# EMPLOYMENT TRIBUNALS

**Claimant:** **Mrs S Wheeley**

**Respondent:** **University Hospitals Birmingham NHS Foundation Trust**

**Heard at:** **Birmingham** **On: 3 to 5 April 2017 and**
**26 to 28 February 2018 and**
**1 and 2 March 2018**

**Before:** **Employment Judge Broughton**

**Members:** **Ms S Campbell**
**Mr NJ Howard**

**Representation**

Claimant: Mr S Brittenden, counsel

Respondent: Mrs H Barney, counsel

# JUDGMENT

The claimant was unfairly dismissed. Her dismissal also amounted to disability discrimination under s15 Equality Act 2010.

She contributed 25% to her dismissal.

Employment Judge Broughton

22 March 2018

# REASONS

## Background

1. The claimant alleged that she was a disabled person by virtue of Bipolar Disorder and, furthermore, that her actions that ultimately led to her dismissal were caused by that disability.

2. In support of her position she initially relied principally on a report from a Professor Oyebode which was commissioned by the respondent during the course of the disciplinary proceedings.

3. The respondent challenged the claimant's case both in relation to whether she met the definition of disability and also on the issue of causation. Initially they appeared to be suggesting that the report of Professor Oyebode was unreliable and therefore that the claimant had failed to satisfy the initial burden upon her.

4. Having commenced hearing the evidence, the respondent's contentions appeared to rest on the suggestion that the report was based on inadequate and/or incomplete or inaccurate information provided to the Professor. There were several alleged examples of this.

5. As a result of these potentially valid challenges in relation to two of the key issues in the case the original hearing was adjourned to allow the parties to jointly instruct an independent expert.

6. Professor Goodwin was instructed to consider all the relevant evidence and, indeed, representations were made by the parties including consideration of the credibility of the claimant's presentation. He produced a detailed report and subsequently responded to further detailed questions from the respondent.

7. Professor Goodwin was not called to give evidence, nor was his report directly challenged before us. None of the contents were put to the claimant, nor was the information that she reported to Professor Goodwin challenged.

## The facts

8. The claimant commenced employment with the respondent in October 1996. After several promotions she became the Head of Informatics, a position she held for some years prior to the events in issue in this case.

9. We heard that she had suffered from recurring periods of depression for many years going back to when she was a teenager. These periods of depression had been treated for many years with anti-depressant medication, primarily Fluoxetine.

10. In around 2006 she had reported to her GP fearing that she may have bipolar disorder. She reported various symptoms to support such a diagnosis. She was put under review. However, as there was, at that stage, only one evidenced period of apparent hypomania, and it was possible that this was attributable to the fluoxetine, she did not receive a diagnosis at that stage.

11. Her evidence, supported by her GP records, was of periods of depression, treated with anti-depressants in the subsequent years but there were initially no evidenced examples before us of further periods of alleged mania until the events that became the subject matter of these proceedings in 2015.

12. That said, she did report a couple of more moderate periods of hypomania to the independent medical expert. Nonetheless, she had no absences from work due to depression or, indeed, bipolar as she said she was able to manage her symptoms with medication and coping strategies.

13. Her ex-husband had reported to Professor Oyebode periods that suggested that, for example, he would not see her in the mornings for weeks at a time which must have been referring to periods when she was either not working or only just coping with work. We note she only worked part-time during this period.

14. The claimant also had a clear disciplinary record with no issues about her conduct at work having been formally addressed.

15. The claimant's GP notes reveal that following a 2 year period of stability in October 2014 she started to feel down and anxious again and she was re-started on the anti-depressant fluoxetine. She remained on that medication and, in March 2015, she reported further stresses at work and home leading to her struggling with motivation such that her medication was increased.

16. The respondent was unaware of any prior mental health concerns at the time they manifested themselves.

17. The respondent's evidence from a number of witnesses was that the claimant's behaviour could regularly be difficult and inappropriate. They

referenced examples such as table banging and walking out of meetings. The claimant denied these allegations but we prefer the respondent's evidence.

18. The respondent's witnesses on this point were credible and measured. We do not think that there was any good reason for them to mislead us or exaggerate. There were several consistent examples from different witnesses including some who gave their evidence to the internal investigation prior to there being any suggestion that the claimant's behaviour in July 2015 may have been influenced by her mental state.

19. It was common ground that the claimant was a challenging employee. That, of itself, is not necessarily a bad thing for a senior manager. We accept, however, that her behaviour was, at times, inappropriate albeit it was common ground that this had never been formally addressed with her.

