**Case No: 2601000/2016**
**2601523/2016**

# EMPLOYMENT TRIBUNALS

**Claimant:** **Mr P Murphy**

**Respondent:** **United Lincolnshire Hospitals NHS Trust**

**Heard at:** **Lincoln** **On:** **11,13,14,18 & 20 June 2018, and deliberations in chambers on 12 July 2018.**

**Before:** **Employment Judge R Clark**
**Mr J Smith**
**Mr R Loynes**

**Representation**

**Claimant:** **Mr K McNerney of Counsel**
**Respondent:** **Mr J Boyd of Counsel**

# JUDGMENT

The unanimous judgment of the Employment Tribunal is :-

1. The claims of disability discrimination **fail and are dismissed**.

2. The claim of unfair dismissal **fails and is dismissed.**

3. The claims of unauthorised deduction from wages **fail and are dismissed.**

# REASONS

1. **INTRODUCTION**

1.1. This is a claim of unfair dismissal, disability discrimination and unlawful deductions from wages. They arise from the events leading Mr Murphy's dismissal by notice expiring on 25 February 2016. Those events start nearly 6 years earlier when Mr Murphy suffered a stroke. The claims concern the attempts to secure a suitable assessment of Mr Murphy's clinical skills and abilities as a consultant colorectal and general surgeon; the various

diversions from that aim that then took place, and the ultimate decision to terminate his employment.

1.2. The essence of Mr Murphy's case is, broadly, that his recovery from the effects of the stroke was such that by mid 2011 he could have returned to his role as a consultant surgeon. He says the reason why he ultimately did not successfully return to his surgical role was because of the respondent's delay in putting in place the necessary assessment and support meaning he was away from clinical practice and prevented from maintaining his skills.

1.3. The respondent says it was sympathetic to Mr Murphy and supported his continued employment for some considerable time but the reality was the process of obtaining a suitable assessment was not straightforward in the meantime other matters arose between the parties. In any event, when the assessment was done, the results showed Mr Murphy's capabilities fell far short of the necessary standards of safe clinical practice.

2. **Jurisdiction**

2.1. Early conciliation was commenced on 22 Feb 2016 and a certificate issued on 17 March 2016. The claim was presented on 8 April 2016.

2.2. A second claim was presented on 15 July 2016 following a second episode of early conciliation between 19 May 2016 and 19 June 2016. We understand that second claim to present the same claims as contained in the first, save for some minor amendments, and that it was presented out of caution because the first episode of early conciliation had taken place before the effective date of termination and to protect the amendment sought. Nothing of substance arises from this. The claims have been consolidated and the amended version relied on.

2.3. There are issues in this case of jurisdiction arising from the application of the relevant time limits. Matters relating to the dismissal effective on 25 February 2016 are in time. We will have to determine whether some of the earlier allegations of discrimination are in time. The earliest date in time is 23 November 2015 and events falling before then are prima facie out of time.

2.4. There is a like issue in respect of the unauthorised deductions from wages. The deductions are alleged to have occurred in July 2011 and July. It is common ground that once each of the alleged deductions takes effect, that state of affairs continued until dismissal. If the payment claimed also remained properly due throughout the period, there will be no issue of time limits as they will form part of a series of deductions, although it would then mean any deduction claim is subject to the backstop limit of two years under s.23(4A) of the Employment Rights Act 1996 ("the 1996 Act"). If not, any deduction that did take place may be subject to determining jurisdiction.

3. **DISABILITY STATUS**

3.1. This case engaged a curious argument between the parties which, at first blush appeared to run in the opposite direction to that which one might have assumed would be the case. The claimant, who argues the effects of his

stroke did not prevent him from preforming the role of consultant surgeon argues he is disabled. The respondent, which concluded he was unable to perform, argued he was not.

3.2. That matter was resolved by EJ Legard at a previous preliminary hearing. Full reference should be made to his judgment of 26 April 2017 which found the claimant was disabled at all times material to this case by virtue of the stroke he suffered in December 2010. A number of his findings of fact have direct relevance to the issues before us in this liability hearing. Those issues and facts have been determined and not appealed. We are bound by those findings and conclusions as are relevant to our issues and draw on them as necessary.

## 4. <u>WITNESSES AND EVIDENCE</u>

4.1. This is a document heavy case as might be expected from a chronology spanning 6 years. Many of the respondent's potential witnesses have moved on or retired. Consequently, some of those with direct involvement in the early stages were not before us to give evidence. There is, however, extensive contemporaneous documentation filling four lever arch binders.

4.2. For the claimant, we heard from Mr Murphy. For the respondent, we heard from five witnesses. Mrs Sue Kirk who was a senior HR Manager latterly responsible for Medical Job Planning. Dr Neil Hepburn, who was Deputy Medical Director at the material time. Dr Suneil Kapadia who was Medical Director and a Consultant Gastroenterologist and General Physician who was principally concerned with Mr Murphy's appeal against dismissal. Mrs Pauline Pratt who was Acting Chief Nurse at the time and concerned principally with the panel's dismissal decision and Mr Jayarama Mohan who is a Consultant General/Vascular Surgeon who was the claimant's clinical director at material times. All witnesses adopted written statements and were questions.

4.3. We were assisted with opening skeleton arguments, and written closing submissions which were supplemented and responded to orally. We are grateful to both counsel who conducted their respective cases both with skill and in a cooperative and professional manner.

## 5. <u>ISSUES</u>

5.1. A proposed list of issues was prepared by the claimant [127AY] and this formed the basis of discussion at the outset. With the agreement of the parties, we determined the legal and factual issues to be the following:-

<u>*Unfair dismissal*</u>

5.2. The reason for dismissal is accepted was capability.

5.3. As to Reasonableness under s.98(4) of the 1996 Act, the claimant takes issue with the fairness under 4 broad headings

a Delay in Clinical laboratory skills assessment ("CLSA") and remediation.

b Failure to hold an appeal hearing.
c Failure to give prior warnings. And,
d Failure to consider alternative employment.

*Discrimination arising from Disability under s.15 Equality Act 2010 (" the 2010 Act")*

5.4. The unfavourable treatment is:
a Dismissal.
b Delay in arranging the skills assessment. And,
c Restricting his duties after returning to work leading to a reduction in pay.

5.5. The "something" said to arise in consequence of the disability relied on is pleaded in respect of the reduction in his capability to carry out surgical procedures, which in turn arose because of his disability caused absences between December 2010 and June 2011. To be clear, we understood this to mean it was the initial period away from practice which the claimant says leads to de-skilling, not any residual organic consequences of the stroke. However, we were required to revisit this during closing submissions and we deal with this further in our conclusions below.

5.6. Clearly, the central issue is whether any unfavourable treatment arose because of the "something arising".

5.7. If it did, the justification advanced is that there was a legitimate aim of "*managing the claimant and his patients in a safe and proportionate manner by reference to health and safety requirements*". The respondent contends that dismissing the claimant when it did was a proportionate means of achieving that aim. Equally, to the extent that the removal of the additional PA's and the claimant not working on theatre lists providing the waiting list initiative procedures, the respondent sought to rely on the legitimate aim of financial governance.

5.8. We also need to determine whether the claims of the alleged unfavourable treatment were in time and, if not, whether they formed part of a discriminatory act extending over a period, the end of which is in time.

*Failure to make reasonable adjustments under s.20 of the 2010 Act*

5.9. Did the respondent apply a PCP of "*a requirement to perform the full range of duties associated with the post of consultant general/colorectal surgeon as it stood prior to December 2011."*

5.10. If so, did that put the claimant at a substantial disadvantage compared to someone without his disability?

5.11. The disadvantage alleged to arise is that the claimant could not undertake the full range of duties such that his was at risk of:-
a loss of income in the short term. And,
b dismissal in the long term.

5.12. The adjustment(s) contended for are:-

a Adjust the claimant's role so as to exclude the requirement to carry out surgery.

b Permanently alter the nature of his role such as to the Clinical complaints review role he had been carrying out since his return to work in July 2011.

5.13. Whether the respondent had, or ought it to have had, knowledge of the disability/disadvantage.

5.14. When did the duty arise and when did the respondent fail to implement any reasonable adjustment?

*Unlawful Deduction from Wages*

5.15. What was properly due to the claimant?

5.16. What was he paid?

5.17. Was any shortfall authorised?

6. **FACTS**

6.1. It is not our role to resolve each and every last dispute of fact between the parties but to reach findings on those matters necessary to resolve the issues before us and to put them in their proper context. On that basis, and on the balance of probabilities, we make the following findings of fact.

6.2. The respondent is an NHS Trust managing four acute hospitals across Lincolnshire. It is a large employer with professional support staff directly employed, trade union engagement and a sophisticated policy framework. During the entirety of the chronology of this case, it has repeatedly incurred heavy financial overspends and has been subject to intervention from various parts of the NHS regulatory framework including being made subject to "special measures". As is common across most NHS providers, it has and continues to be extremely stretched at both ends to reconcile finite resources with increasing service demands and expectations.

6.3. The claimant qualified as a general surgeon in Ireland. In 1987, he became a consultant. He continued to practice in Ireland until 1996 when he moved to work in the UK through various agencies providing long term locum cover. He commenced employment with the respondent as a consultant general surgeon and gastro intestinal surgeon on April 2004. He was based at the Pilgrim Hospital in Boston, Lincolnshire. He was employed on a full-time consultant contract. That meant 40 hours per week, or 10 programmed activities ("PA"). In addition, he undertook 2 additional programmed activities, notionally another 8 hours work per week. We find additional programmed activities are temporary arrangements that the parties to the contract can agree on a periodic, usually annual, basis. We find it is open to either employer or employee to change the arrangement for PA's from year to year. It is possible, but extremely rare, to agree to undertake 3 additional

PA's. Additional PA's are usually limited to 2. The periodic changes agreed between the parties on each review therefore take the form of either an increase from 10 or 11 to 11 or 12, or a decrease from 11 or 12 to 10 or 11, depending on the continuing needs of the employer or desires of the employee.

6.4. There were no issues with Mr Murphy's clinical practice. Prior to 20 December 2010, the Claimant had been successful in his work and we have no reason to doubt he was a well regarded consultant surgeon.

6.5. Mr Murphy's typical working week was spread over 5 days during which he would undertake outpatient clinics at two of the trust's hospital sites, two theatre lists, one of which would be day cases, the other complex surgery; an endoscopy list and an admin session. He would also participate in the 7 day on-call rota undertaking either the weekly 4 nights or during the weekend 3 nights. Around his clinical work plan he would also participate in teaching, ward rounds, chairing a cancer multidisciplinary team meeting and attended other clinical meetings. The balance of his work between surgery and endoscopy lists was around 75/25.

6.6. It may go without saying, but we nonetheless find the work of a consultant surgeon includes lengthy and complex invasive procedures. We find that the work of any consultant surgeon is physically demanding and requires stamina as well as extremely high levels of manual dexterity and physical co-ordination, especially in respect of the fine motor skills engaged during surgery, laparoscopic procedures and endoscopy. The processes involved at the operating table and the use of various surgical tools and equipment used all form part of what is sometimes referred to as the "craft skills" of surgery.

6.7. On 20 December 2010, the claimant suffered a stroke. He suffered a further stroke 10 days later. He suffered some paralysis on the right side of his face. He was admitted to hospital.

6.8. As a result of undergoing further treatment following his stroke, Mr Murphy was diagnosed with Type 2 Diabetes. It seems he may have had the diabetes for some time and was starting to show symptoms but the condition was not diagnosed until he was in receipt of care in respect of the stroke. It is a condition he suffers with but it neither adds to the disability found as a result of the stroke which was made out without reference to it, nor is it, in isolation, a disability in its own right.

6.9. As one might expect, Mr Murphy's initial physical abilities were significantly reduced. We draw on EJ Legard's findings in respect of the immediate consequences. Whilst he was concerned only with whether the statutory definition of disability was made out, his findings of fact have a direct relevance to the matters engaged in this case. In particular, he found Mr Murphy was initially able to walk only with the aid of two walking sticks. His speech was at times difficult to understand. His writing had deteriorated. His ability to play the church organ was adversely affected. His disability was significant in the first 3-4 months during which he had a lack of coordination and muscle weakness and his ability to perform even the most basic of day

to day tasks was profoundly compromised. Through his own significant effort and determination, his condition improved markedly by about 6 months post event although his dexterity, coordination and mobility remained impaired. In respect of where the claimant's recovery was in June 2011, and where it was at the time of the preliminary hearing (and, we find, continuing to the time of this hearing), EJ Legard made the following finding:-

> ***…taking the medical evidence in the round, it is clear that the claimant's recovery effectively plateaued at or around this point and that his residual symptoms resulting from his December stroke have remained with him without any appreciable improvement ever since. I note, for example, that there was no significant change in his dexterity by November 2011 and I am prone to agree with Dr Griffiths who stated in his April 2014 report that the claimant's "stroke has caused fixed disability which is unlikely to change from this point". Indeed, in my view his condition has not change appreciably since 2011".***

6.10. Whilst we cannot reopen the facts already found, we have seen evidence which would lead us to the same conclusion. Whilst there was some improvement in the claimant's abilities, or perhaps his ability to cope with the condition, his level of abilities in late 2011 were not markedly different to that at the end of his employment with the respondent. We find Mr Murphy had competent craft skills prior to his stroke. We find, despite his substantial functional recovery during the 6 months or so following his stroke, his ability to perform those craft skills to the necessary level did not in fact return.

