, which the respondent singularly failed to address at any time.

199. I have made findings about this at [123] to [134] above in the specific context of the MDT meetings. In light of those findings, I find that whilst there were significant problems in the working relationship between Mr Cass and the claimant by February 2022, these did not undermine the collaborative efficacy of the MDT and/or of the respondent's spinal surgical unit.

Point iv: No consideration was given to the Claimant's protected disclosures and/or race and whether they may have influenced Mr. Cass's actions

200. I refer to my findings of fact at [335] and [336] below and find that, as the respondent admits, it did not give consideration to such matters.

Point v: The Respondent did not refer the Claimant to the General Medical Council ("GMC"), suggesting that the threshold of risk of serious harm had not been met

201. I find - and the respondent did not dispute – that the claimant was not referred to the GMC (although limited information was provided to the GMC by the respondent as set out in its email to the GMC of 4 January 2023 (page 3532)). However, I find that this is of limited significance as there is no requirement in the respondent's policies or otherwise that the respondent as a provider of private medical services cannot withdraw a consultant's practising privileges without the threshold for a referral to the GMC having been reached.

Point vi: There has been no medicolegal action to date or intimated as a result of the matters which were the subject of the 2022 performance review process

202. The respondent has denied that this is the case. However, Ms Dixon's evidence about this matter is unclear. She says that she is aware of five claims that the respondent has been notified of which relate to patients treated by the claimant. However, she does not identify whether any of these patients were patients in relation to whom concerns were raised in the 2022 PRC.

Point vii: There was singular lack of investigation of the Claimant's argument that this was the first time he had failed to obtain MDT approval since the PRC in 2019

203. The claimant argued that there was a singular lack of investigation of the claimant's argument that this was the first time he had failed to obtain MDT approval since the 2019 PRC, in particularly in view of the significant number of procedures he had conducted on an annual basis. This was really simply an assertion: the claimant produced no evidence of significance beyond his own recollection to back it up. The numbers given by the claimant were 538 procedures in 2019; 372 procedures in 2020; and 620 procedures in 2021.

204. I find that patient KW was the only patient who the respondent knew at the time of the 2022 PRC had not been referred to the MDT by the claimant. I find that, rather than investigating whether this was indeed the only failure of the claimant in this respect since 2019, as the claimant contended, the respondent chose instead to focus on the claimant's explanation for why the failure had occurred in relation to patient KW. I further find that, in light of the nature of the record keeping concerning references to the MDT, carrying out an investigation of all the claimant's cases since 2019 (more than 1500) would have been very time consuming indeed and might not have been possible at all.

Findings in relation to other matters raised in closing submissions

205. Points i to vii above reflected the claimant's pleaded case in relation to the claimed unfair and disproportionate nature of the sanction imposed on the claimant following the 2022 PRC. However, further factual matters were raised in closing submissions in this regard to which I now turn.

Ms Dixon's approach during the 2022 PRC hearing

206. Ms D'Souza for the claimant contended that various aspects of Ms Dixon's approach to the PRC were indicative of the unfairness of the decision taken.

<u>The incorrect written submission</u>

207. Ms D'Souza for the claimant contended that Ms Dixon did not pay attention to the claimant's anxiety about whether the correct written submission had been sent to the PRC. She submitted that there was no adequate explanation of why this had not been realised during the PRC or in subsequent deliberations, which suggested that the engagement levels of the panel were "limited".

208. I have made findings at [398] to [400] below about the incorrect written submission being provided to the PRC. I find, however, that whilst a forensic

examination of the transcript in the knowledge that the PRC did not have the correct document in front of it can result in certain comments made by the claimant pointing in that direction, that would not have been obvious to the PRC panel at the time and the fact that they did not realise that they were not looking at the correct document does not point to inattention on Ms Dixon's part or to limited levels of engagement. The reality was that the claimant's approach to written communication was often confusing and Ms Dixon had experienced this by the time of the PRC. Indeed, Ms D'Souza submitted (or at least implied) that the claimant was someone who perhaps came across better in person than in writing when criticising the failure to interview him during the PRC process (alleged detriment 17).

A willingness to ignore both experts' view

209. Ms D'Souza for the claimant contended that Ms Dixon had demonstrated a willingness to ignore both experts' views on clinical matters. She gave as an example of this her approach to allegation 1.6 ("The Practitioner failed to adequately examine the patient on 01/06/2021 or 01/09/2021"). The allegation was "substantiated" with Ms Dixon writing under the heading "Summary of PRC panel's conclusions and recommendations and Decision of Chair" (page 2715):

> *The level of examination may have been sufficient if the patient had no neurological symptoms however [the claimant] wrote in his email to the patient 'the aim of surgery is to help the trapped nerve pain that causes the numbness and weakness in your legs and creates difficulty walking'. This appears to indicate neurological symptoms therefore a hands on examination should have taken place to accurately assess the patient prior to surgery.*

210. Mr Trevedi's view (page 2011-2012) was that a physical examination was not necessary but went on to say:

> *If based on the initial observation there was a suggestion that the patient suffers with some form of neurological deficit or had offered such a symptom, then a formal neurological examination would be expected and considered good practice and moreover necessary to ensure that appropriate treatment was being considered. I cannot see from the records that KW described any neurological symptoms in the lower limbs.*

211. Mr Price commented that he thought a face-to-face examination "would have been necessary" (page 2647) but noted that he was not a back expert and would defer to Mr Dyson. Mr Dyson's view appears to be summarised at the bottom of page 2648 and the top of page 2649 in the following exchange:

> *PD: But the patient's got … I think an awful lot of spinal surgeons assess their patients on the basis of the story and the scan. This is 95% inaudible 01:38:24 patient we're taking in when we're making the decision and it's absolutely right that he's been, I would say, I'm rather supportive of you here, I think you're a bit derailed, you're sort of half way down the journey of virtual work and then the patient comes in for a face-to-face and you're sort of, ideally at some point, the patient should be examined, the patient should have been examined on the*

couch, but once you get past the first interview, it's quite rare that we examine our patients on the couch. You meet the patient, you examine them, you get the images, and then it's three or four more conversations and then you're not going to examine them on any of those subsequent three or four consultations. So I'm sympathetic with you

RD: I guess the question is, is it appropriate to proceed with surgery without having conducted that level of examination?

PD: Well I think in terms of medical school, inaudible 01:39:25 behaviour obviously not. But this is in the real world and I think that he's, you know … and I do a lot of litigation work and the lawyers make it clear the threshold changes with inaudible 01:39:40 The doctors are working under an awful lot of stress and inaudible 01:39:46 and you know some of the standards which you might have learned in medical school, they can get stretched a bit. So I'm actually not inaudible 01:39:58

RD: Richard, is there anything you want to come in on that point?

RP: No. If Peter says that's normal practice, I accept that.

212. There is no separate record of the PRC's deliberations. I find that it is not accurate to characterise Ms Dixon in her conclusion as having "ignored both experts' views". The view of Mr Trevedi was that if there was a suggestion of neurological deficit then a physical examination would have been necessary and the conclusion refers to such a deficit. Further, Mr Dyson, whilst being "sympathetic" to the claimant, does not address the question of neurological deficit in his comments and does not approve the approach: his view might reasonably be summarised as being that in terms of "medical school" approach the claimant not examining KW was not appropriate but that in the real world it was not something for which the claimant would be criticised in the event of litigation because standards at medical school "can get stretched" a bit. Taking the evidence in the round, I find that the conclusion reflected the joint view of the PRC following its deliberations, as Ms Dixon said in her oral evidence.

Divergence between experts

213. Ms D'Souza submitted that where there had been a divergence between the experts Ms Dixon had chosen to accept "the most negative view of the claimant". She gave as an example of this their views in relation to the clinical pathway. This was allegation 1.8: "The plan for surgery on 13.01.22 was incorrect in that the correct course of action should have been conservative treatment" (page 2718).

214. Mr Trevedi's view was that "conservative options [for analgesics] were not exhaustively pursued" (page 1951) and that if the case had been discussed "at a complex spinal MDT, it is likely a more vigorous conservative approach including an opinion from a pain physician prior to committing to any form of surgical fusion, would have been recommended…" (page 1952).

215. In relation to the same issue Mr Dyson initially says: "the criticism is reasonable" (page 2652) but appears to be brought round by what the claimant then explains

as he is then recorded as saying "I think I accept what you say really…", although his subsequent comments are not entirely clear. As Ms D'Souza noted, separately, at an earlier point in the PRC hearing, at page 2630 Mr Dyson said that "I think if you had brought this case to an MDT you would have ended up doing exactly the same operations" before going on to criticise how the claimant had dealt with the issue of consent. Mr Dyson was critical of the claimant both doing surgery and dealing with pain management (page 2655).

216. As noted above, there is no record of the PRC panel's deliberations. Again, taking the evidence in the round, I find that the conclusion reflected the joint view of the PRC following its deliberations. It is a commonplace of deliberations that the views of participants may evolve as a result of discussion.

217. Ms D'Souza gave as a separate example of how Ms Dyson had resolved a divergence of expert opinion in her decision in relation to the injections given to MB. This was allegation 2.1 ("the Practitioner failed to inject C1/C2, injected C6/C7 and in doing performed surgery at the wrong site"). Mr Dyson is recorded at page 1699 as saying "I don't understand why the SPECT CT is thought to have given evidence that it wasn't injected". By contrast, Dr Weeks in his report thought that level C1/2 had not been injected (page 2096 and page 2097).

218. Ms Dixon found the allegation to be "substantiated". There were two parts to the conclusion at page 2730: (1) that "on the grounds of probability [sic], we do not believe C1/2 was injected"; (2) that C6/7 was injected without the patient's complaint. It should be noted that, although the claimant contended at the PRC that he had injected C1/2, he did not dispute that C6/C7 had been injected without KW's consent. Ms Dixon explained that the opinion of Dr Weeks had been preferred to that of Mr Dyson in relation to the question of whether C1/C2 had been injected because Dr Weeks was more expert in pain management than Mr Dyson – who said that he did not do injections of this kind.

219. Again, taking the evidence in the round, I find that the conclusion reflected the joint view of the PRC following its deliberations, as Ms Dixon said in her oral evidence.

<u>The claimant's practices in relation to consent</u>

220. Ms D'Souza submitted that Ms Dixon's conclusion at page 2702 that there was "no evidence of any improvement" in the claimant's consent practices was not consistent with the conclusions of Ms Clarke, the Lead Investigator, that "there is evidence of a very robust consent process employed by the surgeon to ensure the patient's fully informed consent to surgery" (page 1705).

221. Ms Dixon's conclusion at page 2702 was made in the context of Allegation 1.2 ("There is inadequate evidence of the informed consent discussion with KW before the surgery dated 13.01.22"). Mr Dyson was extremely critical of the claimant's consent process in relation to KW and the materials he used in it. Some of his thoughts appear in the decision at pages 2702 to 2703. So too was Mr Price ("I do not feel your consent process is Montgomery compliant").

222. Ms Clarke's conclusion was in the context of *one particular patient*, RM. It clearly relates to RM:

> *There is evidence of a very robust consent process employed by the surgeon to ensure the patient's fully informed consent to surgery with realistic expectations set about the intended benefit of surgery and associated risks (including dural tear, bleeding and nerve damage), although the consent to treatment form was signed on the day of admission rather than in the designated consent consultation on 24/05/2021.*

223. I find that, whilst there is some tension between the conclusions of Ms Clarke in relation to one specific patient, RM, and the wider conclusions of Ms Dixon, there is no inconsistency as such in light of the fact that it is clear that Mr Dyson and Mr Price were critical of the claimant's consent process generally.

The change in approach

224. The version of the MED06 policy applicable to the 2022 PRC came into force in October 2021. I find that it did result over time in a change of emphasis in the approach taken to consultants about whom concerns had been raised – and this was reflected in the answer to question 9 of the Equality Act questions (page 2969). This is also reflected clearly in the table at page 3073 which shows that in 2019 31 consultants had practicing privileges suspended and that this number fell in subsequent years as follows: 2020 – 29; 2021 – 11; 2022 – 6; 2023 – 5.

225. The change of emphasis resulted in more "voluntary pauses" to practising privileges and, also, more "voluntary withdrawals" of practising privileges by surgeons themselves. The 9 PRC investigations completed in 2023 did not result in a single permanent withdrawal of practising privileges.

226. I accept the evidence of Ms Dixon that she was not aware of the possibility of a "voluntary pause". I find that she regarded the question of a "voluntary withdrawal" as being something for the claimant to raise.

227. Overall, I find that the permanent withdrawal of practising privileges was a very rare sanction by the time it was imposed on the claimant.

The NHS appraisal

228. Ms D'Souza for the claimant contended that the contents of the "colleague feedback" (page 3913) and "patient feed back" (page 3920) from October 2024 in respect of his NHS role suggested that there was a "jarring difference" between the perception of the claimant in his NHS role and the respondent's perception of him at the Montefiore hospital.

229. The feedback documents do present a positive picture of the claimant. His colleagues' assessment of him (page 3919) shows him as exceeding "benchmarks" in most categories (but not in respect of "commitment to care and wellbeing of patients", "respects patient confidentiality", and "honest and

trustworthy"). They also show his colleagues do not score him as highly as he scores himself: he awards himself a perfect 5.0 in every category.

The MED06 process concerning Mr Cass

The background to the MED06 process concerning Mr Cass

230. The origin of the MED06 process concerning Mr Cass was the appeal of the claimant to Dr Cale considered between [261] and [265] below. The claimant raised the cases of RMc and JD in his appeal of 10 November 2022 at page 2768. He alleged that there was no MDT approval for the surgery on RMc and that there was a new weakness in the left leg post op and yet Mr Cass had not exercised his duty of candour. I make findings of fact below in relation to patient RMc in the context of detriment 14 between [344] and [347] below.

231. In relation to patient JD, the claimant alleged that there had been no MDT approval for lumber disc replacement surgery conducted by Mr Cass in 2021. I make findings of fact in relation to patient JD and MDT approval at [291] to [295] below in the context of detriment 5.

232. Dr Cale dealt with the claimant's appeal in this respect as follows (page 2878):

> *The appeal panel considers that each concern raised with an HD must be assessed on both its individual merits and the broader context. It is not appropriate for the HD to disclose to another individual any actions that have been taken by the HD in respect of others as they are confidential to each practitioner.*
>
> *However, the appeal panel has considered that the HD must assess concerns in an appropriate context. When concerns about your practice were investigated in 2018/19 final actions were not imposed on your PPs, but you were required to make changes to your working practices as a result. This demonstrates that the HD has in your case taken a proportionate approach to concerns raised.*
>
> *The appeal panel does not therefore deem these concerns relevant, and they are not upheld*

233. "these concerns" were not only those relating to patients JD and RMc but also concerns relating to certain metrics and the conduct of another consultant. I have made further findings about the appeal decision in this respect in the context of detriment 32 at [409] to [410] below.

234. Neither patient JD nor patient RMc had made any complaint about Mr Cass or their treatment by him. However, after their cases had been raised by the claimant, Dr Cale spoke to and then emailed (page 2901) Ms Dixon about JD and RMc on 5 December 2022. I have made findings at [294] to [295] about the steps that Ms Dixon then took (in the context of my findings in relation to detriment 5).

235. Dr Cale subsequently wrote to the claimant in relation to patient JD and patient RMc on 13 March 2023 (page 2937) and I make findings of fact in relation to that at [411] to [415] below in the context of detriment 33.

236. The claimant raised questions about patients JD and RMc again in his Equality Act questions (page 2944), and I make findings of fact in relation to that at [416] to [419] below in the context of detriment 34.

237. The claimant the raised further questions in relation to patients JD and RMc in his letter of 13 April 2023 (page 2955), and I make further findings in relation to that at [421] below in the context of detriment 35. In her reply to that letter of 2 May 2023 (page 2980), Dr Cale confirms that the concerns relating to JD and RMc will be "subject to a preliminary review process under the 'Management of Consultant Performance Concerns' policy".

The approach of Ms Dixon to the MED06 investigation concerning Mr Cass

238. The claimant's criticism of Ms Dixon focuses on the quality and quantity of the information she provided to Mr White, who conducted the Preliminary Review and instructed Ms Dobson to carry out the Formal Investigation, in relation to Mr Cass's treatment of patients JD and RMc.

239. In cross-examination Ms Dixon could not recall what documents she had provided to Ms Dobson.

240. **The Nuffield and virtual MDTs:** The criticism is that Ms Dixon did not provide Mr White with much information about the Nuffield MDT or any information about the existence of the virtual MDT, and that was information which was material to his investigation. Ms Dixon accepted in cross-examination that she had not informed Mr White of the Nuffield MDT meetings and that she knew about them because of the 2022 PRC hearing for the claimant. However, she noted that the Montefiore hospital had "developed our own MDT" since she took up her post in March 2021 and said "perhaps" she had forgotten about the Nuffield MDT. It was put to Ms Dixon in cross-examination that it was implausible that she would have known about the Nuffield MDT in September 2022 when she referred to it in the outcome letter for the 2022 PRC but not when contributing to the MED06 process for Mr Cass in 2023.

241. Notes of the interviews conducted by Ms Dobson during the Formal Investigation were at page 3255 of the bundle. In fact, they show that, whatever Ms Dixon could or could not remember during cross-examination, she had mentioned the fact of the Nuffield MDTs when interviewed. The notes record her as having said:

> *Apr 21 RD started… 2019 incident put policy and MDTs in place. Lynette was not an effective DOCS – her job to get policy in place and 2 yrs. later policy not in place. Same surgeons at Nuffield – using Nuffield for MDTs… formal MDTs but not sure of [sic] fully documented. Sept 21 formal MDDT was put in place. 1 x 4 weeks., alternating at Nuffield – accepted practice – bit [sic] was often a quick gathering of the 3 surgeons*

242. Given what Ms Dixon said to Ms Dobson when interviewed, I find that there is no significance in the limited nature of the information provided in relation to Nuffield MDTs to Mr White. Indeed, she also mentioned the existence of such MDTs in her email to him of 26 June 2023 (page 2989). So far as their minutes were concerned, I find that the fact that she had seen at least one Nuffield MDT minute did not mean that she was seeking to deceive or be unhelpful when she told Mr White in the email that she did not have access to them. The overall tenor of the email trail in June 2023 (pages 2991 to 2989) is that Ms Dixon is trying to be helpful in response to Mr White's request for MDT minutes.

243. So far as the virtual MDT is concerned, I find that there is little significance in her failure to mention this to Mr White. This is because the conclusions of the 2022 PRC make clear that Ms Dixon did not regard the virtual MDT as being in any way a satisfactory alternative to an attended MDT (see the conclusions reached at the 2022 PRC in relation to allegation 1.7 at page 2716).

244. A further criticism is made in that the email of 26 June 2023 incorrectly states that there February 2020 was "prior to the formal MDT being in place". It is correct that there was a formal MDT before February 2020. However, it was suspended around that time and was still suspended when Ms Dixon joined the respondent in March 2021, because of the pandemic. I find that the error reflects Ms Dixon's limited history with the respondent.

245. **Failure to provide complete medical records:** I find that the fact that Ms Dixon did not provide full medical records for patient JD or patient RMc simply reflects the fact that the compilation of such medical records is a vexed question for a private hospital such as the Montefiore, because its ability to keep full records is heavily dependent on the consultants who practice at them uploading all relevant documents to its system, which they do not always do. So far as the suggestion that Ms Dixon "cited only positive matters and omitted negative matters" referred to in the clinic letter of 7 March 2022 in her Spinal Cases Summary at page 2914, on any realistic assessment: (1) the one line reference to the clinic letter is not intended to be a summary of the clinic letter; (2) it captures what the patient apparently felt about the operation; (3) overall, the clinic letter did in any event provide a very positive overall pictures. I find that as such the contents of the Spinal Cases Summary do not suggest an intention to provide a falsely positive picture.

246. **The nature of Dixon's review at page 2914:** The claimant suggested in submissions that the fact that Ms Dixon had said that her review at page 2914 in relation to JD and RMc was not an investigation because "she knew that the case was going to be further investigated in due course" was telling in relation to her mindset, given that she did not at that point know there would be a further investigation. It is correct that Ms Dixon did not know at that point that there would be a further investigation. However, she prefaced the comment referred to in the claimant's submissions by the words "I was asked to do a brief snapshot…". This did reflect what she had been asked to do: on 5 December 2022 Dr Cale said to her "I would be grateful if you can confirm what investigations were conducted regarding the 2 patients below" and then she followed up on 9 December 2022 by saying "I would be grateful for any information you have on the below". Ms Dixon's

email by which she sent the review at page 2914 (page 2900) comments “Please see attached summary and some supporting evidence. If you require scans of any other documents, please let me know”. Taking all this into account, I find that Ms Dixon’s answer was not telling as the claimant suggests: rather, if not completely accurate, it did reasonably reflect what Dr Cale had asked her to do.

247. However, notwithstanding these findings, it is appropriate at this point to refer to my findings at [415] in relation to Ms Dixon’s understanding of Dr Cale’s attitude to the allegations made by the claimant in the context of detriment 33.

How the MED06 process proceeded in relation to Mr Cass

248. Ms D’Souza made submissions from [250] of her closing submissions in relation to how, she said, the MED06 process followed in relation to Mr Cass differed from that followed in relation to the claimant. This is an area relevant to the drawing of inferences and the ‘reason why’ questions which arise. I therefore make the following findings of fact in relation to them.

The initiation of the process

249. Dr Cale accepted in cross-examination that the MED06 process would have been unlikely to have come about without the repeated pressing of the claimant. It is true that the claimant raised the issues of JD and RMc on a number of occasions (as set out at [230] to [237] above) before the MED06 process was initiated. By contrast the MED06 process in relation to KW (and subsequently MB) was commenced within a few days of concerns being raised in relation to the claimant’s treatment of patient KW. I have made detailed findings about the beginning of the MED06 process in relation to the claimant in the context of detriment 11 at [327] to [328] below.

250. However, I find there are obvious differences. The issues in relation to JD and RMc came to light as the result of the claimant trawling through Mr Cass’ patient’s records in an attempt to find information which might support his appeal. In neither case had the patient or anyone else expressed concern about the treatment by Mr Cass contemporaneously. By contrast, the MED06 process in relation to the claimant followed both Mr Cass (and, although to a lesser extent, Mr Morassi) expressing concerns about the claimant’s treatment of KW after the patient had raised that in a virtual WhatsApp MDT. Further, those concerns were time sensitive as both Mr Cass and Mr Morassi believed that revision surgery was needed urgently. I refer in this regard in particular to my findings in respect of detriment 6 at [296] to [303] below and also my findings at [315] in respect of detriment 9.

The provision of incomplete information

251. The claimant contends that incomplete information was provided in the investigation leading to the claim in relation to RMc being screened out by Mr White. I refer to my findings of fact at [240] to [245] and find that any inadequacies in the information provided did not result from any decision on Ms Dixon’s part to provide incomplete or misleading information.

The investigation re JD

252. **Taking what Mr Cass said at face value:** The example given is his assertion that the British Spinal Register had had an outage on a particular day which explained why JD's and RMc's details were not on it. In fairness to Mr White, in fact Mr Cass had provided slightly more information than that. In his letter of 13 October 2023 at page 3024 he said:

> *I agree that this BSR data is missing. However, there is evidence that data for all five patients on whom I operated in the two days in question was also missing. According to the Practice Manager this may have been caused by a failure or a glitch in the software at the time (Amplitude Pro 10). The fact that all five patients' data were missing supports the argument that there was no deliberate suppression of data and, in any event the two patients in question had good outcomes*

253. Mr White explained at paragraph 46 of his witness statement why he accepted this explanation and so decided that no further investigation was required. He could of course have sought further information about the other patients on the two days in questions. However, it was reasonable for him to assume that Mr Cass was telling the truth about this because if it would have been obviously unwise to lie about something which could easily have been checked. This can be contrasted with the fact that the 2022 PRC chose not to take at face value the claimant's assertion that he had submitted all of his patients except KW to an MDT. However, as I have found at [203] to [204] above this was little more than an assertion by the claimant that it would have been very difficult indeed for the respondent to have investigated or verified.

254. **High level Gummerson review:** the claimant contends that the Gummerson review (page 3035) was "high level" and not as "forensic" as the reviews conducted by the experts instructed to advise in relation to KW and MB. The specific comparison made is with Mr Trevedi's report (page 1940). It is true that this was longer and more detailed (17 pages) than that of Mr Gummerson (7 pages including medical notes summary). However, given that Mr Gummerson and Mr Trevedi were both instructed specifically because they were *external* experts, and it is not suggested that Mr Gummerson was in some way asked to consider the matters under consideration in less detail than Mr Trevedi, I find that the difference is of very little evidential significance.

255. **Conclusion re MDT:** the Gummerson review (page 3038) states:

> *No major issues, minor care concerns only.*
> *Small points in relation to the availability of a MDT during COVID*

256. By contrast in the appeal decision, considered in more detail at [262] to [265] below, the failure to submit patient KW to an MDT was one of three "overarching concerns" which, collectively, the panel considered to be "extremely serious".

257. The comparison made, however, is between the approach taken by the decision maker in the case of the claimant and that of the external expert in the

case of Mr Cass. The conclusion of the decision maker in the case of Mr Cass was at page 3128 (in Ms Dobson's Formal Investigation Report). She concludes:

> *The investigation has found that the patient's case was not taken through a further MDT in 2021, prior to surgery in October 2021. While a further MDT would have been advisable and best practice in JDs case, I understand that MC has relied upon the findings in the 2019 MDT, and I consider therefore consider the lack of a further MDT 2021 to be a minor concern.*
>
> *I also have considered that the MDT process at Spire Montefiore was in the process of being reinstated at the time the patient was considered for surgery, but was not entirely robust at his point.*
>
> *I have no concerns that MC is usually very diligent in terms of applying the MDT process for his patients, and tends usually to go above and beyond regarding MDTs.*
>
> *In making this decision I heard evidence from Spire colleagues at Montefiore hospital confirming that MC has been a key driving force in getting the MDT process embedded, not just at Montefiore, but also across several Spire hospitals to ensure a robust service for hospitals outside of his own, but within Spire.*

258. I find that Ms Dobson as the report writer (and so decision maker) honestly believed that there were a number of matters which made the failure of Mr Cass in relation to patient JD less serious than it would otherwise have been.

259. Overall, the claimant's failure to submit KW to an MDT was judged more severely by the PRC panel than Mr Cass' failure to submit patient JD to an MDT was judged by Ms Dobson. However, whilst Ms Dobson honestly believed that there was a number of matters which made the failure of Mr Cass in relation to patient JD less serious than it would otherwise have been, the PRC panel did not have a similar view in the case of patient KW.

260. **Taking account of general MDT compliance:** I find that Ms Dobson did take account of the Mr Cass's general approach to MDT compliance – that is reflected in what she wrote at page 3128 set out at [257] above. The evidential basis for what she said can be found at least in part in the interviews she conducted, the record of which is at page 3255. See the comments made by Ms Clarke under the heading "Were MDTs in place in 2021?". By contrast it is true that the claimant's assertion that KW was the only patient he had not submitted to an MDT was not accepted. I refer again to my findings of fact at [203] to [204] in this regard. The claimant has not pointed to other evidence in the investigation preceding the 2022 PRC which supported his assertions in this regard.

The appeal against the 2022 PRC outcome

261. The claimant appealed against the 2022 PRC outcome by writing to Dr Cale on 10 November 2022 (page 2754). The claimant has a habit of copying and pasting extracts from different documents into a single document and the end product can

be confusing. Consequently, when Dr Cale wrote to the claimant acknowledging his appeal on 28 November 2022, she set out what she understood to be the grounds of appeal in a two-page appendix (page 2791).

262. The appeal was considered by Dr Cale, Dr Chris Bouch (Associate Medical Director) and Mr Peter Corfield (Group Chief Commercial Officer) and rejected by a letter dated 15 December 2022 (page 2871). The letter observed:

> *The panel noted that your technical ability as a surgeon is not in question, but all of the concerns are around the processes of decision making for surgery, and a holistic approach to care.*

263. The appeal upheld various grounds of appeal relating to the timescale of the 2022 PRC: not communicating the PRC decision within 10 days (xxxi at page 2884 and xvi at page 2880), the failure to provide a decision on next steps on 13 September 2022 (xix at page 2881), and the failure to set a PRC date within 28 days (xx at page 2881). The other grounds of appeal were rejected.

264. The appeal decision identified what Dr Cale described as 3 overarching concerns:

> *1. Patient KW receiving surgery without going to an MDT and your response to that, with the appeal panel feeling that you failed to take ownership of the lack of a failsafe process for your patients regarding MDT*
>
> *2. The consent process: although you see patients multiple times (as evidenced by the index patient) and provide them with a lot of information, this is all generic, not tailored to that patient and thereby not compliant with Montgomery principles. In addition, you have not updated your website since 2019.*
>
> *3. For both these concerns, the appeal panel noted that they were issues that had been raised with you after the PRC of 2019, but you did not present as an individual who is learning, prepared to accept advice and best practice or consistently involve other colleagues in your decision making. This latter point was emphasised by the discussion of utilisation of pain consultants to support patients prior to making a decision to proceed to surgery.*

265. The claimant contends (detriment 31) that the appeal decision was flawed because of the matters relied upon in respect of detriments 17 to 28 and 30. I have made findings in relation to those detriments above and below.

The claimed detriments

Detriment 1 - Mr. Cass encouraging Patient PT to submit a letter of complaint about the Claimant [on or before 4 August 2017]

266. The factual content of PT's letter of complaint is considered at [437] below and the evidential basis for contending that it was sent by Mr Cass is PT's email considered at [73.6] above.

267. Mr Cass denies having “encouraged” patient PT to complain. PT’s email does not say that he was “encouraged” to complain. The claimant’s email to PT and his reply focused on whether Mr Cass had “prompted” him to complain. Mr Cass could have course have “prompted” PT to complain by disclosing information to him which had the effect of causing PT to wish to complain, without Mr Cass having intended or wished for that effect.

268. Taking the evidence in the round, I find on the balance of probabilities that Mr Cass gave PT his honest professional opinion that he would not have recommended the use of the interspinous device. I find that this was at least part of the reason for PT complaining, hence him accepting that he had been “prompted” to complain. However, I find that Mr Cass did not “encourage” PT to submit a letter of complaint about the claimant.