20. There was no suggestion that any such behaviour was related to her mental health.

21. The claimant reported to Daniel Ray, Director of Informatics who, in turn, reported to Dr Rosser, Medical Director. Mr Ray had managed the claimant for many years but, in the last couple of years they had been in a personal relationship also.

22. In or around May 2016 Dr Rosser was proposing a minor restructure of the department, effectively splitting Informatics in two. He commenced discussions with senior members of the team, including the claimant.

23. We were referred to an email from the claimant to the Medical Director dated 29 May 2015 which obviously followed initial discussions about the potential restructure in which she set out her hopes for promotion and flagged that she would be deliberately challenging and had some insight into the fact that her behaviours could be misinterpreted or irritating.

24. Whilst her initial responses in cross examination were somewhat vague and contradictory (another reason why, on the few matters where facts were in dispute we preferred the evidence of the respondent), it became clear from the claimant's evidence, and that of the medical expert, that they believed that this email evidenced the claimant entering a hypomanic phase. The self-confidence and tone was said to be out of character. It certainly appeared to us to be an unusual communication, at times challenging at others over familiar.

25. There was no suggestion that this sort of correspondence with an executive director formed part of the claimant's normal behaviour and so we are prepared to accept the evidence of the claimant and the medical expert that, with the benefit of hindsight, this did illustrate an early indication of possible mood disturbance.

26. The restructure was announced in July and it was common ground that the claimant was unhappy about a number of matters. These included the fact that she was not promoted and was to report to a different manager, having previously reported to her life partner. She also felt she had been "misled" and there had been inadequate consultation.

27. The claimant had been informed that, in the new structure, she would be reporting to Mark Garrick. She sent an email to Dr Rosser on 20 July 2015 stating that this was "unacceptable" and she went on "I will not be reporting to Mark as he does not have the skills…." She sent a further email that evening that she acknowledged was "wholly inappropriate".

28. Dr Rosser also considered the claimant's reaction to be "wholly inappropriate". He felt he had been fair and clear with the claimant and that he had the right to change her line manager and would not change his mind. He confirmed the same in an email the following day but the claimant maintained her objection. She emailed Dr Rosser claiming she had been shown a lack of respect and been misled. She threatened to email the team at 2pm "informing them that the announced change would not be happening and why" unless he agreed to meet with her beforehand. She was given an express management instruction not to do so.

29. At around lunchtime Dr Rosser emailed relevant individuals with his proposed reconfiguration of the Informatics department. Despite the instruction not to do so the claimant responded to the group email, which included members of her team and the respondent's executive directors, claiming that she was not aware the communication was being sent out and that she was "considering her position".

30. Her reaction resulted in her suspension for responding angrily, allegedly failing to follow a management instruction regarding not sending an email and communicating and acting inappropriately as a senior manager to other

managers and colleagues. She was told not to contact colleagues without express consent.

31. Following her suspension a further allegation of failing to follow management instruction was added in relation to her attending the Executive Medical Director's home outside working hours. This arose because she went to Dr Rosser's house in the evening of 27 July 2015 to attempt to discuss the issues.

32. An investigation commenced in August during which the claimant was interviewed twice. During those interviews she largely sought to justify her actions, albeit she did acknowledge she should not have attended Dr Rosser's home and apologised.

33. The claimant continued to feel justified and wronged throughout September and October. She was reporting symptoms of stress and depression to her GP and remained on anti-depressants. As a result, her initial disciplinary hearing was postponed as she was unfit to attend.

34. By the end of October the claimant remained unrepentant and issued a lengthy grievance. However, at around the same time she changed her union representative.

35. It appears that the advice she received was that there was no defence to the allegations unless she was ill. In the subsequent hearings her new union representative described the difficulty he encountered getting the claimant from a position of denial to one of insight in relation to her actions.

36. He said that from his initial meeting with the claimant he was concerned about her mental health. Moreover, he had informed her that he considered that unless she was unwell there was no defence to her actions, describing her emails as "the shortest suicide note in history". He said it was the claimant's ongoing lack of insight into the seriousness of her actions that set off the "alarm bells" for him.

37. The claimant suggested that this was the turning point in her having some insight into her actions. That seems to us entirely possible, notwithstanding potential alternative explanations.

38. We note, however, that the claimant continued to progress her grievance, albeit a version significantly toned down by her representative, at that stage.

Her evidence was that she still had a strong sense of injustice at that time. Despite her dawning insight, she did nothing at that stage to attempt to put matters right, such as apologise.

39. The claimant obtained a report from her GP but this largely only confirmed her stress and depression over the previous year.

40. At around the same time the claimant was referred to Dr Robertson of Occupational Health primarily in relation to her fitness to attend a disciplinary hearing.