6.11. In May 2011, the Claimant visited Pilgrim Hospital to discuss his return to work. He met with Mrs Ambika Anand, at the time a Consultant Breast Surgeon and then the Clinical Director of Surgery. She was effectively Mr Murphy's line manager. He declared an intention to resume work that summer and we find he received a supportive response from Mrs Anand. We are satisfied that there was a genuine sympathy for Mr Murphy from his clinical colleagues and the Trust's management and a desire to do what they could to support him.

6.12. The claimant's evidence was that he felt that, with a period of mentoring and training, his recovery was good enough that he might have been able to return to work not only in the general sense but, specifically, to return to surgery. We find this view was unrealistic. He had made a substantial recovery from the stroke that many don't, but that had not been so much as to realistically return him to surgery. We return to how this was eventually assessed below.

6.13. As part of the claimant's planned return to work, he was referred to occupational health. Dr Jayne Moore reported on 9 June 2011. She noted his residual problems following the initial good functional recovery. She concluded that :-

> ***Mr Murphy would need to return to a non-intervention role. I think that he has a lot of experience and skill and this could be initially utilised in teaching. He could conceivably manage out-patient clinics. Mr Murphy has not returned to driving so accessing outlying clinics may be problematic.***

6.14. There was a dispute about whether he had returned to driving by this time or not. We find he certainly did eventually return to driving. We are not convinced the fact is material to the issues but to the extent we must resolve it, we find it unlikely that an occupational health doctor relying significantly on what she was told by the claimant would include this fact if she had not been told it. In the course of her own testing and assessment of Mr Murphy, Dr Moore undertook some dexterity tests. The result of which was expressed as being "3 standard deviations, below that expected for production work". In itself, that does not give the lay person, or us, a clear measure of the degree of his impairment. We found that measure was put into context in Dr Hepburn's evidence. His immediate assessment of this result was that "it was terrible". It was not only falling well below the normal measure of ability, but it was in any event measuring against a low bar compared to the demands of a surgeon. We accept his evidence.

6.15. The occupational health conclusion was that it was not appropriate for Mr Murphy to work nights or weekends. Nor was it appropriate for him to have clinical interaction with patients until the level of his skill loss had been assessed and it was proposed that this should take place through a clinical skills lab assessment ("CSLA"). Only if his skills were deemed sufficient would it then be appropriate to return to clinical procedures. Dr Moore hoped that the Trust would be able to find a role for him in a non-surgical context. She suggested teaching or supervising trainees. She suggested a further occupational health review in 3 to 6 months.

6.16. Dr Moore also expressed caution about Mr Murphy's own suggestion that he could supervise junior doctors. Such a proposal would need a thorough and careful risk assessment, the reason being that part of the role of supervising training grades was to intervene in an emergency. We accept that until his skills had been assessed as safe, this would be an unacceptable risk.

6.17. We respected Dr Hepburn's own opinion that recovery of motor skills could continue to improve, albeit it was opinion. Nevertheless, it was an opinion reached from the perspective of a consultant physician with clinical experience of strokes and was reasonable in the circumstances at the time. We find that view may well have been held by many others and was likely to provide part of the underlying reason for the apparent speed at which things happened, or didn't, during the early months. However, the claimant's recovery path was, in fact, somewhat different. Whilst he had benefitted from a remarkable improvement over a short period of time, the level of improvement that followed thereafter was marginal. As has been found, his recovery is variously described as having "plateaued" or "maximised" at that 6 month point.

6.18. Mr Murphy's GP signed him "*fit for work subject to support*" from 4 July. We find the attitude of the respondent was positive. We find David Levy, the then medical director, felt a CSLA would be helpful. Similarly, we note Mrs Anand was corresponding at the time with a view to developing a return to work plan. On 12 July 2011, the Claimant attended a meeting with Dr Greg Ortonowski, at the time his Consultant lead and Sue Kirk, Senior HR Adviser. Two days later the Respondent wrote confirming the outcome of the meeting and a four-week phased return to work. The claimant returned to work on

18 July 2011. A phased return to work schedule was devised [241] so far as working hours were concerned. A specific role was carved out for the claimant in non-clinical activities including giving him a role supporting the clinical complaints process, education and training of junior doctors in surgery, chairing the weekly MDT and work on the Formal RITA/ARCP panel for non-trainee grades. The claimant would in due course voluntarily relinquished the chair of the weekly MDT. We accept that the aim of the work plan at this time was little more than to provide a structure to the working week to ensure the claimant could physically cope with getting to work and manage a routine.

6.19. We find the respondent did not stand on its contractual rights and modified them to ensure the claimant would not go onto half pay when it otherwise would, and he was paid full pay during his part time phased return to work.

6.20. The claimant was not permitted to undertake any clinical work, not just surgery. Indeed, we find any attempt by Mr Murphy to undertake clinical work at this time would have resulted in a referral to the General Medical Council. We accept that the occupational health proposal of "conceivably undertaking" outpatient work was not a practical possibility. The work was so inherently linked to the patients' need for surgery or other intervention about to be, or having just been, undertaken, that there was no reasonably practicable means for the claimant to undertake this in any meaningful way.

6.21. We know that the plan at this stage was aimed at gradually returning Mr Murphy to full time working with a meaningful and relevant role, albeit non-clinical. We have assumed the work would eventually fill that 40 hours week but we have little to assess what work was actually done. The finding we reach is that Mr Murphy was not pressed to achieve any particular outcomes or targets either during the first 6 months of the initial return to work, or at any time thereafter. The retrospective evidence suggests during the 3 years that Mr Murphy was undertaking a clinical complaints role, the Trust's records show he dealt with only 5 complaints. When presented with those figures in cross examination, he felt it was "treble that figure or more like 40 to 50 cases". We find on any assessment, he was not turning out any meaningful workload.

6.22. In fact, Dr Hepburn's view was that he was not of any value to the trust during this time and he was simply not doing anything productive. The purpose and aim of his work activity was entirely supporting him with a view to getting him back into the routine of coming to work and interacting in the workplace. We find no one anticipated this work being anything other than a temporary measure, even though it ended up lasting considerably longer than anyone would have expected at the outset. We therefore find there was no non-clinical job for him to do, as such, but the trust had sought to provide some relevant and meaningful non-clinical work. It was not a role that the trust would create out of choice could not realistically be thought of as a permanent alternative.

6.23. Prior to his absence, the claimant had worked to a full-time contract, that is ten PA's, with two additional PA's. Upon his return to a non-clinical role, he continued to be paid his basic contractual entitlements as well as his two

additional PA's and all other enhancements. For example, he was not required to participate in the on-call rota but continued to be paid the additional 5% supplement due to him for that.

6.24. The claimant, and other relevant surgeons, had also been participating in a waiting list initiative. The effect of this was to pay to those participating surgeons an enhancement of "double sessions" when operating on patients or conditions relevant to the particular waiting list initiative. In everyday language, that meant double time. The claimant was not paid it during his sickness absence when he obviously did not work the initiative. Upon his return to work, he did not return to clinical practice and was not, therefore, undertaking those targeted theatre lists on the "waiting list initiative" and was not therefore being paid the enhanced session rates.

6.25. We received little evidence on the actual mechanics of the waiting list initiative and its effect on pay. We find it is, by definition, a temporary state of affairs aimed at getting through a backlog. Its aim is to reduce waiting lists to within an acceptable period. As to the duration of this temporary arrangement, we find, on balance, that it continued in place over the summer of 2011 for the claimant to be aware he was not getting it. We are not satisfied, however, that it has been established on balance that it would have continued throughout the remainder of his employment with the trust. We find, it was unlikely to be in place for more than a year due to the changing clinical pressures and changing financial landscape the trust was facing. We therefore conclude, on the balance of probabilities, it would not have remained in place from 2016. We further find that it is a payment paid for doing an additional type of work falling within the initiative. It was not paid to everyone and was not paid unless the particular type of work was done. We are satisfied that but for the claimant's reduction in capability, he would, on balance, have continued to undertake the initiative work during 2011 which would have qualified him for the enhanced payment. We are not satisfied that the circumstances he was in during 2011, meant that payment should have been paid to him even though he was not in fact performing the work. Further, we cannot conclude even on the balance of probabilities, that had any different approach been taken to arranging the clinical skills lab assessment, there would have been opportunity for the claimant to participate. It seems to us that this opportunity to earn this enhanced payment was never properly due to the claimant during the time it might otherwise have been available.

6.26. In the wake of the claimant's ill health, and later phased return to work, the respondent had employed a locum consultant to support the work of the colorectal and general surgery department. We find the claimant was one of six undertaking similar roles. In due course, we find this locum would be successful in being appointed to a post of consultant within the department. Whilst this looked like an appointment to "the claimant's post", as he understandably saw it, we find the nature of the workload and medical staffing in the department was such that there remained at all times a consultant post for the claimant to return to should he have been able to.

6.27. The cost of keeping the role open and covered by a locum consultant were broadly comparable to the costs of employing Mr Murphy. In other words,

the respondent was paying twice throughout this time. In the final analysis, the additional costs would exceed £600,000.

6.28. The claimant completed the phased return to full time working and was able to attend work for all 5 days each week. Sue Kirk referred to this state of full time working as then "being easier to put in place a more structured assessment process". The claimant says he had expected that a skills lab assessment would have been arranged by then. We find 4 weeks to have been an optimistic timescale in any event but we agree that a reasonably early date for assessment was a reasonable assumption but we find that the circumstances of arranging a third party assessment of an experienced consultant surgeon would turn out to be far more difficult than anyone had anticipated. We further accept that during the first few months of his return to work, the respondent was simply concerned to put in place a structure which provided a workplace structure and routine.

6.29. The respondent sought the recommended second Occupational Health referral on 7 November 2011. Dr Moore reported the following day [256] and made the following observations:-

a His motor skills assessment had not changed significantly from the previous one.
b As to whether he was ready to re-start clinical skills retraining, she observed that all his skills should be assessed in a non-clinical setting in order to determine a baseline. She suggested that the Trust (and not the third party assessor otherwise suggested) could assess his skills in a CSLA environment on procedures such as sigmoidoscopy or proctoscopy.
c His working hours should not exceed the present 9-5 working day.
d As to the scope to work in Outpatient clinics, she stated that she was not happy for him to undertake any procedures in an outpatient setting until he had been assessed.
e He was not fit to undertake the consultant on call rota.
f On timescales and prognosis generally, she felt this was not possible. The Trust must first undertake the baseline assessment of his clinical skills. She advised he needed to be assessed against the competency framework of a final year trainee. She felt that *"should he reach the standard where he can return to surgical interventions then he would need mentoring initially.*"

6.30. She concluded with a positive view that Mr Murphy could undertake teaching.

6.31. Some reliance was placed on the occupational health advice to undertake the assessment prior to returning to clinical practice as if there should be read into that advice a sense that Dr Moore was expressing the view that Mr Murphy probably was capable of a return to surgery. We do not interpret the advice in that way. We interpret it as saying simply that she was not prepared to say he was able to work at the necessary level of safe practical competence and was deferring it to a specific work place assessment.

6.32. The suggestion of an internal assessment of his capabilities at less invasive procedures such as sigmoidoscopy and proctoscopy did not happen. We find Dr Murphy did not approach his employer within any interim request for mentoring or other activities that might provide benefits to any later assessment.

6.33. We find the notion of a CSLA for an experienced consultant surgeon was far from common place. It was a novel concept to all those involved and something that was not readily available. Any such assessment process would have to be created and tailored made for the claimant.