Detriment 2 - The anonymous complaint to NHS fraud (“the Coding Complaint”) [24 January 2018]

269. The NHS’ record of the Coding Complaint is at page 3285. It resulted in an investigation (page 518) which concluded that the claimant incorrectly coded some spinal decompressions periods for privately funded cases (27% in the period January 2016 to May 2018), which had resulted in Montefiore hospital mistakenly over-charging insurers in some cases. The report concluded that the NHS had not been overcharged. Overall, the matter was dealt with informally. I find, therefore, that whilst some fault was found on the part of the claimant, this was not viewed seriously by the respondent.

270. Mr Cass denied completely that he was the source of the Coding Complaint. The respondent did not know for a fact who was the source of the complaint, but Ms Clarke said that the view at the time had been that it was a member of theatre staff or an anaesthetist (AC WS [66]) and this was Mr Hatrick’s recollection also (CH WS [38]).

271. The claimant relies on the contents of the Coding Complaint itself contending: (1) it shows knowledge of both specialist spinal procedures and coding; (2) the use of “!” after “I have also seen that he has a V3350 'combined anterior-posterior' case listed but I believe we only have one surgeon who does anterior cases and it is not him!” points to the author being Mr Cass.

272. I accept the evidence of Ms Clarke that an anaesthetist would have had sufficient knowledge to write the complaint, as might other members of theatre staff who would routinely see how a surgeon coded their operations. The wording of the Coding Complaint otherwise quite clearly suggests that the author is not Mr Cass, for example the reference to the author being an employee and worrying about losing their job. The use of “!” is not sufficiently curious as to be suspicious because, I find, it was well known that Mr Cass was the only surgeon who did anterior cases.

273. Overall, on the balance of probabilities, I find that Mr Cass was not the author of the Coding Complaint or the driving force behind it. In making this finding I have taken into account that I found Mr Cass to be a generally credible witness. The fact

that Mr Cass' recollection of some matters might be affected by the litigation process is not sufficient for me to find that his memory of not having submitted the Coding Complaint is false.

Detriment 2A – Failing to (1) assess compliance with NICE guidance or (2) conduct an audit of practice against NG59 [February to June 2018 or later]

274. In an email on 8 February 2018 (page 313) Ms Clarke considered the use of spinal pain injections in the context of the NICE guidance. She set out in bullet point form recommendations from the NICE guidance for the assessment and management of low back pain and concluded:

> *My recommendation would be that, in the first instance, the spinal MDT is used to complete a baseline assessment of practices against NG59 using the tool attached. I would also suggest an audit of practices against NG59 using consultant clinic letters.*

275. The question of an audit is mentioned at item 10 of the minutes of the MDT of 12 June 2018 (page 3775), noting that Ms Awdry had "audited 20 NHS and 25 PP across SK/MC/ST/EC and most met criteria. Now to audit 2017 through to March 2018". There is no reference to a wider assessment of compliance with the NICE guidance or of a wider audit of practice against it. The focus was clearly on injections. However, the minutes do note "LA would like MH to draw up its own baseline assessment for LBP which must be met prior to offering injections".

276. Ms Clarke said in cross-examination that she did not believe that such a baseline assessment had ever taken place**.** Ms Awdry said she could not remember if such a baseline assessment had been done.

277. Taking matters in the round, I find that a limited audit of injection practices of various consultants against the NICE guidance was carried out (as reflected in the MDT minutes of 12 June 2018), but that there was no full assessment of the Spinal Unit's compliance with the NICE guidance or audit of practices against it.

Detriment 2B – Narrow investigation into injection practices [19 April to June 2018 or later]

278. The whistleblowing complaint of 19 April 2018 was at page 335. It is headed "Re spinal injections and spinal surgery at the Spire". It enclosed two press articles and stated:

> *The articles are self-explanatory but they all point out that injections into the spine (facet joint injections, epidural steroid injections) and much spine surgery for the relief of low back pain is ineffective and may be damaging. On 2 occasions now in 2009 and 2016 the National Institute for Clinical Excellence (NICE) states that such injections are useless and should not be done. The article and leader point out that not only is this bad medicine but it takes time and resources away from those techniques that do have an evidence base (graded exercise programmes, cognitive behavioural therapy etc).*

279. As found above, the limited audit following Ms Clarke's email of 8 February 2018 that Ms Awdry carried out focused on injections. Further, the respondent accepts that the investigation carried out following the whistleblowing complaint of 19 April also focused on injection practices. It did not, however focus just on the claimant – see my findings at [275] above.

280. Ms Awdry (LA [23]) gave evidence to the effect that this was because the whistleblowing complaint was mainly about injections but recognised with the benefit of hindsight that "concerns were also being raised about spinal surgery which I could have reviewed". I find that, although a careful reading of the letter would have revealed its true scope, and although it is only a short document, it is nevertheless true that its emphasis is on spinal injections. Its operative part as set out above has three sentences. The first refers to both injections and surgery but the second and third deal only with injections.

Detriment 3 – The whistleblower complaint re Patient IM [22 October 2018]

281. The respondent accepts that Mr Cass raised a concern about the kyphoplasty procedure carried out on patient IM by the claimant on 13 September 2018. It was not an anonymous complaint: Mr Cass raised his concern face-to-face with Ms Awdry but he was not identified in the subsequent letter of instruction to Mr McLaren of 22 October 2018 (page 449) which, perhaps, led Mr McLaren to classify Mr Cass as an "anonymous" whistleblower in his one-page report at page 3211.

282. I have already made some findings about the differing recollections of Mr Cass, Ms Awdry and Ms Clarke at [73.3] above. The reality of those differing recollections is that Mr Cass says his attention was drawn to patient IM by a conversation with the Medtronik representative and Ms Clarke says she recalls him telling her his attention was drawn to patient IM by seeing an x-ray image that had been left on display. I have explained above why I attach little significance to the discrepancy in recollections in the context of my assessment of Mr Cass's credibility. For the same reasons, I give very little weight to the discrepancy as being evidence that Mr Cass is lying about what happened on the day and that in fact he had, as Ms D'Souza put to him, been covertly going through the claimant's files for problems – which he denied.

283. What is most striking about Mr Cass speaking to Ms Awdry is in fact that he did not simply raise the matter with the claimant direct. However, Mr Cass pointed out that the incident was the day after the third surgery on patient CD, which was meant to be a joint operation but which the claimant had started before Mr Cass arrived. I find that, in light of how Mr Cass felt about how the claimant had behaved during that surgery, it is likely that he would have been very reluctant to discuss patient IM direct with him the following day.

284. It was put to Mr Cass that his concern about patient IM was not well founded in light of the report produced by Mr McLaren (page 3211). However, the report considers 22 cases in two short paragraphs. It provides limited evidence of significance to enable conclusions to be drawn about whether Mr Cass's specific concerns about the treatment of patient IM were justified.

Detriment 4 – Failure to take action in relation to disclosures 1 to 5 [April 2018, 26 November 19, 14 May 21 & 15 June 21]

285. In light of my finding and conclusions below between [427] to [486] in relation to disclosures 1 to 5, I find that disclosures 1 and 2 did not on any realistic reading relate to Mr Cass and so, whilst it is true that no action was taken against him in relation to them, that is of no significance.

286. So far as disclosure 3 is concerned, if Mr Cass had said that the NICE guidance permitted surgery for "unspecified back pain" that would not, without more, have been contrary to the NICE guidance in light of what its section set out at [105] and [107] above says. It is therefore difficult to see what action the respondent might have taken against Mr Cass in this respect. That is to say the position of the claimant and Mr Cass in relation to the NICE guidance is best classified as a difference in professional opinions. That is reflected in my findings of fact above, in particular those under the heading "The claimant's beliefs in relation to the NICE guidance, spinal fusion surgery, disc replacement surgery, and the practice of Mr Cass".

287. Disclosures 4 and 5 are, in light of my findings of fact below, a little different because in each case the claimant is, in effect, making a broader statement that Mr Cass was generally not following the NICE guidance and that he was acting against the weight of professional opinion.

288. I find that the respondent took no action contemporaneously against Mr Cass in relation to disclosures 4 or 5, although subsequently the lack of MDT approval referred to in disclosure 4 was examined to some extent in the context of Mr White's MED06 investigation in 2024.

289. So far as the anonymous whistleblower complaint is concerned, this is a reference to the complaint considered at [278] to [280] above. In light of my findings above, including those at [275] above, action was taken following it in relation to it against both Mr Cass and the claimant, in that both were included within the ensuing injections practice investigation. No action was taken in relation to Mr Cass or anyone else so far as the question of surgery for low back pain was concerned.

290. In so far as the reference to "strict observance of NICE guidance in all other disciplines" is concerned, I find that NICE guidance was considered generally by the hospital as *guidance.* I find that the claimant has failed to prove on the balance of probabilities that there was any significant difference in approach by the Montefiore hospital to the NICE guidance NG59 and other NICE guidance.

Detriment 5 – Failure to take action re Mr Cass's failure to get MDT approval for JD [December 2022]

291. Ms Dixon considered the issue of patient JD twice. The first time was in December 2021 in the context of patient JD's complaint by phone on 29 November 2021 (page 3416). The complaint as recorded was primarily about the financing of an operation conducted by Mr Cass but JD also queried why he had not been

offered surgery in 2019 (when he was being treated by the claimant) because he had been told that it had been discussed at an MDT. When Ms Dixon met him on 7 December 2021, it became clear that this was also part of his complaint. I have considered her exchanges with the claimant and his clinic letters at [474] to [481] below in the context of my findings and conclusions in relation to disclosure 6.

292. At the time, in addition to contacting the claimant, Ms Dixon contacted Mr Cass and he stated that he and Mr Morassi had agreed that surgical intervention was appropriate at the MDT in 2019, but that the claimant had disagreed. During the course of Ms Dixon's consideration of the matter, neither the claimant nor anyone else alleged that the surgery conducted by Mr Cass in 2021 had been done without MDT approval. The focus was on why surgery had *not* been performed in 2019, which was part of JD's complaint.

293. The second time Ms Dixon considered the issue of patient JD was after the claimant raised concerns with Dr Cale, as part of his appeal against the removal of his practising privileges, that Mr Cass had operated on patient JD without MDT approval. Dr Cale spoke to and then emailed Ms Dixon about this on 5 December 2022 (page 2901).

294. Ms Dixon obtained notes relating to patient JD and sent them to Dr Cale by email on 14 December 2022 (page 2902-2930). Dr Cale then emailed Ms Dixon and Mr Price on 15 December 2022 (page 2899) saying:

> *Richard: For info: both these cases were raised with me as cases of concern that appropriate processes were not followed. Can you please review these (when you are back from leave!) and consider with Rachel whether any further action or investigation is appropriate.*

295. When asked about this in cross-examination, Ms Dixon said that she did not recall whether she had met with Mr Price and then went on to say that Mr Price would have looked at the information provided to him and formed his own judgment on that. I therefore find that Ms Dixon took no further action after receiving the email from Dr Cale on 15 December 2022.

Detriment 6 - Mr Cass encouraging Ms Awdry to complain about the claimant on 15 February 2022

Patient KW and Detriment 6

296. Patient KW is relevant to this and a number of the following alleged detriments and therefore this is a convenient point at which to make findings in relation to how Mr Cass came to be involved in her care.

297. The claimant raised patient KW in the virtual WhatsApp MDT (page 1723 and 1724) on around 11 February 2022. The purpose of this exchange from the claimant's point of view was at least in part to obtain MDT approval for surgery.

298. Mr Morassi replied:

The screws look alright. Probably the articular proves of L5 on the left is compression the nerve root in the foramen. The scan was on the 14th January. Did you not see that then. I believe she needs a decompression of the foramen and do it sooner rather than later.

299. Mr Cass comments include:

I think you've pulled her back too far and hadn't fully decompressed the facet. So what's happened is she's now in retrolistheses and the destabilised facet has been driven into the foramen & taken out the nerve root.

I don't think you've got many options other than to revise this. You may get away leaving her in retrolisthesis if you full decompress that facet, especially the superior facet.

300. Both Mr Morassi and Mr Cass therefore felt further – i.e. "revision" – surgery was necessary and Mr Morassi also indicated that he thought it was urgent ("do it sooner rather than later"). Ms Awdry regarded the messages as being "sign" off for the operation (her text message of 14 February 2022 to the claimant at page 1726).

301. Mr Cass's evidence (MC WS [135]) was that he reviewed the case further after the WhatsApp chat had finished (the claimant having not replied to his or Mr Morassi's messages). He said at that point he realised the imaging was four weeks old and that he was concerned that there had been nerve compromise for over four weeks. He said: "I therefore contacted Lynette Awdry and stressed that this issue required prompt intervention and requested she ensured the revision surgery was expedited by Mr Karmani". Ms Awdry's recollection is similar (LA WS [79]).

302. Ms Awdry's "complaint" about the claimant is an email dated 15 February 2022 to Ms Dixon and Mr Hatrick (page 1730). In summary, it is clear that it is Mr Cass contacting her following the virtual WhatsApp MDT exchange which has first caused her to be concerned but she then had further concerns of her own in relation to KW's treatment following a review of the patient notes undertaken after her pre-assessment of KW.

303. Taking the evidence in the round, I find that Mr Cass did not "encourage" Ms Awdry to complain about the claimant as alleged. Rather his concern about delay – shared also by Mr Morassi – prompted a concern on her part in relation to the treatment of KW that developed into the email of 15 February 2022 after she had conducted the pre-assessment of KW and reviewed the patient notes.

Detriment 7 – Mr Cass' unreasonable refusal to jointly operate with the claimant on 15 February 2022

304. Mr Cass did refuse to operate jointly alongside the claimant.

305. Ms Awdry had made an attendance note on 16 February 2022 following a meeting with Mr Cass and Mr Hatrick which stated (page 1741):

Mr Cass unhappy to operate with Mr Karmani as agreed yesterday due to difficult conversation with Mr Karmani regarding a patient who had sought a second opinion with [Mr Cass] and concerns had been raised regarding laterality of patient's symptoms and management.

Mr Cass feels a joint operation would be difficult at the best of times as during the last experience Mr Karmani had commenced the procedure 45 mins before he arrived, but now feels it would be impossible and not safe.

306. In light of this attendance note and Ms Awdry's witness evidence, I find that she believed that Mr Cass had refused to operate jointly on account of their strained professional relationship which meant that "they were not in a good place to work together".

307. Mr Cass's evidence was that he did not want to operate on account of his experience of operating with the claimant on patient CD (considered at [73.4] above in the context of my assessment of credibility) and because the operation would be conducted through a small incision which would have resulted in he and the claimant "clashing antlers" because they both wore "operating loupes" (a bulky device which mounts magnifying glasses onto the forehead/in front of the eyes of the wearer).

308. The claimant agreed in cross-examination that it would have been difficult for he and Mr Cass to have operated together because they both used operating loupes. He agreed that Mr Cass's refusal to operate was not unreasonable and was unsurprising – he said it would have been "very difficult and challenging" for them to operate together.

309. I find that in refusing to operate with the claimant Mr Cass took into account his difficult previous joint operating experience with him in relation to CD (which was a factor in their strained personal relationship) and practical difficulties arising from operating loupes. I find that in these circumstances the refusal to operate was not unreasonable, as the claimant himself accepted in cross-examination.

Detriment 8 – Mr Cass being critical of claimant/providing slanted or incorrect information

310. The alleged incorrect or slanted information was summarised as follows in the claimant's closing submissions:

i) MC said he disagreed with the Claimant's diagnosis of a Pars fracture (even though the diagnosis had been made by an external radiologist);

ii) MC recorded in the notes that KW was in retrolisthesis (a rare condition involving backwards displacement of a vertebra) caused by the Claimant's surgery (which was not correct, as noted by the external reviewer, Mr. Trevedi [sic]); and

iii) MC recorded that KW had experienced immediate significant post-operative symptoms in her left leg which did not accord with any of the post-operative

records (as noted by Alison Clarke in her investigation report), the implication of which was that the Claimant had misdiagnosed Patient KW post-surgery.

311. Mr Cass accepts in broad terms that points (i) to (iii) are not inaccurate insofar as they set out what he said to KW.

312. Mr Cass clinic letter in respect of his consultation with patient KW on 16 February 2022 is also dated 16 February 2022 (page 1744). In light of this, and indeed, Mr Cass's own evidence, I find that Mr Cass was critical of the claimant in the consultation in that he noted that she had been offered surgery on the basis that she had a pars fracture but on reviewing the MRI scan neither he nor a senior radiologist could see any evidence of a pars fracture. Raising the possibility of retrolisthesis was also an implied criticism of the claimant.

313. I also find, however, that the claimant has not proved on the balance of probabilities that the information provided to patient KW was "incorrect and/or slanted" for the following reasons:

313.1. I find that it was the honest professional opinion of Mr Cass, supported by a radiologist, that there was no pars fracture and there is insufficient evidence to show that that opinion was objectively incorrect;

313.2. I find that it was the honest professional opinion of Mr Cass that KW was in retrolisthesis and that there is insufficient evidence to show that this opinion was objectively incorrect. In particular, I find that the fact that Mr Trevedi subsequently disagreed with this is insufficient to show that the opinion was objectively incorrect. In making this finding I have taken into account that Mr Cass had included this opinion in the WhatsApp virtual MDT (see [299] above), visible to both the claimant and Mr Morassi, in what was his very first observation on the case of KW, which points to it being his professional opinion rather than a slanted or wrong opinion designed to cause trouble for the claimant, which is the underlying allegation;

313.3. I find in accordance with Mr Cass's evidence that KW told him about the immediate post-operative symptoms in her left leg when they spoke on 16 February as he said she had done. I so find because I find it unlikely that he would have included this in the clinic letter at page 1744 if KW had not told him that, and the clinic letter was written when the consultation would have been fresh in his mind. To record information provided by the patient is not to be critical of the claimant.

314. Overall, I find that the context for the consultation with KW on 16 February 2022 included concerns on the part of both Mr Cass and Mr Morassi (see [298] above) that the delay in revision surgery might have negative consequences for KW. It is clear that Mr Cass said this to KW (see numbered point 1 of the handwritten clinic notes at page 1737) and indicated that a possibility was that there would be "no recovery". The note goes on to record that "KW was very shocked and tearful at the thought of no recovery as she leads an active life and the reason for surgery was to allow her to play golf each day". KW's husband was then invited in and was "very angry" (page 1738). Given that it is clear that Mr Morassi shared the concerns

of Mr Cass about delay, I find that Mr Cass was giving KW his honest professional opinion when he said what he said about the possible consequences of the four-week delay. The fact that Mr Trevedi subsequently indicated that he did not agree with Mr Cass does not change this.

Detriment 9 – Failure to update claimant on/involve claimant in care of KW on 15 February 2022

315. Although the parties did not address me specifically on this point, I find that the reference to "Patient KW's admission on 15 February 2022" must in fact be a reference to 16 February 2022: Ms Awdry spoke to KW *by phone* on 15 February 2022 but it was only on 16 February that she *attended* the hospital.

316. I find, in accordance with the respondent's admissions, that Ms Dixon, Mr Hatrick and Ms Awdry did not keep the claimant updated on 16 February 2022 as to discussions being held about him or KW.

317. I find, in accordance with the respondent's admissions, that on 16 February 2022 Mr Hatrick and/or Ms Awdry did not consult with the claimant over KW's care.

318. Ms Awdry's explanation in relation to these two points (LA WS [101]) was that during the consultation on 16 February 2022 KW said she wanted her care transferred to Mr Cass. I find that that was what KW said because I accept the evidence of Ms Awdry in this regard which is reflected in the contemporaneous handwritten clinic note at page 1738. Ms Awdry said in her evidence that in these circumstances updating the claimant was not a priority. Ms Dixon provided a similar explanation (RD WS [78]). Mr Hatrick evidence (CH WS [138]-[139]) was that there was no need to deal with the claimant in relation to KW once she had said she wanted her care transferred to Mr Cass.

319. Overall, the respondent's explanation for these two points is really that, once KW had indicated a desire to have her care transferred to Mr Cass on 16 February 2022, there was no need for the claimant to be involved.

320. The allegation as considered above relates to 16 February 2022 and not any other date. However, in cross-examination Mr Hatrick accepted that it was not courteous to fail discuss KW with the claimant between 11 and 16 February 2022. He explained this by saying he was "otherwise engaged" and that the focus had been on finding a "solution to treat the patient that may or may not involve him". Ms Awdry gave similar evidence as did Ms Dixon, who accepted that with the benefit of hindsight she should have telephoned the claimant.

321. Turning to the question of whether Ms Dixon forbade the claimant from communicating with patient KW, Ms Dixon had no memory of having done this (RC WS [78]). In fact, the claimant's own statement (C WS [104]) seems to suggest that it is his case that it was Mr Hatrick who told him that he should not contact KW when he phoned him to suspend him. I find on the balance of probabilities that Mr Hatrick did tell the claimant not to communicate with KW in the call in which he suspended him. I find, however, that that call was on 16 February 2022, not 17

February 2022, in light of the email from Mr Hatrick at page 1748 which is dated 16 February.

Detriment 10 – Failing to address claimant's concerns about Mr Cass's management of patient KW and denying the claimant access to KW's complete medical notes

322. Turning first to the alleged failure to address the claimant's concerns about Mr Cass' management of patient KW in the subsequent investigation, the claimant referred to this at paragraph 110 of his witness statement and refers to his email at page 1855. However, this email does not really raise concerns about Mr Cass's management of KW ("I am sure he has done a great job") and it is not a matter addressed in the claimant's closing submissions (see their [179] to [182]). It seems likely that this is in fact a reference to paragraph 50 of the particulars of claim (page 38).

323. In so far as the criticism relates to Mr Cass having conducted Posterior Lumbar Interbody Fusion Surgery, I find that it is not well founded (and so there was nothing to address) because I accept the evidence of Mr Cass (MC WS [151]) that such surgery was not in fact performed on KW. So far as it refers to the operation that was performed not having achieved its objectives, I find this *was* addressed in Ms Clarke's RCA report approved by the IRWG on 26 May 2022 (page 2115) (see in particular page 2171).

324. Turning to the allegation that the respondent denied the claimant access to KW's complete medical notes, including those generated by Mr Cass, the scope of the allegation was reduced during the Hearing including in the claimant's closing submissions to a complaint that Mr Cass' clinic notes had not been provided ([180] to [182] of the claimant's closing submissions).

325. Initially, Ms Balboa refused a request to provide Mr Cass's clinic letters (her email of 25 February 2022 at page 1878). The claimant persisted by his email of 28 February 2022 (page 1877) saying "I must insist that you provide me with a copy of the notes of Mr Cass's examination and his clinic letters" and then chases a response to this email on 1 March 2022 and then again on 2 March 2022 (page 1877). Ms Awdry replies on the same day saying that "we are happy to share the [clinic letter] with you as we now have the permission of the patient". The clinic letter was then sent but on 3 March 2022 the claimant wrote again (page 1876) stating:

> *I was most interested in the clinical notes made by Mr Cass in the patient notes. You had sent me everything else except that. I assume Mr Cass had written in the notes following his meeting.*

326. I find the clinical notes were not provided. Indeed, Ms Awdrey had in her witness statement (its [106] to [107]) justified not providing them by reference to the Caldicott Principles but accepted under cross-examination that this made little sense once KW had consented to the clinic letters of Mr Cass being provided to the claimant. Ms Awdrey apologised for the omission.

Detriment 11 – Suspension of claimant's practising privileges on 18 February 2022

327. There is no dispute that the claimant's practising privileges were suspended but this was on 16 February, not 18 February, 2022.

328. It was Mr Hatrick who telephoned the claimant on 16 February 2022 to suspend him. Ms Dixon emailed the claimant the same day (page 1766) saying that a full MED06 review "regarding concerns around the medical care of your patient KW" had been commenced.

329. Mr Hatrick explained the decision to suspend in an email to Ms Dixon on 3 March 2022 (page 1880) as follows:

> *Suspension was the course of action as there had been other complications after spinal surgery under the care of Mr Karmani and after one event a PRC was set-up which stipulated specific requirement for him to follow. One in particular was to discuss any future instrumented cases at an MDT before surgery which was not undertaken in this case. Furthermore, another aspect of the previous case was Mr Karmani's inadequate initial management of a complication. On this occasion the patient had a new neurological deficit immediately after surgery with a scan the next day showing a probable cause but this was not acted on for several weeks. After discussion with Mr Karmani's Responsible Officer it was felt that there was an issue of patient safety and suspension was the appropriate course of action.*

330. Ms Dixon set out what she said were the reasons for the decision to suspend the claimant practising privileges temporarily in a letter to him dated 4 April 2022 (page 2006). In brief summary, they included that there were a number of concerns regarding his performance, most of which related to matters previously raised and reviewed in the 2019 PRC; the recurrence of the concerns in relation to patient KW raised a concern that no learning had taken place; it was alleged that KW's index procedure had not been submitted to a MDT; there was consequently an urgent risk to patient safety.

Detriment 12 – Mr Cass refusing to operate and providing misinformation to KW

331. Mr Cass did refuse to operate with the claimant – see my findings in relation to this at [304] to [309] above.

332. Mr Cass did not provide "misinformation" to patient KW – see my findings in which are relevant to this finding at [310] to [314] above.

333. Because I have found Mr Cass did not provide "misinformation" to patient KW, the next factual question is whether his refusal to operate alone triggered the suspension of the claimant. I find that if he had agreed to operate jointly then that would have delayed the suspension (because the revision surgery on KW took place on 17 February 2022, after the claimant had been suspended). However, in light of the concerns of Mr Hatrick (as set out in his email of 3 March 2022

considered at [329] above), I find that the suspension would have gone ahead anyway and so its factual cause was not Mr Cass refusal to operate jointly.

334. I find that the claimant's suspension did not trigger, or result in, the "transfer" of his practice to Mr Cass. However, in light of the claimant's suspension, Mr Cass did inevitably deal with some of the claimant's patients.

Detriment 13 – Failure to consider Mr Cass's conflict of interest and/or antipathy and/or motivation

335. The respondent accepts that it did not consider any conflict of interest and/or antipathy of Mr Cass to the claimant and/or that he might have been motivated by the claimant's protected disclosures and/or race.

336. I find, however, that during the PRC process there was no reason for the respondent to consider whether Mr Cass had in some way been motivated by the claimant's race or by his alleged protected disclosures when these were not matters which the claimant had raised or to which he had drawn attention.

337. Turning to the conflict of interest, the claimant contends (C WS [215]) that such a conflict existed because "he hated the fact that my practise was so successful. He has benefitted significantly from my suspension and the transfer of my patients to him. There was a clear conflict of interest…".

338. Stepping back slightly, Mr Cass and the claimant had been colleagues for many years and were at the point the claimant was suspended two of the three spinal surgeons at the Montefiore hospital (the third was Mr Morassi). I find that there was no shortage of work for the claimant and Mr Cass – something which was reflected in the claimant's evidence. In cross-examination the claimant said that there was "plenty of pie to go around, no need to encroach on one another". In these circumstances, I find that there was therefore no conflict of interest of the kind alleged by the claimant.

339. Turning to the question of antipathy by Mr Cass towards the claimant, I have made findings of fact about their relationship between [127] and [134]. In particular, I have made findings at [130] about the deterioration of their relationship. I find that as a result of this deterioration there was some degree of mutual antipathy between them by the time the claimant was suspended in February 2022. However, whilst Mr Cass's views in relation to the treatment of patient KW (which I have considered at [296] to [303] above) and his subsequent raising of the question of the treatment of patient MB (which I consider below) were factors in the claimant's initial suspension and in the nature of the concerns considered by the 2022 PRC, the respondent did not involve Mr Cass in any significant way in the 2022 PRC process: he was not interviewed, he was not on the PRC panel, and he did not provide either of the expert reports produced for it.

340. In light of these matters, whilst the respondent accepts that it did not take into account Mr Cass's antipathy to the claimant when "weighing his evidence" in the investigation, the reality is that he did not provide significant evidence and was not involved in any significant way in the PRC process.

341. In making these findings I have rejected the claimant's analysis that there were three "red flags" raised during the PRC process which should have caused the respondent to have been far more sceptical of any information or evidence provided by Mr Cass as set out at [183] to [189] of the claimant's closing submissions:

341.1. **The change to the radiological findings (in relation to KW):** The radiologist explained what happened in an email of 21 March 2022 at page 1961. There was not in fact a "change" to the findings but rather an "addendum report". The radiologist explained, in effect, that the addendum report included information not contained in his original report because he had looked for something further after speaking to Mr Cass:

> *I looked at this again because [Mr Cass] informed me that the patient had persistent symptoms down her left leg.*
>
> *Reviewing of the images showed some foramina stenosis on the left, I guess knowing that there was left sided symptoms instigated a review to see if there was a left sided explanation to fit so in that way this information would have influenced the conclusion.*

341.2. Mr Cass speaking to the radiologist about the radiological findings after being asked by the claimant to consider patient KW in the WhatsApp virtual MDT (as considered at [296] to [301] above), and the radiologist then making further findings as described is not a "red flag". Nor is Mr Cass failing to speak to the claimant about it: whilst I accept that it might have been courteous for him to do so, I accept Ms Awdrey's evidence in cross-examination that the radiologist should have done this.

341.3. **The rejection of Mr Cass's diagnosis by Mr Trevedi and Mr Dyson:** I find that the different professional views was not a "red flag". I refer to my findings in relation to detriments 6 and 8, and to those at [313.2] in relation to Mr Trevedi's diagnosis in this regard.

341.4. **Sharing the "wrong diagnosis" in clinic with KW:** I find that what the claimant said in clinic with KW was not a "red flag" in light of my findings in relation to detriment 8 at [310] to [314] above.

Detriment 14 – Failure to investigate treatment and care of RMc [the patient was previously referred to as RM but the parties changed this to avoid confusion with another patient RM]

342. Patient RMc was a patient of Mr Cass identified by the claimant in his letter of appeal to Dr Cale (page 2768) as an example of how he was, in his view, treated differently to Mr Cass. He complained that patient RMc was not referred to a MDT and that he had post-operative complications ("a post op new weakness left leg in the L5 myotome").

343. The respondent accepts that Mr Cass's treatment of patient RMc was not subjected to any "investigation, suspension or other action" until the claimant raised concerns about him in his appeal. Following that, I find that the concerns were reviewed by Mr White and investigated by Ms Dobson.