41. Dr Robertson also appeared to have concerns about the claimant's mental health and subsequently referred the claimant to Dr White, psychiatrist for the Occupational health service.

42. It was at this stage that the claimant again reported to her GP, in December 2015, that she was worried about having bipolar disorder. The record showed that she was "well read on the subject". This was also the first indication, along with the referral of Dr Robertson, that the claimant could see some of her email content had been inappropriate.

43. That said, the respondent made the point that the claimant did not actually express any remorse or apologise until after this had been raised as an issue in the disciplinary hearing and, indeed, after she had received the diagnosis of Professor Oyebode.

44. Dr White, having spoken to the claimant and her mother, reported on 30 December 2015. He was unable to reach a definitive conclusion on whether the claimant had bipolar disorder or "personality related difficulties" but he felt that a bipolar diagnosis was "certainly possible".

45. He considered that there would need to be clear evidence of periods of normality and abnormality. He felt the evidence would need to include school, GP and personnel records and seeking evidence from both her ex and current partner. He suggested that such a report would take some time to compile. He was, however, clear that bipolar disorder was "eminently treatable".

46. Meanwhile, the claimant's grievance had been heard and considered in the claimant's absence. Her complaints were rejected. The conclusion was essentially that she had been adequately involved in the reconfiguration of her department and Dr Rosser was entitled to change her line management

without any formal process. The evidence of the respondent's witnesses before us confirmed this analysis and it was not an issue in material dispute before us.

47. The claimant appealed the grievance outcome. In the respondent's view this demonstrated that she remained unjustifiably aggrieved by what they saw as a simple and common change to line management. Ultimately the claimant did withdraw her grievance appeal, albeit not until after her dismissal.

48. In January 2016 the claimant made a private appointment with Dr Sonsati, consultant psychiatrist. Her evidence before us was that she did so because she was very ill and needed help desperately before this would be available on the NHS. However, Dr Sonsati's report suggested that their meeting was more for the purpose of diagnosis than treatment. The respondent made the point that even when the claimant did get a diagnosis she did not commence taking her medication for several months.

49. Dr Sonsati felt that a bipolar diagnosis was not supported. She sent her report to the claimant but the claimant claimed not to have received it. The report was only disclosed to the respondent on 17 February 2017, following an express request. That said, the claimant did inform Professor Oyebode of Dr Sonsati's opinion. If she were simply attempting to obtain a diagnosis of convenience she would, perhaps, have been unlikely to do so.

50. As a result of Dr White's opinion, Dr Robertson arranged the referral to an independent psychiatrist, Professor Oyebode.

51. After several postponements the claimant's disciplinary hearing was to take place on 25 January 2016. She remained unfit to attend but the respondent had agreed to certain requests for adjustments such as allowing her union representative to attend and make representations on her behalf and providing her with the panel's questions in advance to allow her to prepare responses with her representative.

52. The hearing proceeded and was adjourned. The following day the claimant saw Professor Oyebode who also spoke to her ex-husband. He did not, however, consider all of the evidence deemed necessary by Dr White. We do not know why.

53. Professor Oyebode reported on 3 February 2016. His view was that the claimant presented with the cardinal features of bipolar disorder. There was, in his view, clear evidence of periods of depression and mania.

54. He reported that it "is well recognised in manic phases that people can exhibit behaviours that are out of character and which demonstrate irritability, hostility, recklessness and may be prone to poor judgments". He referenced the claimant's threatening and insubordinate emails and said that the claimant regretted these behaviours, recognised them as wrong and, further, considered them to be out of character.

55. Professor Oyebode's opinion was that, on balance of probabilities, the claimant was in a manic phase in the period in question and that her behaviour, which formed the basis of the disciplinary allegations against her, was compromised by severe mental illness.

56. The disciplinary hearing continued on 11 February 2016 and again on 8 March 2016. In light of Professor Oyebode's report the claimant's representative sought to shift the focus away from misconduct to the claimant's mental health. The disciplinary panel, however, considered that it remained a conduct issue albeit they were prepared to consider the claimant's mental health in the context of mitigation.

57. The panel's reasons for doing so appeared to include the fact that they were not convinced that the claimant's behaviour was "out of character". They were also concerned that the claimant had not apologised for her actions and was still progressing her grievance appeal. Further questions were put to the claimant via her representative.

58. On 10 March 2016 the claimant's union representative forwarded what the claimant characterised as an unreserved apology for her actions.

59. On 11 March 2016 the claimant was sent a letter outlining the outcome of the disciplinary process. She was dismissed summarily for gross misconduct and offered the right of appeal.