6.34. A clinical skills lab ("CSL") is simply an environment where the craft side surgery and other clinical interventions can be simulated. By definition, it does not involve patients. We find, in hindsight, that some degree of clinical assessment could have taken place within the trust itself at an earlier stage as Pilgrim Hospital had its own CSL although we accept and find that this was subject to two very significant restrictions. The first is that we accept the Boston CLA operated at a basic level, limited to skills such as suturing and certainly not equipped to deal with the sort of level of complex surgical interventions that the claimant would previously have performed in his role. In hindsight, whilst that view was on balance correct, it may also have missed the point as if it had turned out to be the case that the claimant was not safely capable even at that basic level, the question of his safe return to work would have been answered. Conversely, if his capability met that basic standard, it would not answer the question actually required, but would have been a start. The second, and related obstacle, was the availability of an assessor who was in a position to give some degree of formality and authoritative accreditation to whatever skills assessment was undertaken. At one level, the claimant remained registered with GMC and without any restrictions although we do not find that to mean he could simply return to surgery without risk of consequence to him or the Trust. The potential liability and patient safety risk of him practicing needed to be defensible, should some adverse clinical event occur in the future. It was therefore not enough for someone to simply watch over the claimant and give a nod to his competency. We find the difficulty in arranging a skills lab assessment was less about the availability of the potential environments in which such an assessment could take place, and more about the process of assessment and accrediting safe practice.

6.35. In hindsight, Dr Hepburn considered that had the more informal approach to assessment been undertaken at the outset, he felt it unlikely the claimant would have been able to progress further. It seems to us, albeit with the benefit of that same hindsight, that the delay in identifying a suitable assessment process might have been obviated by introducing such an informal assessment prior to the more formal CSLA. Dr Hepburn's view in the end was that Mr Murphy was a long way off being able to safely work as a surgeon in 2011. The 3 standard deviations below that expected for production work was terrible in itself, even before factoring in the extraordinarily high standard of dexterity for surgeons. The fact that there was no significant change in his abilities between then and when the internal assessment would eventually take place means we are inclined to agree with

Dr Hepburn and find as a fact that he was likely to fall short in any skills assessment undertaken at any time after June 2011.

6.36. Around the end of December 2011, the issue of the claimant's pay was raised, particularly in respect of his on-call payment and the two additional PA's. We find Sue Kirk advised against taking any action particularly in respect of the core elements of the full-time contract which included the on call supplement. She advised that he was:-

> ***"entitled to his full pay until he has been fully assessed for his long term clinical skills and abilities..... Only once we know the full extent of his capability and the impact of this on his substantive post can we reach a permanent solution which may involve change of duties (If appropriate) or ill health termination"***

6.37. We found Mrs Kirk to be an honest and genuine witness which we saw reflected in her approach to Mr Murphy's situation at the time. We do not accept the fact she raised the possibility of a change of duties or ill health termination as examples of a permanent solution as meaning that was the forgone conclusion at that stage. They clearly were options and we suspect that the apparent state of affairs was such that they appeared very likely. She and others clearly did have this possible outcome in mind at other stages too. We accept Mr Murphy's own assessment that she was doing her best.

6.38. We reject any contention that Mrs Kirk and others were not interested in supporting Mr Murphy into a clinical skills assessment although she, and others, may well have had their own personal views as to whether or not he would ever return to surgery. In Mrs Kirk's case, this is the view of a lay person although the evidence before her seems to provide a basis for forming such a conclusion. Others' had some specialised basis for doubting Mr Murphy would meet the necessary standard. Nevertheless, we remain satisfied that however much a negative outcome may have appeared inevitable, and Sue Kirk herself expressed a concern that "the likely outcome is that he won't be competent", we do not accept the desire to secure a prompt skills assessment was not present. If nothing else, some form of assessment was as much a necessary step to any alternative resolution as it was for a return to clinical practice.

6.39. By January 2012, the respondent was "*moving to getting Mr Murphy into a clinical skills lab*" [261]. We find Sue Kirk was active in chasing the clinicians organising it in February [265].

6.40. It is clear that the need to assess his skills was becoming entwined with other normal organisational issues such as the annual job plan review across all consultants in the department. The claimant was invited to a review in Feb 2012 [ 267]. This was in the context of revising his job plan in view of the fact that the trust was *"currently seeking an assessment of your motor skills via an external clinical skills laboratory, in conjunction with the royal college, to obtain an independent assessment of your practical skills.*

6.41. By the time of this meeting Mr Murphy had got his driving licence back, was expressing concern about the loss of pay he was suffering from the delay in

getting back to clinical practice, particularly in respect of private practice, and generally feeling frustrated. He felt the sedentary role was hampering rather than helping any recovery. There was discussion in the meeting about the attempts to locate a suitable CSLA and the progress that appeared to have been made with Nottingham hospitals. We find that the conclusions on the changes to the work plan discussed at that meeting were reached with the agreement of the claimant, notwithstanding that a period of notice was applied to the changes that were then implemented.

6.42. The outcome letter from that meeting was not sent until April 2012. It confirmed the Trust was still trying to arrange a CSLA as a condition precedent to returning to any clinical work. The respondent acknowledged the frustration in the delay in getting this arranged. The practical effect of the changes was that Mr Murphy's work plan was limited to the full time ten PA work plan. In other words, the two additional PA's would cease. He retained his 5% on call supplement notwithstanding that he had not, and in fact would never, return to the on-call rota. We note there was no challenge, appeal or grievance raised about this change which is consistent with there having been agreement to the change. We accept the situation that then existed was that there were two elements to the contract that the claimant could not do. The additional PA's and the on call. They were treated differently because of their different nature within the contract. Mr Murphy retained the 5% supplement as this was regarded as part of the core contract. He lost the two additional PA's as these are temporary adjustments agreed periodically. We find that whilst he no doubt would have preferred to retain the additional pay for those two PA's, he agreed to the variation. From July 2012, those payments were not, therefore, properly due to him under the terms of his employment.

6.43. Since the second occupational health report, we find the respondent had been trying to locate a suitable party to undertake the CSLA. It appeared that this would be a straight forward matter but, as we alluded to previously, the level of skills tested in most skills labs was pitched at a junior level and, more particularly, the issue was identifying a person or body with competence and authority to sign off any assessment undertaken. By this time, Sue Kirk had herself made direct contact with the manager of the clinical skills centre at Nottingham University Hospitals and Mr Murphy had engaged similarly with a clinician although it seems both were making contact with different hospitals in Nottingham (City and QMC). Nevertheless, it appeared to the respondent that the necessary CSLA was, at last, falling into place and that an assessment would follow in due course.

6.44. The occupational health advice had suggested, in varying degree of possibility, the prospect of Mr Murphy undertaking procedures short of surgery. We find this was something the trust considered but rejected on grounds that the less invasive process of endoscopy was in any event still an invasive process with potentially serious consequences to a patient. Until such a time as Mr Murphy's abilities were assessed there was no realistic distinction to be made between surgery and other clinical procedures.

6.45. The Nottingham Clinical Assessment Centre appeared to be able to undertake the clinical skills lab assessment and identify an assessor but a

date for the assessment was still not set. However, on 18 May 2012 the head of the clinical skills centre responded to the trust in terms which effectively brought that possibility to an end. He said the consultant assessment was not something he could help with. It was something that had to be arranged between clinicians, despite him apparently being a clinician. We find there was an expectation on the part of all concerned that such assessment facilities readily existed and it would simply be a case of booking Mr Murphy onto a programme. That was clearly not so. Something meant this was not in fact a readily available assessment process and, where it appeared a CSL might be able to undertake an assessment, it fell through. As Sue Kirk observed, "I don't think we anticipated it would be such a difficult thing to arrange", but it was.

6.46. Having said that, the respondent cannot be said to have exhausted all possibilities. We know there were other options to explore a similar unit in Leicester [276] which in the end did not happen. Similarly, there were other possible centres like Nottingham which might have had the capability to undertake such an assessment. They were on the respondent's radar but seem not to have been followed up beyond superficial initial enquiries. For our part, the existence of the National Clinical Assessment Service ("NCAS") was within our knowledge and we understood it was a body set up to support the process of assessing the competence of doctors who, for one reason or another, may be deskilled, poor performing or have been away from the clinical environment for some time. We find that by May 2012, the trust was exploring the assistance available from the Royal College of Surgeons ("RCS") for their advice on NCAS. By June 2012, the prospect that the solution might lay with NCAS increased. By July, the RCS reports [309] show that they could provide no suitable courses or assessment suitable for the claimant's situation but NCAS may assist. RCS also had been involved in putting together "guidance on the return to practice" as part of the academy of medical colleges, published April 2012, only a few months earlier. It was, therefore, very new guidance. The RCS did suggest the possibility of another assessment centre at Anglia Ruskin University which "*might be able to help but I know you have mentioned you have already approached a number of equivalent centres for advice*".

6.47. We also find the claimant was not particularly active in progressing the various routes to a clinical skills assessment. He told us he had been in contact with someone at QMC. We cannot detect any point during the time that progress is now said to have been slow or stalling, that the claimant himself stepped in to progress things further. He accepted that this was new ground, certainly for the trust and they were probably asking the right questions. His complaint is that they took too long.

6.48. The "return to practice guidance" published by the Academy of Medical Royal Colleges in April 2012 is all premised on the guiding principle of patient safety which it stresses must be put first above all other considerations. This guidance identifies the risks to safe practice of any prolonged period of absence for any reason. It recognises absences as short as three months would engage the principles in the guidance. The guidance is undoubtedly helpful in formalising the issue and encouraging those that employ doctors to address the patient safety risk in a structured way. Beyond that, however,

we find it does not add to the advice already undertaken by occupational health and accepted by the employer nor does it provide any real practical assistance on implementing the CLSA. Had a CLSA been identified, we are satisfied the plan would have been compliant with the principals in the guidance. Similarly, the clinical assessment that eventually did take place would appear to be compliant.

6.49. In July, the respondent sought assistance in the application of the assessment process from the GMC. Mr Murphy agreed this was a reasonable step but that they received the wrong answer. By that comment he is referring to the unfortunate fact that, through this request for help, someone at the GMC dealt with it not as a request for assistance with assessment but as a fitness to practice concern. We find that taking this course was down to the GMC and not the respondent. We are satisfied the respondent was genuinely seeking some third party to provide some new direction and it was not the employer's intention to simply have the claimant's registration removed. The respondent was asked to provide a short report on the situation which the medical director did. We find the respondent did not feel able to challenge the GMC approach and instead complied and cooperated with the fitness to practice process. Mr Murphy accepts this was an unexpected twist to its otherwise good intentions in seeking the support from the GMC. We find that it was not open to the Trust to object to the Fitness to Practice panel being convened once that particular ball had started rolling. However, we are satisfied it did not set out to go down that route.

6.50. A GMC investigator was appointed and the case was subsequently closed at what appears to have been a preliminary assessment as to whether there was a case to answer. On 9 October 2012 [389] Mr Murphy was told there would be no further action. The reasons include the following observation:-

> ***"Mr Murphy has been working in a non-clinical capacity since returning to work on 3/7/2011. The main issue appears to be the Trust's difficulty in arranging a skills assessment in order to ascertain Mr Murphy's fitness to practice clinically. No evidence has been provided that the doctor lacks insight or has failed to restrict his practice as required by the trust. It appears he has not practised privately since his CVA. Just because a doctor has been unwell does not mean that action needs to be taken on their registration, providing suitable steps are taken by the individual and their employer, as in this case."***

6.51. We regard this conclusion as a rebuke to the GMC officer that interpreted the trusts request for advice as a fitness to practice issue, rather than being directed at the Trust. Nevertheless, the practical reality was that whilst that fitness to practice enquiry concluded, much further time was lost in respect of identifying any clinical skills assessment. On 17 October 2012, Sue Kirk referred the claimant to occupational health for a third time. We note the claimant's criticism that the trust had already received the same advice twice which it had not yet auctioned, so a third referral must be for some other reason. We are satisfied that Sue Kirk was still genuinely trying to facilitate some form of assessment and had received a suggestion that an in house Occupational Therapist might be used. She wrote that "*Stephen also suggested that we might consider using a ULH OT person to conduct some*

*assessment – even if it was only to use to justify ill-healthing him.........*". We interpret the phrase *"ill-healthing him*" to mean justifying an ill health retirement or termination. Of course, she may be relaying part of Stephen's suggestion, not her own. Equally, it may not disclose an intention, only a potential outcome. Considering all of the evidence we have heard from Mrs Kirk, we interpret that comment as being simply that the OT may not be able to undertake an assessment of clinical skills but if his dexterity and coordination were so far off the safe standard, it may engage the ill health threshold.

6.52. The third occupational health referral took place on 31 October 2012. During the appointment, Dr Moore herself made enquiries with QMC and was able to confirm in her report [397] that she believed QMC were able to help undertake a skills assessment. QMC is (or was at the time) a different NHS trust to City Hospital where the previous enquiries had been made. She also advised that Mr Murphy was fit to undertake some out-patients work albeit short of any procedures. She also advised of a need to provide some scope to refresh clinical skills she wrote:-

> ***"It would appear that the rehabilitation to work in terms of allowing him to maintain or refresh his clinical skills has not been forthcoming. I hope you will be able to facilitate his attendance at a clinical skills laboratory so that he can refresh his skills prior to a formal assessment"*.**

6.53. In that , there appears to be a distinction now being drawn between the use of a CSL as the means of assessment, and as a means to merely refresh skills.