344. Turning to the treatment patient RMc received, he flew back from the Caribbean because of the pain he was in to seek treatment. Mr Cass saw him on 4 February 2022. After discussion of treatment options, patient RMc chose to have a TLIF operation. Mr Cass emailed Mr Hatrick about this on the same day (page 2902) and on 9 February 2022 Mr Hatrick emailed back saying:

> *Given his symptoms and reported scan results I agree with the proposed management plan.*

345. It was common ground during the hearing that a TLIF operation required the approval of the MDT and this is reflected in section 5.2 of its terms of reference set out at [121] above. Mr Cass's evidence was that there was no scheduled MDT meeting before the scheduled date of surgery. In those circumstances, what he should have done was contact Ms Awdry as set out in section 6.3 at [122] above and request an extraordinary meeting. Section 6.3 is poorly drafted. However, its opening words may suggest that in "clinically urgent" cases surgery may be undertaken without the case first being considered at an MDT if an extraordinary meeting cannot be convened. As such, simply emailing Mr Hatrick was a breach of the MDT terms of reference.

346. Further, there was at this very time a virtual WhatsApp MDT operating considered at [297] to [300] above in relation to patient KW. It would therefore clearly have been possible for Mr Cass to submit patient RMc to that – the operation was not due until 22 February and he emailed Mr Hatrick on 4 February. Mr Hatrick accepted in cross-examination that he might have said "squeeze in an MDT before surgery", that there had been a lapse on his part and that he should have said "make sure it's discussed at a virtual MDT".

347. The post-operative clinic letter of 7 March 2022 notes that Patient RMc regarded his improvement as "nothing short of a miracle" (page 2905). The upbeat assessment of Mr Cass (MC WS [184]) of Patient RMc's recovery post surgery was challenged in cross-examination by reference to the clinic letter dated nearly a year later on 27 February 2023 (page 3800). However, Mr Cass' evidence, which I accept, was that that was a secondary pathology, and there is of course a gap of a year. On the balance of probabilities I conclude that there were not post operative complications of the kind alleged by the claimant.

Detriment 15 – Instigation of addition of patient MB

348. The claimant accepted in cross-examination that it was in principle reasonable to add patient MB to the 2022 PRC investigation. The focus of my findings of fact is therefore whether the concern expressed by Mr Cass which led to her being added reflected his honest professional opinion.

349. MB had been a patient of the claimant prior to his suspension on 16 February 2022. However, she was seen by Mr Cass in clinic on 17 March 2022 not because the claimant had been suspended but because she had requested a second opinion. The claimant had recommended injections at C1/2, C3/4, C4/5 and C5/6 and she sought a second opinion because the pain continued after the injections she had received.

350. Mr Cass reported in his letter of 17 March 2022 to Mr Hatrick (page 2077) what he said appeared to be "a wrong level procedure". He said that "it became apparent from the fluoroscopy imaging from theatre that C1/2 hadn't been blocked. There were 4 adjacent facet injections made which are most likely C6/7, C5/6, C3/4". He went on to say:

> *Therefore, it appears C1/2 was certainly not injected, bearing in mind that the MRI imaging seems to suggest that might well be the most likely source of this lady's issue, that probably accounts for her lack of any improvement.*
>
> *Furthermore, I do note that the consent did not mention stroke as a significant risk which for a fluoroscopic injection of C1/2 according to the literature is definitely a high risk procedure, much more so than injecting the lower cervical facets.*

351. He also sent an email on the same date to Mr Hatrick copied to various others saying "I have to report what appears to have been a never event here at MH".

352. I find that there is no significance in the fact that the letter and email were sent on the day of the appointment with MB. I find that simply reflected Mr Cass's normal practice in relation to the production of clinic letters and other correspondence.

353. Mr Cass was not challenged in cross-examination in relation to whether his letter of 17 March 2022 represented his honest professional opinion and I find that what he said in the letter did reflect his honest professional opinion. Rather the focus was on alleged discrepancies between the speed with which he raised the case of MB with Mr Hatrick and an alleged lack of action in relation to other wrong-site injections.

354. This is a convenient point at which to make findings in relation to the issue of wrong site injections. The documentary evidence referred to by the claimant in relation to the question of wrong site injections by others was primarily the Practice Review Document relating to Mr Cass (page 3340). This is a sprawling document containing a vast amount of biennial data. The process resulting in the document is performed once every two years for every consultant of the respondent. The focus of Ms D'Souza's cross-examination and submissions in relation to this document was to a considerable extent two wrong site injections. The first was at page 3352 (incident DW-183779). Against "Action Taken" is recorded "Tracey Coates confirmed not a never event therefore not CQC notifiable". Ms Coates is the respondent's group clinical director for surgery and surgical safety. The second was at page 3459 which, under complaint ID-17870, records a patient complaining about delay in being notified of a wrong-site injection. Ms Clarke accepted in cross-examination that this section of the Practice Review Document did not show the wrong-site injection being treated as a never event. In neither case had the wrong-site injection been carried out by Mr Cass, but the patients concerned were his patients.

355. The claimant contended that whereas his wrong-site injection of patient MB by the claimant was treated as a never event, classified as a Serious Incident Requiring Investigation ("SIRI") and resulted in a RCA, the respondent seemed to have treated the wrong site injections classified as incident DW-183779 and resulting in complaint ID-17870 as being less serious incidents. Further, he contended that the reaction of Mr Cass to on the one hand the MB wrong-site injection and on the other hand incident DW-183779 and complaint ID-17870 was significantly different.

356. Turning to the first point, as cross-examination on the contents of the Practice Review Document proceeded, it became clear that it was a complex document the contents of which did not lend themselves to simple explanation. For example, the data concerning either incident DW-183779 or complaint ID-17870 might be incomplete when Mr Cass's Practice Review Document is reviewed because the data concerning them might well be contained in the Practice Review Document of the radiologist who had actually carried out the wrong-site injections.

357. I accept Ms Clarke's evidence that on checking she established that both incident DW-183779 and complaint ID-17870 were subject to a RCA and that, because both injections had been carried out by the same radiologist that had triggered a process involving him, although she did not know the details because she had not been involved. Overall, in the absence of further detail in relation to the actions taken in relation to the radiologist, I find that there is no clear difference between the view the respondent took of the claimant's alleged wrong-site injection of patient MB, and the wrong-site injections by an radiologist giving rise to incident DW-183779 and complaint ID-17870.

358. Turning to the "reaction" of Mr Cass, I find that a comparison is of no real evidential value for the following reasons. So far as patient MB was concerned, he was the first clinician who realised what had happened and in light of my findings at [348] above it is entirely unsurprising that he reported what he believed had happened as he did. By contrast, I find that Mr Cass was not the first clinician to pick up the wrong-site injections giving raise to incident DW-183779 and complaint ID-17870 and that consequently it was not he who had the obligation to raise the issue as he had done in relation to patient MB.

Detriment 16 - The respondent adding patient MB notwithstanding 'low harm' on Datix

359. The respondent accepts that patient MB was added to the existing investigation and that the incident was classified as 'low harm' on the Datix reporting system.

360. As noted at [348] above, the claimant accepted in cross-examination that it was in principle reasonable to add MB to the investigation.

Detriment 17 – The lead investigator not interviewing the claimant

361. Strictly speaking, alleged detriments 17 to 28 were all alleged failures in the 2022 PRC process which were said to be either breaches of the MED06 policy or of natural justice. However, in their submissions the parties did not specifically address the question of whether each alleged detriment was or was not a breach of the MED06 policy or of natural justice. This doubtless reflected the fact that the alleged detriments could be detriments for the purpose of the claims brought

whether or not they breach of the MED06 policy or of natural justice. I have taken the same approach in my findings of fact and conclusions.

362. The respondent accepts that Ms Clarke did not interview the claimant. Ms Clarke accepted in cross-examination that she was the Lead Investigator in the investigation carried out under the MED06 policy. As set out at [90] above, that policy required the Lead Investigator to interview the claimant.

363. Ms Clarke accepted that she had not done this. Her failure in this respect was a breach of section 9.7.3 of the MED06 policy.

364. In cross-examination, Ms Clarke could not remember why she had not interviewed the claimant but thought the probable explanation was that she had "two very long reports from the claimant, each over 20 pages long" and that she must have judged that she "had sufficient information and so there would be no additional benefit to interviewing him".

Detriment 18 – Only giving claimant limited access to patient notes during the investigation stage

365. The claimant's particulars of claim (page 29) give no further information in relation to what was not provided and the claimant's witness statement (C WS [130]) treats the allegation as being identical to the second part of alleged detriment 10. The claimant's closing submissions ([179] to [182]) throw no further light on the investigation.

366. In light of this I find that the only patient notes covered by the allegation which were not provided were those of Mr Cass relating to patient KW as identified at [326] above.

Detriment 19 – Denying the claimant access to evidence relating to the intervention of Mr Cass with the claimant's patients

367. The claimant does not identify the evidence that was not provided with any further specificity in his particulars of claim (page 29), his witness statement (its [130]) or in his closing submissions (their [179] to [182]). Ms Clarke notes (AC WS [197]) that any duty of candour letter would have been sent out by Montefiore hospital and not Mr Cass.

368. In light of this, and the claimant saying that he had received everything except Mr Cass's clinic notes for patient KW (see [325] above), I find that the claimant has failed to prove such failure other than in respect of those clinic notes.

Detriment 20 – Not giving claimant sight of case against him re MB until 31 August 2022

369. The claimant explains this allegation at [136] of his witness statement saying: "The MB case was presented to me by Lisa Wickwar 30 August 2022 [p2357]". The email at page 2357 attaches an amended version of the terms of reference for the 2022 PRC investigation and says:

In order for me to complete my review of the concerns raised, please could you provide me with your response to the allegations under part two of the TORS.

370. Part two of the amended terms of reference (page 2360) is the part dealing with the allegations which relate to patient MB.

371. The respondent contends that in fact the respondent's case in relation to patient MB was largely as set out in Ms Dixon's letter to the claimant's solicitors of 5 July 2022 (page 2216). This letter does confirm that concerns relating to patient MB will be added to the existing terms of reference. Further, a careful reading of that letter does largely enable the reader to identify as likely matters for inclusion in the terms of reference those points subsequently set out at their [1.1] to [1.5]. Nevertheless, the fact remains that the precise case against the claimant was not notified to him until the amended terms of reference were sent to him on 30 August 2022.

Detriment 21 – The release of the RCA analysis in relation to patient MB to the claimant on 18 August 2022

372. The RCA commissioned into the treatment of patient MB was carried out by Ms Clarke and completed on 22 July 2022 (page 2251). Ms Awdry wrote to patient MB on the same day apologising for the length of time it had taken to conclude the report and inviting patient MB to attend a meeting to discuss it. That meeting took place between patient MB and Ms Awdry on 10 August 2022 (page 3465). Patient MB had not been given a copy of the RCA before the meeting and so was given a copy at the meeting. The note of the meeting records patient MB as being "very upset" and feeling "let down" by the claimant after she had read the RCA. I find that, when Ms Awdry gave the RCA report to patient MB in the meeting, she did not know whether the claimant had been sent MB's medical records or whether he had seen the RCA report. I find that she did not regard it as her role to deal with such matters, given that it was Ms Clarke who had prepared the RCA report.

373. Patient MB complained on 19 August 2022. Her claim included that she had not been injected at Level C1/2 (page 2315). The claimant was sent a copy of the RCA on the same day.

374. Ms Clarke had provided a draft of the RCA report to the claimant for comment on 7 April 2022 (page 2015). There was no procedural requirement for her to send him MB's medical records or the final RCA report itself before it was sent to MB.

375. Overall, I find that the RCA report was released to patient MB before the claimant had been sent a final version of it and before the claimant was sent MB's medical records. However, the cause of the complaint was not the fact that the claimant had not been sent MB's medical records. The cause of the complaint was the content of the RCA report, in relation to which the claimant had had an opportunity to comment when the report was still in draft form.

Detriment 22 – Rachel Dixon failing to consult with Mr Hatrick re PRC process

Detriment 23 – Rachel Dixon inconsistently concluding that Mr Hatrick should not be consulted

376. The claimant addressed these two alleged detriments together in his closing submissions ([203] to [208]) and I do similarly, given that the relevant findings of fact overlap considerably.

377. The respondent admits that Ms Dixon did not consult with Mr Hatrick at any stage of the PRC process but does not accept that section 4.4 of the MED06 policy required her to do so. The respondent also denies any inconsistency of decision making.

378. I have set out section 4.4 of the MED06 policy at [85] above. It did not require Ms Dixon, as Managing Director (the Montefiore hospital equivalent of Hospital director) to consult with Mr Hatrick during the PRC process. Nor did it impose any specific obligation on Ms Dixon to obtain advice from him at "key stages" of the PRC process. It does, however, identify his role as being generally to provide advice to the Hospital director in relation to MED06 matters.

379. I have set out the section of the MED06 policy dealing with PRC panel composition at [92] above. It required Mr Hatrick to be a member of the PRC unless there was a conflict of interest (the other exceptions being irrelevant). No exhaustive definition of conflict of interest is given.

380. The claimant's key concern in relation to these matters was explained during the Hearing as being that Mr Hatrick was "stepped down" from the PRC because he "no longer fitted with the management intentions for the composition of the panel". What the claimant meant by that was that there was a concern that Mr Hatrick would be too sympathetic to him and that was why he was "stepped down".

381. Ms Dixon's explanation of Mr Hatrick being "stepped down" was at [185] of her witness statement, and is, essentially, that Mr Hatrick "found it difficult" because the claimant was a member of BOSIC with him and a colleague and he had a relationship with both the claimant and Mr Cass. Her oral evidence in cross-examination was somewhat confused. In the end her evidence was that there was a conflict of interest within section 11.3 of the MED06 policy because Mr Hatrick and the claimant were colleagues with BOSIC and the Spring group.

382. Mr Hatrick explained in his oral evidence that he had been informed that he would not be a member of the PRC by Mr Price, the respondent's medical director for South Region. He understood that the reason for this was that both he and the claimant were shareholders in Montefiore hospital. What Mr Hatrick explained was in effect this: it might be felt that there was a conflict between his position as a fellow shareholder of the claimant (which might to someone external be felt to dispose him towards the claimant's position) on the one hand, and his obligation as a member of the PRC (to reach a decision on the evidence and nothing else) on the other hand.

383. Mr Hatrick distinguished between the position in 2019 and the position in 2022 by noting that there had been a number of "clinical events" after the 2019 PRC (when he had been on the panel) leading up to the 2022 PRC. That is to say, that his position on the PRC panel was liable to be scrutinised more closely in 2022 because it was the claimant's second PRC.

384. Turning to the question of Mr Cass's alleged involvement in the PRC, I refer to my finding at [340] above: Mr Cass did not provide significant evidence and was not significantly involved in the PRC process.

Detriment 24 - Alison Clarke and/or Rachel Dixon accepting unquestioningly Mr. Cass' evidence in relation to Patient KW and MB

385. The claimant grouped this alleged detriment with alleged detriment 13 and accordingly I refer to my findings of fact above between [335] and [341].

386. I find that Ms Clarke and Ms Dixon did not accept Mr Cass's evidence in relation to patient KW and patient MB "unquestioningly", and this was reflected in the instruction of two separate external experts in the course of the PRC process (Mr Trevedi and Dr Weeks) and the attendance at the PRC of another expert, Mr Dyson.

Detriment 25 – Not interviewing the radiographer until many months into the investigation

387. This alleged detriment relates to the fact that the radiographer who had been present when the claimant had injected patient MB was not interviewed until 20 September 2022.

388. Ms Clarke emailed the radiographer in relation to the treatment of patient MB on 11 April 2022 (page 2017). Her email included the following explanation:

> *The patient (MB) was admitted under Mr Karmani for cervical facet joint blocks at 4-levels (C1/2, C3/4, C4/5 and C5/6). A review of fluoroscopy images captured during the procedure relate to levels C3/4, C4/5, C5/6 and C6/7 (not C1/2). On the operation note, Mr Karmani has recorded that injections were undertaken at 5 levels (C1/2, C3/4, C4/5, C5/6 and C6/7).*
>
> *Mr Karmani is confident that he did inject level C1/2 and has suggested that you didn't capture the image of this. I have discussed this with Mark, who has agreed that it's possible (which of course it is because it's a human task), but unlikely because the task is so routine and you are so diligent. What are your thoughts about this?*

389. The radiographer replied on 20 April 2022 (page 2072) saying "I can't remember really but happy to chat with you regarding it anyway". I therefore find that the radiographer's reply suggested that her evidence was unlikely to be of much assistance to Ms Clarke.

390. In fact, Ms Clarke did not speak to the radiographer until 13 September 2022 (page 2601) and did not send the note of their conversation to her for approval until 20 September 2022 (page 2600). The note included the following:

> *CD thought it highly unlikely that she had assisted SK with an injection at C1/2 and not saved any images at all. In fact, she thought it much more likely that*

images would have been saved because "this is an unusual anatomical location for injection" so she would have been more consciously aware of what she was doing. She also felt that "even SK", who she described as working "ultra-fast", would have been more inclined to remember to instruct her to save images. She also stated that "he always works so fast and doesn't always remember to give instruction.

391. However, it also notes:

When [the radiographer] learned that only four images were transferred to the PACS system in respect of patient MB, she appeared to be shocked and couldn't explain this in light of what she had previously told me.

392. And:

When I asked CD if it was possible that SK had injected a level different to that planned and consented, she explained that neither the radiographer or the theatre team are involved in identifying or confirming levels at which the practitioner is working. However, she thought that if a four-level injection was planned and consented, it unlikely that a five-level injection would go unnoticed. Also, because of it "being unusual", it unlikely that a C1/2 injection would be planned and consented and not performed by the practitioner or vice versa (i.e. performed by the practitioner when not planned or consented).

393. I find that realistically the discussion between Ms Clarke and the radiographer was of neutral evidential value: on the one hand, it suggested that the radiographer would have captured an injection at C1/2 if that had taken place, but on the other hand there appeared to be a surprising lack of images, which suggested that not all of them had been saved. However, her comment about 4/5 level injections suggested that, if C6/7 had been injected, then if a four-level injection had been planned and consented, it was unlikely that a C1/2 injection would also have been done. In the end, the most obvious conclusion to draw from the discussion was that images had been taken which had not been saved.

394. However, the point remains that if Ms Clarke had interviewed the radiographer earlier, she might have remembered what had actually happened rather than reconstructing her recollection from what she normally did and her general experience of working with the claimant.

395. Ms Clarke's explanation for why she had not interviewed the radiographer sooner than she did was that she felt able to draw a conclusion without her evidence "bearing in mind the timeline pressure". She did not remember what had triggered her speaking to the radiographer in September, having not got in touch with her for the previous five months.

Detriment 26 – Alison Clarke and Rachel Dixon breaching time limits in MED06 policy

396. The respondent accepts that the time limits set out in the MED06 policy were breached and that updates as to its progress were not always provided.

397. I find that the factual context for the delay included: (1) the investigation being complex; (2) the addition of further allegations in relation to MB; (3) delays by external experts (in this respect I note the email exchange at page 1536 between Ms Clarke and Mr Nannapaneni).

Detriment 27 - Rachel Dixon not submitting the Claimant's defence document to the PRC panel

398. In response to the request by Ms Wickwar contained in her email of 30 August 2022 considered at [369] above, the claimant sent Ms Wickwar the 55-page document beginning at page 2385. This document related to patient MB only ("the MB document").

399. On 15 September 2022, Ms Dixon emailed the claimant the investigation report which was to be used at the PRC hearing (page 3493). The claimant responded to that email on 21 September (page 2604), by adding comments to the investigation report in blue font. The copy of the report which was marked up in this way begins at page 2443. This mark-up set out the claimant's position in relation to KW and MB ("the KW and MB document").

400. Ms Dixon in error provided the MB document to the panel rather than the KW and MB document. The claimant accepts this was done in error and that the reason for it was that Ms Dixon was herself provided with the wrong document by an employee of the respondent's IT department.

Detriment 29 – Not providing the claimant with support measures as directed by 2019 PRC

401. The recommendation of the 2019 PRC relied upon by the claimant as clarified in his closing submissions appeared in the PRC report of September 2019 (page 1113) and was as follows:

> *It was noted by the committee that Mr Karmani had had very little support during this long process. The committee recommends that someone is appointed from either within the medical body or externally in any case where a professional review committee is required to support the doctor under investigation and help ensure that the investigation process is fair and equitable.*

402. This became point 28 of Ms Clarke's final action plan following the 2019 PRC:

> *In instances where a serious adverse event investigation involves a doctor, someone should be appointed from either within the medical society or externally to support the doctor under investigation and to help ensure that the investigation process is fair and equitable.*

403. The evidence of Mr Hatrick (CH WS [141]) was that he asked "my senior colleague Robin Turner if he would keep in contact with Mr Karmani. I know he had interactions with Mr Karmani because intermittently he would ask me to put pressure on the Spire investigation team to speed up the investigation process".

Mr Hatrick was not challenged in relation to this evidence in cross-examination. Ms Clarke's evidence in cross-examination was that she did not know what had happened to her recommendation after it had been passed up to group level, but remembered speaking to Mr Hatrick saying that the respondent should make sure the claimant was supported.

404. The claimant said (C WS [141]) that he had received "no support from the hospital". He was not cross-examined on this point but on instructions it was put to Ms Dixon that "the claimant reached out to Turner rather than the other way round and didn't know Turner assigned to him".

405. The state of the evidence is unsatisfactory. However, putting it together the best I can, I find on the balance of probabilities that Mr Hatrick asked Mr Turner to keep in touch with the claimant but did not tell the claimant he had done so, with the result that it is now the claimant's recollection that when the claimant and Mr Turner did have contact, as they clearly did, it was he and not Mr Turner who had initiated the contact.

406. The claimant says that the true significance of this point is that when Mr Cass subsequently underwent the MED06 process various steps were taken to support him, such as Disc replacement Cale contacting Mr White to move the process along and the provision of occupation health support. However, so far as the first point is concerned, I find that Mr Hatrick tried to move the process along on behalf of the claimant (for example his email of 10 August 2022 to Dr Cale at page 3906) and that, unlike Mr Cass, the claimant did not seek assistance from Occupational Health.

Detriment 30 – Applying an unfair and disproportionate sanction to the claimant

407. My findings of fact in relation to detriment 30 are at [193] to [229] above.

Detriment 31 – On appeal, upholding the original decision to withdraw the claimant's practising privileges

408. The respondent accepts that the claimant's appeal was unsuccessful. I have made findings of fact in relation to the appeal at [261] to [265] above.

Detriment 32 – Dr Cale stating not appropriate to disclose actions taken in respect of others

409. I have made findings of fact above about what Dr Cale said in her appeal decision of 15 December 2022 at [232] above. Specifically of relevance to this alleged detriment, she also wrote:

> *It is not appropriate for the HD to disclose to another individual any actions that have been taken by the HD in respect of others as they are confidential to each practitioner.*

410. I find that Dr Cale and the appeal panel took the view that, whilst there should be consideration of whether there were shortcomings in Mr Cass's treatment of patients as alleged by the claimant, this was not a matter which was directly

relevant to the claimant's appeal. I find that this was because she took the view that the basic question for the appeal panel was whether the withdrawal of practising privileges was appropriate in light of the conclusions of the PRC Panel and not whether it was "fair" by reference to the treatment of others. I find that the panel did not therefore carry out a "comparative" exercise in relation to the treatment of the claimant and that of Mr Cass. I so find because in her oral evidence Dr Cale accepted that she was still in the process of "considering" (but had not yet "considered") the information about JD and RMc sent to her 14 December 2022 (page 2914) – that is to say just the day before the appeal decision was sent to the claimant. Consequently, when she wrote to the claimant rejecting his appeal, she had reached no view on whether the claimant's criticisms of Mr Cass' treatment of the two patients were well founded.

Detriment 33 – Failure to provide detail in letter of 13 March 2023

411. The respondent accepts that Dr Cale wrote what the claimant alleges in detriment 33. Specifically (page 2937) she wrote on 13 March 2023:

> *I am now in a position to share that the review of the concerns you raised has been concluded. In line with our governance processes, these concerns have been investigated and discussed with the Consultant, and it has been concluded that the outcome for both patients was positive and the standard of care provided was acceptable. However, I am sure you will appreciate that I cannot provide more details of the outcome of the review, owing to our data protection and confidentiality obligations.*

412. I accept the evidence of Dr Cale that she did not think it appropriate to provide more information to the claimant in light of data protection and confidentiality obligations. However, I also find that there was only limited consideration of the issues raised by the claimant in his appeal in relation to patients JD and RMc before this letter was sent. This is because, as I have found at [293] to [295] above, in the context of detriment 5, Ms Dixon took no further action after receiving the email from Dr Cale on 15 December 2022 (page 2899). I further find, in light of Dr Cale's vague recollections in her oral evidence in relation to this issue, that Mr Price did not, following the email of 15 December 2022 (page 2899), carry out any significant investigation, although I accept her evidence that at some point she had a discussion with him about the concerns raised by the claimant which informed the conclusion set out in her letter of 13 March 2023.

413. The claimant drew attention in relation to this issue to the email sent by Ms Dixon to Mr Cass on 30 December 2022 at page 2887, in which she said:

> *Thank you for your email received today. As discussed when we met in person, these are allegations made by Mr Karmani during his appeal with Cathy Cale. Cathy passed the concerns on to me for your comments as I believe she needs to close these allegations down but seen [sic] to take action where any concerns are raised so Mr Karmani cannot claim any unfair process.*

414. This email was sent in response to Mr Cass's preliminary response at page 2888 to a request for comments in relation to patients RMc and JD, sent to him on

15 December 2022 (page 2895). In that email he deals with the allegations made by the claimant but also expresses very considerable surprise ("How on earth…") at the fact that the claimant was apparently accessing the medical records of his patients, commenting that this was unethical and probably also a breach of confidentiality and the GDPR.

415. The claimant's submission is that the motivation of Dr Cale was at this point to "close down" the claimant's concerns whilst being seen to take action. I find the wording of the email suggests to some extent both that that is what *Ms Dixon* thought but also that she was seeking to placate Mr Cass in relation to what were reasonable concerns about his patients' medical records being accessed by the claimant without proper authorisation. I further find that there was considerable scepticism on Dr Cale's part about the likely merit of the specific issues raised by the claimant in relation to Mr Cass because the claimant had raised them in the course of his own appeal.

Detriment 34 – Failing to engage meaningfully in response to the Equality Act questions

416. The focus of the claimant's allegation in this respect is what the respondent said (or did not say) in response to the questions asked in relation to Mr Cass's treatment of patient JD (questions 11 to 15) and patient RMc (questions 16 to 21) (page 2969 onwards). In both cases the claimant set out a series of factual propositions and asked the respondent to comment on them and answer various questions in relation to them.

417. The respondent commented (page 2969) in relation to question 11:

> *We do not see how this question relates to the Equality Act 2010 or any alleged discrimination, and the information requested goes over and above what is expected to be requested in [sic] regarding questions about alleged discrimination at work.*
>
> *You appear to be requesting that we specifically look into and investigate a scenario here and confirm to you our findings. This is not something you are entitled to request and, as such, we will not be providing a substantive answer to this question.*
>
> *The answering of this question would also require us to disclose to you the sensitive personal data of a patient and of other consultants engaged by Spire with PPs. As such, we are also unable to provide a substantive response as this would breach our confidentiality obligations and obligations under Data Protection Legislation.*

418. The respondent referred back to this answer in response to various of the subsequent questions but also commented in answer to question 12:

> *However, we would like to confirm that the matters you raised were looked into, as confirmed by Dr Cale in her letter to you dated 13 March 2023, and it was found that the standard of care was acceptable. This is different to your own*

situation as, in relation to the allegations against you, it was found that the standard of care you provided to patients was not acceptable in several aspects. This is clearly set out to you in the Outcome Letter and the Appeal Outcome referenced above.

419. A little more information is provided in relation to patient RMc. The answers in relation to questions 16 and 17 suggests that the surgery conducted on RMc was urgent and that there was some kind of exception to the requirements to put his case before an MDT. This was not correct, as I have found at [345] to [346] above in the context of my findings in relation to detriment 14.

420. I find that when it answered the Equality Act questions the respondent had in mind obligations of confidentiality and under the GDPR which it had or reasonably believed it had to both Mr Cass and the patients concerned. However, I find that its approach to the questions asked was affected also by the limited nature of the investigation that it had up to that point carried out in response to the issues raised by the claimant in relation to patients JD and RMc. I refer to my findings at [412] above in that regard. Further the implied suggestion that no MDT was required for patient RMc was incorrect.

Detriment 35 – Only indicating that concerns about Mr Cass would be subject to the preliminary review process on 2 May 2023

421. I have made findings at [230] to [237] above about the background to the MED06 process concerning Mr Cass. In light of those findings, the claimant's letter of 13 April 2023 (page 2955) was the third occasion on which he had raised the question of patients RMc and JD with the respondent (the previous two being in his appeal and in the Equality Act questions).

Conclusions

Qualifying Disclosures

422. The claimant says that in the alleged qualifying disclosures he disclosed information which in his reasonable belief tended to show that:-

422.1. the health or safety of an individual had been, was being, or was likely to be, endangered, within the meaning of s.43B(1)(d) ERA; and/or

422.2. that Mr. Cass was failing to comply, or was likely to fail to comply, with a legal obligation to which he was subject, more particularly the legal obligation conferred by one or both of:-

422.2.1. the Spinal MDT Terms of Reference which provided that "*the overall aim of the Spinal MDT is to … ensure compliance with all relevant national guidance and quality standards*"; and/or

422.2.2. the contractual obligation imposed by the Consultant Handbook, which provided at page 10 paragraph 21 that 'Consultants must ensure

that patients are discussed in multidisciplinary team meetings where mandated by Spire Policy'.

423. Before considering the alleged qualifying disclosure individually, I reach the following conclusions on the alleged legal obligation.

424. The Spinal MDT Terms of Reference are dated March 2018 and are at page 317. Having due regard to the way that it was drafted, I conclude that it did not impose any legal obligation on Mr Cass. It was simply a document setting out the framework for meetings of a multidisciplinary team for the purpose referred to in [422.2.2].

425. Turning to the question of whether it imposed a legal obligation when read together with paragraph 21 of the Consultants' Handbook as set out above, the version of the Consultants' Handbook relied on is October 2021 and so the documents read together could not have given rise to a legal obligation before that date.

426. I conclude that from October 2021 the section quoted from the Consultants' Handbook whether read alone or in conjunction with the Spinal MDT Terms of Reference does not give rise to a legal obligation. This is because the Consultant's Handbook is not drafted in such as way as to suggest that it imposes legal obligations on consultants. Rather it sets out "information and guidance" (page 251) relevant to the exercise of practising privileges which are described at its paragraphs in section 1.1 and 1.2 as a "discretionary personal licence".