60. The dismissal letter was detailed. It spelt out that the allegations included two counts of failing to follow reasonable management instructions in relation to the sending of the email and visiting Dr Rosser at home. It also referenced inappropriate conduct and communications which included refusing to report

to Mr Garrick and deliberately emailing her team and the executive directors of the respondent.

61. The allegations were not particularly in dispute but, nonetheless, the evidence against the claimant was summarised in some detail. The claimant's case was also summarised. In short, the claimant admitted the allegations but contended that they amounted to serious misconduct as opposed to gross misconduct for a first offence. Primarily, however, the claimant relied on the medical opinion and, specifically, the finding that the claimant's behaviour had been compromised by her disability.

62. The claimant's arguments remained effectively the same before us.

63. Each of the allegations were upheld. That was not surprising given the claimant's admissions and the weight of evidence.

64. The panel considered that the allegations amounted to gross misconduct. The claimant herself acknowledged that her conduct was "wholly inappropriate". We agree. Moreover, we are satisfied that, absent any mitigation, they amounted to gross misconduct. This was a senior manager who expressly breached two clear and direct management instructions. She also, effectively, made threats, refused to be managed and was attempting to stir up dissent.

65. In those circumstances this was gross insubordination on a grand scale and, notwithstanding the claimant's long service and clean disciplinary record, dismissal would, ordinarily, have been well within the band of reasonable responses available to a reasonable employer. That was the position of the respondent and was in accordance with their procedures.

66. It also appeared to be the view of the claimant's union representative, notwithstanding his representations to the contrary, given his "suicide note" comments

67. The issue was, therefore, what difference should the claimant's recent diagnosis of bipolar disorder make to the situation.

68. The panel seemingly considered that the claimant was culpable for failing to report her mental health difficulties sooner and for not seeking additional support sooner. That seemed to us to be an unfair criticism. Until the events

in question the claimant appeared to be successfully managing her depression and she was unaware that she had bipolar disorder.

69. The panel expressly accepted the claimant's diagnosis and the opinion that she was in a manic phase at the time of the events that lead to her suspension. That appeared inconsistent with their expressed reservations about the quality of the evidence before Professor Oyebode. Those reservations were not unreasonable but the appropriate response in those circumstances would have been to revert to the expert.

70. The panel did not consider that the claimant's diagnosis could explain all the claimant's behaviour. That may well be right. Specifically, they did not consider that her conduct had been "out of character" as she had reported to Professor Oyebode.

71. They acknowledged that the behaviours may have been exaggerated from, or stronger than, those exhibited previously but they considered that this was because they were personal to the claimant and her career. Elsewhere, however, the panel rightly acknowledged that it was difficult to identify which parts of the claimant's behaviour were down to her bipolar and which were not.

72. Again, it appears that the correct response would have been to seek more information from the expert.

73. For example, we heard that the claimant had never before flouted a direct management instruction, visited a director at home uninvited or inappropriately emailed the executive and/or her team.

74. It was, seemingly, those behaviours and the subsequent lack of insight into them which contributed to the diagnosis.

75. The respondent, however, focussed on the fact that the claimant was likely to have reacted strongly and inappropriately absent any disability.

76. They also relied on the claimant's ongoing grievance appeal to support their view that she remained angry and aggrieved. It was far from clear, however, how the panel considered these ongoing feelings to be inconsistent with a manic phase.

77. It seems to us that the claimant was entitled to raise a grievance and, indeed, that this would have been the appropriate response to her frustrations

in July 2015, rather than her actual actions. Whether she remained aggrieved at the restructure gives little or no indication as to when or whether she was in a manic phase.

78. As an aside we observe that the claimant's grievance included a complaint of sex discrimination. As a result, to subject her to a detriment as a result of raising it, or pursuing it, would potentially amount to victimisation but that was not part of the case before us.

79. The panel appear to have confused the cause of the claimant's anger and frustration and the expression of the same. The medical evidence before them, which has been further confirmed before us, was that her reactions were impaired by mental illness, at least in part.

80. The respondent effectively concluded that:-

a. the claimant was guilty of the allegations against her and

b. she did suffer from bipolar disorder and was in a manic phase at the relevant time but

c. her mental health did not substantially cause or exacerbate her misconduct

81. The panel did, however, go on to conclude that the claimant was likely to be disabled as defined by the Equality Act 2010 and proceeded to consider reasonable adjustments. That latter point was somewhat inconsistent with their previous findings because the duty to make reasonable adjustments would not arise if the claimant was not disadvantaged by her disability. That said, we do not criticise them for attempting a belt and braces approach.