6.54. We find that, irrespective of the fact of the stroke and its consequences, a period of absence of around 6 months is one for which a return to practice plan of some description would be necessary. A doctor taking a sabbatical for that period would need that.

6.55. Before any enquiries had been made with QMC or any other potential CSL, we find the direction of travel was diverted once again, this time into dealing with Mr Murphy's grievance lodged on 7 November 2012. A further copy was sent to David Levey, on 19/11/12. The claimant was supported by his trade union, the Hospital Consultants and Specialists Association ("HCSA"). The grievance was set out in writing [404]. The thrust of his complaint was the delay in getting the assessment which was acknowledged as the first step to a return to practice. The grievance included a list of 18 questions a large number of which seemed to be unrelated to the employment issues arising before us, but instead related to the criticisms of an earlier occupational health failure to diagnose the claimant's diabetes. That was said to be an indicator which would have anticipated an increased risk of stroke. The grievance set out 5 desired outcomes. They were:-

a That's reasonable adjustments are made in order to enable Mr Murphy to continue working a meaningful capacity within the trust.

b That Mr Murphy received payment of all monies lost as a result of the loss of hours and potential breach of contract.

c That Mr Murphy receives compensation for the loss of income from private work resulted from my current situation.

d That Mr Murphy receives written acknowledgement of the failure of the occupational health department in failing to recognise my symptoms and family history

e That Mr Murphy received compensation for the loss of income from private work resulting from my current situation.

The fifth desired outcome is clearly a duplication of the third.

6.56. The allegations took on a flavour of an allegation of a clinical negligence dispute. The grievance was investigated by Richard Watson then the Principal HR Manager for medical workforce.

6.57. The grievance was investigated and a meeting took place on 27th February 2013. Present were Mr Murphy, Dr Neil Hepburn, Annette Mansell-Green from the HCSA and Richard Watson [429].

6.58. Whilst the claimant raised his criticisms of the conduct of his case to date, it is clear to us that by this time there had become a settled intention on his part to explore ill-health retirement or some other mutual termination. The phrase used was that he was "looking for an exit". An equally significant development was that the claimant indicated "he would not undertake an assessment". In evidence before us, the claimant took issue with how this came about. He says it was not, and never was, his view and he was not seeking an exit and did not want this outcome. He says whatever is contained in the notes was not known to him nor was anything said by the HCSA on his instructions. It was, in effect, the HCSA acting on their own initiative. We dismiss that contention. As Mr Boyd put it in closing submissions, this case is not about credibility but Mr Murphy did himself no favours in this argument. We found his account simply did not stand up to the contemporaneous documentation. We find that it was in the claimant's contemplation to seek a mutually acceptable exit from the Trust. We reject his contention that he did not know what his trade union were seeking or that they did what they did without his authority. He was clearly at the meetings where the terms on which he might take retirement were discussed and had access to the correspondence that followed. The notes record that "*AMG suggested PDM sees the window of opportunity has now passed and will be looking at an exit, and wouldn't undertake an assessment*" and that "*AMG suggested how can we facilitate early retirement, and can we obtain forecast, plus explore possibility of a compensatory award for the loss of income*". Whilst we accept that the notes of the meeting are not verbatim, it is impossible to conceive of why the claimant did not speak up in the meeting to correct his representative, if he truly held the contrary view. The absence of subsequent challenge suggests the notes fairly reflect the discussion at the meeting. We therefore find this was the view of the claimant, that he was not now going to undertake an assessment and that he was interested in exploring ill-health retirement. Indeed, pension figures were to be obtained on his behalf. In due course, he would reject this course on financial grounds.

6.59. This marked a new episode and we find that the trust acted reasonably on what the HCSA, and the claimant was now requesting. Consequently, progress in respect of the prospect of an assessment or the grievance was suspended again. We find Mrs Kirk actioned the request for the pension provider to give the claimant details of his benefits. We find there was some unfortunate delay in this request being processed as the figures were not in fact provided for some time. On 3 June 2013, the pension figures were provided to the claimant [446].

6.60. Before then, on 18 May 2013, the HCSA had chased the new chief Executive, Jane Lewington, on the progress of the grievance [441]. We find the formal grievance itself had also been effectively suspended in the face of the ill-health retirement request. In fact, Ms Mansell-Green of the HCSA explicitly refers to the expectation that pension estimates would be provided but, to date, they had not been received. The terms of this letter lead us to conclude that there was an understanding between the parties that the grievance would be suspended whilst the option of a pension based exit was explored. The fact that it refers to a "*resubmission*" of the formal grievance and the absence of those pension figures supports that conclusion. It may well be this letter is what identified the error in the provision of pension figures which then followed within a couple of weeks.

6.61. We find the pension figures were considered by Mr Murphy. We have seen a reference in the contemporaneous documentation by the middle of June, albeit hearsay, that Mr Murphy "*did not feel he had sufficient NHS service to make it financially worthwhile*". We find this was Mr Murphy's view which is consistent with how he articulated the pension benefits before us. Had the pension figures been to his liking, we are satisfied it is more likely than not that he would have proceeded down that route. The financial implications were the only reason he did not.

6.62. At this point, although the ill health retirement option had been ruled out, there remained the fact, or at least the reasonable belief of the respondent's managers, that the claimant was not prepared to undertake any assessment. It was faced with dealing with the employment situation then before it. On 10 July 2013, Sue kirk informed john Coleman, the acting deputy director of operations that:-

> ***"we are now at the stage of meeting with [Mr Murphy] to inform him that there are no reasonable adjustments that can be made to enable him to return to his substantive post and we will therefore follow the process for ill-health termination on grounds of incapacity due to ill health"***

6.63. At this time, we find the HCSA were still seeking to pursue discussions on the basis that the claimant wanted an exit from the trust [457]. Again, we are not satisfied that this was an example of a union representative straying off instructions. On balance, we find this was accurately representing the position of the claimant. By 23 July [457A] the trust had explored the mechanics of a mutually acceptable "exit" without success. It stated its position at that time to the HCSA as being that it had considered but was unable to ascertain suitable alternative employment. The trusts position was to terminate the claimant's employment on grounds of capability due to ill-

health. The proposal at that stage was to that Mr Murphy would be given notice of this intention which would be subject to a period of three months to explore redeployment. If there was no scope for redeployment identified, a future panel would then consider the matter again and whether to confirm a decision to dismiss.

6.64. The claimant was invited to a further grievance meeting to be held on 18 September 2013. Prior to that, the claimant was himself in contact with NCAS. At that stage they could provide no help in the assessment itself but referred to the process under the national publication “Maintaining High Professional Standards in the NHS” otherwise known as the MHPS. A side issue arose from this enquiry which caused Mr Murphy concern that the trust may not, in fact, have contacted NCAS for advice earlier. Their letter referred to having no record of him or his registration number. We do not accept that follows. The fact that they did not hold details of him or his GMC number did not mean that they had not given general advice in the past. The letter says as much and we find, on balance, such enquiries as the trust had made when it was seeking assistance of other bodies was likely to be without personal details, in the initial stages at least.

6.65. The meeting took place as planned on 18 September 2013 present was Mr Murphy, Annette Mansell-Green, Dr Neil Hepburn and Richard Watson [462]. Again, we are satisfied that the notes of that meeting are a fair summary of the points discussed. At that meeting, the claimant was notified of the respondent’s intention to terminate his employment. He was told there would be a 12 week redeployment period. The reference to “intention” is we find, the future intention to do so. It did not give notice at that stage but would be in line with the procedure proposed already, in other words, there would still be some form of panel decision to take place at the end of it. In fact, a different course was taken. The claimant and the HCSA set out their criticism in the delay in securing a CLSA and that the trust’s efforts had not be pursued rigorously. It is not clear whether Mr Murphy had at this time reversed his previous position of no longer being prepared to undertake an assessment but in response to the challenge as to the extent to which NCAS had previously been involved, Dr Hepburn agreed that he would formally seek the advice of NCAS.

6.66. We find the prospect if ill health termination was at that stage suspended. Dr Hepburn did take matters forward with NCAS. He was in contact with them a number of times over the following few weeks. On 2nd October 2013, Dr Hepburn wrote to Mr Murphy to say that NCAS had confirmed they would assist in the process of assessment covering both occupational health and a fairly basic surgical simulation. A meeting was arranged to discuss this breakthrough further.

6.67. That further meeting took place on 7 November 2013. However, the apparent breakthrough of NCAS support for the CSLA came to nothing. We find this was explored with Mr Murphy who at that stage declined the assessment being offered. The trust where then in a position of returning to the option of ill-health termination. The respondent began the process of convening a hearing to consider termination

6.68. Before that hearing could take place, on 17 January 2014, solicitors instructed by the claimant wrote to his employer [487]. The letter was premised on the intention to convene a hearing to consider termination on grounds of capability. It set out criticisms of the handling of the claimant's case so far and stated that the claimant was:-

> ***"entirely prepared to undertake and to cooperate with any scheme of retraining and we skilling that is necessary to enable him to return [to] his former work"***

6.69. Whether the claimant intended this or not, we find the objective message being conveyed to the employer over the past year had been that he was not prepared to undertake an assessment, and by this letter, he had changed his mind and was now prepared to undertake the assessment. That understanding is reflected in Dr Hepburn's account that just before the hearing the claimant had *"decided he would like to undergo a capability assessment".*

6.70. Whilst the plans to arrange a hearing in March continued for a short while, we find before then it was cancelled in favour of revisiting the scope for an assessment supported by NCAS. We find this was due to the claimant revisiting whether he was still prepared to undertake the assessment proposed by NCAS.

6.71. Various things happened as part of preparing for the assessment. The first is that a fourth occupational health referral was made. A Dr Griffiths provided a report on 17 April 2014 [523]. His assessment was that the claimant's abilities represented a fixed disability that was unlikely to change. Dr Griffiths also opines that "it is possible he has de-skilled from such work to some extent by virtue of the time over which he as not undertaken it, in addition to the stroke. He felt that there was no medical reason why he could not undertake his normal work but anticipated he would struggle with some aspects. He felt it hard to know how Dr Murphy's would get on with fine motor skills using his right hand and suggested it may be easier to consider outpatient or teaching rather than surgery. In short, he confirmed the need for a skills assessment to determine any limitations on Mr Murphy's clinical practice. Reasonable adjustments were contemplated at this stage included allowing more time for each task than is available to other surgeons and avoiding on call work for several months whilst assessments of his performance was undertaken.

6.72. Dr Griffiths also recorded that the claimant had good insight into his condition. We also find this to be the case. Whilst his own self-assessment of his capabilities was inevitably a little biased, or at least optimistic, we did not find the claimant was viewing his capabilities through rose tinted spectacles. On a number of occasions he acknowledged any assessment may well have demonstrated shortcomings.

6.73. The second is that the surgical department, under Mr Mohan's lead, devised the minimum requirements of the job. These were expressed in summary form as: –

- ***General surgical and colorectal outpatients, including the ability to perform rigid sigmoidoscopy /Banding of haemorrhoids.***
- ***Main surgeon in general and colorectal operating lists, including major collar rectal right resection and preferably laparoscopic resections. Definitely includes lesser skilled laparoscopic surgery like laparoscopic cholecystectomy***
- ***Four-day/3 day split week 24-hour on-call, including ability to operate on technically difficult patients and to sustain working over the entire period.***

In setting this minimum job role, Mr Mohan observed:-

> ***"This is the realistic job plan for all equivalent posts and we would be unable to offer an alternative job plan that is short of this. Obviously, to reach this level will take some time, given Mr Murphy's absence from practice for an extended period, but this should be the job skills at the end of any proposed retraining period.***
>
> ***It is my sincere opinion that Mr Murphy will not be able to undertake work to this level, but I would welcome an assessment by an independent authoritative source to confirm or refute my opinion."***

6.74. On 12 May 2014, Dr Murphy and his HCSA rep met Dr Christine Hopton, an adviser from NCAS together with Dr Hepburn. The outcome was recorded in a letter of the same date [529]. In short there was now agreement to prepare a programme of refreshing knowledge, of assessment and various milestones were identified. It was agreed it would be based on what a trainee at the appropriate grade would be expected to achieve within a busy clinical schedule. The parties agreed that the claimant would devote time preparing in study and would return to observe and assist under supervision in the clinical workplace.

6.75. We find the level of NCAS involvement and support was unusual, if not at that time almost unique. It seems to have broken through the barrier of needing an external CSL and also the notion of some sort of simulated assessment first. Instead it provided a supported and managed supervised programme of observation followed by assessment which could take place within the workplace. With the input from occupational health, the trust including Mr Mohan and Mr Murphy himself, a formal and detailed NCAS action plan was developed [633]. This plan sets out various milestones and expectations of both parties over its duration through to March 2015. The NCAS plan was not a one way process and Mr Murphy was equally expected to take responsibility for a number of aspects of both his retraining and evidencing his competencies. For example, by use of a reflective log.