Disclosure 1 – Email to Matthew Bloomer

In an email dated 18 July 2017 to Matthew Bloomer (Spire Montefiore's Finance and Commercial Manager) relating to two spinal procedures which had not been the subject of an Individual Funding Request and which were being challenged by the Clinical Commissioning Group, the Claimant correcting Mr. Bloomer that it was not him who conducted the procedures in question and pointing out that he did not do those types of procedures '*in accordance with the guidance*' (meaning NG59).

It is admitted that the C sent this email [291]. It is denied that he believed that the information he disclosed tended to show that an individual's health and safety was being or likely to be endangered; or that any such belief was reasonable. It is also denied that the C believed that the information he disclosed was in the public interest or that any such belief was reasonable.

Did the claimant disclose information as set out in disclosure 1?

427. The respondent admits that the claimant sent the email.

Did the claimant believe any disclosure of information tended to show that (a) the health or safety of an individual had been, was being, or was likely to be, endangered within the meaning of section 43B(1)(d) of the 1996 Act and/or (b)

that Mr Cass was failing to comply, or was likely to fail to comply, with a legal obligation to which he was subject as set out in issue 10(b)(i) and (ii)?

428. The claimant's email is a response to an email from Mr Bloomer (page 292) informing him that Sussex MSK require an Individual Funding Request for "disc replacement surgery in the lumbar spine and also for lumbar spine provocation testing and spinal fusion". Mr Bloomer was at the time the finance and commercial manager of the respondent and was writing in that capacity – his email is about funding. The claimant's response is essentially that he does not do the surgery in question – or at least not "on the NHS". His reference to "the guidance" is simply his explanation of why he does not do that surgery. He says nothing further about "the guidance".

429. Overall, the email exchange is about funding. The reference to the Sussex MSK letter of 15 June 2016 (page 284) does not change that. It is highly artificial to argue that by implication the claimant was saying that whoever did the two procedures in question had done so in breach of the NICE guidance when the subject matter of the email exchange is finance.

430. The way in which the claimant expresses himself does not suggest that at the time he believed what the allegation requires him to have believed about the disclosed information. There is not enough factual content and specificity for the claimant to have believed that the information disclosed tended to show that the health or safety of an individual had been, was being or was likely to be endangered, particularly in light of my findings at [110] to [116] above in relation to his beliefs concerning the NICE guidance and surgery for low back pain. I therefore conclude that the claimant did not hold the required belief.

431. The question of "legal obligation" does not arise in light of my conclusions above and, also, because the earliest date a legal obligation relied on was said to have come into force was October 2021.

Was that belief reasonable?

432. This issue does not arise in light of my conclusion above.

Did the claimant believe the disclosure of information was made in the public interest?

433. This issue again does not arise. However, if it had, I would have concluded that the claimant did not so believe. If he had had such a belief, it is highly likely that he would have said something to Mr Bloomer to the effect that whoever was carrying out the surgery in question was doing something that was unsafe and would have added that something should be done about that. He did not do either of these things. In reaching this conclusion I have taken into account that a belief in the public interest of the disclosure does not have to be the predominant motive in making it (Chesterton).

Was that belief reasonable?

434. This issue again does not arise.

Overall conclusion in relation to disclosure 1

435. In light of my conclusion above, disclosure 1 was not a qualifying disclosure and therefore was not a protected disclosure.

Disclosure 2 – Email dated 4 September 2017

In an email to [sic] dated 4th September 2017 to Patient PT, copied to David Eglinton (Hospital Director), relating to surgery which Mr. Cass had conducted, the Claimant stating that - "*the* [NICE] *guidance is very clear that disc replacement surgery is not recommended and spinal fusion surgery should only be performed if you are part of an experimental trial, which you are not on. I refer you to sections 1.3.9 and 1.3.10 of NICE Guidance NG59*";

It is admitted that the C sent this letter (dated 6/9/17 [304]) to PT and that he forwarded it to Mr Eglington as a "draft response" [303] on 3/9/17. It is denied that he believed that the information he disclosed tended to show that an individual's health and safety was being or likely to be endangered; or that any such belief was reasonable. It is also denied that the C believed that the information he disclosed was in the public interest or that any such belief was reasonable.

Did the claimant disclose information as set out in disclosure 2?

436. The respondent accepts that the claimant claimant's email of 3 September 2017 to Mr Eglington (page 303) forwarded the claimant's draft response to a complaint made by patient PT (page 304).

Did the claimant believe any disclosure of information tended to show that (a) the health or safety of an individual had been, was being, or was likely to be, endangered within the meaning of section 43B(1)(d) of the 1996 Act and/or (b) that Mr Cass was failing to comply, or was likely to fail to comply, with a legal obligation to which he was subject as set out in issue 10(b)(i) and (ii)?

437. The claimant forwarded a draft of the letter of 4 September 2017 to patient PT (page 297) so Mr Eglington could comment on it before it was sent ("please let me know your thoughts"). The letter is a response to patient PT's complaint of 4 August 2017 (page 297). Patient PT says in the letter, which is addressed to the claimant "I am writing to make a complaint about the treatment I have received from you". He sets out six specific concerns all focused on the treatment given (or not given) by the claimant.

438. The claimant's response of 4 September 2017 sets out the chronology of the treatment and refers to the NICE guidance as being supportive of the initial treatment provided by the claimant (page 304). It similarly refers to it in the context of the insertion of an interspinous device (page 305). On its final page the letter refers to the interspinous device having been removed by Mr Cass before going on to explain the cause of the claimant's ongoing back pain and saying that "This

cannot be corrected surgically". It then refers to the NICE guidance again as referred to above in "Disclosure 2".

439. The surgery conducted by Mr Cass was either spinal fusion surgery or disc replacement surgery which was conducted when the interspinous device was removed. However, the letter does not say this. No link is set out in the letter between the surgery conducted by Mr Cass and the subsequent reference to the NICE guidance set out in disclosure 2. The content of the letter does not therefore have sufficient factual content and specificity to be capable of tending to show that the NICE guidance had been breached and so, in the belief of the claimant, the health or safety of an individual endangered. This is all the more so in light of my findings at [110] to [116] above in relation to his beliefs concerning the NICE guidance and surgery.

440. In light of this I conclude that the claimant did not believe that was what the disclosure of information in the letter tended to show. I conclude that at this time he was focused entirely on rebutting the complaint brought by patient PT and that his reference to spinal fusion surgery and disc replacement surgery was a response to the complaint, which did not complain at all about the surgery conducted by Mr Cass but did at least imply (see its point 1, 4 and 6) that the claimant should have provided patient PT with further treatment beyond physiotherapy at an earlier stage.

441. The question of "legal obligation" does not arise in light of my conclusions above and, also, because the earliest date a legal obligation relied on was said to have come into force was October 2021.

Was that belief reasonable?

442. This issue does not arise in light of my conclusion above.

Did the claimant believe the disclosure of information was made in the public interest?

443. This issue again does not arise. However, if it had, I would have concluded that the claimant did not hold such a belief. If he had had such a belief, he would have set out the information which he contends tends to show that the NICE guidance had been breached clearly, either in the letter itself, or in the email to Mr Eglington.

Was that belief reasonable?

444. This issue again does not arise.

Overall conclusion in relation to disclosure 2

445. In light of my conclusions above, disclosure 2 was not a qualifying disclosure and therefore was not a protected disclosure

Disclosure 3 – Spinal MDT meeting on 26 November 2019

At a Spinal MDT meeting on 26 November 2019, when discussing Patient JD, the Claimant stating that the NICE guidance stated there should be no surgery for unspecified back pain contrary to what Mr. Cass was saying.

It is admitted that the C made the alleged comment. It is denied that he believed that the information he disclosed tended to show that an individual's health and safety was being or likely to be endangered; or that any such belief was reasonable. It is also denied that the C believed that the information he disclosed was in the public interest or that any such belief was reasonable.

Did the claimant disclose information as set out in disclosure 3?

446. The respondent accepts that the claimant did.

Did the claimant believe any disclosure of information tended to show that (a) the health or safety of an individual had been, was being, or was likely to be, endangered within the meaning of section 43B(1)(d) of the 1996 Act and/or (b) that Mr Cass was failing to comply, or was likely to fail to comply, with a legal obligation to which he was subject as set out in issue 10(b)(i) and (ii)?

447. JD was one of the claimant's patients that the claimant had put forward for discussion at the MDT on 26 November 2019. In the context of a discussion about appropriate treatment for patient JD, it is accepted by the respondent that the claimant said that the "NICE guidance stated that there should be no surgery for unspecified back pain contrary to what Mr Cass was saying". As such, this was one in a significant number of discussions in which the claimant and Mr Cass adopted differing position in relation to whether surgery was appropriate.

448. However, the discussion during which the claimant made the comment was about patient JD. Mr Cass and another surgeon, Mr Morassi, thought patient JD might benefit from surgery. The claimant did not agree with this and, I find, his reference to NICE guidance was made to support his position.

449. There was no 'risk' that patient JD would in 2019 be subject to surgery contrary to the views of the claimant because he was a patient of the claimant. In light of this, and my findings at [110] to [116] above in relation to the claimant's beliefs concerning the NICE guidance, spinal fusion surgery and disc replacement surgery, there is not enough factual content and specificity in disclosure 3 for the claimant to have believed that the information disclosed tended to show that the health or safety of an individual had been, was being, or was likely to be, endangered within the meaning of section 43B(1)(d) of the 1996 Act. Similarly, there is not enough factual content and specificity in disclosure 3 for the claimant to have believed that the information disclosed tended to show or that Mr Cass was failing to comply, or was likely to fail to comply, with a legal obligation to which he was subject as set out in issue 10(b)(i) and (ii). Further, the argument in respect of legal obligation fails in light of the conclusions set out at [422] to [426] above.

Was that belief reasonable?

450. This issue does not arise in light of my conclusion above. However, if it had arisen, I would have concluded that such a belief was not reasonable because the conversation was about patient JD and there was no 'risk' that patient JD would in 2019 be subject to surgery contrary to the views of the claimant. This is because he was a patient of the claimant, not of Mr Cass.

Did the claimant believe the disclosure of information was made in the public interest?

451. This issue again does not arise.

Was that belief reasonable?

452. This issue again does not arise.

Overall conclusion in relation to disclosure 3

453. In light of my conclusion above, disclosure 3 was not a qualifying disclosure and therefore was not a protected disclosure

Disclosure 4 – Email of 14 May 2021

In an email dated 14 May 2021 from the Claimant to Cameron Hatrick (Medical Director), the Claimant stated that "*Cass is doing regular instrumented cases for back pain against NICE guidance. He is doing revision cases. None of these get discussed at any MDT I am invited to.*";

It is admitted that the C sent the email [1427] in which these comments are made. It is denied that he believed that the information he disclosed tended to show that an individual's health and safety was being or likely to be endangered; or that any such belief was reasonable. It is also denied that the C believed that the information he disclosed was in the public interest or that any such belief was reasonable.

Did the claimant disclose information as set out in disclosure 4?

454. The respondent accepts that the email was sent.

Did the claimant believe any disclosure of information tended to show that (a) the health or safety of an individual had been, was being, or was likely to be, endangered within the meaning of section 43B(1)(d) of the 1996 Act and/or (b) that Mr Cass was failing to comply, or was likely to fail to comply, with a legal obligation to which he was subject as set out in issue 10(b)(i) and (ii)?

455. I find that the claimant did believe that Mr Cass was doing regular lumber fusion surgery and spinal fusion surgery for low back pain contrary to NICE guidance as he set out in disclosure 4. That is to say, I find that the claimant believed that Mr Cass was performing such surgery on a significant number of patients.

456. In light of my findings at [110] to [116] above in relation to the claimant's beliefs in relation to the NICE guidance, spinal fusion surgery and disc replacement surgery, and Mr Cass' practice, I find that disclosing that Mr Cass was doing surgery on a significant number of patients would, in the belief of the claimant, have tended to show that the health of safety of (at least) one individual was being or was likely to be endangered. I have taken into account in reaching this conclusion that "tends to show" is a lower hurdle than "does show".

457. The most significant difference between this and the previous disclosures considered is that this disclosure focuses specifically on a potentially wide group of patients.

Was that belief reasonable?

458. In light of my findings in relation to the contents of the NICE guidance at [97] to [109], most importantly my findings at [108], it was. In reaching this conclusion I have taken into account the specialist knowledge of the claimant both in relation to the relevant surgery and his knowledge in relation to Mr Cass. I have concluded that even though he was aware of Mr Cass' expertise, and even though he could not identify a particular patient who had suffered injury as a result of Mr Cass conducting the relevant surgery, it was still reasonable for him to have that belief in light of his own professional assessment of the NICE guidance and the CDG document.

Did the claimant believe the disclosure of information was made in the public interest?

459. I conclude that he did. This is because a disclosure which tended to show that the health or safety (of at least) one individual was being or was likely to be endangered was clearly in the public interest, bearing in mind the essential distinction between disclosures which serve the private or personal interest of the person making the disclosure and those that serve a wider interest. In reaching this conclusion I have taken into account the fact that the disclosure is contained in an email complaining about what the claimant perceived as restrictions on his practice. However, the public interest does not have to be the predominant motive in making the disclosure (Chesterton).

Was that belief reasonable?

460. The belief was reasonable, given that the disclosure related to a number of patients and was potentially relevant to many more.

Overall conclusion in relation to disclosure 4

461. In light of my conclusion above, disclosure 4 was a qualifying disclosure and so a protected disclosure, given the respondent's acceptance that any qualifying disclosure was made to the claimant's "employer" in accordance with section 43C of the 1996 Act.

Disclosure 5 - Meeting on 15 June 2021

At the inaugural Spinal MDT meeting on 15 June 2021, in response to Mr. Cass' comment that the NICE guidance did not mean very much and was merely guidance, the Claimant stated that the NICE guidance was important, that Mr. Cass was not following NICE guidance with his procedures, and in doing that, he was acting against the weight of professional opinion (including the British Orthopaedic Association, the British Association of Spine Surgeons, the British Pain Society, the United Kingdom Spinal Societies Board, the Society of British Neurological surgeons).

It is denied that the C made this comment. It is not recalled by any of RD, MC, or CH

Did the claimant disclose information as set out in disclosure 5?

462. The witnesses divided on party lines in relation to this issue. The claimant recalled the comments having been made, Ms Dixon, Mr Cass and Mr Hatrick did not recall the comments having been made. However, Ms Dixon accepted that what the claimant said he had said was in keeping within what he had said in other disclosures and Mr Hatrick, on being pressed, accepted similarly that any comment by the claimant about NICE guidance not being followed would have been consistent with the position the claimant had set out in his email of 14 May 2021 (i.e. disclosure 4).

463. The agenda for the meeting is at page 1451 and the first item on it is "Nice back pain guidance (updated December 2020" and a hyperlink to the NICE guidance is provided. So far as the minutes of the meeting are concerned, item 9 (page 1454) records:

> *NICE back pain guidance – Lumbar disc replacement only done when subject to joint registry and audit. Must be open and transparent.*

464. Over the page there are reference to coflex and injections.

465. On the balance of probabilities, in light of the contents of the agenda and the minutes of the meeting, I find that the claimant stated NICE guidance was important, that Mr Cass was not following it with his procedures and that he was acting against the weight of professional opinion. I so find in particular in light of my findings of fact about the claimant's beliefs in relation to the NICE guidance.

466. I find that he did not, however, list the various professional associations, because that is not how he couched his references in writing to the NICE guidance in the other alleged disclosures and I find it improbable that he would have expressed himself in that manner in a meeting such as that conducted on 15 June 2021. I also find that Mr Cass did not say that "NICE guidance did not mean very much" because that is not in accordance with the careful and more nuanced view he gave of it during his oral evidence.

Did the claimant believe any disclosure of information tended to show that (a) the health or safety of an individual had been, was being, or was likely to be,

endangered within the meaning of section 43B(1)(d) of the 1996 Act and/or (b) that Mr Cass was failing to comply, or was likely to fail to comply, with a legal obligation to which he was subject as set out in issue 10(b)(i) and (ii)?

467. I have found above that the claimant did believe that Mr Cass was doing regular lumber fusion surgery and spinal fusion surgery for low back pain contrary to NICE guidance as he set out in disclosure 4. In light of my findings at [110] to [116] above in relation to the claimant's beliefs in relation to the NICE guidance, spinal fusion surgery and disc replacement surgery, and Mr Cass' practice, I find that disclosing that Mr Cass was doing surgery as he did in the MDT meeting would, in the belief of the claimant, have tended to show that the health of safety of (at least) one individual was being or was likely to be endangered. I have taken into account in reaching this conclusion that "tends to show" is a lower hurdle than "does show".

468. The most significant difference between this and disclosures 1 to 3 considered is that this disclosure focuses specifically on a potentially wide group of patients.

Was that belief reasonable?

469. In light of my findings in relation to the contents of the NICE guidance at [97] to [109], most importantly my findings at [108] it was. I refer also in this respect to my conclusions at [458] above.

Did the claimant believe the disclosure of information was made in the public interest?

470. I conclude that he did. This is because a disclosure which tended to show that the health or safety (of at least) one individual was being or was likely to be endangered was clearly in the public interest, bearing in mind the essential distinction between disclosures which serve the private or personal interest of the person making the disclosure and those that serve a wider interest.

Was that belief reasonable?

471. The belief was reasonable, given that the disclosure related to a number of patients and was potentially relevant to many more.

Overall conclusion in relation to disclosure 5

472. In light of my conclusion above, disclosure 5 was a qualifying disclosure and so a protected disclosure, given the respondent's acceptance that any qualifying disclosure was made to the claimant's "employer" in accordance with section 43C of the 1996 Act.

Disclosure 6 – Email of 24 December 2021 and forwarded clinic letters
On 24 December 2021, following an email from Rachel Dixon (the Respondent's Hospital Director) headed 'Complaint':-

1. ~~**in a phone call between Rachel Dixon and the Claimant, and in answer to her question whether Patient JD had ever been discussed at a Spinal**~~

~~**MDT, the Claimant confirmed that JD had been discussed at MDT in November 2019 and that the agreed course of action was physiotherapy in line with NICE guidance;**~~

2. **After the call, the Claimant sent Ms Dixon a copy of his patient letter to JD which confirmed that JD's case had been discussed at the Spinal MDT in November 2019 and physiotherapy agreed.**

It is admitted that the C (or his secretary) [3636] send the patient letters at [3335/6 and 3338/9].

Did the claimant disclose information as set out in disclosure 6?

473. The respondent accepts that it did.

Did the claimant believe any disclosure of information tended to show that (a) the health or safety of an individual had been, was being, or was likely to be, endangered within the meaning of section 43B(1)(d) of the 1996 Act and/or (b) that Mr Cass was failing to comply, or was likely to fail to comply, with a legal obligation to which he was subject as set out in issue 10(b)(i) and (ii)?

474. The claimant emailed the Ms Dixon on 24 December 2021 (page 1602) after Ms Dixon had on 23 December 2021 (page 1601) emailed him saying:

> *I am dealing with a complaint regarding this man and need a couple of points clarifying please.*
>
> *[JD] was an NHS patient under you for back pain issues. He asked about spinal fusion surgery and was told it was not approved unless via MDT.*
> *He claims you informed him it went to MDT and was declined by a majority vote.*
>
> *Can you confirm if this was the case and if so, do you have any notes of this meeting.*

475. The claimant's reply stated:

> *I will get Bec my Secretary to forward you all my. Clinic letters [sic]*
> *Spinal fusion is not recommended for back pain as per the NICE guidance updated 2020….*

476. As such, the overall impression of the email exchange is that the claimant is justifying spinal fusion surgery not having been undertaken on the basis that it was not recommended by the NICE guidance.

477. The clinic letters to JD's GP which were forwarded began at pages 3335 (dated 22 November 2019) and 3338 (dated 22 May 2020). The first notes where relevant:

> *I have advised him that the NICE guidelines do not recommend surgery for backpain. I have agreed that I will discuss his case at the spinal MDT and he*

will get the combined opinion of all the spinal surgeons working at the Montefiore Hospital.

478. The second notes where relevant:

I went through the results of the MRI scan of his lumbar spine and his SPECT CT scan. This confirms disc degeneration at L3/4 and L4/5 and modic 1 endplate changes at L4/5. The SPECT CT scan showed increased uptake at the L3/4 disc space. I have explained this to him. We discussed his case at the spinal MDT and it was decided that due to the NICE guidance, surgery for back pain is not advised.

479. I conclude that the claimant did not when writing to Ms Dixon as he did or forwarding the letters believe any disclosure of information in them tended to show that (a) the health or safety of an individual had been, was being, or was likely to be, endangered within the meaning of section 43B(1)(d) of the 1996 Act and/or (b) that Mr Cass was failing to comply, or was likely to fail to comply, with a legal obligation to which he was subject as set out in issue 10(b)(i) and (ii).

480. I have reached this conclusion because it would have been utterly illogical of the claimant to have believed this. The email and letters when read together simply disclose that the claimant believes that spinal fusion surgery is not recommended by NICE guidance for back pain, that he told the GP (and JD) this by his letter of November 2019 and reiterated the position in the letter of 22 May 2020, this time saying also that the possibility of spinal fusion surgery had been considered at an MDT.

481. Read together, the claimant's email and letters suggest that he believed that nobody's health or safety was being endangered because the NICE guidance was being complied with. They also do not suggest in any way that the claimant believed Mr Cass was failing to comply with a legal obligation to which he was subject. Further, the argument in respect of legal obligation fails in light of the conclusions set out at [422] to [426] above.

Was that belief reasonable?

482. This issue does not arise in light of my conclusion above.

Did the claimant believe the disclosure of information was made in the public interest?

483. This issue again does not arise.

Was that belief reasonable?

484. This issue again does not arise.

Overall conclusion in relation to disclosure 6

485. In light of my conclusion above, disclosure 6 was not a qualifying disclosure and therefore was not a protected disclosure.

Overall conclusion in relation to the qualifying disclosures

486. Disclosures 4 and 5 were qualifying disclosures and therefore, in light of the respondent's position in relation to section 43C of the 1996 Act, protected disclosures. Disclosures 1 to 3 and 6 were not qualifying disclosures and were not therefore protected disclosures.

Alleged detriments

Detriment 1 - Mr. Cass encouraging Patient PT to submit a letter of complaint about the Claimant [on or before 4 August 2017]

Mr. Cass encouraging Patient PT to submit a letter of complaint about the Claimant.

This is denied. Michael Cass says he did not write the complaint letter or have any input into it. He says the first he knew of this letter was when he was sent a copy of it by David Eglington (MC/40-41; p.57 WSB).

487. In light of my findings of fact above, and in particular those at [266] to [268], I conclude that the factual allegation is not made out. The claimant was not therefore subjected to a detriment as alleged.

Detriment 2 – The anonymous complaint to NHS fraud [24 January 2018]

In January 2018, Mr. Cass submitting or being the driving force behind an anonymous complaint to NHS Fraud about the Claimant, alleging that he was routinely miscoding a surgical procedure and thereby defrauding the NHS and private insurers, and that he had not performed a procedure for which he had claimed payment ("the Coding Complaint").

This is denied. Michael Cass says he did not submit this complaint, nor did he cause it to be made (MC/43-44; p.58 WSB). This evidence is supported by that of Alison Clarke (AC/66; p.92-93 WSB] and Cameron Hatrick (CH/38; p.164 WSB).

488. In light of my findings of fact above, and in particular those at [269] to [273], I conclude that the factual allegation is not made out. The claimant was not therefore subjected to a detriment as alleged.

Detriment 2A – Failing to (1) assess compliance with NICE guidance or (2) conduct an audit of practice against NG59 [February to June 2018 or later]

In February 2018, the Respondent failing to (1) assess the Spinal Unit's compliance with the NICE guidance or (2) conduct an audit of practices against NG59 using consultant clinic letters, as recommended by Alison Clarke her email dated 8 February 2018 to the Senior Leadership Team, and agreed upon at an SLT meeting on 13 February 2018, instead focusing its limited investigation on the Claimant's injection practices and infection rates.

This is denied. There is documentary evidence that Lynette Awdry did conduct the audit, see extracts from Notes of Spine MDT held on 12 June 2018 at pp.3774-3775 HB. See note 10: "LA has audited 20 NHS and 25 PP across SK/MC/ST/EC and most met criteria. Now to audit 2017 through to March 2018."

489. In light of my findings of fact above, and in particular those at [274] to [277], I conclude that the factual allegation is made out.

Did that amount to a detriment?

490. A reasonable worker would not have regarded the failures found as a disadvantage or as being to their detriment in the circumstances. This is because a reasonable worker would in the circumstances not find their work and the work of others not being subject to a compliance assessment or an audit of the kind in question a disadvantage or detriment. This did not therefore amount to a detriment.

Detriment 2B – Narrow investigation into injection practices [19 April to June 2018 or later]

Following receipt of an anonymous whistleblower complaint dated 19 April 2018 asserting that *"injections into the spine (facet joint injections, epidural steroid joint injections) and much spine surgery for the relief of low back pain is ineffective and may be damaging' and referring to "a system that profits from troubled and suffering patients by providing ineffectual and inappropriate treatment at great cost to the patient or NHS"*, the Respondent conducted a narrow investigation into injection practices only, and failed to conduct any assessment or audit of surgical practices.

It is denied that the Respondent failed to conduct any assessment or audit of surgical practices. As set out in relation to Detriment 2A above, the Notes of the Spine MDT on 12 June 2018 show Lynette Awdry did audit some procedures. It is admitted that the focus of the subsequent investigation was however, largely upon injection practices only, for the reasons set out at LA/23; pp.6-7 WSB.

491. In light of my findings of fact above, and in particular those at [278] to [280], I conclude that the factual allegation is made out.

Did that amount to a detriment?

492. A reasonable worker would not have regarded the failures found as a disadvantage or as being to their detriment in the circumstances. This is because a reasonable worker would not in the circumstances find their work and the work of others not being subject to an assessment or an audit of the kind in question a disadvantage or detriment. This did not therefore amount to a detriment.

Detriment 3 – The whistleblower complaint re Patient IM [22 October 2018]

On 22 October 2018, Mr. Cass submitting ~~or being the driving force behind~~ an anonymous 'whistleblower' complaint against the Claimant alleging that the Claimant had inappropriately conducted a kyphoplasty procedure on Patient IM.

It is admitted that Michael Cass raised concerns about the patient's procedure with Lynette Awdry. His account of this is given at MC/85-89; pp.62-63 WSB.

493. In light of my findings of fact above, and in particular those at [281] to [284], I conclude that the factual allegation is made out, except that the complaint was not anonymous and its date was 13 September 2018, not 22 October 2018.

Did that amount to a detriment?

494. A reasonable worker would or might view a colleague raising concerns about them in this way as a disadvantage or as being to their detriment in the circumstances. The actions of the respondent as found did therefore amount to a detriment.

Detriment 4 – Failure to take action in relation to disclosures 1 to 5 [26 November 19, 14 May 21 & 15 June 21]

The Respondent's failure to take any action in relation to Mr. Cass in response to the concerns raised by the Claimant in Disclosures 1 to 5, and/or as raised by the anonymous whistleblower in April 2018, when there was strict observance of NICE guidance in all other disciplines.

This detriment is predicated on a finding that the Claimant was raising concerns about Michael Cass in Disclosures 1, 2, 3 and 5, which is disputed. As to Disclosure 4, it is denied that the Respondent failed to take any action against Michael Cass, as the concerns the Claimant raised about Michael Cass's alleged lack of MDT approval were investigated by Ben White as part of the MED06 investigation (MC/115; p.66 WSB). The Respondent denies that it was necessary to take any action against Michael Cass. See Alison Clarke's evidence at AC/79-80; p.95 WSB and Cameron Hatrick's evidence at CH/93; p.175 WSB. It is not accepted that there was "strict observance of NICE guidance in all other disciplines". Rather, the Hospital had systems, process and controls for overseeing adherence to best practice which included consideration of NICE guidance to enhance patient safety and optimal care.

495. In light of my findings of fact above, and in particular those at [285] to [290], I conclude that the factual allegation is partially made out in so far as it relates to disclosures 4 and 5 and the whistleblowing complaint of April 2018.

Did that amount to a detriment?

496. So far as the whistleblowing complaint is concerned, I conclude that the failure to take action was not a detriment for essentially the same reasons as those set out at [492] above. So far as the lack of action in relation to disclosures 4 and 5 are concerned, I find that, in light of the way in which the claimant made the points he made, a reasonable worker would not have regarded the lack of action against Mr Cass as being to their detriment in the circumstances. This is because the claimant did not ask for any action to be taken and, as found at [286] above, the differences between the claimant and Mr Cass are best classified as a difference in professional opinions. This did not therefore amount to a detriment.

Detriment 5 – Failure to take action re Mr Cass's failure to get MDT approval for

JD [December 2022]

Rachel Dixon failing to take any action in relation to Mr Cass' failure to obtain Spinal MDT approval for L3/4 lumbar disc replacement on Patient JD conducted in June 2021.

This is denied. Rachel Dixon reviewed this concern when it was passed to her by Dr Catherine Cale, Group Medical Director and she referred documents and findings on to Catherine Cale for her to consider what further action was needed. She was not then involved in the subsequent preliminary review of MED06 process undertaken by Ben White and so the decision as to what if any action to take in relation to the lack of MDT approval for Patient JD was not her decision. See RD/199; p.155 WSB.

497. This issue first arose so far as Ms Dixon was concerned in 2022 when the claimant complained about it in the context of his appeal against the suspension of his practising privileges. It had not been an issue when JD had complained in 2021. In 2022 Ms Dixon did take some action by gathering materials as requested by Dr Cale. It cannot be said that she failed to take action simply because Mr Price subsequently failed to discuss the matter with her. The question of lack of MDT approval was then considered by Mr White in the context of the MED06 process against Mr Cass.

498. Overall, in light of findings of fact above, and in particular those at [291] to [295], I conclude that the factual allegation is not made out. The claimant was not therefore subjected to a detriment as alleged.

Detriment 6 - Mr Cass encouraging Ms Awdry to complain about the claimant on 15 February 2022

Mr. Cass encouraging Matron (Lynette Awdry) to make a complaint about the Claimant on 15 February 2022 that the Claimant had culpably delayed in his actions in relation to Patient KW.

This is denied. Michael Cass did not encourage Lynette Awdry to make this complaint. He says he explained his concerns about the patient to Lynette Awdry after the Claimant had asked for an MDT opinion and he realised that the patient had a likely neurological compromise for over four weeks (MC/138; p.69 WSB). This is supported by Lynette Awdry, who says she discussed her concerns with Michael Cass and Mr Morassi but Michael Cass did not "encourage" her to write the email setting out her concerns (LA/88; p.19 WSB). This is supported by Alison Clarke (AC/127; p.181 WSB).