82. The disciplinary panel did not consider that there were any reasonable adjustments that they could make as they felt the claimant's actions had irreparably damaged her relationships within Informatics and, indeed, with the executive directors, including Dr Rosser. Moreover, they felt that the claimant still objected to the new structure and being managed by Mark Garrick. They were unaware of any suitable alternative roles elsewhere within the trust.

83. As a result they concluded that the claimant was guilty of gross misconduct and she was dismissed summarily with effect from 11 March 2016.

84. The claimant was given the right to appeal which she exercised. She appealed on 30 March 2016 and withdrew her grievance appeal on 5 April 2016.

85. The appeal hearing took place before an independent internal panel on 17 May 2016 and the claimant was again represented by her union representative in her absence.

86. The appeal was rejected and the dismissal upheld and this was confirmed in a letter dated 20 May 2016. The appeal panel considered that the disciplinary panel had appropriately considered the claimant's mental health.

**The issues and the law**

**Unfair dismissal**

87. What was the reason for the dismissal? The respondent asserts that it was a reason related to conduct which is a potentially fair reason for section 98(2) Employment Rights Act 1996. It must prove that it had a genuine belief in the misconduct and that this was the reason for dismissal.

88. Did the respondent hold that belief in the claimant's misconduct on reasonable grounds following a reasonable investigation? The burden of proof is neutral here but it is helpful to note that the claimant's principal challenge was that the respondent should have sought further medical evidence before rejecting some of the key findings of Professor Oyebode.

89. Was the decision to dismiss a fair sanction, that is, was it within the reasonable range of responses for a reasonable employer?

90. If the dismissal was unfair, did the claimant contribute to the dismissal by any culpable conduct? This requires the respondent to prove, on the balance of probabilities, that the claimant was responsible for the conduct alleged. If so, by what proportion should the compensatory award be reduced as a result?

91. Was the claimant's conduct prior to notice of termination being given such that it would be just and equitable to reduce the basic award? If so, by how much?

92. Can the respondent prove that if it had adopted a fair procedure the claimant would/may have been fairly dismissed in any event? If so to what extent and when?

**Disability**

93. Did/does the claimant have a physical or mental impairment, namely bipolar disorder? This was no longer disputed.

94. If so, did the impairment have a substantial adverse effect on the claimant's ability to carry out normal day-to-day activities?

95. If so, was that effect long term? In particular, when did it start and did the impairment last for at least 12 months? If not

95.1. is or was the impairment likely to last at least 12 months or

95.2. was it likely to recur after at least 12 months

and, if so, from which date?

We note that in assessing the likelihood of an effect lasting 12 months, account should be taken of the circumstances at the time the alleged discrimination took place. Anything which occurs after that time will not be relevant in assessing this likelihood. See the Guidance on the definition of disability (2011) paragraph C4.

96. Are or were any measures being taken to treat or correct the impairment? But for those measures would the impairment be likely to have a substantial adverse effect on the claimant's ability to carry out normal day-to-day activities?

97. The relevant time for assessing whether the claimant had/has a disability (namely, when the discrimination is alleged to have occurred) is March 2016. It was, therefore, conceded that the respondent had knowledge at the relevant time by virtue of Professor Oyebode's report.

**S.15 Equality Act 2010**

98. This arises where an employer treats an employee unfavourably because of something arising in consequence of their disability and where

they cannot show that their actions were a proportionate means of achieving a legitimate aim.

99. We considered paragraph 5.2.1 of the Employment Code of Practice. If an employer has failed to make a reasonable adjustment which would have prevented or minimised the unfavourable treatment, it would be difficult to show that it was objectively justified.

100. The claimant contended that her unfavourable treatment was her dismissal.

101. She said, effectively, that the something arising in consequence of her disability was her behaviours that ultimately led to her dismissal. We were reminded that the "something arising" need only be a substantial cause of the subsequent treatment.

102. The respondent contended that, if that were the case, their actions were, nonetheless, justified.

103. We reminded ourselves of the relevant authorities and that the test for justification is in two parts:

103.1 was there a legitimate aim, and

103.2 was the treatment a proportionate means of achieving that aim?

104. It is an objective balance between the discriminatory effect on the individual and the reasonable needs of the employer.

105. It would be an error of law for us to focus on any procedural failures of the employer as a reason for rejecting a justification defence. It was accepted on the part of the respondent that the burden of establishing this defence is on them.

106. Regarding the issue of a legitimate aim, the aim should be legal and not discriminatory in itself and represent a real objective consideration.