6.76. The refresher or reskilling part of the process started in May 2014 on an observational basis intended to reintroduce the claimant to the clinical environment, refresh his knowledge and skills and prepare him for the formal part of the remediation programme that was planned to start in 3 or 4 months' time. In other words, the claimant would initially attend theatre without direct involvement or responsibility for the procedures being undertaken. As confidence grew, opportunities for scrubbing and taking a more direct role in assisting the procedure would develop. During the process, we find there were already occasions when Mr Murphy's physical ability to attend a theatre list appeared to be a challenge. There was also differences of opinion

between what Mr Murphy felt was appropriate use of his time and what his managers and mentors felt was needed. For example, the claimant planned to reduce his theatre time but was asked not to. He was refused study leave support to attend two conferences which, although in his specialist area, were clearly not a priority use of his time when such fundamental elements of his role remained uncertain. We find this was in some respects symptomatic of Mr Murphy's engagement with the process. We find Mr Murphy did not always engage with the opportunities that were available to him. In fact, the planned start of his formal part of the remediation programme in September had to be delayed by a week simply because the claimant could not be reached.

6.77. From 9 September 2018, Mr Murphy belatedly commenced his formal assessment under the remediation programme. Mr Murphy was to work under a clinical attachment to Mr Barlow, a consultant surgeon at Lincoln. We find it was necessary to undertake the assessment at Lincoln due to the need to have Mr Murphy assessed in a suitably appropriate work environment and by a suitably experienced consultant with a suitable case load. We find the other hospital centres would not have provided a suitable programme. To the extent this would have caused Mr Murphy additional travel time, we find alternative arrangements were made available to support Mr Murphy with his own suggestion of residing in Lincoln during the week although we do not understand Mr Murphy to have taken that up.

6.78. Mr Barlow was tasked with undertaking the assessment of the claimant's clinical skills and formally identified as such in the NCAS action plan. We find the combination of Mr Barlow being both prepared to undertake a formal assessment process together with the support and framework of NCAS provided the formality, integrity and authority to the assessment process that appeared to us to be part of the initially difficulty in arranging a third party CLSA. As the claimant says, Mr Barlow was not there to train him but we find Mr Barlow was actively engaged in directing the claimant appropriately so that he could, in due course, give a fair assessment of his skills. We find his role was one of directing supervised exposure to various clinical experience in order to make the assessment of Mr Murphy's skills. We have not heard from Mr Barlow. We have seen his contemporaneous reports on progress and we are satisfied that Mr Barlow was an appropriate person to undertake this role and his reports demonstrate his aim was to undertake a fair and open process of assessment.

6.79. Mr Barlow prepared his first interim report on 1 November 2018 [647-649]. It is a lengthy and detailed first assessment of Mr Murphy's clinical skills in respect of surgery, endoscopy and ward rounds. He identified Mr Murphy's slow speed, but recognised his lack of clinical practice over the previous 3 years. He identified a series of deficiencies in Mr Murphy's manual dexterity meaning he was not at a level to allow him to safely act as first surgeon in any procedure. He gave specific examples of concerns, including occasions when he had to take over from Mr Murphy to maintain patient safety. He described errors in aspects of theatre practice, such as the orientation of the operating table, which appear to us to reflect an absence from practice, rather than consequences of the stroke itself (the same mistake was made by the specialist registrar also in theatre). He recorded that Mr Murphy had

not produced any written assessments despite being reminded by him to do so. He recorded how Mr Murphy had attended to his ward rounds albeit was rather passive.

6.80. Mr Barlow concluded by expressing his concerns about Mr Murphy's operable skills. He had so far only assisted in operations, and then only at the level at which a senior house officer would be expected to assist, and even then, not without some concerns arising. We understand "senior house officer" to be a junior doctor in training two levels below consultant and many years away from that grade. Mr Barlow planned to gradually increase the complexity of the surgical procedures but warned *"I do not feel that he has the manual skills, decision making process and physical speed, agility and strength to ever undertake safely abdominal surgery*". Mr Barlow also expressed a conclusion that Mr Murphy should not be judged as having completed month 2. We understand that comment to be expressing a need to undertake further assessment at that level despite the time on the programme.

6.81. We found this assessment read as being a genuine and balanced assessment. We do not detect any ulterior agenda and find the objective was a desire to undertake a fair assessment of whether Mr Murphy could safely return to clinical practice.

6.82. Following the initial milestone report, Dr Hepburn wrote to the claimant on 10 November 2014. He recorded how he was pleased that Mr Murphy was making some progress but was concerned he had achieved only the month 1 milestones by the end of month 2. For that reason, the timescale for achieving month 2 milestones was extended.

6.83. On 15 December 2014, Mr Barlow prepared a second and equally detailed milestone report [653]. Although the plan was expected to last through until March 2015, this would, in fact, be the final report. In it, he set out some positive aspects of progress such as his opportunity to work alongside other surgeons and that his stamina was improving. Otherwise, however, the milestone report was negative. He recorded that Mr Murphy was not fulfilling the requirements of the assessment; that he had quite an inadequate and incomplete log of surgical activity despite Mr Barlow offering his support and providing examples of what the RCS require. He was concerned that Mr Murphy's understanding of the formal assessment process also suggested an absence of him ever having done it correctly with his own trainees previously. In short, he had come to the conclusion that Mr Murphy was comprehensively failing to meet the requirements of the assessment process, even at the level of a final year trainee. He set out his observations and examples that had informed his conclusion. In particular he recorded his slow speed despite the reduction in the number of patients he saw; him frequently contaminating his sterile gloves during towelling up; his inability to undertake laparoscopic surgery; his pronounced tremor and how he has to steady one hand with the other when using a scalpel or instruments which he described as totally unacceptable, a conclusion we suspect most prospective patients would share. His concern was such that he concluded *"for this reason alone I have been unable to allow him to open an abdomen*" beyond the first occasion. He again set out specific examples within the

context of endoscopy, outpatients and theatre. On a lay reading, there appeared to be slightly better performance in some of the basic elements of endoscopy but still unacceptably low success rates with IV Cannulation which was attributed to a loss of the fine motor skills. Mr Barlow had previously described him as lacking confidence with the endoscope and being a long way off competently to do any gastro intestinal endoscopy independently. The overall conclusion he reached is significant. He said how Mr Murphy had:-

> ***"made no progress in the operating theatre due mainly to physical difficulties. This is not a matter of practice or training. He is not able to perform any procedures unassisted and his technical ability to act as an assistant are limited. I am certain that no further training or experience will improve this."***

6.84. Mr Barlow also had other concerns about clinical judgment and decision making. He described how Mr Murphy was aware of his assessment stating-

> ***"Paul recognises the difficulties he has and correctly states that his main concern is that patient safety should not be compromised."***

6.85. Mr Barlow saw no value in continuing the assessment after December.

6.86. On 18 December 2014, Dr Hepburn wrote to the claimant enclosing the milestone report from Mr Barlow and setting out the view of the local Medical Decision Making Group [657]. It had reached a conclusion that Mr Murphy had not made the progress required under in the NCAS remediation programme. It proposed two options both of which would lead to a hearing the following February to consider his continued employment. The letter also reminded him of his own options in respect of ill health retirement.

6.87. The respondent sought a further report from Dr Griffiths in occupational health. Sue Kirk made her referral on 19 December 2014, in which she sought further advice following the outcome of Mr Barlow's assessment of the claimant in the clinical setting. By this time the only option seemed to be termination either through ill health retirement or on grounds of capability. She sought consideration of reasonable adjustments prior to that. Dr Griffiths did not feel the circumstances warranted a further consultation with the claimant. He responded on 22 December 2014 saying:-

> ***"the consultant has stated that he is confident that further training would not remedy at least some of those problems. They are therefore likely to be permanent performance deficits. I would suggest that you discuss that with Mr Murphy and seek his view. I cannot think of adjustment that are realistically going to be able to enable him to undertake his substantive role on the basis of what is said below. I would suggest you also discuss that with him in case he can think of anything.***

6.88. There is a fundamental dispute in this case as to whether the timing of the assessment would have made any difference to the outcome. The claimant accepts Dr Barlow's assessment as it stood in December 2014. He does not forcefully say that he would have passed an early assessment soon after his return to work but believes he might have. It is necessary to come to a finding on that matter. In doing so, we have before us three significant points in the evidential landscape. First the fact that the claimant's recovery in respect of

the physical aspects of dexterity, mobility and coordination were largely fixed around the time of his return to work in mid 2011. Such further improvement that there was thereafter, we find was negligible and particularly so in the context of performing clinical procedures. Secondly, Dr Barlow's assessment of Mr Murphy's inability to safely perform the various clinical procedures was at the level of the same type of physical aspects of dexterity, mobility and coordination. Thirdly, there are other factors at play whenever a surgeon is away from the clinical workplace for any protracted period of time. We have found that it is recognised some refresher process may be needed after as little as 3 months' absence. It follows that this will be all the more pronounced after 3 years. We have come to the conclusion, however, that the evidence does not support a finding that the mere absence from practice is the reason Mr Murphy was not successful in the remediation assessment. There are aspects where this did feature in his assessment, such as the failure to set up the theatre table in a certain orientation, and if that were the only basis of concern we may have reached a different finding. As it is, we find as a fact that that despite Mr Murphy's substantial functional improvement in the six months' following his stroke, he was nonetheless left with a level of deficiency in his dexterity, mobility and coordination particularly the fine motor skills, that would on the balance of probability have resulted in the same outcome whenever the assessment of his clinical skills had taken place.

6.89. In early January 2015, Mr Murphy met with Dr Hepburn. The purpose was to explore the various options for either Mr Murphy, or indeed for the trust, to take matters further. We find Dr Hepburn was reluctant to force Mr Murphy down a formal capability route if there were other options and we accept he had invited Mr Murphy to consider his options for ill health retirement. At the time of this meeting, Mr Murphy had not yet decided how he wished to proceed.

6.90. We find Dr Hepburn also considered the possibility of creating an alternative role based solely on endoscopy and removing any requirement for surgery. Dr Hepburn explained that this was not possible due to the outcome of Mr Barlow's assessment that even with further training, he would not be able to undertake that to the safe standard required.

6.91. We pause there to note that during the chronology of Mr Murphy's own case, his colleague, Mr Ortonowski, had himself suffered a stroke and upon returning to work his workload had been modified so that he performed only an endoscopy role. We were given an extremely superficial picture of his circumstances and were able to form only a limited understanding of his residual capabilities and clinical workload. Indeed, the claimant himself was particularly reluctant to identify Mr Ortonowski in evidence. Based on what we have, we have concluded that what appears to be an apparent difference in the response to his circumstances is not in fact so. We find his circumstances were materially different in respect of both his residual dexterity and coordination and the nature of his practice which in any event had more of a bias towards endoscopy work. The result was that he was in a position for his workload to be adjusted with minimal disruption to others and for him to perform endoscopy procedures safely.

6.92. We find the claimant would have been supported in seeking ill health retirement had he wanted to pursue it. On 9 January, a revised estimate of pension benefits was provided. He did not indicate his wish to explore this further and Dr Hepburn began the process of arranging the formal capability panel. Before the capability panel could be convened, the claimant commenced a period of sickness absence from mid-January which continued until August 2015. Nothing of significance happened during the duration of his sickness absence. In July 2015, Mr Murphy had a discussion with Ali Vernon, the Operational Services Manager to the effect that he hadn't heard anything further about a panel, that he wanted to go (leave the Trust's employment) but he was happy to continue getting paid in the meantime. There clearly was concern amongst a number of his colleagues that there was not a meaningful role for him to perform and, until the matter was resolved, the trust could not seek to recruit into his substantive post.

6.93. In that respect, we have already dealt with the suggestion that the original locum employed to cover Mr Murphy's initial absence had been appointed to a substantive post. That was not the claimant's post and there remained a need for locum cover for the work Mr Murphy would have done. We are satisfied that had the claimant ever been in a position to safely return to clinical practice, there was a role for him. Without him returning to practice or his employment ending, not only was the work being covered by locum doctors, but it was not possible to recruit on a permanent basis. We find this had a real risk of implications for clinical management because of the nature of the skill set available through the locum workforce compared to that which might be attracted from career grade doctors. In short, there was pressure put on the remaining consultant body to cover the specialised areas of practice.

6.94. In late August, the claimant's sick note expired. He was asked to help the department completing mortality pro-forma, dealing with complaints and teaching medical students. We find these were tasks put together once again to provide some sort of meaningful role for the claimant to undertake in the short term and along the lines of those initially put in place for him. We find the value to the trust was such that they would not have justified an alternative role in the long term. He was not being closely line managed and we find his attendance and engagement was, perhaps for understandable reasons, sporadic during this period.