499. In light of my findings of fact above, and in particular those at [296] to [303], I conclude that the factual allegation is not made out. The claimant was not therefore subjected to a detriment as alleged.

Detriment 7 – Mr Cass' unreasonable refusal to jointly operate

On 15 February 2022, Mr. Cass' unreasonable refusal to jointly operate alongside the Claimant on account of '*poor interpersonal relations*' with the Claimant.

It is admitted that Michael Cass refused to operate jointly with the Claimant (LA/103; p.21 WSB) (MC/140; p.69 WSB) but it is denied that this refusal was unreasonable or solely on account of 'poor interpersonal relations'. Michael Cass explains the reasons why he was unwilling to operate jointly with the Claimant at MC/141; pp.69-70 WSB.

500. In light of my findings of fact above, and in particular those at [304] to [309], I conclude that the factual allegation is not made out. The claimant himself accepted that the refusal was not unreasonable in cross-examination. It is important, of course, to bear in mind that the allegation was not that Mr Cass has refused to operate jointly with the claimant but that such refusal was "unreasonable". The claimant was not therefore subjected to a detriment as alleged.

Detriment 8 – Mr Cass was critical of claimant/providing slanted or incorrect information on 15 February 2022

On 15 February 2022, during a consultation with Patient KW, Mr. Cass being critical of the Claimant and providing incorrect and/or slanted information to the patient, as particularised at paragraph 48.1-48.3 of the Claimant's Particulars of Claim.

It is denied that Michael Cass knowingly or intentionally gave incorrect and/or slanted information to Patient KW. To the extent that Michael Cass did give incorrect and/or slanted information, he did so based on his honest, professional opinion based on his review of MRI scans, CT scans, and discussions with radiologists and Mr. Morassi, as well as the information given by the patient when she met him in clinic. Michael Cass gives his account of why he said the things he did at MC/149-150; p.71 WSB.

501. In light of my findings of fact above, and in particular those at [310] to [314], I conclude that the factual allegation is partially made out: Mr Cass was critical of the claimant.

Did that amount to a detriment?

502. A reasonable worker would or might view being criticised in this way by a professional colleague as a disadvantage or as being to their detriment in the circumstances. The actions of the respondent as found did therefore amount to a detriment.

Detriment 9 – Failure to update claimant on/involve claimant in care of KW

During the period of Patient KW's admission on 15 February 2022 (a) Rachel Dixon, Cameron Hatrick and/or Lynette Awdry not keeping the Claimant updated as to discussions being held about him or his patient, (b) Cameron Hatrick and/or Lynette Awdry not consulting him over patient care, despite the fact that he retained full clinical responsibility for KW until there was a formal transfer of clinical responsibility, and (c) Rachel Dixon forbidding the Claimant from

communicating with KW despite her urgent and anxious attempts to contact him directly and causing her to think that the Claimant had abandoned her.

It is admitted that Rachel Dixon, Cameron Hatrick and/or Lynette Awdry did not keep the Claimant updated as to discussions being held about him or Patient KW. Lynette Awdry gives her reasons for this at LA/101; p.21 WSB. Rachel Dixon gives her reasons for this at RD/78; p.129 WSB. Cameron Hatrick gives his reasons at CH/138-139; p.183 WSB.

It is admitted that Lynette Awdry and Cameron Hatrick did not consult with the Claimant over Patient KW's care. It is denied that the Claimant retained full clinical responsibility for the patient. Lynette Awdry says that the patient told her she no longer wanted to have the Claimant as her doctor and wanted her care transferred to Michael Cass and once the Claimant's practising privileges has been suspended from 16 February 2202, it would not have been appropriate to keep him updated (LA/101; p.21 WSB). Cameron Hatrick says at CH/139; p.183 WSB, the patient accepted the offer to transfer her care to Michael Cass and therefore from this point, no communications needed to go through the Claimant.

It is not admitted that Rachel Dixon forbade the Claimant from communicating with Patient KW. Rachel Dixon's evidence at RD/78; p.129 WSB is that "I cannot remember asking Mr Karmani not to contact Patient KW and would have seen no reason to do this (before his practising privileges were withdrawn) unless Lynette Awdry had advised me that the patient did not want contact from him."

503. In light of my findings of fact above, and in particular those at [315] to [321], I conclude that;

503.1. Parts (a) and (b) of the factual allegation are made out;

503.2. Part (c) is partially made out: the claimant was told not to contact patient KW but this was by Mr Hatrick and not Ms Dixon.

Did that amount to a detriment?

504. A reasonable worker would or might view being excluded from the treatment of someone who was or had been their patient in this way as a disadvantage or as being to their detriment in the circumstances. The actions of the respondent as found did therefore amount to a detriment.

Detriment 10 – Failing to address claimant's concerns about Mr Cass's management of patient KW

Failing to address the Claimant's concerns about Mr. Cass' management of Patient KW in the subsequent investigation as promised, and denying the Claimant access to KW's complete medical notes, including those generated by Mr. Cass.

It is denied that the Respondent failed to address the Claimant's concerns about Michael Cass' management of Patient KW in the subsequent investigation. Alison Clarke says the concerns were addressed in her RCA report (AC/180-183) [p.109 WS

Bundle]. Rachel Dixon says no issues were identified in Michael Cass's treatment of patient KW and she believed that the patient was happy with the treatment from him (RD/189; p.153 WS Bundle). See also Michael Cass's response to the alleged concerns about his treatment of Patient KW, which are disputed, at MC/151 – 153; pp.71-72 WSB.

It is not admitted that the Respondent denied the Claimant access to KW's complete medical notes, including those generated by Mr Cass. See AC/185; p.110 WSB and email from Lynette Awdry to the Claimant at p.1877 HB. See also RD/181; pp.150-151 WSB. In the event that any notes were not shared, if this is established, the Respondent denies that this was because of the Claimant's race and/or any alleged protected disclosures (AC/195; p.111 WSB). Rachel Dixon's evidence is that anything that took place after the Claimant's involvement with the patient had ended would not have been relevant and that is why it would not have been provided to him (RD/181; pp.150-151 WSB).

505. In light of my findings of fact above, and in particular those at [322] to [326], I conclude that the factual allegation is not made out except that the clinic notes of Mr Cass were not provided to the claimant.

Did that amount to a detriment?

506. A reasonable worker would or might have viewed the failure to provide the clinic notes of Mr Cass as a disadvantage or as being to their detriment in the circumstances because at that point the claimant would clearly wish to know exactly what treatment KW had received. The actions of the respondent as found did therefore amount to a detriment.

Detriment 11 – Suspension of claimant's practising privileges on 18 February 2022

On 18 February 2022, suspending the Claimant's Practising Privileges.

It is admitted that the Claimant's practising privileges were suspended but this was on 16 February 2022 not 18 February 2022 (RD/75-76; p.128 WSB). For Rachel Dixon's reasons for this, see RD/75 [p.128 WSB] and RD/140 [p.183 WSB].

507. The factual allegation is made out, but the date was 16 February 2022, not 18 February 2022.

Did that amount to a detriment?

508. A reasonable worker would or might have viewed the suspension of practising privileges as a disadvantage or as being to their detriment in the circumstances. This did therefore amount to a detriment.

Detriment 12 – Mr Cass refusing to operate and providing misinformation to KW

By Mr. Cass' actions in (a) not agreeing to operate with the Claimant, and (b) providing misinformation to Patient KW, thereby triggering the Claimant's

suspension and the transfer of the Claimant's practice to Mr. Cass, with significant gain to himself.

It is admitted that Michael Cass would not operate with the Claimant. See response above at Detriment 7. It is denied that this triggered the Claimant's suspension.

As to 'misinformation', see response to Detriment 8 above. It is denied that this triggered the Claimant's suspension. The reasons for suspending the Claimant's practising privileges are set out at RD/75-76; pp.128-129 WSB and RD/140; p.183 WSB. It is denied that this triggered the transfer of the Claimant's practice to Michael Cass, with significant gain to himself.

509. In light of my findings of fact above, and in particular those at [331] to [334], I conclude that the factual allegation is not made out. The claimant was not therefore subjected to a detriment as alleged.

Detriment 13 – Failure to consider Mr Cass's conflict of interest and/or antipathy and/or motivation

The Respondent's failure to consider Mr. Cass' conflict of interest and/or antipathy towards the Claimant when weighing his evidence in the investigation and/or that he might have been motivated by the Claimant's protected disclosures and/or race in his actions against the Claimant.

It is denied that Michael Cass had a conflict of interest, and/or antipathy and/or that he was motivated by the Claimant's protected disclosures and/or race (MC/213-213; p.79 WSB). AC's evidence is that she was only ever interested in determining the facts of the patient safety concern and not interested in ulterior motives (AC/187; p.110 WSB). To the extent that these factors existed it is admitted they were not specifically considered but denied that not doing so was unreasonable in circumstances where the Claimant drew no attention to his race of alleged protected disclosures being a relevant factor. Furthermore, in circumstances where Mr Cass was not interviewed, did not sit on the PRC, and independent experts were instructed, his "evidence" was of marginal relevance.

510. In light of my findings of fact above, and particularly those at [335] to [340] above, I conclude that the factual allegation is partially made out in that the respondent did not take into account Mr Cass's antipathy to the claimant (that being one side of their mutual antipathy) when "weighing his evidence" in the investigation. However, the reality is that Mr Cass did not provide significant evidence and was not significantly involved in the PRC process. It is further made out in that the respondent did not consider that Mr Cass might have been motivated by the claimant's protected disclosures and/or race in his actions against the claimant.

Did that amount to a detriment?

511. A reasonable worker would or might view a failure to take into account Mr Cass's antipathy to the claimant as a disadvantage or as being to their detriment in the circumstances, despite his very limited involvement in the PRC process. This did therefore amount to a detriment. A reasonable worker would not, or might not, however, view a failure to consider whether Mr Cass might have been motivated

by the claimant's protected disclosures and/or race in his actions as a disadvantage or as being to their detriment in all the circumstances, particularly when the claimant himself had not suggested that this was the case.

Detriment 14 – Failure to investigate treatment and care of RMc [the patient was previously referred to as RM but the parties changed this to avoid confusion with another patient RM]

Rachel Dixon, Cameron Hatrick (or his delegated cover, in the event that Mr. Hatrick had by this date commenced sabbatical leave), Alison Clarke and/or Lynette Awdry failing to subject Mr. Cass' treatment and care of Patient RM to any investigation, suspension or other action.

It is admitted that Rachel Dixon, Cameron Hatrick, Alison Clarke and/or Lynette Awdry did not subject Michael Cass's treatment and care of patient RM to any investigation, suspension, or other action. Their reasons for doing so are at: RD/198; pp.154-155 WSB; CH/149-153; pp.184-185; AC/188; p.110 WSB; LA/116; p.24 WSB. When the Claimant raised his concerns about this patient to Catherine Cale as part of his appeal, the concerns were reviewed by Ben White and investigated by Sue Dobson (CC/66-74; pp.45-46 WSB).

512. In light of my findings of fact above, and in particular those at [342] to [347], I conclude that the factual allegation is made out in that no action was taken to investigate Mr Cass's treatment of patient RMc until after the claimant raised the matter in his appeal against the suspension of his practising privileges.

Did that amount to a detriment?

513. In light of my findings above out the treatment received by RMc, the only matter which fell for investigation was the failure of Mr Cass to submit RMc to an MDT. The reason the claimant might have regarded that as a detriment was because of the way in which his failure to submit KW to an MDT was dealt with. However, in light of my findings at [545] to [546] in relation to why the circumstances of RMc and KW were not comparable, a reasonable worker would not and might not have regarded the failure to investigate or take other action at an earlier point to be a detriment or to their disadvantage.

Detriment 15 – Instigation of addition of patient MB

Mr. Cass instigating the addition of Patient MB to the Respondent's investigation by alleging that the Claimant had failed to administer an injection at level C1/C2 and had conducted a sub-optimal physical examination.

It is admitted that Michael Cass brought Patient MB to the attention of Cameron Hatrick. This was because he was concerned about the treatment that had been provided to this patient, who was now under his care, (MC/162; p.73 WSB).

514. The respondent admitted that Mr Cass brought patient MB to the attention of Mr Hatrick, I conclude that the factual allegation is made out.

Did that amount to a detriment?

515. A reasonable worker would or might view a colleague bringing an issue to the attention of their employer as Mr Cass did as a disadvantage or as being to their detriment in the circumstances. This did therefore amount to a detriment.

Detriment 16 - The respondent adding patient MB notwithstanding 'low harm' on Datix

The Respondent adding Patient MB to the existing investigation, notwithstanding that it had classified the incident as a 'low harm' incident on its Datix risk reporting system.

It is admitted that the incident was classified as 'low harm' on the Datix reporting system. Rachel Dixon's reasons for adding this patient to the existing investigation are at RD/121-123; pp.137-138 WSB

516. The respondent admitted that this happened and so I conclude that the factual allegation is made out. However, as found at [348], the view of the claimant in cross-examination was that it was reasonable of the respondent to have acted as it did.

Did that amount to a detriment?

517. A reasonable worker would not view this as a disadvantage or as being to their detriment in the circumstances, given that those circumstances included the claimant believing that it was reasonable for the respondent to have acted as it did. This did not, therefore, amount to a detriment.

In respect of Detriments 17 to 28, breaching its policy on Managing Consultant Performance Concerns and/or of natural justice, by:-

Detriment 17 – The lead investigator not interviewing the claimant

The lead investigator not investigating the Claimant (at section 6.12) and receiving input from the Claimant in writing only.

It is assumed this is a typographical error and the Claimant means 'interviewing' rather than 'investigating'. If so, it is admitted that Alison Clarke did not interview the Claimant. It is denied that this amounted to a breach of the Managing Consultant Performance Concerns Policy and/or natural justice for the reasons given at AC/191-194; pp.110 -111 WSB.

518. In light of my findings of fact above, and in particular those at [361] to [364], I conclude that the factual allegation is made out in that the respondent acted in breach of the MED06 policy by failing to interview the claimant during the Formal Investigation stage. I conclude that this not was a breach of natural justice because the claimant was made aware of the case against him in detail and had an opportunity (which he took) to put his response to that case in detail.

Did that amount to a detriment?

519. A reasonable worker would or might view not being interviewed in an investigation of such obvious importance to them as a disadvantage or as being to their detriment. This did therefore amount to a detriment.

Detriment 18 – Limited access to patient notes

Alison Clarke, Rachel Dixon and/or Lisa Wickwar giving the Claimant only limited access to patient notes during the investigation stage.

This is not admitted. See response on Detriment 10 above. See AC/195; p.111 WSB; RD/181; p.150 WSB; and LW/37; p.207 WSB. The Claimant is not stating what notes he was allegedly not provided with and at what point, such that the Respondent cannot fully address this allegation.

520. In light of my findings of fact at [365] to [366] above, I conclude that the factual allegation is not made out except that the clinic notes of Mr Cass were not provided to the claimant. I conclude that this was not a breach of natural justice because the claimant was made aware of the case against him in detail, had an opportunity (which he took) to put his response to that case in detail and the clinic notes of Mr Cass were only a very small part of the relevant evidence.

Did that amount to a detriment?

521. A reasonable worker would or might have viewed the failure to provide the clinic notes of Mr Cass as a disadvantage or as being to their detriment in the circumstances because at that point the claimant would clearly wish to know exactly what treatment KW had received. This did therefore amount to a detriment.

Detriment 19 – Denying the claimant access to evidence relating to the intervention of Mr Cass with the claimant's patients

Denying the Claimant access to evidence relating to the intervention of Mr. Cass with the Claimant's patients, including duty of candour letters sent by Mr. Cass which will have concerned the Claimant.

This is not admitted. Alison Clarke's evidence is that Rachel Dixon shared Patient KW's notes with the Claimant (AC/185; p.109 WSB), as did Lynette Awdry in her email at p.1877 HB where she explained she would provide him with Mr Cass's clinic letters and the Claimant then makes reference to the contents of the notes at p.1876 HB. See also Rachel Dixon's evidence on this at RD/181; pp.150-151 WSB. In the event that any notes were not shared, if this is established, the Respondent denies that this was because of the Claimant's race and/or any alleged protected disclosures (AC/195; p.111 WSB). Rachel Dixon's evidence is also that anything that took place after the Claimant's involvement with the patient had ended would not have been relevant and that is why it would not have been provided to him (RD/181; p.150 WSB).

522. In light of my findings of fact at [367] to [368] above, I conclude that the factual allegation is not made out is not except that the clinic notes of Mr Cass were not provided to the claimant. I conclude that this was not a breach of natural justice because the claimant was made aware of the case against him in detail, had an opportunity (which he took) to put his response to that case in detail, and the clinic notes of Mr Cass were only a very small part of the relevant evidence.

Did that amount to a detriment?

523. A reasonable worker would or might have viewed the failure to provide the clinic notes of Mr Cass as a disadvantage or as being to their detriment in the circumstances because at that point the claimant would clearly wish to know exactly what treatment KW had received. This did therefore amount to a detriment.

Detriment 20 – Not giving claimant sight of case against him re MB until 31 August 2022

In relation to Patient MB, giving the Claimant sight of the case against him in an email from Lisa Wickwar on 31 August 2022, which was 5 months after the start of the investigation.

This is denied for the reasons at AC/199; p.112 WSB and RD/149; pp.142-143 WSB. The concerns had been shared with the Claimant as part of the RCA process and the preliminary review process and those added to the terms of reference sent by Lisa Wickwar on 31 August 2022 were largely as Rachel Dixon has set out in her letter to the Claimant's solicitors, DWF, on 5 July 2021.

524. In light of my findings of fact above, and in particular those at [369] to [371], I conclude that the factual allegation is made out except that the date in question is 30 August, not 31 August, 2022. Whilst the claimant would have had a very good idea of what the case against him would be in relation to MB from the letter sent to his solicitors on 5 July 2021, I conclude he did not have sight of the actual case against him in relation to MB until the amended terms of reference were sent to him on 30 August 2022. (The respondent's reference to these having been sent to the claimant on 31 August 2022 is erroneous – see page 2357. They were sent first on 30 August and then again on 31 August.) I conclude that this was not a breach of natural justice because the claimant was made aware of the case against him in detail and had an opportunity (which he took) to put his response to that case in detail.

Did that amount to a detriment?

525. A reasonable worker would or might have viewed the failure to provide the exact terms of reference until 30 August 2022 as a disadvantage or as being to their detriment because such failure would inevitably delay their preparation of a response in circumstances where they wanted the PRC to take place as soon as possible. This did therefore amount to a detriment.

Detriment 21 – The release of the RCA analysis in relation to patient MB to claimant on 18 August 2022

On 18 August 2022, releasing the Root Cause Analysis report to Patient MB when (a) the Claimant has not been sent MB's medical records (b) the Claimant had not seen the report before it was sent to the patient, consequently prompting a complaint letter to the Claimant based on the contents of the report.

It is unclear as to whether or not the Claimant was sent MB's medical records prior to Lynette Awdry releasing the report to Patient MB at their meeting on 10 August 2022.

Lynette Awdry did not undertake the RCA investigation (LA/114-115; p.23 WSB). Alison Clarke's evidence is that once the RCA report is approved by the IRWG, the report can be released to the patient and there does not need to be prior approval from the responsible consultant, although the Claimant was sent a copy by Rachel Dixon on 19 August 2022 (AC/159-160; p.106 WSB). It is denied that the patient's complaint was prompted by the report being released to her without the Claimant's consent. The complaint was prompted because of the Claimant's care of MB.

526. In light of my findings of fact above, and in particular those at [372] to [375], I conclude that the factual allegation is made out. I conclude that this was not a breach of natural justice because the claimant was made aware of the case against him in detail and had an opportunity (which he took) to put his response to that case in detail. This was not affected by the release of the RCA analysis to patient MB.

Did that amount to a detriment?

527. A reasonable worker would or might view an RCA report of this nature being sent to a patient before they had seen it in its final form and before they had seen the patient's medical records as a disadvantage or as being to their detriment in the circumstances. This did therefore amount to a detriment.

Detriment 22 – Rachel Dixon failing to consult with Mr Hatrick re PRC process

Rachel Dixon failing to consult with the MAC Chair (Cameron Hatrick) at any of the key stages of the process at which his advice should have been sought, as required by the policy (Section 4.4).

It is admitted that Rachel Dixon did not consult with Cameron Hatrick. Her reasons for this are set out at RD/185 [p.183-186]. It is denied that section 4.4 of the policy required her to do so (RD/183; p.151 WSB).

528. In light of my findings of fact above, and in particular those at [376] to [384], I conclude that the factual allegation that Ms Dixon did not consult with Mr Hatrick is made out. However, section 4.4 of the MED06 policy did not require Ms Dixon to do this or to take advice from him at "key stages of the procedure", particularly in light of my conclusions in relation to detriment 23 below. Given that there was no breach of procedure, I conclude that there was no breach of natural justice either.

Did that amount to a detriment?

529. A reasonable worker would not view the respondent not doing things that the relevant procedure did not require it to do as a disadvantage or as being to their detriment in the circumstances. This did not therefore amount to a detriment.

Detriment 23 – Rachel Dixon inconsistently concluding that Mr Hatrick should not be consulted

Rachel Dixon inconsistently concluding that the MAC Chair (Cameron Hatrick) should not be consulted on the Claimant's case because of a 'conflict of interest' (being a shareholder) when (a) Mr. Cass had been allowed to contribute to the investigation despite the existence of the same supposed 'conflict of interest',

and (b) Mr. Hatrick had been permitted to attend the 2019 PRC hearing in his capacity as MAC Chair notwithstanding the same 'conflict of interest', suggesting that the reason as given in 2022 was not genuine or significant.

It is denied that Rachel Dixon's decision making was inconsistent, as alleged. Rachel Dixon's reasons for not involving Cameron Hatrick are at RD/185; p.152 WSB. It is admitted that Alison Clarke sought Michael Cass's version of events, it is not accepted that in doing so, there was a conflict of interest (RD/185; p.152 WSB). Rachel Dixon cannot comment on whether Cameron Hatrick sitting on the 2019 panel was appropriate or not, as she was not in post in 2019 when it took place (RD/185; p.152 WSB).

530. In light of my findings of fact above, and in particular those at [376] to [384], I conclude that there was a conflict of interest as outlined to Mr Hatrick by Mr Price.

531. I conclude that there was no inconsistency between the exclusion of Mr Hatrick as the part of the decision-making panel and the extremely limited involvement of Mr Cass as found above. The "same supposed 'conflict of interest" did not exist.

532. I conclude that there was also no inconsistency between Mr Hatrick as the MAC Chair being permitted to sit on the PRC panel in 2019 and not being consulted on the claimant's case in 2022. This is because the circumstances were not the same, in particular the 2022 PRC was the second one relating to the claimant and so its outcome might well be subjected to greater scrutiny than that of the 2019 PRC.

533. In light of these two conclusions, Ms Dixon's conclusions were not inconsistent as alleged. There was for the same reason no breach of natural justice. Consequently, therefore, I find that the factual allegation is not made out. The claimant was not therefore subjected to a detriment as alleged.

Detriment 24 - Alison Clarke and/or Rachel Dixon accepting unquestioningly Mr. Cass' evidence in relation to Patient KW and MB

Alison Clarke and/or Rachel Dixon accepting unquestioningly Mr. Cass' evidence in relation to Patient KW and MB, when it was known that there were extreme tensions between Mr. Cass and the Claimant rendering him unsuitable to provide evidence to the investigation, or at the very least that caution was required.

This is denied. See AC/201; p.112 WSB and RD/187; p.152 WSB. In particular, the concerns regarding the Claimant's practice for these two patients was addressed by two separate external experts (Mr Trivedi for Patient KW and Dr Weeks for Patient MB). Rachel Dixon also ensured that there was a further external expert on the panel during the PRC hearing (Mr Dyson) so that there would be no reasonable allegation of bias during the process.

534. In light of my findings of fact above, and in particular those at [385] to [386], I conclude that the factual allegation is not made out. The claimant was not therefore subjected to a detriment as alleged.

Detriment 25 – Not interviewing the radiographer until many months into the

investigation

Not interviewing key witnesses (for example, the radiographer in the case of Patient MB) until many months into the investigation when recollections had dimmed. [The claimant confirmed at [209] of his submissions that the only witness in respect of whom this issue arose was the radiographer].

The Claimant has given only one example of a witness who was not interviewed at paragraph 60.9 of his particulars of claim (p.44 HB). It is accepted that Alison Clarke did not interview Christina Deyl, the radiographer, until September 2022. It is denied that this made any difference to the judgment or findings she made (AC/203; p.113 WSB).

535. I have made findings of fact in relation to this issue at [387] to [395] above. The respondent accepted that Ms Clarke did not interview the radiographer until 13 September 2022. I conclude that can reasonably be characterised as not interviewing the radiographer until "many months" into the investigation and so the factual allegation is made out. It is not a sufficiently serious matter to amount to a breach of natural justice.

Did that amount to a detriment?

536. A reasonable worker would or might view the failure to interview a relevant witness for a number of months as a disadvantage or as being to their detriment in the circumstances. This did therefore amount to a detriment.

Detriment 26 – Alison Clarke and Rachel Dixon breaching time limits in MED06 policy

Alison Clarke and Rachel Dixon breaching all time limits prescribed by the policy, and failing to provide monthly updates as to the progress of the investigation.

It is admitted that the investigation breached time limits set out in the policy and that monthly updates as to progress were not always provided. Alison Clarke addresses this at AC/204; p.113 WSB and Rachel Dixon at RD/188; p.153 WSB.

537. The factual allegation is made out in light of the respondent's response to it. It is not, however, a sufficiently serious matter to amount to a breach of natural justice.

Did that amount to a detriment?

538. A reasonable worker would or might view the delay and the failure to provide monthly updates as a disadvantage or as being to their detriment given the importance of the PRC process and the effect it had on the claimant's ability to work. This did therefore amount to a detriment.

Detriment 27 - Rachel Dixon not submitting the Claimant's defence document to the PRC panel

Rachel Dixon not submitting the Claimant's defence document to the PRC panel before the PRC's meeting with the Claimant.

In respect of this detriment, Rachel Dixon did submit the Claimant's defence documents, being his letter to the PRC and his response to the terms of reference. It is admitted that she did not submit the Claimant's document entitled "Dr Karmani file – MED06 final with comments for PRC" because she did not receive this when downloaded successfully by the Respondent's IT department and she did not appreciate this document was different to the Claimant's response to the terms of reference (RD/171; p.146 WSB).

539. The factual allegation is made out in light of the respondent's response to it. Given that the claimant accepts that the wrong defence document was provided in error (see my findings of fact at [398] to [400]), the claimant submits that the real significance of the error was that it prejudiced the claimant at the PRC hearing because: (1) not all the participants were working from the same document; (2) the other participants may not have correctly understood his case); and (3) this may have had real consequences, given that on one occasion Mr Dyson seemed to changed his mind have seen a clinic letter which he apparently not seen before the hearing. (Claimant's submission at [214].) Failing to put the claimant's defence document before the PRC panel is a sufficiently serious procedural failing as to amount to a breach of natural justice.

Did that amount to a detriment?

540. A reasonable worker would or might view the correct document not being provided to the PRC as a disadvantage or as being to their detriment: it resulted in the PRC panel not having a significant document before them. This did therefore amount to a detriment.

Detriment 28 – Rachel Dixon providing all other docs to the PRC Panel only 3 days in advance of it

Rachel Dixon providing all other documents (totalling 200 pages) to the PRC Panel only 3 days in advance of the Committee hearing, which was, in the circumstances of this case, insufficient time.

541. The claimant confirmed in his closing written submissions that this allegation was no longer pursued.

Detriment 29 – Not providing the claimant with support measures as directed by 2019 PRC

Not providing the Claimant with any of the support measures directed by the 2019 PRC in their Recommendations

The Claimant has not specified what support mechanisms he means in this regard. The Respondent's evidence is that he was provided with additional training, Alison Clarke also regularly shared 'learning matters' with consultants and updates were given to consultants on informed consent, documentation standards (RD/177; p.148 WSB). Cameron Hatrick's evidence is that he asked Robin Turner to keep in touch with the Claimant during the investigation to act as a conduit for his concerns (CH/147;

p.184 WSB). If (which is not pleaded or referred to in the list of issues) the Claimant complains he was not permitted to be accompanied at the hearing, he was given the chance to be accompanied and RD checked he was happy to continue (p.3502 HB and RD/118; p.146 WSB)

542. In light of my findings of fact generally, and in particular those at [401] to [406] above, I find that the factual allegation is not made out. The claimant was not therefore subjected to a detriment as alleged.

Detriment 30 – Applying an unfair and disproportionate sanction to the claimant
Applying an unfair and/or disproportionate sanction to the Claimant, having regard to the following matters:

2019 PRC recommendations

i. The Claimant was penalised for having failed to comply with some of the 2019 PRC Recommendations, in circumstances where the Respondent had failed to deliver on most of the Recommendations which it had agreed to, including the failing to provide the infrastructure for a 'regular, well-structured and reliable Spinal MDT' in collaboration with Spire Gatwick Park, and/or the provision of an agreed pathway for cases involving neurological deficit and/or an education campaign on the duty of candour.

This is denied for the reasons set out at RD/179(i); p.148 WSB, AC/207; p.113 WSB, MC/207-210; p.79 WSB.

Ms D'Souza for the claimant clarified on Monday 17 February that the detriment contended for in detriment 30 was the withdrawal of practising privileges and that points i to vii were not advanced as discreet detriments.

543. I have made findings about the particular recommendations of the 2019 PRC that the claimant contends the respondent did not comply with and which his submissions focused on at [194] to [195] above. In summary, the Spinal MDT did not meet regularly and reliably between early 2020 and the autumn of 2021 because of the pandemic and the relationship of the claimant and Mr Cass and their respective views of the NICE guidance had a negative effect on it. Further I have found that the respondent did not implement the recommendations of the 2019 PRC in relation to the provision of an agreed pathway for cases involving neurological deficit and/or an education campaign on the duty of candour.

544. It is true that the 2019 PRC was very relevant to the outcome of the 2022 PRC (as is reflected in the findings I have made in particular at [191] and [192] above). However, what the PRC regarded as the failings of the claimant, including those summarised at [190], were not on any realistic understanding of the evidence failings which had arisen *because of* any failings by the respondent to deliver on some of the recommendations of the 2019 PRC which were directed towards it. Overall, I conclude that this is not a matter which points towards the sanction being unfair and/or disproportionate.

