RM

EMPLOYMENT TRIBUNALS

Claimant: **Mrs S Carter**

Respondent: **Barts Health NHS Trust**

Heard at: **East London Hearing Centre**

On: **24, 25, 26 July and 20 August (in chambers) 2019**

Before: **Employment Judge Moor**

Members: **Ms J Houzer**
Mr T Brown

Representation

Claimant: Ms S Brown, counsel

Respondent: Mr L Dilaimi, counsel

JUDGMENT

It is the unanimous judgment of the Tribunal that:

1. **The Respondent discriminated against the Claimant contrary to section 15 of the Equality Act 2010.**

2. **The Respondent failed to comply with its obligation to make reasonable adjustments under section 20 of the Equality Act 2010.**

3. **The complaint of unfair dismissal well-founded.**

4. **There is a 100% chance that the Claimant would have been dismissed by 31 December 2018 in any event fairly.**

REASONS

1. The Claimant, Mrs Carter, worked at the Respondent health care trust ('the Trust) as a senior sister from 11 November 2002 until her dismissal on 10 April 2018. This case concerns whether that dismissal was unfair and/or whether the Trust treated her unfavourably because of something arising in connection with disability which it

cannot justify and/or whether it had a duty with which it failed to comply to make reasonable adjustments.

2. It is admitted that at the material time Mrs Carter was a disabled person within, the meaning of the Equality Act 2010, by reason of two conditions: symphysis pubis and a foot deformity known as hallux valgus (bunion).

Issues

3. The issues were clarified at a Preliminary Hearing before EJ Russell and over the course of the hearing before us. The outstanding issues are as follows (we retain the original numbering):

'Unfair Dismissal

4.2 Was the dismissal fair or unfair in accordance with the Employment Rights Act 1998 ('ERA') section 98(4), and, in particular, did the Respondent in all respects act within the so-called 'band of reasonable responses'? The Claimant says it was not as she should have been redeployed or other reasonable adjustments made to enable her to remain in employment.

4.3 If the Claimant was unfairly dismissed and the remedy is compensation, should there be any Polkey reduction to reflect any possibility that she would have been fairly dismissed in any event?

Disability

4.4 The Trust concedes that the Claimant is a disabled person by reason of the physical impairments of symphysis pubis and deformity of the feet/hallux valgus.

Section 15, Equality Act 2010 (EQA) discrimination arising from disability

4.5 Did the Respondent treat the Claimant unfavourably as follows:

(ii) 27 March 2018: implementation by Ms Senyard of the sickness management policy and listing a stage 3 meeting;

(iii) 10 April 2018: dismissal and rejection of alternatives by Ms Senyard;

(iv) 10 April 2018: instruction by Ms Senyard that the Claimant must not contact any of the Respondent staff and/or visit its premises;

(v) 1 August 2018: decision by Ms Butler to reject the Claimant's appeal.

4.6 If so, was it because of something arising in consequence of her disability? The Claimant relies upon time off work caused by her disabilities.

4.7 If so, has the Respondent shown that the unfavourable treatment was a proportionate means of achieving a legitimate aim? The Respondent's legitimate aim is managing sickness absence to ensure adequate attendance levels and seeking to improve the Claimant's attendance in order to meet the needs of the organisation.

Reasonable adjustments: EQA, sections 20 & 21

4.9 Did the Respondent have the following PCP(s):

(i) a requirement for satisfactory and regular attendance;

(ii) performance of full contractual duties.

4.10 Did the PCP put the Claimant at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled at any relevant time in that

(i) she had an increased need to take sickness absence;

(ii) she was unable to perform some of the physical requirements of her job? The Claimant relies upon the symphysis pubis and foot deformity as the causes of her physical pain.

4.11 If so, did the Respondent know or could it reasonably have been expected to know the Claimant was likely to be placed at any such disadvantage?

4.12 If so, did the Respondent take reasonable steps to avoid any such disadvantage?

(i) In respect of the first alleged PCP the Claimant says that the Respondent should have disregarded disability-related absence and/or allowed more time to enable it to obtain OH advice and/or not dismissed her.

(ii) In respect of the second PCP, the Claimant says that the Respondent should have varied her duties to remove some of the physical aspects of the job; reduced the length of her shifts, redeployed her, provided the auxiliary aids of a specialist chair and/or specialist footwear and/or not dismissed her.'

4. On the first day of the hearing, Ms Brown, for Mrs Carter, withdrew original issue 5.4(i) (a claim concerning training). As to the disability issue, she clarified that Mrs Carter relied on 'status migraine' and depression, which disabilities were not admitted by the Trust. After 2 hours of hearing on the second day, Ms Brown formally conceded for Mrs Carter that she no longer relied upon migraine, status migraine and depression as disabilities.

5. Mr Dilaimi, for the Trust, conceded that it had knowledge of the admitted disabilities at the material time. Knowledge of the alleged substantial disadvantage in relation to

the reasonable adjustments claim was not admitted.

Findings of Fact

6. Having heard the evidence of Mrs H Hewitt, Ms E Senyard, Ms L Butler and Mrs Carter, and having read the documents referred to us in the evidence, we make the following findings of fact.

7. Mrs Carter has been a nurse for many years. She has a great deal of experience in critical care both at the Trust where she became a full time senior sister in the Adult Critical Care Unit ('ACCU') and also at Kings' College Hospital. By the time of her dismissal she had been a band 7 nurse for 16 years.