6.95. On 12 October 2015, Dr Hepburn wrote to the claimant inviting him to a panel hearing at which his situation would be considered as a capability matter. The hearing was scheduled to take place on 25 November 2015. It set out the arrangements and process to be followed.

6.96. The hearing took place as planned chaired by Mrs Pauline Pratt, the Acting Chief Nurse. The panel also included an external clinician, Mr Bill Cunliffe, colorectal surgeon and secondary care clinician with The Newcastle & Gateshead CCG; Dr David O'Brien consultant interventional cardiologist and clinical director and Karen Taylor, Assistant Director of HR. We accept the role of the two senior doctors on the panel was to scrutinise the prospect of further remediation and the possibility of Mr Murphy's return to safe practice.

6.97. The employer's position was set out in a management statement of case. Despite the prior invitation to do so, neither Mr Murphy nor the HCSA had provided any documentation. He did, however, attend with a small bundle and we find the panel accepted them and considered them.

6.98. We are satisfied that the panel gave consideration to whether Mr Murphy was a disabled person; the impact the time between then and the original stroke may have had on his abilities and redeployment to alternative roles. NCAS had itself identified the possibility of redeployment to a non-clinical role within its own action plan upon the remediation plan failing.

6.99. We find that during the hearing the claimant accepted Mr Barlow's conclusion that he was unable to perform his clinical practice to the required standard; he blamed it on the delay in being assessed in the clinical environment; he explained how he did not wish to seek ill health retirement as it was not financially feasible and, in any event, he wanted to remain a consultant. We find he could not offer any suggestions as to how he might contribute to the trust at that level, what type of work he could do and could not expand on the non-clinical work he had been doing since 2011. We are satisfied the possibility of a non-clinical role was in the mind of the panel. We find there was no such suitable role available.

6.100. We find the only option proposed by the claimant of allowing him to continue as he was until his retirement date was rejected on grounds that it was not reasonable to expect the employee to continue to pay the full salary of a consultant surgeon without deriving any meaningful value from it. Whilst the respondent is criticised for delay, it is also perfectly proper to see this as an employer that had also been slow to move to dismissal. We find the full pay paid to the claimant during the period was a sum approaching £700,000. During the same period, the cost of locum cover had just exceeded £600,000.

6.101. The panel concluded that the claimant's employment would be terminated with notice on grounds of capability. The decision was confirmed in writing by letter dated 26 November 2015. He was given a right to appeal against the decision. Any appeal was to be submitted in writing within 10 working days to Dr Kapadia.

6.102. On 7 December 2015, the claimant did write to Dr Kapadia. His letter opens with the first two paragraphs stating:-

> ***"I wish to respond to certain aspects of the letter written by Ms Pratt….."***

and,

> ***"Overall, I agree with a finding of incapability and would no longer wish to return to my role as an independent consultant surgeon.***

6.103. The thrust of his response was not a challenge to the conclusion reached, but a disagreement with a statement in the panel's conclusions that the trust had acted in his best interests in supporting him. He set out the chronology and concluded with:-

> ***"I fully accept the ultimate findings of the panel in terms of capacity, but the initial OH views were that a clinical skills assessment in 2011 should have determined my return to clinical work, not an assessment in late 2014."***

6.104. The letter was sent as an attachment to an email of the same date which stated:-

> ***"the appeal is not against the termination of contract on the grounds of incapability per se, but rather against assertions that the trust made all efforts to support me…."***

6.105. Against that, and the fact that there was no challenge to the decision, we find it unsurprising that Dr Kapadia replied in the manner he did on 12 January 2016 [875]. Dr Kapadia did not convene an appeal hearing as he noted that the claimant was not challenging the decision reached. Insofar as the claimant's wider grounds of concern were considered, we find Dr Kapadia did give consideration to the points the claimant was raising and reviewed the evidence presented at the capability hearing. He responded with the conclusion that what was presented was markedly different to the points now being raised and the panel could only consider the points put to them. He undertook his own review of the points in the chronology when the trust had sought to support the claimant's assessment and return to work.

## 7. DISCUSSION AND CONCLUSIONS ON THE ISSUES

7.1. In any disability related dismissal case, where there are also claims under s.15 and s.20 of the 2010 Act, it is appropriate to deal with them in the reverse order to which they have been articulated before us. The reason is because the answer to the reasonable adjustment claim *may* inform any justification for the s.15 claim, and the outcome of both *may* inform the fairness of the decision to dismiss. Finally, we consider the unauthorised deduction claims.

## 8. Failure to Make a Reasonable Adjustment

8.1. So far as is relevant to the circumstances of this case, the duty to make adjustments arises under section 20(3) of the 2010 Act where: –

> ***a provision, criterion or practice of A's puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, to take such steps as it is reasonable to have to take to avoid the disadvantage.***

8.2. In determining whether the duty has arisen, the Tribunal must identify each element of the section in turn, that is to identify the PCP; the identity of a non-disabled comparator (where appropriate) and the nature and extent of the substantial disadvantage suffered by the Claimant. Only by breaking down those elements can a proper assessment be made of whether the adjustment contended for was reasonable or not. ***(Environment Agency v Rowan [2008] IRLR 20 EAT***)

8.3. Paragraph 20 of part 3 of schedule 8 imports a requirement of knowledge on the employer in respect of both the employee's disability and that he is likely to be placed at the disadvantage created by the PCP. Unless there is or ought to have been the required level of knowledge of both elements, the duty to make a reasonable adjustment does not arise.

8.4. Whether an adjustment is reasonable or not is a question of fact for the Tribunal taking into account all the relevant circumstances and applying the test of reasonableness in its widest sense. Guidance similar to that which used to exist under s.18B of the repealed Disability Discrimination Act is now found in the code of practice.

8.5. The provision, criteria or practice contended for by the Claimant is "being required to carry out surgery and perform the full range of duties associated with the post of consultant general/colorectal surgeon as it stood prior to December 2011". The next consideration is whether the PCP puts the Claimant at a substantial disadvantage in relation to his employment (and where appropriate, by comparison with persons who are not disabled). The disadvantage is that he cannot carry out this role and we are satisfied that is the case. It is said to manifest in two particular disadvantages of, in the short term loss of income and, in the long term, dismissal.

8.6. The respondent argues that after the claimant became disabled by virtue of the stroke, he was never thereafter expected to carry out that role. We agree in fact that was the case, but in the context of the employment relationship that does not mean that the requirement did not exist. Otherwise, why else was he dismissed from that role? The claimant was contracted to that role. The respondent was satisfied he could not carry out that role. When one considered the disadvantage that flows from the PCP, namely a greater risk of being dismissed, it is clear to us that the PCP was applied to the claimant which put him at a substantial disadvantage compared to someone who did not have his disability, as they could perform the role and would be exposed to a much reduced risk of dismissal.

8.7. The duty to make adjustments therefore arose if there was knowledge of both the disability, and the disadvantage flowing from its interaction with the PCP. We are satisfied that there was sufficient knowledge and therefore the duty to make reasonable adjustments did engage.

8.8. We must then consider the reasonableness of the adjustments contended for by the claimant that he says the respondent has unreasonably failed to make. The first adjustment contended for is to adjust the claimant's role so as to remove the requirement to carry out surgery. The claimant confirmed what was meant by this was to create a role that was limited to performing endoscopy procedures only. We were not addressed further on this adjustment in the claimant's closing submissions but we have considered it. There are two main elements to assessing the reasonableness of that adjustment. The first is whether the claimant could safely perform such a role. If he could, whether it was reasonable for the employer to create such a role. As to the first, we are not satisfied the evidence shows this was a realistic option for the claimant to safely perform an endoscopy list as an unsupervised consultant. Whilst there is an obvious difference in the degree

of bodily invasion between classic surgery and endoscopy, it does not mean that endoscopy is not invasive or that there are no patient safety issues arising. We are satisfied these were considered by Mr Barlow in his assessment of the claimant's capability and summarised in his milestone reports. The ability of the claimant to undertake any meaningful endoscopy clinic without close supervision was too far below the line of safe practice to render even further training worthwhile. That alone satisfies us that this adjustment was not reasonable to make.

8.9. We have also come to the conclusion that even had the claimant been capable of performing endoscopies safely, it was not reasonable to create a role limited to such activities. Endoscopy was a small proportion of the claimant's work by a ratio of 3:1. The clinical workload of the claimant's work and that of his department had to be balanced across the areas of clinical activity. We heard how there were issues arising with the limited skill set of locum cover. An imbalance of work had implications for how the work was distributed across the team of surgeons which ultimately was a factor in clinical governance. The respondent had already made some adjustment to the clinical workload split in respect of Mr Ortonowski and whilst that clearly showed there was some scope for such redistribution of work, we found a material difference in the nature of his work to be a factor in enabling that to happen. Additionally, the very fact that was already in place would render any further redeployment on similar lines less practicable.

8.10. The second adjustment contended for is to permanently allow Mr Murphy to continue with the temporary work plan that he had been given on his return to work in 2011. In other words, supporting the clinical complaints process, chairing the MDT and supporting the teaching of doctors in training. We are satisfied such an adjustment was not a reasonable one to make permanent in the circumstances. We do not accept that the role that was created was anything other than a means of providing some broadly relevant occupation to the claimant in the interim, even though that interim ended up lasting a number of years. We have considered whether the fact that it had lasted for much longer than either party might have initially anticipated adds weight to the contention it should be made permanently. In our judgment, we have concluded it does not. We first view it from the perspective of the additional cost. There had been a substantial additional cost to the employer of almost 1:1 in providing the colorectal surgery services through locum cover. We did not regard that as being reasonable to go on permanently. The fact that the trust had, by then, already incurred over £600,000 additional expenditure reflects more on the time it took to reach the final decision to terminate. It does not follow that it thereby renders it reasonable, or more reasonable, to let it continue permanently. The trust was throughout the period in a serious financial situation. There was an established alternative to the claimant in early access to his pension which he did not wish to do.

8.11. We then consider the value the trust would derive from such a role. Appointing the claimant to an alternative role that he was suited to, at an appropriate salary and which had value to the employer would, of course, be a potentially suitable reasonable adjustment to make. This contention, however, comes with concern about the suitability of the claimant to perform it, is manifestly a role that the trust derived no value from, other than

occupying the claimant's time in the interim and it would be hard to see why it would be reasonable to remunerate such a role at the salary level of a consultant. Anything less than that would not have been acceptable to the claimant but any figure would not have been value for money for the trust. We are satisfied those concerns outweigh the disadvantage caused to the claimant in the assessment of reasonableness.

8.12. Consequently, the reasonable adjustment claim fails in respect of both adjustments contended for. We note neither adjustment contended for appeared to go to the stated disadvantage of short term loss of pay which we understand to be exclusively linked to performing his clinical practice.

8.13. We have also considered the issue of our jurisdiction to consider this claim. We are satisfied that whilst the PCP engaged from the time of the stroke, the ultimate disadvantage arising from the risk of dismissal needs to be seen in the context of when that risk crystallised. That was when the dismissal process was decided upon in the run up to the hearing in November 2015. The decision to dismiss was an act inconsistent with making the adjustments and time ran from then. The claim first presented on 8 April 2016 is in time.

9. ***Unfavourable treatment because of something arising in consequence of his disability?***

9.1. Section 15 of the 2010 Act provides:-

> ***(1) A person (A) discriminates against a person (B) if-***
> > ***(a) A treats B unfavourably because of something arising in consequence of B's disability, and***
> > ***(b) A cannot show that the treatment is a proportionate means of achieving a legitimate aim.***
>
> ***(2)Subsection (1) does not apply if A shows that A did not know, and could not reasonably have been expected to know, that B had the disability.***

9.2. Having regard to the 2011 Code of Practice in Employment, in particular chapter 5, and to **Basildon & Thurrock NHS Trust v Weerasinghe UKEAT/0397/14/RN** and **Pnaiser v NHS England and Another [2016] IRLR 170**, this statutory provision requires analysis in stages. First is the identification of unfavourable treatment. Secondly, the identification of the "something arising" and whether that does actually arise in consequence of the disability. Thirdly, if it does, whether that was the reason for the unfavourable treatment.

9.3. The claimant points to three acts of unfavourable treatment. They are the decision to dismiss, the delay in arranging the skills assessment and the restriction on his duties upon his return to work with a consequential reduction in pay.