107. The respondent argued that the legitimate aims were

107.1 to be seen to be dealing appropriately with misconduct

107.2 to maintain their values

107.3 to ensure that management decisions are respected

108. It was conceded that each of these were, potentially, legitimate aims.

109. We considered the test of objective justification that the employer is required to show to our satisfaction that the aim alleged to be discriminatory corresponds to a real need on the part of the employer, that the policy is appropriate to achieve that objective and that it is reasonably necessary. That reasonably necessary test is stricter than the range of reasonable responses test but that does not mean that the employer has to demonstrate that no other proposal was possible, but rather we had to make our own judgment regarding whether it was necessary.

110. So, in considering proportionate means, the means have to be appropriate and reasonably necessary. Effectively we have to carry out a balancing exercise by evaluating the discriminatory effect on the individual against the employer's reasons for applying the aim, considering all relevant facts.

111. The effect here was not really in dispute, the loss of the claimant's job. We reminded ourselves that the reasons put forward by the respondent should be respected, albeit not uncritically accepted, and that we should consider the non-discriminatory alternatives put forward by the claimant in the context of determining whether or not they should have been adopted.

112. Section 136 of the Equality Act provides that if there are facts from which the tribunal could decide in the absence of any other explanation that there had been a contravention of the Act, then the tribunal must hold that such a contravention occurred.

113. The first stage is to establish whether there are facts, on the balance of probabilities, from which a tribunal could conclude, in the absence of an adequate explanation, that an act of discrimination has taken place. If there are not then the claim will fail. That said it is unusual to find direct evidence of discrimination and the discrimination may be unintentional. Accordingly it is for a tribunal to draw appropriate inferences from the primary facts.

114. At this stage a tribunal does not have to reach a definitive determination that there was unlawful discrimination merely that there could have been and, in those circumstances, we must assume that there could also be an adequate explanation at the second stage. We can have reference to any relevant code of practice and draw inferences from any failure to comply with any provision of such code.

115. Where facts are proved from which conclusions could be drawn of less favourable treatment because of a protected characteristic, then the burden of proof moves to the respondent and it is then for them to prove that they did not commit, or are not to be treated as having committed, the discriminatory act.

116. 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 the protected characteristic.

117. Accordingly, the tribunal must assess not merely whether there is an explanation for the facts but also whether such explanation is adequate to discharge the burden of proof. Cogent evidence is required to discharge that burden.

**Decision**

**Disability**

118. Professor Goodwin's report was clear that he believed that the claimant suffered from bipolar disorder. The respondent did not dispute his diagnosis or directly challenge any specific aspect of his report. We were, however, invited to consider the extent to which the claimant's presentation may have been affected by viewing her medical history through a different lens once it became clear to her that she needed a medical excuse for her behaviours in July 2015.

119. Professor Goodwin described several periods of depression over the course of the claimant's life, commencing as a teenager in a period he described as "major" and which caused disturbed sleep, social withdrawal, tearfulness and an inability to concentrate resulting in significantly lower exam results than expected. It seems to us that she was, at this time, suffering substantial adverse effects to her normal day to day life.

120. In 2004 the claimant had reported similar symptoms to her GP and was started on anti-depressants. Thereafter, of course, we need to consider what the likely adverse effects of such periods of depression would have been absent any medication.

121. The claimant first thought she may have bipolar disorder in 2006 and she was referred for assessment, describing periods of mood elevation. The conclusion at that time was that she did not meet the criteria. This appears to have been because only one episode of potential hypomania was described and evidenced and, in any event, that episode could have been caused by her anti-depressant medication.

122. Professor Goodwin felt that he would, nonetheless, have been able to diagnose bipolar at this stage. He identified two subsequent periods of mood elevation and further periods of depression managed by medication.

123. He described the condition as being "lifelong".

124. He stated that between episodes the disorder had little effect on day to day activities.

125. In depressive periods the effect could be negligible to severe. We are satisfied form the claimant's evidence, her medical records and the

opinion of the medical expert that, in at least some of the claimant's depressive periods, there was a substantial adverse effect on her day to day activities. She described periods of disturbed sleep, loss of concentration, being unable to care for her family and social withdrawal. Her ex husband described periods when she would not get out of bed in the mornings. It seems to us likely that the effect during these periods would have been greater but for her medication. There was clear evidence of substantial adverse effects, even when medicated, from around October 2015 when she was deemed unfit to attend work related hearings.

126. In relation to the claimant's periods of hypomania prior to the summer of 2015 the evidence appeared to be that these were largely positive experiences and so could not be described as having an adverse effect. That said both professors considered that the claimant was in a manic phase during the summer of 2015 and they felt that her actions evidenced this. Loss of "cognitive control" was a symptom of the disorder. The claimant's behaviours seriously damaged working relationships. Lack of insight exacerbated the situation. It seems, therefore, that in 2015 there was also a substantial adverse effect during a manic phase.