Mr Cass not held to the same standard re MDT

ii. Mr. Cass was not held to the same standard as far as the requirement of Spinal MDT approval was concerned in the cases of JD and/or RM, which

was in breach of the Handbook, the 2019 PRC Recommendations and/or the Spinal MDT ToR. [Patient RM was in fact referred to at the hearing as patient RMc to avoid confusion with another patient]

This is denied. It is accepted that Michael Cass did not get Spinal MDT approval for Patient JD in 2021 but the patient had been discussed at a MDT in 2019 and the MDT process at the Montefiore was not robust at the time (BW/54 & 68; p.197; 200 WSB). It is accepted that Michael Cass did not get Spinal MDT approval for Patient RM but he did consult with Cameron Hatrick to get approval for the surgery. This was in clear distinction to the Claimant, who sought no approval for KW at all (CH/150-153; p.185 WSB).

545. I have made findings about the requirement of MDT approval and Mr Cass's patients of JD and RMc at [196] to [197.2] above. In summary, Mr Cass did not get MDT approval for either of those patients and so, in one sense, was not held to the same standard as the claimant in that he was not then subjected to a PRC at which his failure to do so was considered, as the claimant was in the case of patient KW.

546. However, I conclude that the circumstances were not truly comparable: unlike patient KW, neither JD nor RMc had required revision surgery following the surgery conducted by Mr Cass; further and separately, unlike KW, neither JD nor RMc had complained following the surgery conducted by Mr Cass; further and separately, whereas the claimant had not discussed patient KW with anyone, Mr Cass had discussed both JD and RMc with others as set out in [196] to [197.2]. Overall, I conclude that this is not a matter which points towards the sanction being unfair and/or disproportionate. However, it is a matter which points to the 2022 PRC panel not being inclined to give the claimant the benefit of the doubt.

Dysfunction in relationship undermining MDT

iii. There was an evident dysfunction in the working relationship between Mr. Cass and the Claimant which plainly undermined the collaborative efficacy of the Spinal MDT and of the Respondent's spinal surgical unit, which the Respondent singularly failed to address at any time.

This is not admitted for the reasons set out at MC/212; p.79 WSB where Michael Cass explains that he acknowledges there were difficulties in his interactions with the Claimant but still sought to have a functioning MDT. Even if there was a dysfunction – and it is denied that the MDT was dysfunctional in the sense that patient outcomes were compromised, the Respondent relies upon the evidence of Cameron Hatrick at CH/148; p.184 WSB, where he sets out the efforts he made to set up a functioning, efficient MDT. The Respondent also refers to the evidence of Rachel Dixon at RD/179(iii); p.149 WSB where she explains that during her tenure, once up and running, the spinal MDT worked well and promoted good, clinical discussion.

547. In light of my findings of fact generally, and particularly those at [198] to [199], I conclude that such difficulties as there were in the working relationship between Mr Cass and the claimant did not amount to evident dysfunction which plainly undermined the collaborative efficacy of the Spinal MDT and/or of the respondent's spinal surgical unit. However, if the only spinal surgeons in attendance were Mr Cass and the claimant, then a particular MDT meeting could become difficult and borderline dysfunctional, as reflected in my findings at [134] above. Overall, I

conclude that this is not a matter which points towards the sanction being unfair and/or disproportionate.

Consideration of protected disclosures and race as matters which might have influenced Mr Cass

iv. No consideration was given to the Claimant's protected disclosures and/or race and whether they may have influenced Mr. Cass's actions.

As set out by Rachel Dixon at RD/179(iv); p.149 WSB, it is admitted that she did not give any consideration to the Claimant's protected disclosures. This was because she was either not employed by the Respondent at the time the alleged disclosure(s) were made (Disclosures 1-4) or, if they were made to her, she did not consider that any comments made by the Claimant were protected disclosure(s) and so she did not treat them, or him any differently. As such, she had no reason to consider that another consultant would be "influenced" by them. In relation to the Claimant's race, she considered this was irrelevant in the process that led up to the Claimant's practising privileges being withdrawn and she had no basis for believing that any other colleague at the Respondent involved in the process (including Mr Cass) was "influenced" by this either. Notably, the Claimant did not complain about these alleged unlawful motivations so he cannot reasonably complain that the Respondent did not consider them.

548. I refer to my findings at [200], [335] and [336] in this respect. I conclude in light of those findings, and in particular in light of the fact that there was no reason for the respondent to consider whether Mr Cass had in some way been motivated by the claimant's race or his alleged protected disclosure, that the failure of the respondent to give consideration to such matters is not a matter which points towards the sanction imposed on the claimant being unfair and/or disproportionate.

No referral to GMC

v. The Respondent did not refer the Claimant to the GMC, suggesting that the threshold of risk of serious harm had not been met.

It is admitted that the Respondent did not refer the Claimant to the GMC for the reasons at (RD/179(v); p.149 WSB). As an independent provider, the Respondent's decision to remove practising privileges can be for real and good reasons, with patient safety borne in mind, without reaching the threshold for making a referral to the GMC.

549. I refer to my findings at [201] in this regard. I conclude that in all the circumstances the fact that the respondent did not refer the claimant to the GMC is not a matter which points towards the sanction imposed on the claimant being unfair and/or disproportionate. However, it is a matter which points to the 2022 PRC panel not being inclined to give the claimant the benefit of the doubt.

Medicolegal action

vi. There has been no medicolegal action to date or intimated as a result of the matters which were the subject of the 2022 performance review process.

This is denied. Rachel Dixon is aware of five claims that the Respondent has been notified about relating to patients who were treated by the Claimant (RD/179(vi); p.149 WSB).

550. I refer to my findings of fact generally and in particular those at [202]. I conclude that the respondent is aware of a number of medicolegal claims concerning treatment carried out by the claimant but it is unclear whether any of these claims related to patients in relation to whom concerns were raised in the 2022 PRC.

551. Overall, however, I conclude, in light of the nature of the concerns identified by the 2022 PRC about the claimant's practice, that the fact that the respondent has not proved that there has been a claim by a patient in relation to whom concerns were raised in the 2022 PRC is not a matter which points towards the sanction imposed on the claimant being unfair and/or disproportionate.

Lack of investigation of MDT compliance generally

vii. There was singular lack of investigation of the Claimant's argument that this was the first time he had failed to obtain MDT approval since the PRC in 2019, particularly in view of the significant number of procedures conducted by the Claimant on an annual basis (538 procedures in 2019; 372 procedures in 2020; and 620 procedures in 2021).

This is denied. The Respondent refers to the evidence given by Rachel Dixon for the consideration given to the issues around MDT approval at RD/179(vii); p.150 WSB.

552. I refer to my findings of fact generally and in particular those at [203] to [204]. In light of those findings I conclude that this is not a matter which points towards the sanction being unfair and/or disproportionate. I would have seen this point differently if the claimant had been able to point to documentary evidence which he had shown to the respondent supporting what was in reality simply an assertion on his part. However, it is a matter which points to the 2022 PRC panel not being inclined to give the claimant the benefit of the doubt.

Other points raised by the claimant in relation to the sanction being unfair and disproportionate

553. I have made factual findings at [207] to [230] above in relation to the additional matters relating to Ms Dixon's approach during the 2022 PRC relied on by the claimant in his closing submissions as pointing to the sanction of the withdrawal of practising privileges being unfair and/or disproportionate. I now reach the following conclusions in relation to those matters:

The incorrect written submission

554. I refer to my findings of fact generally and in particular those at [207] to [208]. In light of those conclusions, I find that this is not a matter which points towards the sanction being unfair and/or disproportionate.

A willingness to ignore both experts' views

555. I refer to my findings of fact generally and in particular those at [209] to [212]. In light of those findings, I conclude that Ms Dixon did not demonstrate a "willingness to ignore both experts' views". Overall, I conclude that this is not a matter which points towards the sanction being unfair and/or disproportionate given the background to the 2022 PRC, in particular the fact and details of the 2019 PRC. However, it is a matter which points to the 2022 PRC panel not being inclined to give the claimant the benefit of the doubt when it came to matters of professional judgment on which there might reasonably be differing opinions.

Divergence between experts

556. I refer to my findings of fact generally and in particular those at [213] to [219]. Overall, I conclude that this is not a matter which points towards the sanction being unfair and/or disproportionate given the background to the 2022 PRC, in particular the fact and details of the 2019 PRC. However, it is a matter which points to the 2022 PRC panel not being inclined to give the claimant the benefit of the doubt when it came to matters of professional judgment on which there might reasonably be differing opinions.

The claimant's practice in relation to consent

557. I refer to my findings of fact generally and in particular those at [220] to [223]. In light of my finding that there was no inconsistency, I conclude that this is not a matter which points towards the sanction being unfair and/or disproportionate given the background to the 2022 PRC, in particular the fact and details of the 2019 PRC.

The change in approach

558. I refer to my findings of fact generally and in particular those at [224] to [227]. In particular, I refer to my finding that the sanction of a permanent withdrawal of practising privileges was a very rare sanction by the time it was imposed on the claimant.

559. I conclude that this is a matter which points towards the sanction being a severe one taking into account also the non-referral to the GMC, and the fact that the respondent has not proved that any of the patients which were considered in the 2022 PRC has brought a legal claim against the respondent as a result of their treatment by the claimant.

The NHS appraisal

560. I refer to my findings of fact generally and in particular those at [228] to [229]. However, I conclude that the fact that feedback documents prepared in October 2024 present a positive picture of the claimant does not point towards the sanction being unfair and/or disproportionate. The feedback documents are a high-level view of recent perceptions of performance and do not reflect long term experience of the claimant. By contrast, the context for the 2022 PRC was lengthy experience of the claimant, including the 2019 PRC. Further, it looked at specific aspects of

the claimant's treatment of specific patients in a way that those contributing to the feedback documents did not purport to do.

Overall conclusion on whether the permanent suspension of practising privileges was unfair and/or disproportionate

561. Taking these various conclusions together, I find that the sanction imposed on the claimant was severe and that the respondent was, where relevant, unwilling to give him the benefit of the doubt. However, the sanction must be seen in its proper context. In particular, the decision was taken against the background of the 2019 PRC. Taking all the circumstances into account, I do not find that the sanction was unfair and/or disproportionate.

Did that amount to a detriment?

562. A reasonable worker would or might have viewed the withdrawal of practising privileges as a detriment in the circumstances which included that the sanction was severe and that the respondent's approach indicated that it was not willing to give him the benefit of the doubt. This did therefore amount to a detriment.

Detriment 31 – On appeal, upholding the original decision to withdraw the claimant's practising privileges

On appeal, upholding the original decision to withdraw the Claimant's PP despite upholding 3 of the Claimant's appeal grounds. The decision on appeal was flawed on the same grounds as those set out at paragraphs q and s above.

[*The references to paragraphs q and s are to alleged detriments 17 to 27 and 30*]

It is admitted that this was the decision reached on appeal. It is denied that this decision was flawed. The Respondent refers to Catherine Cale's statement for the evidence considered and rationale for the outcome of the appeal and CC/62; p.44 WSB.

563. In light of my findings of fact generally, and in particular those at [261] to [265] above, I find that the factual allegation that the original decision was upheld is made out. So far as the matters referred to in detriments 17 to 27 and 30 are concerned, I refer to the conclusions I have already reached in relation to those above.

Did that amount to a detriment?

564. A reasonable worker would or might view having their appeal against the withdrawal of practising privileges rejected as a disadvantage or as being to their detriment in the circumstances, those circumstances including that the sanction was severe and that the respondent's approach indicated that it was not willing to give him the benefit of the doubt. This did therefore amount to a detriment.

Detriment 32 – Dr Cale stating not appropriate to disclose actions taken in respect of others

In response to the Claimant's concerns about differential treatment of Mr. Cass, Dr. Cale stating that it was not appropriate to disclose actions taken in respect

of others and accordingly rejected that appeal ground in its entirety on that unsatisfactory basis.

It is denied that Catherine Cale explained that it was not appropriate to disclose actions taken in respect of others and accordingly rejected this ground of appeal. As set out by Catherine Cale at CC/61; p.44 WSB the matter of treatment of Michael Cass as compared to the Claimant was something which the panel considered as part of appeal ground viii.

565. In In light of my findings of fact generally, and in particular those at [409] to [410] above, I find that the factual allegation is made out.

Did that amount to a detriment?

566. A reasonable worker would or might view the failure to provide further information in relation to that ground of appeal as a disadvantage or as being to their detriment in the circumstances. This did therefore amount to a detriment.

Detriment 33 – Failure to provide detail in letter of 13 March 2023

In a letter dated 13 March 2023, Dr Cale informing the Claimant that his concerns had been discussed with the consultant in question (Mr. Cass) and that the Respondent had concluded that "*the outcome for both patients was positive and the standard of care provided was acceptable*" without providing any further detail.

It is admitted that Catherine Cale provided a response in these terms (p.2937 HB). She did not consider it was appropriate to provide more details of the outcome of the review, owing to the Respondent's data protection and confidentiality obligations (CC/71; p.46 WSB).

567. In In light of my findings of fact generally, and in particular those at [411] to [420] above, I find that the factual allegation is made out.

Did that amount to a detriment?

568. Whatever the ultimate merit of a comparison between the treatment of RMc and JD by Mr Cass on the one hand, and the treatment of KW by the claimant on the other, and the data protection and confidentiality and data protection issues arising, a reasonable worker would or might view the failure to provide information necessary to address his concerns as a disadvantage or as being to their detriment in the circumstances. This did therefore amount to a detriment.

Detriment 34 – Failing to engage meaningfully in response to the Equality Act questions

On 21 April 2023, in its response to the Claimant's Equality Act questions, failing to engage meaningfully with the questions raised by the Claimant and providing no insight into why he had apparently been treated differently to Mr. Cass.

This is denied. The Respondent refers to the evidence of CC/89; p.49 WSB. She set out responses to each of the Claimant's questions in so far as she was able to do so

due to the Respondent's confidentiality obligations and obligations under data protection legislation and availability of data.

569. In light of my findings of fact generally, and in particular those at [416] to [420] above, I find that the factual allegation is not made out. The respondent did engage "meaningfully" with the Equality Act questions although, for various reasons, as found, the respondent did not provide all the information which the claimant would have liked to receive.

570. Further, the respondent did provide *some* insight in relation to why the claimant had apparently been treated differently to Mr Cass, as found in particular at [418] and [419] above. The claimant was not therefore subjected to a detriment as alleged.

Detriment 35 – Only indicating that concerns about Mr Cass would be subject to the preliminary review process on 2 May 2023

Only after 4 attempts by the Claimant to raise his concerns about Mr. Cass, finally indicating that the concerns raised by the Claimant about Mr. Cass would be subject to the preliminary review process.

The Claimant has not specified the dates of these attempts. It is admitted that he raised his concerns about Mr Cass in his letter of appeal dated 10 November 2022 (p.2753-2777 HB). Those were addressed by Catherine Cale in her letter of 13 March 2023 (CC/71; p.46 WSB). It is admitted that the Claimant raised his concerns again on 12 April 2013 (p.2955-2960 HB) and following this, Catherine Cale wrote to him to confirm that Michael Cass was now subject to a preliminary review process (CC/75; (p.46 WS Bundle). The Respondent refers further to CC79; p.16 WSB. It is unclear as to what further two occasions the Claimant is saying he raised these concerns and they were not addressed, so this is not admitted.

571. In light of my findings of fact generally, and in particular those at [421] above, I find that the factual allegation is made out, except that it was after three attempts rather than four that the respondent indicated to the claimant that Mr Cass would be subject to the preliminary review process.

Did that amount to a detriment?

572. Given that the claimant had had his practising privileges withdrawn as a result in part of his failure to submit patient KW to an MDT, and he considered that Mr Cass was guilty of a similar failure, a reasonable worker would or might view the failure to subject Mr Cass to the preliminary review process at an earlier time as a disadvantage or as being to their detriment, irrespective of the ultimate merit of a comparison between the treatment of RMc and JD by Mr Cass on the one hand, and the treatment of KW by the claimant on the other. This did therefore amount to a detriment.

Direct Race Discrimination

Was the Claimant subjected to Detriments 1 to 35 by the Respondent?

573. Yes, the claimant was subjected to alleged detriments 3, 8, 9, 10, 11, 13, 15, 17, 18, 19, 20, 21, 25, 26, 27, 30, 31, 32, 33 and 35 to the extent that I have set out in my conclusions above.

Did any acts or omissions as the Claimant may prove amount to detriments also amount to less favourable treatment when compared with the treatment of a hypothetical comparator (whose construction draws upon the treatment of Mr. Michael Cass)?

Did such treatment as the Claimant may prove amount to less favourable treatment by the Respondent because of the Claimant's race (being Pakistani and/or non-white)?

The appropriate hypothetical comparator

574. The respondent contends that the hypothetical comparator is a practitioner who has been through a PRC.

575. The claimant contends that the hypothetical comparator should have the attribute of being a practitioner in respect of whom there have been past incidents involving (a) serious clinical events (b) non-clinical events ([263] of claimant's closing submissions).

576. The claimant contends that what the respondent says is relevant about the PRC is (a) the seriousness of a clinical event and (b) a lack of learning. The claimant contends that those two matters can be relevant attributes without attaching the attribute of having been through a PRC. Such an attribute "risks masking discrimination especially where it is argued that serious clinical events have been treated differently in the claimant's case".

577. The respondent's response to this point by the claimant is that the treatment of CD, which gave rise to the 2019 PRC, was a highly significant event in the life of the hospital. Further, the claimant does not argue that the 2019 PRC was an act of race discrimination.

578. If the claimant had argued that subjecting him to the 2019 PRC had been an act of discrimination, I would agree with the claimant that having been through a PRC should not be an attribute of a hypothetical comparator. However, he has not argued this. Further, I conclude, in light of my findings of fact above, that Mr Cass had not been involved in the Montefiore hospital in a clinical event as serious as that resulting in the 2019 PRC.

579. I conclude that the fact that the claimant had previously been subjected to a PRC is clearly a relevant circumstance. Most of the alleged detriments arise directly or indirectly from the 2022 PRC, and of course the most significant detriment of all, the permanent withdrawal of practising privileges, was a direct consequence of the 2022 PRC. I conclude that in these circumstances the fact of an earlier PRC is clearly a relevant circumstance. This is because: (1) as a matter of logic, an employer would inevitably consider the nature of the previous PRC and how a consultant had responded to its conclusions and recommendations if a second PRC arose within just a few years; (2) further and separately, whether or

not the various detriments I have found were tainted by race discrimination, it is clear that the 2019 PRC was regarded as a relevant matter during the 2022 PRC.

580. I therefore conclude that the appropriate hypothetical comparator is a white consultant orthopaedic spinal surgeon who had been through a PRC.

Has the burden of proof shifted to the respondent?

581. I turn now to the question of whether the claimant has proved facts from which I could conclude in the absence of any other explanation that the respondent had committed an act or acts of discrimination against the claimant.

582. Before considering this issue in detail, it is appropriate to step back and consider the nature of the comparative exercise in this case. The claimant contends that by being subjected to the various detriments he was treated less favourably than a hypothetical white comparator would have been treated. He says that the way that Mr Cass (a white consultant orthopaedic spinal surgeon who had not been through a PRC) was treated provides evidence of such discrimination. The nature of such a comparison was described by HHJ Tayler as being as follows at [62] of Virgin Active v Hughes [2023] EAT 130:

> *The second situation in which a comparison with the treatment of another person may provide evidence of discrimination is where the circumstances are similar, but not sufficiently alike for the person to be an actual comparator. The treatment of such a person may provide evidence that supports the drawing of an inference of discrimination, sometimes by helping to consider how a hypothetical person whose circumstances did not materially differ to those of the claimant would have been treated (generally referred to as a hypothetical comparator). Evidence of the treatment of a person whose circumstances materially differ to those of the claimant is inherently less persuasive than that of a person whose circumstances do not materially differ to those of the claimant. That distinction is not always sufficiently considered when applying the burden of proof provisions in section 136 EQA: …*

583. I now turn in light of my findings of fact above the various matters raised by the claimant at [264] of his closing submissions as being relevant to whether the burden of proof has shifted.

Different treatment so far as clinical events were concerned

584. The claimant's closing submissions cross-refer to their paragraph [7] and I have made findings of fact in relation to relevant matters at [144] to [157] above except in relation to wrong-site injections where I have made findings at [354] to [358] above.

585. The claimant contends that the matters relied on demonstrate that the respondent dealt with Mr Cass more leniently when there were clinical events relating to his patients or, indeed, related questions of conduct (the annual leave cover point and the question of incivility). I turn now to my conclusions in light of my findings in relation to a number of the specific points raised.

586. **AS:** my findings do not suggest any particular leniency on the part of the respondent in relation to AS. The point of note – no Datix entry – was, I have found, explained by what was in effect a misunderstanding. My findings do not point to Mr Cass being leniently treated but to an error being made.

587. **Patients RM and JS:** my findings above are to the effect that the difference in investigative vigour is explained by the difference in residual harm. My findings do not point to Mr Cass being more leniently treated because like is not being compared with like.

588. **Annual leave cover:** the lack of investigation in relation to the emergency readmission of one patient remains unexplained. This could point to Mr Cass being leniently treated but the evidence in relation to this matter is extremely limited.

589. **Mr Cass' SIRIS:** only very brief details are provided in relation to them. There is no evidence before me about whether they were investigated. Action was not taken in relation to any of them. This could point to Mr Cass being leniently treated but the evidence in relation to this matter is too limited to enable me to reach a more detailed conclusion.

590. **Wrong site injections:** this point as set out in the claimant's closing submissions (their [7v)] is to the effect that the claimant was treated less favourably than an unnamed radiologist whose ethnicity is unknown, in that his alleged wrong-site injection of MB was treated as a never event but two by the unnamed radiologist were not. In light of my conclusion at [357] above, I conclude that the claimant had not proved that he was treated less favourably than the unnamed radiologist of unknown ethnicity. Further, in light of my findings at [358] above, I conclude that Mr Cass did not act inconsistently in his reaction to on the one hand a wrong site injection by the claimant and the other wrong-site injections by the unnamed radiologist.

591. **Patient HO and the question of incivility**: it is unsurprising that the question of the claimant's incivility was treated as it was when it arose whilst the patient he was treating was under anaesthesia and, in the end, it was not pursued formally once the RCA had been completed. It is clear that incivility by Mr Cass was not simply ignored, in light of the findings of fact at [157] about the meeting instigated by Ms Awdry. I accept that that was not the only incident involving Mr Cass, but overall, I conclude that the evidence does not show that Mr Cass was treated more leniently in comparable circumstances in relation to questions of incivility, taking full account of my findings at [158] above.

The way the claimant's concerns about NICE guidance were "ignored or dismissed" compared with the "low threshold for investigation and audit in the claimant's cases"

592. The claimant refers at [264ii] of his closing submissions to the more detailed points made at [11] of his closing submissions. I have made findings above in relation to the points raised, particularly between [159] to [168]. In light of those findings, I conclude that there is no obvious contrast, as the claimant submits,

between “the number of times C’s concerns about NICE guidance were ignored or dismissed” and “a low threshold for investigation and audit in C’s cases”. Further, in light of my findings above, the relevant circumstances were different.

The “manifestly different” treatment of MC in his Med-06 procedure so far as MDT compliance and provision of information are concerned

593. I have made findings relevant to this and related issues at [248] to [260] above. I have found at [250] that there were obvious differences between the circumstances giving rise to the two MED06 procedures. I have found at [251] that incomplete information provided in the MED06 procedure relating to Mr Cass did not result from any decision on Ms Dixon’s part to provide incomplete or misleading information in light of my findings at [240] to [245]. I have found at [259] above that the claimant’s failure to submit patient KW to an MDT was judged more seriously than the failure of Mr Cass to submit patient JD to an MDT, but I have also found that Ms Dobson, the decision maker in the case of Mr Cass, honestly believed that there was a number of matters which made the failure of Mr Cass in relation to patient JD less serious than it would otherwise have been. The PRC panel, which was the decision maker in the case of the claimant – and which did not include Ms Dobson - did not have a similar belief in the case of patient KW.

594. Overall, I conclude that although Mr Cass and the claimant were treated differently in their respect MED06 procedures, there were many differences in the circumstances of their two cases.

The respondent had not disclosed any equality policy for Montefiore hospital or Spire more generally

595. I conclude, in accordance with the respondent’s response to the questionnaire responses at page 2965, that the respondent does not collate information regarding the race of consultants subject to the MED-06 procedure. The respondent has not provided an equality policy.

596. The claimant in his contention that the EHRC Code of Practice recommends equality monitoring for workers, whilst making clear at its section [18.25] that it is not “mandatory” for employers in the private sector.

The “evasive and/or selective answers” provided by the respondent in its Equality Act questions response

597. I have reached conclusions in relation to whether the respondent engaged “meaningfully” with the Equality Act question in relation to detriment 34 above. My findings of fact were between [416] and [420] and my conclusions at [569] to [570]. My conclusion was that the respondent did engage “meaningfully” but did not provide all the information the claimant would have liked to receive.

598. However, it is possible that whilst the respondent engaged “meaningfully”, some of its responses were “evasive and/or selective”. Taking the response in the round, I conclude that it cannot be fairly characterised as “evasive and/or selective”.

599. However, as I have concluded at [419], it did incorrectly assert that the surgery conducted on RMc was urgent and that there was some kind of exception to the requirements to put his case before an MDT. Further I have concluded that whilst the respondent had in mind obligations of confidentiality and under the GDPR when replying to the Equality Act questions, its approach also reflected the limited nature of the investigation it had up to that point carried out in relation to the issues raised by the claimant in relation to patients JD and RMc.

600. I have considered the limited nature of the investigation at [411] to [415] above in the context of detriment 33. Taking matters in the round, I conclude that what the respondent's answers to the Equality Act questions reflected so far as relevant to the submissions made by the claimant is concerned was above all the limited nature of the investigation conducted (which to some extent reflected considerable scepticism on Dr Cale's part about the likely merit of the specific issues raised by the claimant in relation to Mr Cass because the claimant had raised them in the course of his own appeal).

The "resistance on R's part to provide information relating to clinical and non-clinical events involving MC"

601. The claimant refers to what he describes as "the resistance on R's part to provide information relating to clinical and non-clinical events involving MC [3700-3703 at Requests 55, 56, 58 and 62], applying McCorry v Keith".

602. The context for the respondent's "resistance" includes the following:

602.1. Overall, the claimant's response for specific disclosure and subsequent responses by both the respondent and the claimant (to the respondent) begins at page 3664 and concludes at page 3706. It deals with 64 different requests. They cover a very wide range of materials.

602.2. The final hearing bundle contains 4000 pages.

602.3. The application of the relevant tests for what is and is not discloseable involves questions of judgment. The answer is often not clear cut.

602.4. This is perhaps reflected in the fact that the documents sought in relation to "a wrong site surgery event by Mr Cass" (items 55 and 56) would not in fact have revealed a wrong site surgery event by Mr Cass (see my findings at [354] to [358] above).

603. Overall, I conclude that the respondent has not been resistant to providing information relating to clinical and non-clinical events involving Mr Cass in a way which sought to obscure how Mr Cass was treated.

Conclusion in relation to the shifting of the burden of proof – all the allegations together

604. I have considered whether I should decide whether the burden of proof has shifted by reference to each detriment which has been factually proven or by references to all of them together. The claimant made no submissions specifically on this point but [265] of his submissions begins:

> *If the burden of proof does reverse generally in this case, or in relation to particulars incidents, it is submitted…*

605. Perhaps more significantly, despite polished submissions running to 54 pages, which were supplemented by oral submissions, Ms D'Souza did not make her submissions in relation to the shifting of the burden of proof in such a way as to argue to any significant extent that different considerations arose in this respect in relation to different detriments or different alleged perpetrators.

606. HHJ Tayler considered this issue recently in Leicester City Council v Parmar [2024] EAT 85. He concluded at [57] that Essex County Council v Jarrett [2015] UKEAT 0045/15/041 was not authority for the proposition that in every case where there is a number of allegations the Tribunal will err if the shifting of the burden of proof is not considered separately for each allegation. Equally, he concluded at [59] that Commissioner of Police of the Metropolis v Maxwell [2013] EqLR 680 was authority for the proposition that it would never be an error of law to consider the burden of proof together for all of the allegations. He went on to state at [59]:

> *There may be some circumstances in which a blanket approach is inappropriate, but others in which it is permissible. All depends on the facts of the case, including the nature and number of allegations and whether there are a number of alleged perpetrators. Save in the clearest of cases the EAT should be slow to decide that the Employment Tribunal, that was best placed to make that assessment, got it wrong.*

607. I have concluded that in this case I should begin by considering the shifting of the burden of proof in relation to all the allegations together. This is for the following reasons. First, it is really how both the representatives dealt with the issue in their submissions, despite the fact that there are different alleged perpetrators. Secondly, it reflects the claimant's case when it is stripped back to its basic argument: a negative group think had developed in relation to him (about which I have made findings at [135] to [142] above) which was tainted by sub-conscious race discrimination. The claimant makes no allegation of conscious race discrimination against any of the alleged perpetrators. However, I have concluded that I should then also consider go on to consider whether there are additional factors which shift the burden of proof in relation to any particular detriment which has been factually proved.

608. I have concluded at [580] above that the appropriate hypothetical comparator is a white consultant orthopaedic spinal surgeon who had been through a PRC. Starting by considering all the allegations together, I conclude that the claimant has not proved facts from which I could conclude in the absence of any other explanation that the respondent had committed acts of discrimination by subjecting the claimant to the detriments which have been factually proved – that is to say he has not proved facts from which I could conclude in the absence of any other

explanation that the claimant has been treated less favourably than the hypothetical comparator would have been treated.

609. Stepping back, taking matters in the round, and with regard to the matters relied on by the claimant, I have concluded that the burden of proof has not shifted to the respondent for reasons including the following:

609.1. The claimant has not proved that Mr Cass was treated more leniently than he was in relation to comparable clinical events in relation to matters where there was significant evidence available. There are just two areas where Mr Cass may have been treated leniently, but even in relation to those the relevant circumstances differ materially;

609.2. Further and separately, the claimant has not proved that Mr Cass was treated more leniently than the claimant in comparable circumstances in relation to questions of civility;

609.3. Further and separately, there is no obvious contrast between "the number of times C's concerns about NICE guidance were ignored or dismissed" and "a low threshold for investigation and audit in C's cases". In light of my findings above, the relevant circumstances were very different;

609.4. Further and separately, although Mr Cass and the claimant were treated differently in their respective MED06 procedures, there were many differences in the circumstances of their two cases;

609.5. Further and separately, although the respondent does not collate information regarding the race of consultants subject to the MED06 procedure, and has not provided an equality policy, these are not factors of sufficient significance to shift the burden, taking all my findings and conclusions in the round;

609.6. Further and separately, although the responses to the Equality Act questions reflected the limited nature of the investigation up to that point carried out in relation to the issues raised by the claimant in relation to patients JD and RMc, this is not a factor of sufficient significance to shift the burden, taking all my findings and conclusions in the round.