9.4. We had some difficulty during the course of the hearing keeping hold of a consistent articulation of the "something" said to arise in consequence of the disability. In the ET1, that something was pleaded as being:-

> ***"the reduction in his capability to carry out surgical procedures, which in turn arose because of his disability cause absences between December 2010 and June 2011*".**

As pleaded, this appeared to rely on the disability related absences as the cause of the reduced capability, not the disability itself. In other words, the chain of causation included a degree of removal between the effects of stroke itself, and the effects of the 6 months or so away from practice. Whilst is a perfectly legitimate to advance a s.15 claim relying on consequences which are two or more degrees removed from the disability itself, what the claimant appeared to be arguing by this pleading was that it was the consequential period of sickness absence, and not the direct consequences of the stroke itself, which led to the reduced capability to perform his role. Whatever the merits of such a claim, we readily understood this distinction as it appeared to be consistent with, and necessary to maintain, the claimant's wider argument that the stroke *itself* did not cause the loss of capability to carry out surgical procedures.

9.5. However, by the time of closing submissions the claimant was no longer maintaining such a distinction between the stroke and the absence caused by it. The cause of his unfavourable treatment became expressed as "the perceived reduction in Mr Murphy's surgical skills" and that "the stroke was potentially the cause of the reduction in Mr Murphy's surgical skills and the delay potentially caused the reduction in skills that caused the unfavourable treatment". We have therefore considered the claimant's case under both formulations of the s.15 claim so far as we understand them.

9.6. We are entirely satisfied that the evidence clearly shows the period of absence relied on between December 2010 and June 2011 arose in consequence of the disability. We are also satisfied that there is, during any prolonged period of absence from practice, a risk to anyone of a temporary deterioration in skills.

9.7. We are equally satisfied that the stroke itself did cause a significant reduction in the claimant's capability to carry out surgical procedures because of the significant reduction in the claimant's dexterity, mobility and physical coordination. To the extent that the employees of the respondent "perceived" that to be the case, they had an objective basis for holding that belief in the occupational health reports and more specifically from Mr Barlow's assessment.

9.8. The first and most significant of the treatments claimed is the decision to dismiss. Dismissal is clearly unfavourable. The issue is whether that decision was reached because of the matter(s) arising in consequence of the disability. We can say without hesitation that Mr Murphy was not dismissed because he took 6 months sickness absence in 2011. To that extent the claim as pleaded fails. We can further state in our judgment that such deterioration in his capability as we accept was likely to arise when any surgeon was absent for around 6 months was also not the reason why he was dismissed. Neither of the parties, nor the occupational health professionals were focused on the mere period of absence although we recognise by 2014, the plan to provide a period of observation and re-

familiarisation training undertaken before the formal assessment programme started was linked to his time away from practice. The issue at all times was not the risk of the claimant's practice having become "rusty" due to the sickness absence, it was the extent to which the organic consequences of the stroke had affected his mobility, dexterity and physical coordination necessary to safely perform in the role. We are therefore satisfied that so far as the something arising is the claimant's period of 6 months absence in 2011, or such loss of skills arising from it, that is not causative of the of the unfavourable treatment alleged.

9.9. We are satisfied that the claimant was dismissed because of the reduction in his capability to carry out surgical procedures. We are satisfied that that arose in consequence of the stroke. There will therefore be unlawful discrimination unless such treatment is justified as a proportionate means of achieving a legitimate aim.

9.10. The legitimate aim the respondent relies on is expressed broadly as clinical governance. That is, more specifically, that patient safety is maintained through those it employs to deliver its clinical services. We are satisfied that that is a legitimate aim. As to the proportionality of dismissal, that is typically expressed as taking the least discriminatory course. In practice, if there were reasonable adjustments that could have been made to avoid the otherwise discriminatory step being taken, then it will not have been proportionate to impose the particular treatment. We have concluded that the reasonable adjustment claim is not made out. There are no other adjustments before us that could have avoided this treatment and met the aim in any other way. We have considered the treatment in the wider context of alternative forms of termination and note the claimant's choice not to explore ill health retirement. We respect his right not to pursue it but that was an option available to him. The aim is not only a legitimate one but one which weighs heavily in the balance for obvious reasons. The claimant himself accepted the that incapability was made out and did not seek to return to his role. He recognised the imperative of patient safety. The dismissal decision itself was not a quick response, whilst in other respects the claimant criticises the delay in obtaining the assessment, even when that was eventually concluded in the negative, there was then over a year before dismissal actually took effect. We are satisfied that in the circumstances the decision to dismiss was a proportionate means of achieving the stated legitimate aim.

9.11. The second treatment complained of is the delay in arranging the skills assessment. We must first consider whether that is in itself unfavourable treatment when the claimant was, save for the elements we consider below, paid his full pay throughout and where our findings are such that, had it occurred sooner, in all probability so too would the decision to dismiss. In this context, we are doubtful it can be described as unfavourable. The chronology, as lengthy as it is, can be understood as a series of reasonable steps according to the different prevailing situations both parties faced. Firstly, the idea of an independent skills assessment for a consultant was a novel process to all those involved; secondly, the process of identifying one did not start in earnest until late 2011 due to the desire for the claimant to return to a normal working routine; what then was expected to be a straight forward process of instructing a third party assessor in fact turned out to be

anything but straight forward; there was then a series of sequential diversions from 2012 through the fitness to practice enquiry, the claimant's own grievance and then exploring ill-health retirement. Between 2013 and 2014 the claimant was explicitly declining to participate in any assessment. The employer contemplated termination on capability grounds only to abandon it in favour of the NCAS supported internal remediation programme. At the end of which, the parties had a negative assessment which, ultimately, the claimant did not dispute. The only period in that chronology for which the respondent takes the principal responsibility to explain why an assessment had not taken place, is from late 2011 to mid 2012.

9.12. However, even if delay does amount to unfavourable treatment (and there would seem to be some risk of further dulling of the clinical skills the longer a clinician is away from practice over and above that cause by the sickness absence) we are satisfied it is not treatment because of the something arising. There was not delay because of the reduction in the claimant's capability, or because he had taken time off sick. Any delay was because of the reasons we summarise above explaining the chronology. A large part of the delay after 2012 arises because of the claimant's own position exploring an alternative exit and expressing a view that he would not undertake an assessment. We are also satisfied there, even where there was a presumption that Mr Murphy would fail any assessment, that is not the reason for the chronology unfolding as it did. We found as a fact that the prospect of capability termination or ill health related termination was a real possibility in this case, but the fact that that obvious possibility was expressed by the likes of Mrs Kirk during the time she was attempting to identify an appropriate clinical skills assessment is not, on our findings, the reason why it did not happen until sometime later. We have referred to our findings of the reason why arranging the assessment was so difficult already.

9.13. The third treatment suffered is said to be the restriction on the claimant's duties upon his return to work which led to a consequential reduction in pay. This manifests in two respects and mirrors the unauthorised deduction claim. They are (a) the 2012 review of job plan to remove the two additional PA's and (b) the fact the claimant could not participate as he had previously in the waiting list initiative. We are satisfied those two alleged matters are treatment in which income is reduced and must fall within the concept of unfavourable treatment.

9.14. We are unable to bring the cause of either treatment within the pleaded "something arising". We are entirely satisfied that neither was because of any reduction in Mr Murphy's capabilities arising from the period of sickness absence following his stroke. Both arose because the initial occupational health advice was for him not to undertake surgical work that necessarily underpinned each of those aspects of pay. Underlying that, is the fact this advice arose in consequence of the reduction in the claimant's ability to safely perform his surgical role because of the stroke, that clearly does arise in consequence of his disability, albeit not quite how the claimant advances the claim.

9.15. The respondent relies on financial governance as a legitimate aim. Specifically, that the waiting list initiative was something surgeons were paid

for if and only if they participated in it. The claimant was not able to participate in it at any time. It was a voluntary and non-contractual additional payment, in the nature of voluntary overtime that might be found in other industries. The loss of this additional income was balanced by the fact that the claimant did continue to receive all of his contractual payments as a full time surgeon including a 5% allowance for on-call which he equally did not participate in. We are satisfied that reducing the claimant's non contractual pay for work that was not being undertaken but not removing the core contractual entitlements was proportionate means of achieving this legitimate aim.

9.16. Similarly, we found as a fact that payment of the two additional PA's was maintained until the next job plan review which did not take effect until the middle of 2012. We found additional PA's were always agreed on a periodic basis as a temporary addition to the basic full-time contract based on a consensus of the employee being prepared to undertake them and the employer having a need. Where there was no need, it was open to the employer to reduce the additional PA's. We are satisfied this was a proportionate response. It was not done with haste, there was discussion and agreement and, even then, a further period before the change took effect. It needs to be seen in the context of a continuation of the core contractual entitlements including on call enhancement which was itself not performed.

9.17. The unfavourable treatment claim therefore fails on its merits. We had considered, in any event, whether we would have found we had jurisdiction to determine the claim. The dismissal allegation is clearly in time. The other two allegations of unfavourable treatment date from 2012. That is a substantial delay of 4 years. We did not hear evidence explaining the delay in bringing these claim's. In the absence of evidence being adduced on the point we did not feel able to embark on our own generic assessment of the balance of injustice to rule it just and equitable to extend time.

10. **<u>Unfair dismissal</u>**

*Law*

10.1. Section 98 of the 1996 Act is our starting point. It states, so far as is relevant:-

> ***"(1) In determining for the purposes of this Part whether the dismissal of an employee is fair or unfair, it is for the employer to show—***
>
> ***(a) the reason (or, if more than one, the principal reason) for the dismissal, and***
>
> ***(b) that it is either a reason falling within sub-section (2) or some other substantial reason of a kind such as to justify the dismissal of an employee holding the position which the employee held.***
>
> ***(2) A reason falls within this subsection if it—***
>
> ***(a)relates to the capability or qualifications of the employee for performing work of the kind which he was employed by the employer to do,***
>
> ***…***
>
> ***…***

***(4) Where the employer has fulfilled the requirements of subsection (1), the determination of the question whether the dismissal is fair or unfair (having regard to the reasons shown by the employer)—***

***(a) depends on whether in the circumstances (including the size and administrative resources of the employer's undertaking) the employer acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the employee, and***

***(b) shall be determined in accordance with equity and the substantial merits of the case."***

10.2. In **Iceland Frozen Foods Ltd v Jones [1982] IRLR 439** (Browne-Wilkinson J (P)) held the correct approach to adopt in answering the question posed by section 98(4) of the 1996 Act is as follows: -

> ***"(1) the starting point should always be the words of section 57(3) themselves:***
> ***(2) in applying the section an industrial tribunal must consider the reasonableness of the employer's conduct, not simply whether they (the members of the industrial tribunal) consider the dismissal to be fair;***
> ***(3) in judging the reasonableness of the employer's conduct an industrial tribunal must not substitute its decision as to what was the right course to adopt for that of the employer;***
> ***(4) in many (though not all) cases there is a 'band of reasonable responses' to the employee's conduct within which one employer might reasonably take one view, another quite reasonably take another;***
> ***(5) the function of the industrial tribunal, as an industrial jury, is to determine whether in the particular circumstances of each case the decision to dismiss the employee fell within the band of reasonable responses which a reasonable employer might have adopted. If the dismissal falls within the band the dismissal is far; if the dismissal falls outside the band it is unfair."***

10.3. In **Post Office v Foley [2000] IRLR 827** Mummery LJ at paragraph 53 commenting on the approach set out in **Iceland Foods** for the ET to adopt, observed:-

> ***"…that process must always be conducted by reference to the objective standards of the hypothetical reasonable employer which are imported by the statutory references to 'reasonably or unreasonably' and not by reference to their own subjective views of what they would in fact have done as an employer in the same circumstances. In other words, although the members of the tribunal can substitute their decision for that of the employer, that decision must not be reached by a process of substituting themselves for the employer and forming an opinion of what they would have done had they been the employer, which they were not."***

10.4. Counsel for the parties were agreed on the relevant law governing the basic propositions of fairness. It is common ground that the reason for dismissal was capability, in that the reason for his dismissal falls within the definition provided by s.98(3) of the 1996 act, namely, relating to "skill, aptitude, health or any other physical or mental quality."

10.5. The only question for us is whether the respondent acted reasonably in the circumstances as relying on that as a sufficient reason to dismiss the claimant in accordance with s.98(4) of the 1996 act. A capability reason requires a similar three stage analysis as applies to conduct. (**DB Shenker Rail (UK) Limited v Doolan (2009) UKEAT/0053/09**). That is, a genuine belief that capability meant the employment could not continue, whether that

belief was based on reasonable investigation and whether the conclusion was reasonable. There is no legal burden on either party at this stage. Each however, advanced their respective evidential case. For the claimant, he relies on the following matters which he submits undermine fairness. In summary, they are:-

a The delay in arranging the CLSA and remediation.
b The failure to hold an appeal hearing.
c The failure to give prior warnings.
d The failure to consider alternative employment.