127. Periods of depression and hypomania were and are likely to recur. At least some of those were and are likely to have substantial adverse effects on the claimant's normal day to day activities. Without medication those effects are likely to be more substantial. That has been the case since at least 2006.

128. Accordingly the claimant met the definition of disability from 2006.

**Causation**

129. Both professors considered that the claimant was in a manic phase in the summer of 2015. Whilst there were some legitimate questions and challenges in relation to Professor Oyebode's report these were answered by Professor Goodwin.

130. He formed the view that the claimant's email of 29 May 2015 to Dr Rosser evidenced increased confidence and assertiveness. He suggested that this evidenced the commencement of a period of mood elevation, initially hypomanic in severity and, as a result, not having an adverse effect at that stage. He saw no contradiction in the claimant reporting to her GP with

symptoms of depression. It is apparently not uncommon for symptoms of both states to co-exist.

131. Professor Goodwin then considered the events of July 2015. He did not consider that the claimant's anger or resentment were caused by her mood disorder. Rather, it was his view that her condition was likely to have amplified her response. As a result he effectively concluded that the claimant's condition was a significant influence on her subsequent actions. He considered that the claimant's defence of her actions over the next 2 to 3 months further evidenced significant impairment to her judgment.

132. Specifically, the medical expert appears to have formed the view that the claimant would not have expressly flouted management instructions but for her elated state.

133. The respondent was able to put their challenges to the claimant's presentation to Professor Goodwin and he considered them all. They did not alter his view and we have no good reason to challenge his experience, qualifications or conclusions.

134. The respondent's own evidence was that they accepted that the claimant was in a manic phase in the relevant period in July 2015. They sought to argue, however, that the claimant's mental state had no substantial impact on her behaviours and, in this regard, they relied principally on previous examples of inappropriate conduct.

135. That seems to us to be an untenable conclusion. It is unsustainable on the evidence before us to suggest that the impact of the claimant's mental health on her behaviours at the relevant time was no more than trivial. The medical evidence is clear. The claimant's judgment was impaired and her reactions were amplified as a result of her condition.

136. To put it another way, by virtue of the medical evidence, the claimant has established facts from which we could conclude that her behaviours were substantially affected by her bipolar disorder. The respondent accepted that her reactions were stronger and more exaggerated than she had exhibited previously. Their conclusion that she would have reacted as she did in any event amounts, at best, to an assumption. They have failed to produce cogent evidence that her mental health played no more than a trivial part in the events.

137. That said, we have accepted the respondent's evidence about previous examples of unprofessional conduct. None of those were as serious as the events in July 2015. It seems to us, therefore, likely that the claimant would still have been angry and would still have responded unprofessionally but her reactions would not have been as extreme as those she actually manifested.

138. In those circumstances her condition did have a significant impact on her actions which, therefore, arose because of something in consequence of her disability.

**Justification**

139. The respondent had knowledge of this given Professor Oyebode's report. Whilst a number of their initial challenges to that report were potentially valid the correct response would have been to revert to the medical expert and raise those issues with him. Had they done so it seems to us likely that the respondent would have received the additional clarity that we now have courtesy of Professor Goodwin.

140. We therefore move on to consider the issue of justification. Both the claimant and her representative accepted that the respondent's aims were legitimate and we agree.

141. We do not, however, consider that summary dismissal was a proportionate response.

142. We have already highlighted that the appropriate response to the challenges to the medical evidence was to seek clarity from the expert. To simply reject one of the key findings of the report, that the claimant's actions were compromised by severe mental illness, was unreasonable.

143. Had additional clarity been received the respondent would have had to consider discounting the impact of her condition from her actions. They did not do so.

144. We note at this stage that all of the evidence suggested that the claimant's disability was eminently treatable and so there was not, necessarily, any indication that there was likely to be any recurrence.

145. The respondent had been seen to act in accordance with their values and in upholding their disciplinary policy by suspending the claimant

and subjecting her to a disciplinary process. That was not unreasonable. The claimant's conduct needed to be addressed and, indeed, needed to be seen to have been addressed.

146. We do not, however, accept that, at the time of the claimant's dismissal, there was no reasonable alternative but to dismiss summarily. The claimant was a long serving employee in a senior management post. The respondent's values and policies also included promoting diversity and making adjustments for disabled employees.

147. Issues around the impact on colleagues seeing the claimant apparently getting away with gross insubordination could have been addressed in a number of ways, as could relationships with the executive directors and the claimant's subordinates.