609.7. Further and separately, the respondent was not resistant to providing information relating to clinical and non-clinical events involving Mr Cass in a way which sought to obscure how Mr Cass was treated.

610. The claimant's case has been presented with very considerable skill and sophistication. However, in the end it remains highly dependent on a comparison of the treatment of the claimant with the treatment of Mr Cass. As I have found and concluded above in relation to a number of issues, their circumstances materially differ in many ways and, in the end, that fatally undermines the claimant's case.

Conclusion in relation to the shifting of the burden of proof (the detriments

individually)

Detriment 3 – The whistleblower complaint re Patient IM [22 October 2018]

611. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

612. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [683] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

613. Further and separately, there are other matters which in fact generally positively point away from race being a significant or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, and the significance of Mr Cass to the claimant's case as argued both directly and indirectly. These include: the fact that Mr Cass supported the appointment of the claimant (as I have found at [127] above); the history of the claimant and Mr Cass working together willingly (as I have found at [128] in relation to the possible "3 amigos" project); the fact that unguarded communications relied upon by the claimant such as those considered at [73.8] above do not hint at any hostility based on race; and the fact that one of the founding members of the Montefiore hospital was Mr Chauhan, who is not white, and who on the claimant's case was or had been part of an inner-clique.

Detriment 8 – Mr Cass was critical of claimant/providing slanted or incorrect information on 15 February 2022

614. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

615. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [686] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

616. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 9 – Failure to update claimant on/involve claimant in care of KW

617. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

618. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [689] below about the actual

reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

619. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 10 – Failing to address claimant's concerns about Mr Cass's management of patient KW and denying the claimant access to KW's complete medical notes

620. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment. In reaching this conclusion, I specifically considered whether the confused evidence of Ms Awdry as found at [326] above was, when taken with other factors considered above, sufficient to cause the burden of proof to shift. I concluded that it did not because I found the confusion genuine rather than an attempt to obfuscate.

621. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [692] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

622. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 11 – Suspension of claimant's practising privileges on 18 February 2022

623. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

624. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [695] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

625. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 13 – Failure to consider Mr Cass's conflict of interest and/or antipathy

and/or motivation

626. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

627. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [698] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

628. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 15 – Instigation of addition of patient MB

629. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

630. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [701] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

631. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 17 – The lead investigator not interviewing the claimant

632. **Burden of proof**: I conclude that there are no additional matters which, when taken with other factors considered above, cause the burden of proof to shift in relation to this specific detriment. In reaching this conclusion I have specifically considered the fact that the failure to interview the claimant was a breach of the MED06 policy.

633. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [704] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

634. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 18 – Limited access to patient notes

635. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment. In reaching this conclusion I have specifically considered whether the confused evidence of Ms Awdry as found at [326] above was, when taken with other factors considered above, sufficient to cause the burden of proof to shift. I have concluded that it was not because I found the confusion genuine rather than an attempt to obfuscate.

636. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [707] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

637. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 19 – Denying the claimant access to evidence relating to the intervention of Mr Cass with the claimant's patients

638. **Burden of proof**: I conclude that there are no additional matters which, when taken with other factors considered above, cause the burden of proof to shift in relation to this specific detriment. In reaching this conclusion, I have specifically considered whether the confused evidence of Ms Awdry as found at [326] above was sufficient to cause the burden of proof to shift. I have concluded that it was not because I found the confusion genuine rather than an attempt to obfuscate.

639. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [710] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

640. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 20 – Not giving claimant sight of case against him re MB until 31 August 2022

641. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

642. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [713] below about the actual

reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

643. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 21 – The release of the RCA analysis in relation to patient MB to claimant on 18 August 2022

644. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

645. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [716] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

646. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 25 – Not interviewing the radiographer until many months into the investigation

647. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

648. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [719] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

649. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 26 – Alison Clarke and Rachel Dixon breaching time limits in MED06 policy

650. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

651. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [722] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

652. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 27 - Rachel Dixon not submitting the Claimant's defence document to the PRC panel

653. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

654. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [725] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

655. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 30 – Applying an unfair and disproportionate sanction to the claimant

656. **Burden of proof**: I conclude that there are no additional matters which, when taken with other factors considered above, cause the burden of proof to shift in relation to this specific detriment. In reaching this conclusion I have considered carefully whether my conclusions above that in a number of respects the 2022 PRC panel was not inclined or willing to give the claimant the benefit of the doubt, and that the decision to withdraw practising privileges was a severe one, should cause the burden of proof to shift, particularly given that Mr Cass has been through a PRC process and has not been treated with comparable severity. I concluded that it was not. This was above all for two reasons. First, the events giving rise to their respective PRCs were, as found above, significantly different. Secondly, the fact of the 2019 PRC in the case of the claimant was clearly an important factor in the decision taken regarding sanction. Mr Cass had not of course been through a PRC previously.

657. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [729] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

658. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 31 – On appeal, upholding the original decision to withdraw the claimant's practising privileges

659. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

660. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [733] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

661. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 32 – Dr Cale stating not appropriate to disclose actions taken in respect of others

662. **Burden of proof**: I conclude that there are no additional matters which, when taken with other factors considered above, cause the burden of proof to shift in relation to this specific detriment. In reaching this conclusion I have specifically considered the fact that the appeal panel failed to carry out a "comparative" exercise in relation to the treatment of the claimant and that of Mr Cass. I have also specifically considered my findings at [413] to [415] about Ms Dixon's email of 30 December 2022. I have concluded that these are not sufficient to shift the burden of proof because, for the reasons I have set out above, the circumstances of the claimant and Mr Cass were really very different.

663. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [736] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

664. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 33 – Failure to provide detail in letter of 13 March 2023

665. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

666. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [739] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

667. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Detriment 35 – Only indicating that concerns about Mr Cass would be subject to the preliminary review process on 2 May 2023

668. **Burden of proof**: I conclude that there are no additional matters which cause the burden of proof to shift in relation to this specific detriment.

669. **Reason why conclusion**: in case I am wrong about that, and the burden of proof has shifted, I have reached conclusions at [742] below about the actual reason for the treatment complained of. In light of those conclusions, I conclude that race was not a significant or material influence on the detrimental treatment: it was in no sense whatsoever because of race.

670. Further and separately, there are other matters which in fact generally positively point away from race being a significance or material influence in relation to the matters complained of, taking full account of the fact that the allegations are of unconscious bias, as I have concluded at [613] above.

Alternative conclusions in relation to detriments which have not been factually proved

671. I have in effect concluded in respect of the following alleged detriments either (1) that they were not factually proved despite there being limited or no dispute about the underlying factual event because of the way in which the alleged detriment was worded; and/or (2) that a reasonable worker would not have found the treatment in question to be a disadvantage or as being to their detriment: alleged detriment 1, alleged detriment 2A, alleged detriment 2B, alleged detriment 4, alleged detriment 5, alleged detriment 6, alleged detriment 7, alleged detriment 12, part of alleged detriment 13, alleged detriment 14, alleged detriment 16, alleged detriment 22, alleged detriment 23, and alleged detriment 34.

672. Given the nature of the fact finding exercise that I have carried out, I am able to conclude, in particular in light of my conclusions above between [604] and [610], that if I had concluded that any of those alleged detriments was in fact a detriment, I would have also concluded that the burden of proof had not shifted to the respondent.

If so, did the Respondent contrary to ss.13 and 39(2) EqA 2010 discriminate against the Claimant:-

a. As to the terms of his employment?

b. In the way in which the Claimant was afforded access, or not afforded access to, opportunities for promotion or for receiving any other benefit, facility or service?

By subjecting him to any other detriment?

673. In light of my conclusions, the detriments proved did not amount to less favourable treatment when compared with the treatment of the hypothetical comparator identified. The detriments proved did not amount to less favourable treatment by the respondent because of the claimant's race. The respondent did not therefore discriminate against the claimant contrary to sections 13 and 39(2) of the Equality Act.

Vicarious Liability

Is the Respondent vicariously liable for any discriminatory acts or omissions of Mr. Cass which were done in the course of his employment and/or done as agent with the Respondent's authority, in accordance with s.109(1) and (2) EqA?

674. It is not necessary to reach any conclusion in relation to this issue in light of my conclusions above.

Protected disclosure detriment

Did any of the above acts or omissions which the Claimant may prove amount to detriment within the meaning of s.47B(1) ERA?

It is not admitted that detriments 1, 2A, 2B, 4, 5, 7 14, 16, 19, 22, 23, 25, or 33 are detriments in that any sense of grievance about them on the C's part would be in the circumstances unjustified.

675. Yes, in light of my conclusions above alleged detriments 3, 8, 9, 10, 11, 13, 15, 17, 18, 19, 20, 21, 25, 26, 27, 30, 31, 32, 33 and 35 amount to detriments within the meaning of s.47B(1)ERA.

In respect of any detriments inflicted by Mr. Cass on the grounds of Protected Disclosures 1 to 6 (Detriments 1, 2, 3, 6, 7, 8, 12 and 15), is the Respondent vicariously liable for those acts/omissions?

The Respondent denies detriments 1 and 2, if they occurred in the manner alleged by the C, were done by Mr Cass in the course of his employment as defined under the EqA 2010.

676. It is not necessary to reach a conclusion in relation to this issue in light of my conclusions in relation to the next issue.

Did the Respondent subject the Claimant to such detriment as the Claimant may prove on grounds of Protected Disclosures 1 to 6 set out above, contrary to s.47B(1) ERA? More particularly:

a. Was Detriment 1 caused by Disclosure 1?

b. Were Detriments 2, 2A, 2B and 3 caused by Disclosures 1 and/or 2?
c. Was Detriment 4 caused by Disclosures 1, 2, 3, 4 and/or 5?
d. Were Detriments 5-35 caused by Disclosures 1, 2, 3, 4, 5 and/or 6?

The Claimant has never indicated which specific detriment(s) are said to have been caused by which specific alleged disclosure or disclosures. Since he is unable or unwilling to do so the Respondent cannot provide a more meaningful response of its position on this point.

The question of causation and protected disclosure detriment generally

677. Ms D'Souza drew together the claimant's submissions in relation to causation and protected disclosure detriment at [253] of her closing submissions. In summary:

677.1. The claimant had made a wide audience aware of his concerns over a sustained period of time (2017 to 2023). The key question was whether the disclosures acted on the minds of any of them and in particular on the minds of the decision makers.

677.2. Mr Cass had an obvious reason to react negatively to the protected disclosures because the MDT needed to run smoothly and, also, having one's judgment questioned repeatedly would have been likely to displease him.

677.3. Ms Dixon did not wish to address Mr Cass' surgical practice and that was evident across the Montefiore hospital from 2018. Ms D'Souza cross-referred back to [11] of her submissions in this respect.

677.4. Even if Dr Cale was not aware of the claimant's protected disclosures, she was aware of his concerns in relation to the NICE guidance which was resonant of protected disclosures 3 and 6.

678. I have made findings of fact at [159] to [168] above about how the respondent reacted to the claimant raising concerns about NICE guidance and Mr Cass' practice. I refer in particular to my findings at [168]. I conclude that whilst the claimant has sought to portray himself as having consistently and coherently raised specific concerns in relation to the NICE guidance and Mr Cass' practice, the reality was substantially different.

679. So far as Mr Cass is concerned, I refer to my findings of fact above, and in particular those at [127] to [130] and those at [133] to [134]. In light of those findings of fact, the differing views of Mr Cass and the claimant in relation to the NICE guidance were only one and, I conclude, a relatively insignificant factor in the deterioration in their relationship. In these circumstances, I conclude that, to the extent that Mr Cass was aware of the factual matters said to comprise the six protected disclosures, they were no more than a minor irritation to him.

680. So far as Ms Dixon is concerned, and the matters referred to in [11] of the claimant's written submissions, I refer to findings above in relation to the points raised, particularly between [159] to [168]. I conclude in light of those findings that

it was not the case that the respondent wished to avoid addressing Mr Cass's surgical practice. Rather it did not consider that there was any reason to do so.

681. So far as Dr Cale is concerned, I find that she was not aware of any of the protected disclosures. The question of the NICE guidance was a very minor aspect of the claimant's letter of appeal to her and did then appear in her summary of his letter (point 8.2 at page 2791). This was not a matter addressed by the respondent when it rejected his appeal (see my findings in relation to detriment 32 at [409] to [410] above). In light of those findings, I conclude that when reaching her decision to reject the appeal Dr Cale simply did not regard what the claimant was saying about the NICE guidance and Mr Cass as a relevant consideration.

682. Taking the claimant's overarching submissions in relation to causation together, I conclude that in fact the various employees of the respondent who are alleged to have subjected the claimant to detriments because he made the alleged protected disclosures did not regard what he was saying or writing as being of any great consequence (because of the way and the circumstances in which he was making the points he made), whether or not what he said amounted to a protected disclosure. I have therefore concluded, as set out in more detail below, that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant. This is perhaps reflected in the fact that at no point prior to the withdrawal of his practising privileges did the claimant contend that he was being subjected to a detriment because of any of the matters subsequently identified by him as being protected disclosures. The matters relied upon as being protected disclosures have acquired a significance as a result of these proceedings that they did not previously have.

The reasons for the treatment complained of

Detriment 3 – The whistleblower complaint re Patient IM [22 October 2018]

683. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [281] to [284], that Mr Cass raised the concern he raised with Ms Awdry because he had genuine professional concerns about the claimant's treatment of KW and for no other reason.

684. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

685. Further, if I had concluded that either alleged protected disclosure 1 or alleged protected disclosure 2 was in fact a protected disclosure, I would have also concluded that neither of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 3.

Detriment 8 – Mr Cass was critical of claimant/providing slanted or incorrect information on 15 February 2022

686. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [310] to [314], that Mr Cass was critical of the claimant because he took the view that he had to provide his honest professional opinion and for no other reason.

687. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

688. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 8.

Detriment 9 – Failure to update claimant on/involve claimant in care of KW

689. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [315] to [321], that the reason for the claimant not being updated or consulted as found was the honest belief of those involved that this was not in all the circumstances necessary and no other reason. So far as Mr Hatrick telling the claimant not to communicate with KW in the call in which he suspended him, I conclude that the reason for this was Mr Hatrick's view that it was not appropriate for the claimant to communicate with patient KW once he was suspended and no other reason.

690. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced its treatment of the claimant.

691. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 9.

Detriment 10 – Failing to address claimant's concerns about Mr Cass's management of patient KW and denying the claimant access to KW's complete medical notes

692. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [322] to [326], that the reason that the clinic notes of Mr Cass were not provided by Ms Awdry was that she made a mistake and for no other reason.

693. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

694. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 10.

Detriment 11 – Suspension of claimant's practising privileges on 18 February 2022

695. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [327] to [330], that the reasons for the suspension of the claimant's practising privileges on 18 February 2022 were as set out in Mr Hatrick's email of 3 March 2022 (page 1880) and for no other reason.

696. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

697. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 11.

Detriment 13 – Failure to consider Mr Cass's conflict of interest and/or antipathy and/or motivation

698. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [335] to [341], that the reason for the respondent not taking into account Mr Cass' antipathy to the claimant was that it did not have this in mind as a relevant consideration and no other reason. I conclude that the reason that the respondent did not have it in mind as a relevant consideration was that Mr Cass did not provide significant evidence and was not significantly involved in the PRC process and no other reason. So far as the respondent not considering that Mr Cass might have been motivated by the claimant's protected disclosures and/or race, I conclude that the reason that the respondent did not have this in mind as a relevant consideration was that there was no reason for the respondent to consider such matters when these were not matters which the claimant had raised or to which he had drawn attention.

699. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

700. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 13.

Detriment 15 – Instigation of addition of patient MB

701. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [348] to [358], that the reason for Mr Cass bringing patient MB to the attention of Mr Hatrick, and so "instigating" their addition, was that he had an honest professional concern about her treatment by the claimant and no other reason.

702. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

703. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 15.

Detriment 17 – The lead investigator not interviewing the claimant

704. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [362] to [364], that the reason for Ms Clarke not interviewing the claimant was that she honestly believed in light of the detailed information that he had provided that there would be no additional benefit to interviewing him, and no other reason.

705. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

706. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 17.

Detriment 18 – Limited access to patient notes

707. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [365] to [366] and [324] to [326], that the reason that the clinic notes of Mr Cass were not provided was that Ms Awdry made a mistake and no other reason.

708. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

709. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them

materially influenced the respondent's treatment of the claimant as found in relation to detriment 18.

Detriment 19 – Denying the claimant access to evidence relating to the intervention of Mr Cass with the claimant's patients

710. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [367] to [368], [365] to [366] and [324] to [326], that the reason that the clinic notes of Mr Cass were not provided was that Ms Awdry made a mistake and no other reason.

711. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

712. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 19.

Detriment 20 – Not giving claimant sight of case against him re MB until 31 August 2022

713. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [369] to [371], that the reason for the amended terms of reference not being provided until 30 August 2022 – that is to say late in the day – was that the respondent took the view that the claimant was already aware of the allegations against him in light of the contents of the letter of Ms Dixon of 5 July 2022 (and so took the view that providing amended terms of reference was not urgent) and no other reason.

714. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

715. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 20.

Detriment 21 – The release of the RCA analysis in relation to patient MB to claimant on 18 August 2022

716. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [372] to [375], that the reason for Ms Awdry giving patient MB the RCA report when the claimant had not been sent patient MB's medical records and had not seen the final version of

the report was that she did not regard it as being her role to deal with such matters and no other reason.

717. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

718. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 21.

Detriment 25 – Not interviewing the radiographer until many months into the investigation

719. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [387] to [395], that the reason for the delay in interviewing the radiographer was Ms Clarke initially taking the view that she could draw a conclusion without the radiographer's evidence which seemed likely to be of little value and no other reason. If Ms Clarke had been motivated by a desire to exclude the evidence of the radiographer, she would not have got in touch with her again in September.

720. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

721. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 25.

Detriment 26 – Alison Clarke and Rachel Dixon breaching time limits in MED06 policy

722. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [396] to [397], that the only reasons for the time limits prescribed by the MED06 policy being breached and monthly updates not being provided were the complexity of the investigation, the addition of the further allegations in relation to MB, delays by external experts, and the fact that both Ms Clarke and Ms Dixon had "day jobs".

723. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

724. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 26.

Detriment 27 - Rachel Dixon not submitting the Claimant's defence document to the PRC panel

725. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [398] to [400], that the reason for Ms Dixon not submitting the claimant's defence document was an error on her part caused by the an employee of the respondent's IT department providing her with the wrong document. There was no other reason.

726. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

727. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 27.

Detriment 30 – Applying an unfair and disproportionate sanction to the claimant

728. This is the most significant of the detriments. I have made detailed findings of fact in relation to it between [193] and [229] above and reached detailed conclusions in relation to whether the sanction of the withdrawal of practising privileges was "unfair and disproportionate" at [543] to [564] above. In summary, I have concluded that the withdrawal of practising privileges was not in all the circumstances "unfair and disproportionate" but that it was "severe" and the respondent was unwilling, where relevant, to give the claimant the benefit of the doubt. I concluded that the withdrawal of practising privileges in these circumstances was a detriment.

729. Taking account of my findings of fact generally, and in particular my findings of fact and conclusions referenced in the previous paragraph, I conclude, in light also of my conclusions at [677] to [682] above, that the reason that the respondent withdrew the claimant's practising privileges was that Ms Dixon honestly believed it was the appropriate sanction in all the circumstances, which in particular included the 2019 PRC and its recommendations, and no other reason. Indeed, I conclude that if the claimant had not been through the 2019 PRC (and so no recommendations had been made as a result of it) his practising privileges would not have been withdrawn. I conclude that it was above all the fact of the 2019 PRC that resulted in a "severe" sanction and Ms Dixon being unwilling, where relevant, to give the claimant the benefit of the doubt.

730. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that

the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

731. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 30.

Detriment 31 – On appeal, upholding the original decision to withdraw the claimant's practising privileges

732. The claimant contends that the appeal decision was flawed because of the same matters relied upon in respect of detriments 17 to 28 and 30. To the extent that those detriments were factually upheld, I have reached conclusions above that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

733. I have reached the same conclusion in relation to the appeal panel upholding the original decision. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [261] to [265] and at [410], that the only reason for the original decision being upheld on appeal was that the appeal panel honestly believed it was the appropriate sanction in all the circumstances, which in particular included the 2019 PRC and its recommendations.

734. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

735. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 31.

Detriment 32 – Dr Cale stating not appropriate to disclose actions taken in respect of others

736. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [409] to [410], that the reason for Dr Cale stating, in response to the Claimant's concerns about differential treatment of Mr. Cass, that it was not appropriate to disclose actions taken in respect of others, and so rejecting that appeal ground, was that she and the appeal panel took the view that the basic question for them was whether the withdrawal of practising privileges was appropriate in light of the conclusions of the PRC Panel and not whether it was "fair" by reference to the treatment of others.

737. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that

the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

738. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 32.

Detriment 33 – Failure to provide detail in letter of 13 March 2023

739. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [411] to [415], that the reason for Dr Cale writing to the claimant as she did, after only limited consideration of the issues raised by the claimant as found at [412], was a combination of her concerns about data protection and confidentiality, her view as set out at [736] above about what the basic question for the appeal panel had been, and considerable scepticism on her part about the likely merit of the specific issues raised by the claimant in relation to Mr Cass because the claimant had raised them in the course of his own appeal, and no other reason. In summary, in light of these matters she did not believe that she needed to or should address the matters the claimant had raised in any detail.

740. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

741. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 33.

Detriment 35 – Only indicating that concerns about Mr Cass would be subject to the preliminary review process on 2 May 2023

742. Taking account of my conclusions at [677] to [682] above, I conclude, in light of my findings of fact above generally, and in particular those at [421] and [230] to [237], that the reason for the respondent indicating that concerns about Mr Cass would be subject to the preliminary review process on 2 May 2023 and not earlier was that the respondent did not wish to be seen to be ignoring such concerns in light of the fact that by 2 May 2023 it was fairly obvious that a claim by the claimant was likely. The preliminary review process therefore went ahead despite the considerable scepticism on Dr Cale's part about the likely merit of the issues raised by the claimant in relation to Mr Cass, such scepticism arising because the claimant had raised the issues in the course of his own appeal

743. In light of this, and of course my conclusions above in relation to which of the alleged protected disclosures actually were protected disclosures, I conclude that the respondent has proved that none of the proved protected disclosures materially influenced the respondent's treatment of the claimant.

744. Further, if I had concluded that alleged protected disclosure 1, 2, 3 or 6 were in fact protected disclosures, I would have also concluded that none of them materially influenced the respondent's treatment of the claimant as found in relation to detriment 35.

Overall and alternative conclusions in relation to protected disclosure detriment

745. In light of the conclusions set out above, the respondent did not subject the claimant to any detriment on the ground that he had made any of the proved (or alleged) protected disclosures.

746. I have concluded above that the respondent has shown the grounds on which the proved detriments were done. However, if I had concluded that the respondent had not done this in relation to any particular alleged or proved detriment, I would not have inferred that the detriment was on the ground that the claimant had made a protected disclosure. This would have been because the matters relied upon by the claimant as supporting such an inference, in particular as I have considered them at [677] to [682] above, were insufficient to support such an inference. In summary, this would have been because the matters relied upon as being protected disclosures have acquired a significance as a result of these proceedings that they did not previously have.

Time Limits – ERA and EQA

747. It is not necessary to reach any conclusion in relation to the time limit issues in light of my conclusions above.

Appendix one – List of Issues

The respondent's position in relation to each alleged protected disclosure and each detriment is set out below in *underlined italics.* Its position has been taken from (1) the two sets of further particulars referred to in [6] above and (2) the respondent's closing written submissions.

Clarifications that were given during the hearing of both parties' cases are also set out in *underlined italics*.

Time limits – ERA

1. Did any acts or failures to act alleged to have caused detriment occur before 11 December 2022?
2. If so, did the act extend over a period? If so, did the relevant period end on or after 12 December 2022?
3. If not, can the Claimant prove that the act or failure to act alleged to have caused detriment is part of a series of similar acts? If so, did the last such act or failure to act occur on or after 12 December 2022?
4. If not, was it not reasonably practicable for the complaint to have been presented in time?
5. If so, was the complaint presented within such a further period as was reasonable?

Time limits – EqA

6. Are any complaints related to acts which occurred before 11 December 2022?
7. If so, was there conduct extending over a period which is to be treated as done at the end of the period? If so, did the relevant period end on or after 12 December 2022?
8. If not, was the complaint presented within such other period as the Tribunal thinks just and equitable?

Protected Disclosure Detriment - s.47B ERA

Qualifying Disclosures

9. Did the Claimant disclose information as follows?

    a. **Disclosure 1** – in an email dated 18 July 2017 to Matthew Bloomer (Spire Montefiore's Finance and Commercial Manager) relating to two spinal procedures which had not been the subject of an Individual Funding Request and which were being challenged by the Clinical Commissioning Group, the Claimant correcting Mr. Bloomer that it was not him who conducted the procedures in question and pointing out that he did not do those types of procedures '*in accordance with the guidance*' (meaning NG59);

It is admitted that the C sent this email [291]. It is denied that he believed that the information he disclosed tended to show that an individual's health and safety was being or likely to be endangered; or that any such belief was reasonable. It is also denied that the C believed that the information he disclosed was in the public interest or that any such belief was reasonable.

b. **Disclosure 2** - in an email to dated 4th September 2017 to Patient PT, copied to David Eglinton (Hospital Director), relating to surgery which Mr. Cass had conducted, the Claimant stating that - "*the* [NICE] *guidance is very clear that disc replacement surgery is not recommended and spinal fusion surgery should only be performed if you are part of an experimental trial, which you are not on. I refer you to sections 1.3.9 and 1.3.10 of NICE Guidance NG59*";

It is admitted that the C sent this letter (dated 6/9/17 [304]) to PT and that he forwarded it to Mr Eglington as a "draft response" [303] on 3/9/17. It is denied that he believed that the information he disclosed tended to show that an individual's health and safety was being or likely to be endangered; or that any such belief was reasonable. It is also denied that the C believed that the information he disclosed was in the public interest or that any such belief was reasonable.

c. **Disclosure 3** - at a Spinal MDT meeting on 26 November 2019, when discussing Patient JD, the Claimant stating that the NICE guidance stated there should be no surgery for unspecified back pain contrary to what Mr. Cass was saying;

It is admitted that the C made the alleged comment. It is denied that he believed that the information he disclosed tended to show that an individual's health and safety was being or likely to be endangered; or that any such belief was reasonable. It is also denied that the C believed that the information he disclosed was in the public interest or that any such belief was reasonable.

d. **Disclosure 4** - in an email dated 14 May 2021 from the Claimant to Cameron Hatrick (Medical Director), the Claimant stated that "*Cass is doing regular instrumented cases for back pain against NICE guidance. He is doing revision cases. None of these get discussed at any MDT I am invited to.*";

It is admitted that the C sent the email [1427] in which these comments are made. It is denied that he believed that the information he disclosed tended to show that an individual's health and safety was being or likely to be endangered; or that any such belief was reasonable. It is also denied that the C believed that the information he disclosed was in the public interest or that any such belief was reasonable.

e. **Disclosure 5** - at the inaugural Spinal MDT meeting on 15 June 2021, in response to Mr. Cass' comment that the NICE guidance did not mean very much and was merely guidance, the Claimant stated that the NICE guidance was important, that Mr. Cass was not following NICE guidance

with his procedures, and in doing that, he was acting against the weight of professional opinion (including the British Orthopaedic Association, the British Association of Spine Surgeons, the British Pain Society, the United Kingdom Spinal Societies Board, the Society of British Neurological surgeons).

It is denied that the C made this comment. It is not recalled by any of RD, MC, or CH

f. **Disclosure 6** - On 24 December 2021, following an email from Rachel Dixon (the Respondent's Hospital Director) headed 'Complaint':-

i. ~~in a phone call between Rachel Dixon and the Claimant, and in answer to her question whether Patient JD had ever been discussed at a Spinal MDT, the Claimant confirmed that JD had been discussed at MDT in November 2019 and that the agreed course of action was physiotherapy in line with NICE guidance;~~

ii. After the call, the Claimant sent Ms Dixon a copy of his patient letter to JD which confirmed that JD's case had been discussed at the Spinal MDT in November 2019 and physiotherapy agreed.

It is admitted that the C (or his secretary) [3636] send the patient letters at [3335/6 and 3338/9].

10. Did any disclosure of information, in the Claimant's reasonable belief, tend to show that:-

a. the health or safety of an individual had been, was being, or was likely to be, endangered, within the meaning of s.43B(1)(d) ERA; and/or

b. that Mr. Cass was failing to comply, or was likely to fail to comply, with a legal obligation to which he was subject, more particularly the legal obligation conferred by one or both of:-

i. the Spinal MDT Terms of Reference which provided that "*the overall aim of the Spinal MDT is to … ensure compliance with all relevant national guidance and quality standards*"; and/or

ii. the contractual obligation imposed by the Consultant Handbook, which provided at page 10 paragraph 21 that 'Consultants must ensure that patients are discussed in multidisciplinary team meetings where mandated by Spire Policy'.

11. Did the Claimant reasonably believe any alleged disclosure of information to be made in the public interest?

12. Was any qualifying disclosure made to the Claimant's employer, in accordance with s.43C ERA? *It is admitted that it was.*

Alleged detriments

13. Was the Claimant subjected to the following acts or omissions by the Respondent?

    a. **Detriment 1** – Mr. Cass encouraging Patient PT to submit a letter of complaint about the Claimant;

       This is denied. Michael Cass says he did not write the complaint letter or have any input into it. He says the first he knew of this letter was when he was sent a copy of it by David Eglington (MC/40-41; p.57 WSB).

    b. **Detriment 2** – in January 2018, Mr. Cass submitting or being the driving force behind an anonymous complaint to NHS Fraud about the Claimant, alleging that he was routinely miscoding a surgical procedure and thereby defrauding the NHS and private insurers, and that he had not performed a procedure for which he had claimed payment ("the Coding Complaint");

       This is denied. Michael Cass says he did not submit this complaint, nor did he cause it to be made (MC/43-44; p.58 WSB). This evidence is supported by that of Alison Clarke (AC/66; p.92-93 WSB] and Cameron Hatrick (CH/38; p.164 WSB).