10.6. We start with our conclusion on the position as at November 2015. We are satisfied that there was a genuine belief, accepted by the claimant, that he could not perform his role. We are satisfied that that belief was established on the basis of reasonable investigation into the claimant's health, his prospects of future improvements and the assessment of his skills at that time. We are satisfied what was before the employer at that stage formed a reasonable basis for a reasonable employer to reach the conclusion to end Mr Murphy's employment as a consultant surgeon. To that extent, and subject to our conclusions on the four specific matters of challenge to fairness, we are satisfied the dismissal would be fair within the meaning of s.98 of the 1996 Act. Some of those challenges are of greater significance than others. For example, the question of alternative employment will always be a particularly significant factor in capability cases when deciding whether dismissal fell within the range of reasonable responses.

*Delay in Clinical Skills Assessment*

10.7. The assessment of the claimant's clinical skills did not take place until 2014. The claimant's principal contention is that the respondent's delay in arranging a CSLA was itself the reason his clinical skills had deteriorated to a level below the level of safe practice or, to use his word that they had "atrophied". This word is apt to sum up how the claimant puts this case. Its dictionary meaning being to *"gradually decline in effectiveness or vigour due to underuse or neglect"*. This approach ignores the starting point which is the extent to which the claimant's skills had been adversely affected by the effect of the stroke itself.

10.8. The claimant says, the respondent's delay meant he was bound to fail any later assessment. We consider the key stages throughout the chronology further below but, before doing so, we considered whether the fairness of the subsequent dismissal is undermined by the suggestion that the employer somehow caused or brought about the underlying condition that led to the capability dismissal. In that regard, the respondent submits such a state of affairs does not mean it cannot fairly dismiss. Such circumstances may well arise in cases of workplace accidents although in such cases, any alternative to dismissal may have as much to do with minimising a special damage claim as the fairness of the situation. The respondent accepts that in dismissing an employee in such circumstances a tribunal may well expect to see the employer "go the extra mile" for example to accept a longer period of absence or to proactively consider alternatives but not that it can never dismiss. It relies on the Court of Appeal decision in **Royal Bank of Scotland**

**v McAdie [2008] ICR 1087** as authority. We accept that proposition of law and this challenge, in isolation, fails.

10.9. In any event, we do not accept the claimant's case as a fact that the respondent was the cause, or even the principal cause, of the deterioration in his surgical skills. That, we have found, was the consequences of the stroke. However, we have also accepted that there is always likely to be some further dulling of a surgeon's skills which arises simply from being away from practice for a period of time. In this case, we found the measure of that to be negligible compared to the consequences of the stroke itself. It undoubtedly increased with the time away from practice, but we found it did not explain the deficiencies identified by Mr Barlow. They were of a far more fundamental nature. We do not accept, therefore, that the timing of the clinical skills lab assessment had any material bearing on the outcome. We found that the claimant would, on the balance of probabilities, have failed any CSLA whenever it had been undertaken.

10.10. Notwithstanding our principal conclusion, we have, however, still considered the various stages in the chronology to identify where delay could have arisen. In doing so, we take the view that there would have to be some culpability on the part of the employer in causing or allowing that delay to occur. Secondly, to the extent that the steps taken by the employer in those earlier stages can be said to go to the fairness of the later dismissal decision, we are bound to approach the question not by reference to what we might have done, not by what more might have been done, but simply by reference to whether what was in fact done was reasonably open to the reasonable employer in those circumstances. We recognise that having accepted these events fall outside the scope of the fairness of the dismissal, there is an artificiality in applying the band of reasonableness test to the earlier events but we do not see how else we could analyse the claimant's contention in the context of this claim.

10.11. The chronology shows the prospect of arranging the CSLA was unhindered between July 2011 and July 2012 at which point the first of the series of diversions occurred. That was the GMC considering the claimant's fitness to practice. Even then, it was not unreasonable that a reasonable employer would allow the first few months or so of return to work to be focused on the basic requirements building up a working routine, rather launching immediately into a skills assessment if one were available. It is, therefore, only really the period between late 2011 until July 2012 that the attempts to identify and isolate a suitable CSLA can be said to be wholly down to the employer's efforts. We found those efforts were genuine and that those involved in sourcing an assessment were met with a degree of difficulty no one anticipated. We found that was a genuine difficulty. As Mr Murphy said, Mrs Kirk was doing her best and asking the right questions. We accept that there were other providers that could have been approached and might have thrown up new ideas but we did not have an evidential basis for finding there was a third party out there at the time that would have been able to undertake the assessment. There clearly were other enquiries that could have been made and with the hindsight we now have, we might have hoped we would make them. In the minute forensic scrutiny of these proceedings, it may seem that the respondent was at times ready to give in to the difficulty of

identifying and arranging the assessment, but it was a real difficult and a novel situation and we also found how they were equally slow to turn, instead, towards any dismissal process. We cannot therefore say that the steps taken by the respondent in that period were not within the reasonable range of those that a reasonable employer would take. For around 18 months, thereafter, the prospect of assessment was simply not being pursued due either to the GMC, the claimant exploring an alternative exit or indicating that he was not prepared to undertake an assessment. It is not until 2014 that the claimant's position changes and he then indicates he is prepared to undertake an assessment after all. This coincides with NCAS coordinating the assessment in a way that it can take place within an internal remediation programme. It then does take place.

10.12. If and to the extent that the employer's actions bringing about a loss of capability can be factored into the fairness of the resulting dismissal, we are satisfied that the actions of this employer in this case do not fall outside the range of reasonable responses of a reasonable employer in like circumstances.

10.13. Alternatively, our findings are such that if the respondent had arranged a skills assessment at any earlier time, it would have made no material difference to the ultimate outcome except in one respect. That is, the dismissal would have occurred commensurately sooner than it did. The fact a course of action would make no difference to the outcome is, of course, not part of the question of fairness but it is relevant to the question of remedy. We have, therefore, considered the effect on compensation should we be wrong to assess the respondent's timing and handing of the arrangements for the CSLA in the way we have. If this was itself the basis that rendered the dismissal unfair, the fact that we are satisfied that any earlier assessment would have reached exactly the same outcome means there must be a complete reduction in compensation under the principles arising in section 123 of the 1996 Act and **Polkey v AE Dayton Services Ltd [1987] UKHL 8.**

*The Failure to Hold an Appeal Hearing*.

10.14. The issue in the claimant's contention is the absence of a hearing. We are, nonetheless, satisfied that on receipt of the claimant's appeal and in composing his reply, Mr Kapadia did consider the point raised by the claimant in his appeal letter and in the context of the information put before the panel that decided on dismissal. The fundamental difficulty for the claimant in the context of the band of reasonable responses is that the right of appeal is against the decision itself, and the claimant's appeal not only did not challenge the decision, it expressly agreed with it. We then have to ask ourselves whether the employer's response fell within the range of reasonable responses of a reasonable employer.

10.15. We accept the respondent's contention that the question of fairness does not exist in a vacuum. If the ultimate decision is accepted, the basis on which the decision maker expressed its reasoning does not go to any substantive unfairness. Based on the manner in which the appeal was couched, it is obvious and clear why there was no hearing and the absence of a hearing

does not create an unfairness to the overall situation governing the decision to dismiss. In the circumstances, it does not fall outside the range of reasonable responses. In reaching that conclusion we have considered whether this decision offends the ACAS code on discipline and grievances. We are not satisfied it does in these circumstances but even if it did, it does not seem to us to have been an unreasonable failure.

*Failure to Give a Prior Warning*

10.16. This aspect of the challenge to fairness was not developed in the claimant's closing submissions but we do not treat it as abandoned. However, in considering how it could affect the fairness of this dismissal, we do not accept it is engaged in the circumstances of this case.

10.17. This is not a case where the reason for dismissal goes in any way to the claimant's conduct or any form of deliberate behaviour or anything which the claimant could overcome as a result of prior warnings. The notion of a warning is simply not engaged in the facts of this case in such a way that it could be said that a reasonable employer acting reasonably in the circumstances would have issued any warnings before reaching the ultimate decision to dismiss. Failing to issue a formal warning of potential dismissal does not, therefore, fall outside the range of reasonable responses of a reasonable employer.

10.18. In any event, there are various points during the chronology where the prospect of the claimant's employment being terminated was clearly started as being a real possibility. The claimant instructed solicitors to respond on one occasion. If the purpose of a warning is to indicate a possible future outcome and/or to encourage a change, those points in the chronology do that although, as we have said, this is not a case that fits with the concept of prior warnings.

*The Reasonableness of Consideration of Alternatives to Dismissal*

10.19. In any capability dismissal, the consideration given to alternative roles as an alternative to dismissal is a significant part of the overall fairness. It is clearly not fair to dismiss from one role where a reasonable alternative role exists. In this case the claimant has not advanced any particular alternative role that he could have carried out beyond continuing in the interim role he had been given upon returning in 2011. In fact, the effect alternative employment had on the fairness of dismissal was not developed further in his closing submissions. However, it arose, in part, within the reasonable adjustment claim and we regard it as still being a live issue before us.

10.20. The alternative contended for was principally that of allowing the claimant to continue in the interim role he had undertaken previously. We have considered that as a reasonable adjustment and rejected it. Although we recognise the tests under the 2010 and the 1996 Acts are different, we cannot conceive a situation where the answer to the question of reasonableness under each test could result in different answers. We are satisfied that this role was not a reasonable solution and was one that the

hypothetical reasonable employer was entitled to reject in considering alternative employment.

10.21. Similarly, we reach the same conclusion in respect of the possibility of a role dedicated to endoscopy work only. We are satisfied that the dismissal hearing process did give consideration to the prospect of alternative employment and in the absence of any other alternatives being identified at the time by either party, the conclusions it came to were within the range open to the hypothetical reasonable employer.

11. **Unauthorised Seduction from Wages**

11.1. Section 13 of the1996 Act, so far as is relevant to this case:-

***1) An employer shall not make a deduction from wages of a worker employed by him unless-***

> ***(a) the deduction is required or authorised to be made by virtue of a statutory provision or a relevant provision of the worker's contract, or***
> ***(b) the worker has previously signified in writing his agreement or consent to the making of the deduction.***

***2) …***
***3) Where the total amount of wages paid on any occasion by an employer to a worker employed by him is less than the total amount of the wages properly payable by him to the worker on that occasion (after deductions), the amount of the deficiency shall be treated for the purposes of this Part as a deduction made by the employer from the worker's wages on that occasion.***

11.2. Whether a payment is properly payable is to be resolved by considering the ordinary contractual principals. (**Greg May (Carpet fitters and contractors) Ltd v Dring 1990 ICR 188 EAT)** and if not arising in contract, must still have some legal basis (**New Century Cleaning v Church 2000 IRLR 27 CA**).

11.3. The concept of prior authorisation is not engaged in this case. Resolving what is properly payable is the key to determining whether a deduction has in fact taken place. In considering the evidence, we made the following findings of fact in respect of each type of payment alleged to have been deducted.

a Payments due for participation in the waiting list initiative were payable only in respect of work actually done on lists engaging the initiative. If no work was done, no additional payment would be due. Further, we found on balance that the waiting list initiative would not have continued into 2012.

b The two additional PA's were temporary. The respondent continued to pay them, until the next work plan review in early 2012. By the claimant's agreement to the new work plan, they ceased in July 2012 after which they were no longer properly payable.

11.4. If follows from those findings that the claims fail. In respect of the payments for waiting list initiative, the claimant had not done the work for which the enhanced payment would have been otherwise payable, even though we found the initiative itself continued throughout 2011. As that was a condition of payment, it was not properly payable. Alternatively, it was not properly payable from 2012 as we found, on balance, it would not have continued.

Similarly, the 2 additional PA's were subject to review and agreement. They ceased by agreement from July 2012 after which they were not properly payable. Unless the payment was properly payable under contract or some other legal authority, it not being paid cannot be a deduction from wages.

11.5. In these circumstances, a jurisdiction issue arises. Although it was common ground between the parties that the reduction in the claimant's income attributable to these two payments ceasing in 2011 and 2012 had continued at that level thereafter through to his dismissal, that is not the same thing as there being a series of deductions keeping the jurisdiction alive unless the underlying amount properly payable also continued throughout the same period. On our principal conclusions, there was no deduction at all. But even if there was a deduction of both type of payment, that deduction came to an end when the payment was no longer properly due. That is in January and July 2012 respectively. By section 23(2) of the 1996 Act, the claimant was required to present his claim within three months of the deduction, or last deduction in a series. In fact, the claim was presented approximately 4 years later. The discretion to extend time falls within the "reasonably practicable" test as set out in section 23(4) of the 1996 Act. We have not received any evidence addressing the reasonable practicability of presenting a claim in time but, in any event, in the circumstances of what evidence do have before us we cannot see that the discretion to extend time could be properly engaged in this case. The claims therefore fail on their merits but, in any event, on the findings we have reached are out of time.

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Employment Judge Clark

Date 24 October 2018

REASONS SENT TO THE PARTIES ON

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FOR THE TRIBUNAL OFFICE