148. For example, the claimant's permission could have been sought to circulate her apology. That permission could have included at least some insight into her medical condition. Such permission may not have been granted but there could, at least, have been a joint communication that such behaviours were wholly inappropriate and would, ordinarily, result in dismissal save for the extenuating mitigating circumstances in this case.

149. We accept that there were no suitable alternative posts but do not accept that the respondent reasonably explored alternative approaches to restoring working relationships and upholding their values and policies. As a result, summary dismissal for gross misconduct was not a proportionate response.

150. The claimant's dismissal was, therefore, an act of disability discrimination under section 15 Equality Act 2010.

**Unfair Dismissal**

151. For similar reasons we find that the claimant's dismissal was unfair.

152. The claimant's actions were grossly insubordinate. They were potentially gross misconduct. It was reasonable for the respondent to suspend and investigate and they did so reasonably.

153. They made considerable adjustments to the process to allow the claimant to fully respond. A fair process was followed and an independent appeal arranged.

154. The allegations were admitted and so the respondent's belief that the allegations were made out was both genuine and reasonable.

155. However, no reasonable employer would have rejected the key finding of Professor Oyebode, that the claimant's actions were compromised by severe mental illness, without, at least, seeking further clarification or information. Had they sought the same and received findings similar to those of Professor Goodwin they would have had no reasonable alternative but to discount the effect of the condition.

156. In those circumstances no reasonable employer would have dismissed summarily for gross misconduct.

**Contributory conduct**

157. However, the claimant was not blameless in this situation. Her previous inappropriate and unprofessional behaviour was a key factor in the disciplinary panel's deliberations and clearly contributed to her dismissal. Indeed, it was likely that she would have responded inappropriately in July 2015 even had she not suffered from bipolar disorder.

158. Whilst she apologised for attending Dr Rosser's home relatively quickly, the claimant clearly started to have insight into the rest of her actions by November 2015, yet she did not apologise until a diagnosis was confirmed and, indeed, until her failure to do so had been expressly raised by the disciplinary panel. It was not unreasonable for the disciplinary panel to draw adverse inferences from that.

159. We note that Professor Goodwin felt that she would not have sent the insubordinate email but for her condition and that her disorder contributed >50% to the rest of the circumstances. That said, the respondent may not have dismissed but for the previous misconduct and the delay in apologising. It seems to us that the principal reason for the dismissal was the respondent's failure to appropriately discount the effects of the claimant's disability from their deliberations but the claimant's contribution was, nonetheless, substantial. As a result, we consider that the claimant's conduct contributed 25% to her dismissal.

160. We do not consider that pursuing her grievance was culpable conduct on the part of the claimant. She was entitled to feel aggrieved, however misguided that feeling may have been. We accept on the evidence

we have heard that the respondent acted reasonably in not upholding her grievance.

**Remedy issues**

161. It is, however, potentially relevant to the issue of remedy. We will need to consider what would have happened but for the unfairness and discrimination we have found.

162. We consider that it would not have been unreasonable for the respondent to have censured the claimant for her actions and, potentially, to have issued her with some form of disciplinary warning. Her previous unprofessional behaviour only came to the respondent's attention through the internal proceedings due, it seems to us, in large part, to the fact that she had previously been line managed by her partner.

163. On the evidence we have seen it seems unlikely that she would have accepted such a sanction, given that she continued to deny any inappropriate conduct at all, save that which she fully attributed to her disability.

164. The claimant may have been unwilling to return in those circumstances or, ultimately, depending on her reaction the respondent may have been in a position to dismiss fairly.

165. That is before we get to consider the necessary steps that the respondent would have had to take to manage a return to work, looking at alternative means of achieving their legitimate aims which would have required some cooperation from the claimant which may not have been forthcoming. It was clear from her GP notes shortly before her dismissal that she retained a strong, but unjustified, sense of having been unfairly treated. Ultimately, a failure to reach a resolution may have resulted in a possible dismissal for some other substantial reason.

166. We may also have to consider the effect of the claimant's ongoing ill health at the time of her dismissal and when and whether she may have been fit to return in any event, including in the circumstances described above. In that regard we also observe that any injury to the claimant's health and/or feelings prior to her dismissal must be disregarded for the purposes of compensation.

167. If, despite all the above, there was a prospect of a return to work we will then have to go on to consider how long the claimant was likely to remain in employment, attempts to mitigate, pension loss and other normal remedy principles.

168. There will be a closed preliminary hearing before me by telephone on a date to be arranged to give further directions for such a hearing. If the parties are unable to reach a resolution within 28 days they should contact the tribunal and propose dates for such a telephone hearing.