       Detriment 2A – in February 2018, the Respondent failing to (1) assess the Spinal Unit's compliance with the NICE guidance or (2) conduct an audit of practices against NG59 using consultant clinic letters, as recommended by Alison Clarke her email dated 8 February 2018 to the Senior Leadership Team, and agreed upon at an SLT meeting on 13 February 2018, instead focusing its limited investigation on the Claimant's injection practices and infection rates;

       This is denied. There is documentary evidence that Lynette Awdry did conduct the audit, see extracts from Notes of Spine MDT held on 12 June 2018 at pp.3774-3775 HB. See note 10: "LA has audited 20 NHS and 25 PP across SK/MC/ST/EC and most met criteria. Now to audit 2017 through to March 2018."

       Detriment 2B – following receipt of an anonymous whistleblower complaint dated 19 April 2018 asserting that *"injections into the spine (facet joint injections, epidural steroid joint injections) and much spine surgery for the relief of low back pain is ineffective and may be damaging' and referring to "a system that profits from troubled and suffering patients by providing ineffectual and inappropriate treatment at great cost to the patient or NHS"*, the Respondent conducted a narrow investigation into injection practices only, and failed to conduct any assessment or audit of surgical practices;

       It is denied that the Respondent failed to conduct any assessment or audit of surgical practices. As set out in relation to Detriment 2A above, the Notes of the Spine MDT on 12 June 2018 show Lynette Awdry did audit some procedures. It is admitted that the focus of the subsequent investigation was however, largely upon injection practices only, for the reasons set out at LA/23; pp.6-7 WSB.

c. **Detriment 3** – on 22 October 2018, Mr. Cass submitting ~~or being the driving force behind~~ an anonymous 'whistleblower' complaint against the Claimant alleging that the Claimant had inappropriately conducted a kyphoplasty procedure on Patient IM;

It is admitted that Michael Cass raised concerns about the patient's procedure with Lynette Awdry. His account of this is given at MC/85-89; pp.62-63 WSB.

d. **Detriment 4** – the Respondent's failure to take any action in relation to Mr. Cass in response to the concerns raised by the Claimant in Disclosures 1 to 5, and/or as raised by the anonymous whistleblower in April 2018, when there was strict observance of NICE guidance in all other disciplines;

This detriment is predicated on a finding that the Claimant was raising concerns about Michael Cass in Disclosures 1, 2, 3 and 5, which is disputed. As to Disclosure 4, it is denied that the Respondent failed to take any action against Michael Cass, as the concerns the Claimant raised about Michael Cass's alleged lack of MDT approval were investigated by Ben White as part of the MED06 investigation (MC/115; p.66 WSB). The Respondent denies that it was necessary to take any action against Michael Cass. See Alison Clarke's evidence at AC/79-80; p.95 WSB and Cameron Hatrick's evidence at CH/93; p.175 WSB. It is not accepted that there was "strict observance of NICE guidance in all other disciplines". Rather, the Hospital had systems, process and controls for overseeing adherence to best practice which included consideration of NICE guidance to enhance patient safety and optimal care.

e. **Detriment 5** – Rachel Dixon failing to take any action in relation to Mr Cass' failure to obtain Spinal MDT approval for L3/4 lumbar disc replacement on Patient JD conducted in June 2021;

This is denied. Rachel Dixon reviewed this concern when it was passed to her by Dr Catherine Cale, Group Medical Director and she referred documents and findings on to Catherine Cale for her to consider what further action was needed. She was not then involved in the subsequent preliminary review of MED06 process undertaken by Ben White and so the decision as to what if any action to take in relation to the lack of MDT approval for Patient JD was not her decision. See RD/199; p.155 WSB.

f. **Detriment 6** – Mr. Cass encouraging Matron (Lynette Awdry) to make a complaint about the Claimant on 15 February 2022 that the Claimant had culpably delayed in his actions in relation to Patient KW;

This is denied. Michael Cass did not encourage Lynette Awdry to make this complaint. He says he explained his concerns about the patient to Lynette Awdry after the Claimant had asked for an MDT opinion and he realised that the patient had a likely neurological compromise for over four weeks (MC/138; p.69 WSB). This is supported by Lynette Awdry,

who says she discussed her concerns with Michael Cass and Mr Morassi but Michael Cass did not "encourage" her to write the email setting out her concerns (LA/88; p.19 WSB). This is supported by Alison Clarke (AC/127; p.181 WSB).

g. **Detriment 7** – on 15 February 2022, Mr. Cass' unreasonable refusal to jointly operate alongside the Claimant on account of '*poor interpersonal relations*' with the Claimant;

It is admitted that Michael Cass refused to operate jointly with the Claimant (LA/103; p.21 WSB) (MC/140; p.69 WSB) but it is denied that this refusal was unreasonable or solely on account of 'poor interpersonal relations'. Michael Cass explains the reasons why he was unwilling to operate jointly with the Claimant at MC/141; pp.69-70 WSB.

h. **Detriment 8** – on 15 February 2022, during a consultation with Patient KW, Mr. Cass being critical of the Claimant and providing incorrect and/or slanted information to the patient, as particularised at paragraph 48.1-48.3 of the Claimant's Particulars of Claim;

It is denied that Michael Cass knowingly or intentionally gave incorrect and/or slanted information to Patient KW. To the extent that Michael Cass did give incorrect and/or slanted information, he did so based on his honest, professional opinion based on his review of MRI scans, CT scans, and discussions with radiologists and Mr. Morassi, as well as the information given by the patient when she met him in clinic. Michael Cass gives his account of why he said the things he did at MC/149-150; p.71 WSB.

i. **Detriment 9** – During the period of Patient KW's admission on 15 February 2022 (a) Rachel Dixon, Cameron Hatrick and/or Lynette Awdry not keeping the Claimant updated as to discussions being held about him or his patient, (b) Cameron Hatrick and/or Lynette Awdry not consulting him over patient care, despite the fact that he retained full clinical responsibility for KW until there was a formal transfer of clinical responsibility, and (c) Rachel Dixon forbidding the Claimant from communicating with KW despite her urgent and anxious attempts to contact him directly and causing her to think that the Claimant had abandoned her;

It is admitted that Rachel Dixon, Cameron Hatrick and/or Lynette Awdry did not keep the Claimant updated as to discussions being held about him or Patient KW. Lynette Awdry gives her reasons for this at LA/101; p.21 WSB. Rachel Dixon gives her reasons for this at RD/78; p.129 WSB. Cameron Hatrick gives his reasons at CH/138-139; p.183 WSB.

It is admitted that Lynette Awdry and Cameron Hatrick did not consult with the Claimant over Patient KW's care. It is denied that the Claimant retained full clinical responsibility for the patient. Lynette Awdry says that the patient told her she no longer wanted to have the Claimant as her doctor and wanted her care transferred to Michael Cass and once the Claimant's practising privileges has been suspended from 16 February

2202, it would not have been appropriate to keep him updated (LA/101; p.21 WSB). Cameron Hatrick says at CH/139; p.183 WSB, the patient accepted the offer to transfer her care to Michael Cass and therefore from this point, no communications needed to go through the Claimant.

It is not admitted that Rachel Dixon forbade the Claimant from communicating with Patient KW. Rachel Dixon's evidence at RD/78; p.129 WSB is that "I cannot remember asking Mr Karmani not to contact Patient KW and would have seen no reason to do this (before his practising privileges were withdrawn) unless Lynette Awdry had advised me that the patient did not want contact from him."

j. **Detriment 10** – failing to address the Claimant's concerns about Mr. Cass' management of Patient KW in the subsequent investigation as promised, and denying the Claimant access to KW's complete medical notes, including those generated by Mr. Cass;

It is denied that the Respondent failed to address the Claimant's concerns about Michael Cass' management of Patient KW in the subsequent investigation. Alison Clarke says the concerns were addressed in her RCA report (AC/180-183) [p.109 WS Bundle]. Rachel Dixon says no issues were identified in Michael Cass's treatment of patient KW and she believed that the patient was happy with the treatment from him (RD/189; p.153 WS Bundle). See also Michael Cass's response to the alleged concerns about his treatment of Patient KW, which are disputed, at MC/151 – 153; pp.71-72 WSB.

It is not admitted that the Respondent denied the Claimant access to KW's complete medical notes, including those generated by Mr Cass. See AC/185; p.110 WSB and email from Lynette Awdry to the Claimant at p.1877 HB. See also RD/181; pp.150-151 WSB. In the event that any notes were not shared, if this is established, the Respondent denies that this was because of the Claimant's race and/or any alleged protected disclosures (AC/195; p.111 WSB). Rachel Dixon's evidence is that anything that took place after the Claimant's involvement with the patient had ended would not have been relevant and that is why it would not have been provided to him (RD/181; pp.150-151 WSB).

k. **Detriment 11** – on 18 February 2022, suspending the Claimant's Practising Privileges;

It is admitted that the Claimant's practising privileges were suspended but this was on 16 February 2022 not 18 February 2022 (RD/75-76; p.128 WSB). For Rachel Dixon's reasons for this, see RD/75 [p.128 WSB] and RD/140 [p.183 WSB].

l. **Detriment 12** – by Mr. Cass' actions in (a) not agreeing to operate with the Claimant, and (b) providing misinformation to Patient KW, thereby triggering the Claimant's suspension and the transfer of the Claimant's practice to Mr. Cass, with significant gain to himself.

It is admitted that Michael Cass would not operate with the Claimant. See response above at Detriment 7. It is denied that this triggered the Claimant's suspension.

As to 'misinformation', see response to Detriment 8 above. It is denied that this triggered the Claimant's suspension. The reasons for suspending the Claimant's practising privileges are set out at RD/75-76; pp.128-129 WSB and RD/140; p.183 WSB. It is denied that this triggered the transfer of the Claimant's practice to Michael Cass, with significant gain to himself.

m. **Detriment 13** – the Respondent's failure to consider Mr. Cass' conflict of interest and/or antipathy towards the Claimant when weighing his evidence in the investigation and/or that he might have been motivated by the Claimant's protected disclosures and/or race in his actions against the Claimant;

It is denied that Michael Cass had a conflict of interest, and/or antipathy and/or that he was motivated by the Claimant's protected disclosures and/or race (MC/213-213; p.79 WSB). AC's evidence is that she was only ever interested in determining the facts of the patient safety concern and not interested in ulterior motives (AC/187; p.110 WSB). To the extent that these factors existed it is admitted they were not specifically considered but denied that not doing so was unreasonable in circumstances where the Claimant drew no attention to his race of alleged protected disclosures being a relevant factor. Furthermore, in circumstances where Mr Cass was not interviewed, did not sit on the PRC, and independent experts were instructed, his "evidence" was of marginal relevance.

n. **Detriment 14** –Rachel Dixon, Cameron Hatrick (or his delegated cover, in the event that Mr. Hatrick had by this date commenced sabbatical leave), Alison Clarke and/or Lynette Awdry failing to subject Mr. Cass' treatment and care of Patient of RM to any investigation, suspension or other action;

It is admitted that Rachel Dixon, Cameron Hatrick, Alison Clarke and/or Lynette Awdry did not subject Michael Cass's treatment and care of patient RM to any investigation, suspension, or other action. Their reasons for doing so are at: RD/198; pp.154-155 WSB; CH/149-153; pp.184-185; AC/188; p.110 WSB; LA/116; p.24 WSB. When the Claimant raised his concerns about this patient to Catherine Cale as part of his appeal, the concerns were reviewed by Ben White and investigated by Sue Dobson (CC/66-74; pp.45-46 WSB).

o. **Detriment 15** - Mr. Cass instigating the addition of Patient MB to the Respondent's investigation by alleging that the Claimant had failed to administer an injection at level C1/C2 and had conducted a sub-optimal physical examination;

It is admitted that Michael Cass brought Patient MB to the attention of Cameron Hatrick. This was because he was concerned about the

treatment that had been provided to this patient, who was now under his care, (MC/162; p.73 WSB).

p. **Detriment 16** - the Respondent adding Patient MB to the existing investigation, notwithstanding that it had classified the incident as a 'low harm' incident on its Datix risk reporting system;

It is admitted that the incident was classified as 'low harm' on the Datix reporting system. Rachel Dixon's reasons for adding this patient to the existing investigation are at RD/121-123; pp.137-138 WSB.

q. Breaching its policy on Managing Consultant Performance Concerns and/or of natural justice, by:-

i. **Detriment 17** - the lead investigator not investigating the Claimant (at section 6.12) and receiving input from the Claimant in writing only;

It is assumed this is a typographical error and the Claimant means 'interviewing' rather than 'investigating'. If so, it is admitted that Alison Clarke did not interview the Claimant. It is denied that this amounted to a breach of the Managing Consultant Performance Concerns Policy and/or natural justice for the reasons given at AC/191-194; pp.110 -111 WSB.

ii. **Detriment 18** - Alison Clarke, Rachel Dixon and/or Lisa Wickwar giving the Claimant only limited access to patient notes during the investigation stage;

This is not admitted. See response on Detriment 10 above. See AC/195; p.111 WSB; RD/181; p.150 WSB; and LW/37; p.207 WSB. The Claimant is not stating what notes he was allegedly not provided with and at what point, such that the Respondent cannot fully address this allegation.

iii. **Detriment 19** - Denying the Claimant access to evidence relating to the intervention of Mr. Cass with the Claimant's patients, including duty of candour letters sent by Mr. Cass which will have concerned the Claimant;

This is not admitted. Alison Clarke's evidence is that Rachel Dixon shared Patient KW's notes with the Claimant (AC/185; p.109 WSB), as did Lynette Awdry in her email at p.1877 HB where she explained she would provide him with Mr Cass's clinic letters and the Claimant then makes reference to the contents of the notes at p.1876 HB. See also Rachel Dixon's evidence on this at RD/181; pp.150-151 WSB. In the event that any notes were not shared, if this is established, the Respondent denies that this was because of the Claimant's race and/or any alleged protected disclosures (AC/195; p.111 WSB). Rachel Dixon's evidence is also that anything that took place after the Claimant's involvement with the patient had ended would not have been relevant and that is why it would not have been provided to him (RD/181; p.150 WSB).

iv. **Detriment 20** - In relation to Patient MB, giving the Claimant sight of the case against him in an email from Lisa Wickwar on 31 August 2022, which was 5 months after the start of the investigation;

This is denied for the reasons at AC/199; p.112 WSB and RD/149; pp.142-143 WSB. The concerns had been shared with the Claimant as part of the RCA process and the preliminary review process and those added to the terms of reference sent by Lisa Wickwar on 31 August 2022 were largely as Rachel Dixon has set out in her letter to the Claimant's solicitors, DWF, on 5 July 2021.

v. **Detriment 21** – on 18 August 2022, releasing the Root Cause Analysis report to Patient MB when (a) the Claimant has not been sent MB's medical records (b) the Claimant had not seen the report before it was sent to the patient, consequently prompting a complaint letter to the Claimant based on the contents of the report;

It is unclear as to whether or not the Claimant was sent MB's medical records prior to Lynette Awdry releasing the report to Patient MB at their meeting on 10 August 2022. Lynette Awdry did not undertake the RCA investigation (LA/114-115; p.23 WSB). Alison Clarke's evidence is that once the RCA report is approved by the IRWG, the report can be released to the patient and there does not need to be prior approval from the responsible consultant, although the Claimant was sent a copy by Rachel Dixon on 19 August 2022 (AC/159-160; p.106 WSB). It is denied that the patient's complaint was prompted by the report being released to her without the Claimant's consent. The complaint was prompted because of the Claimant's care of MB.

vi. **Detriment 22** - Rachel Dixon failing to consult with the MAC Chair (Cameron Hatrick) at any of the key stages of the process at which his advice should have been sought, as required by the policy (Section 4.4);

It is admitted that Rachel Dixon did not consult with Cameron Hatrick. Her reasons for this are set out at RD/185 [p.183-186]. It is denied that section 4.4 of the policy required her to do so (RD/183; p.151 WSB).

vii. **Detriment 23** - Rachel Dixon inconsistently concluding that the MAC Chair (Cameron Hatrick) should not be consulted on the Claimant's case because of a 'conflict of interest' (being a shareholder) when (a) Mr. Cass had been allowed to contribute to the investigation despite the existence of the same supposed 'conflict of interest', and (b) Mr. Hatrick had been permitted to attend the 2019 PRC hearing in his capacity as MAC Chair notwithstanding the same 'conflict of interest', suggesting that the reason as given in 2022 was not genuine or significant;

It is denied that Rachel Dixon's decision making was inconsistent, as alleged. Rachel Dixon's reasons for not involving Cameron Hatrick are at RD/185; p.152 WSB. It is admitted that Alison Clarke sought Michael Cass's version of events, it is not accepted that in doing so, there was a conflict of interest (RD/185; p.152 WSB). Rachel Dixon cannot comment on whether Cameron Hatrick sitting on the 2019 panel was appropriate or not, as she was not in post in 2019 when it took place (RD/185; p.152 WSB).

viii. **Detriment 24** - Alison Clarke and/or Rachel Dixon accepting unquestioningly Mr. Cass' evidence in relation to Patient KW and MB, when it was known that there were extreme tensions between Mr. Cass and the Claimant rendering him unsuitable to provide evidence to the investigation, or at the very least that caution was required;

This is denied. See AC/201; p.112 WSB and RD/187; p.152 WSB. In particular, the concerns regarding the Claimant's practice for these two patients was addressed by two separate external experts (Mr Trivedi for Patient KW and Dr Weeks for Patient MB). Rachel Dixon also ensured that there was a further external expert on the panel during the PRC hearing (Mr Dyson) so that there would be no reasonable allegation of bias during the process.

ix. **Detriment 25** - Not interviewing key witnesses (for example, the radiographer in the case of Patient MB) until many months into the investigation when recollections had dimmed [**the claimant confirmed at [209] of his submissions that the only witness in respect of whom this issue arose was the radiographer]**;

The Claimant has given only one example of a witness who was not interviewed at paragraph 60.9 of his particulars of claim (p.44 HB). It is accepted that Alison Clarke did not interview Christina Deyl, the radiographer, until September 2022. It is denied that this made any difference to the judgment or findings she made (AC/203; p.113 WSB).

x. **Detriment 26** - Alison Clarke and Rachel Dixon breaching all time limits prescribed by the policy, and failing to provide monthly updates as to the progress of the investigation;

It is admitted that the investigation breached time limits set out in the policy and that monthly updates as to progress were not always provided. Alison Clarke addresses this at AC/204; p.113 WSB and Rachel Dixon at RD/188; p.153 WSB.

xi. **Detriment 27** - Rachel Dixon not submitting the Claimant's defence document to the PRC panel before the PRC's meeting with the Claimant;

In respect of this detriment, Rachel Dixon did submit the Claimant's defence documents, being his letter to the PRC and

his response to the terms of reference. It is admitted that she did not submit the Claimant's document entitled "Dr Karmani file – MED06 final with comments for PRC" because she did not receive this when downloaded successfully by the Respondent's IT department and she did not appreciate this document was different to the Claimant's response to the terms of reference (RD/171; p.146 WSB).

xii. ~~**Detriment 28** – Rachel Dixon providing all other documents (totalling 200 pages) to the PRC Panel only 3 days in advance of the Committee hearing, which was, in the circumstances of this case, insufficient time;~~**[the claimant confirmed in his closing written submissions that this detriment was not pursued]**

r. **Detriment 29** - not providing the Claimant with any of the support measures directed by the 2019 PRC in their Recommendations;

The Claimant has not specified what support mechanisms he means in this regard. The Respondent's evidence is that he was provided with additional training, Alison Clarke also regularly shared 'learning matters' with consultants and updates were given to consultants on informed consent, documentation standards (RD/177; p.148 WSB). Cameron Hatrick's evidence is that he asked Robin Turner to keep in touch with the Claimant during the investigation to act as a conduit for his concerns (CH/147; p.184 WSB). If (which is not pleaded or referred to in the list of issues) the Claimant complains he was not permitted to be accompanied at the hearing, he was given the chance to be accompanied and RD checked he was happy to continue (p.3502 HB and RD/118; p.146 WSB)

s. **Detriment 30** – applying an unfair and/or disproportionate sanction to the Claimant, having regard to the following matters:

i. The Claimant was penalised for having failed to comply with some of the 2019 PRC Recommendations, in circumstances where the Respondent had failed to deliver on most of the Recommendations which it had agreed to, including the failing to provide the infrastructure for a 'regular, well-structured and reliable Spinal MDT' in collaboration with Spire Gatwick Park, and/or the provision of an agreed pathway for cases involving neurological deficit and/or an education campaign on the duty of candour;

This is denied for the reasons set out at RD/179(i); p.148 WSB, AC/207; p.113 WSB, MC/207-210; p.79 WSB.

ii. Mr. Cass was not held to the same standard as far as the requirement of Spinal MDT approval was concerned in the cases of JD and/or RM, which was in breach of the Handbook, the 2019 PRC Recommendations and/or the Spinal MDT ToR;

This is denied. It is accepted that Michael Cass did not get Spinal MDT approval for Patient JD in 2021 but the patient had been

discussed at a MDT in 2019 and the MDT process at the Montefiore was not robust at the time (BW/54 & 68; p.197; 200 WSB). It is accepted that Michael Cass did not get Spinal MDT approval for Patient RM but he did consult with Cameron Hatrick to get approval for the surgery. This was in clear distinction to the Claimant, who sought no approval for KW at all (CH/150-153; p.185 WSB).

iii. There was an evident dysfunction in the working relationship between Mr. Cass and the Claimant which plainly undermined the collaborative efficacy of the Spinal MDT and of the Respondent's spinal surgical unit, which the Respondent singularly failed to address at any time;

This is not admitted for the reasons set out at MC/212; p.79 WSB where Michael Cass explains that he acknowledges there were difficulties in his interactions with the Claimant but still sought to have a functioning MDT. Even if there was a dysfunction – and it is denied that the MDT was dysfunctional in the sense that patient outcomes were compromised,, the Respondent relies upon the evidence of Cameron Hatrick at CH/148; p.184 WSB, where he sets out the efforts he made to set up a functioning, efficient MDT. The Respondent also refers to the evidence of Rachel Dixon at RD/179(iii); p.149 WSB where she explains that during her tenure, once up and running, the spinal MDT worked well and promoted good, clinical discussion.

iv. No consideration was given to the Claimant's protected disclosures and/or race and whether they may have influenced Mr. Cass's actions;

As set out by Rachel Dixon at RD/179(iv); p.149 WSB, it is admitted that she did not give any consideration to the Claimant's protected disclosures. This was because she was either not employed by the Respondent at the time the alleged disclosure(s) were made (Disclosures 1-4) or, if they were made to her, she did not consider that any comments made by the Claimant were protected disclosure(s) and so she did not treat them, or him any differently. As such, she had no reason to consider that another consultant would be "influenced" by them. In relation to the Claimant's race, she considered this was irrelevant in the process that led up to the Claimant's practising privileges being withdrawn and she had no basis for believing that any other colleague at the Respondent involved in the process (including Mr Cass) was "influenced" by this either. Notably, the Claimant did not complain about these alleged unlawful motivations so he cannot reasonably complain that the Respondent did not consider them.

v. The Respondent did not refer the Claimant to the GMC, suggesting that the threshold of risk of serious harm had not been met;

It is admitted that the Respondent did not refer the Claimant to the GMC for the reasons at (RD/179(v); p.149 WSB). As an independent provider, the Respondent's decision to remove practising privileges can be for real and good reasons, with patient safety borne in mind, without reaching the threshold for making a referral to the GMC.

vi. There has been no medicolegal action to date or intimated as a result of the matters which were the subject of the 2022 performance review process.

This is denied. Rachel Dixon is aware of five claims that the Respondent has been notified about relating to patients who were treated by the Claimant (RD/179(vi); p.149 WSB).

vii. There was singular lack of investigation of the Claimant's argument that this was the first time he had failed to obtain MDT approval since the PRC in 2019, particularly in view of the significant number of procedures conducted by the Claimant on an annual basis (538 procedures in 2019; 372 procedures in 2020; and 620 procedures in 2021).

This is denied. The Respondent refers to the evidence given by Rachel Dixon for the consideration given to the issues around MDT approval at RD/179(vii); p.150 WSB.

Ms D'Souza for the claimant clarified on Monday 17 February that the detriment contended for in detriment 30 was the withdrawal of practising privileges and that points i to vii were not advanced as discreet detriments.

t. **Detriment 31** – on appeal, upholding the original decision to withdraw the Claimant's PP despite upholding 3 of the Claimant's appeal grounds. The decision on appeal was flawed on the same grounds as those set out at paragraphs q and s above;

It is admitted that this was the decision reached on appeal. It is denied that this decision was flawed. The Respondent refers to Catherine Cale's statement for the evidence considered and rationale for the outcome of the appeal and CC/62; p.44 WSB.

u. **Detriment 32** - In response to the Claimant's concerns about differential treatment of Mr. Cass, Dr. Cale stating that it was not appropriate to disclose actions taken in respect of others and accordingly rejected that appeal ground in its entirety on that unsatisfactory basis;

It is denied that Catherine Cale explained that it was not appropriate to disclose actions taken in respect of others and accordingly rejected this ground of appeal. As set out by Catherine Cale at CC/61; p.44 WSB the matter of treatment of Michael Cass as compared to the Claimant was something which the panel considered as part of appeal ground viii.

v. **Detriment 33** – in a letter dated 13 March 2023, Dr Cale informing the Claimant that his concerns had been discussed with the consultant in

question (Mr. Cass) and that the Respondent had concluded that "*the outcome for both patients was positive and the standard of care provided was acceptable*" without providing any further detail;

It is admitted that Catherine Cale provided a response in these terms (p.2937 HB). She did not consider it was appropriate to provide more details of the outcome of the review, owing to the Respondent's data protection and confidentiality obligations (CC/71; p.46 WSB).

w. **Detriment 34** - on 21 April 2023, in its response to the Claimant's Equality Act questions, failing to engage meaningfully with the questions raised by the Claimant and providing no insight into why he had apparently been treated differently to Mr. Cass;

This is denied. The Respondent refers to the evidence of CC/89; p.49 WSB. She set out responses to each of the Claimant's questions in so far as she was able to do so due to the Respondent's confidentiality obligations and obligations under data protection legislation and availability of data.

x. **Detriment 35** - on 2 May 2023, only after 4 attempts by the Claimant to raise his concerns about Mr. Cass, finally indicating that the concerns raised by the Claimant about Mr. Cass would be subject to the preliminary review process.

The Claimant has not specified the dates of these attempts. It is admitted that he raised his concerns about Mr Cass in his letter of appeal dated 10 November 2022 (p.2753-2777 HB). Those were addressed by Catherine Cale in her letter of 13 March 2023 (CC/71; p.46 WSB). It is admitted that the Claimant raised his concerns again on 12 April 2013 (p.2955-2960 HB) and following this, Catherine Cale wrote to him to confirm that Michael Cass was now subject to a preliminary review process (CC/75; (p.46 WS Bundle). The Respondent refers further to CC79; p.16 WSB. It is unclear as to what further two occasions the Claimant is saying he raised these concerns and they were not addressed, so this is not admitted.

14. Did any of the above acts or omissions which the Claimant may prove amount to detriment within the meaning of s.47B(1) ERA?

It is not admitted that detriments 1, 2A, 2B, 4, 5, 7 14, 16, 19, 22, 23, 25, or 33 are detriments in that any sense of grievance about them on the C's part would be in the circumstances unjustified.

15. In respect of any detriments inflicted by Mr. Cass on the grounds of Protected Disclosures 1 to 6 (Detriments 1, 2, 3, 6, 7, 8, 12 and 15), is the Respondent vicariously liable for those acts/omissions?

The Respondent denies detriments 1 and 2, if they occurred in the manner alleged by the C, were done by Mr Cass in the course of his employment as defined under the EqA 2010.

16. Did the Respondent subject the Claimant to such detriment as the Claimant may prove on grounds of Protected Disclosures 1 to 6 set out above, contrary to s.47B(1) ERA? More particularly:

    a. Was Detriment 1 caused by Disclosure 1?
    b. Were Detriments 2, 2A, 2B and 3 caused by Disclosures 1 and/or 2?
    c. Was Detriment 4 caused by Disclosures 1, 2, 3, 4 and/or 5?
    d. Were Detriments 5-35 caused by Disclosures 1, 2, 3, 4, 5 and/or 6?

    The Claimant has never indicated which specific detriment(s) are said to have been caused by which specific alleged disclosure or disclosures. Since he is unable or unwilling to do so the Respondent cannot provide a more meaningful response of its position on this point.

Direct Race Discrimination

19. Was the Claimant subjected to Detriments 1 to 35 by the Respondent?

17. Did any acts or omissions as the Claimant may prove amount to detriments also amount to less favourable treatment when compared with the treatment of a hypothetical comparator (whose construction draws upon the treatment of Mr. Michael Cass)?

18. Did such treatment as the Claimant may prove amount to less favourable treatment by the Respondent because of the Claimant's race (being Pakistani and/or non-white)?

19. If so, did the Respondent contrary to ss.13 and 39(2) EqA 2010 discriminate against the Claimant:-

    a. As to the terms of his employment?

    b. In the way in which the Claimant was afforded access, or not afforded access to, opportunities for promotion or for receiving any other benefit, facility or service?

    c. By subjecting him to any other detriment?

Vicarious Liability

20. Is the Respondent vicariously liable for any discriminatory acts or omissions of Mr. Cass which were done in the course of his employment and/or done as agent with the Respondent's authority, in accordance with s.109(1) and (2) EqA?

    Mr Tatton Brown for the respondent indicated:

    a. on 12 February 2024 that for the purposes of this claim the respondent accepted that Mr Cass was a worker (for the purposes of the ERA) and in employment (for the purposes of the EQA);

    b. on 13 February 2025 that the respondent was not pursuing the reasonable steps defence.

Employment Judge Evans

Approved on: 1 May 2025

Public access to employment tribunal decisions

All judgments (apart from those under rule 52) and any reasons for the judgments are published, in full, online at www.gov.uk/employment-tribunal-decisions shortly after a copy has been sent to the claimant(s) and respondent(s) in a case.

Recording and Transcription

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

https://www.judiciary.uk/guidance-and-resources/employment-rules-and-legislation-practice-directions/