ACCU Unit/Impact of Absence

8. The ACCU, a 44-bed unit, specialising in major trauma. It is a high dependency unit. All agree it is a fast-paced environment in which critically ill patients are cared for. It is a ward dealing with emergencies, and life and death situations.

9. All agree that the band 7 role was critical on the ACCU and therefore in the business of saving lives. A band 7 was a senior nurse manager on the ward (the level below matron). The band 7 managed the clinical shifts, oversaw patients, ensured the quality of care and safety, and supported nurses and clinicians. The band 7 was responsible for improving 'patient flow' and had responsibility for improving infection control, falls prevention and pressure risks. As a band 7, Mrs Carter managed a team of about 16 nurses both in their day-to-day work but also in relation to their performance, development and sickness. The junior nurses relied to a large extent upon the experience of the senior nurses including band 7s.

10. The Trust employed 16 clinical band 7s in the ACCU and aimed to have 2 or 3 band 7s on each 12-hour shift. If one was absent, that necessarily put pressure on the whole team and, on occasion, it would mean that there was only 1 band 7 supervising a 44-bed unit. The Trust was obliged to maintain a certain number of staff on the ACCU at any one time but it could not obtain cover from its bank of staff or any agency for a band 7. At best, it could cover with a band 6. Generally, the Trust tried to avoid using temporary staff: because it is agreed that the substantive staff offered better quality of care than having bank staff fill-in.

11. There was a cost of £31.65 per hour for an 11.5 hour shift i.e. £364 per shift each time bank staff were used in a permanent member of staff's absence. In addition the Trust paid the absent person's sick pay. Mrs Carter was entitled to 6 months' full pay and 6 month's half pay in any 12-month rolling period (291).

12. On their appointment as matrons in 2016, Mrs Hewitt and Ms Rudkin, as part of a service review, asked staff to participate in an anonymous survey on the ACCU. One point that came out of this was that staff were unhappy at the lack of visible support by band 7 senior nurses.

Disabilities

13. In pregnancy Mrs Carter developed the condition symphysis pubis, which was worsened by various life events. As a result she experienced pain in her pelvis for which she has taken a variety of strong painkillers.

14. From summer 2016, Mrs Carter first noticed the symptoms of what has been called a 'foot deformity' known as hallux vagus, commonly known as 'bunion'. The big toe and second toe on each foot are bent towards the other toes. As it progressed it made wearing some shoes difficult and walking sometimes more painful. It can cause a swelling at the joint. It also could exacerbate pelvic pain. In Mrs Carter's case this condition developed so that by August 2017 it was reported to her (albeit not the Trust at that stage) by Mr Louette, consultant orthopaedic surgeon, to be '*a most impressive deformity'*. He advised surgery to correct it and she was placed on a waiting list.

15. Mrs Carter did not take sickness absence in relation to her foot problems until March 2018. She used inserts in her normal shows that she purchased at the chemist that she told us were effective in normal shoes. On the exceptional occasion of the walk in the snow (see below) these were not sufficient, but in our view, they were an effective solution to the problem of the bunion in normal shoes on normal days. She has not been advised to or sought permission from the Trust to purchase specialist footwear.

16. It is agreed that, during the 16 years she was a band 7, Mrs Carter has had a high level of sickness absence and for a variety of conditions including but not limited to her symphysis pubis. She took substantial sickness absent in every year from 2011 until her dismissal (see her GP's summary dated 28 June 2016). Latterly, in 2015-16, she was absent from 7 September 2015 to 3 July 2016 (almost 10 months) with problems related to her symphysis pubis. In 2017 she was off for 2 months with migraine following a viral illness. From 29 January 2018 to 5 February 2018 she was absent for 8 days with flu-like symptoms. And from 9 March to 13 March 2018 for 5 days with problems caused because she had walked a long way into work in the snow and this had resulted in a bursitis, which had blistered in relation to her bunion on her right foot.

17. It is accurate to state that since September 2015 until her dismissal she had had 375 days of sickness absence. Mrs Carter disputes this number but we have added up all the red days on the calendars provided to us and this amounts to 380. Those calendars do not include any days of paid leave but do include the 5 days since she stated she was willing to return on 24 September when a sick note ran out 29 September. Thus, 375 is an accurate figure. (The calendar does not include those days of additional absence that the Trust required while it was obtaining OH advice.)

18. There has therefore been a pattern of lengthy absences over the years with different illnesses at different times. Some absences, as a matter of fact, began after holidays but by no means all.

Policies

19. The Trust has a policy for managing sickness absence (277f). Its aim is to support staff through periods of ill health to return to work or remain in work while also ensuring that the Trust delivers a high standard of care to its patients (279).

20. According to the policy the employee and manager have a number of duties and responsibilities. These include that the employee is to 'talk to their manager about any adjustments or support they may need in order to attend work' (282). HR are there to advise managers. The manager takes decisions under the policy (283).

21. According to its policy, the Trust calculates a 'Bradford score' by measuring an employee's attendance over the past rolling 12 months (280). The Bradford score is weighted so that intermittent sickness results in a higher score. It can be used to monitor attendance levels and '*as a trigger to start the problematic intermittent sickness absence process'* (280). All calendar days are counted, not just days the employee is expected to be at work. The formula is O x O x D, where O is the number of occasions of absence in the last 12 months and D is the total number of days' absence in the same period. For example 10 one-day absences are calculated as 10 x 10 x 10 = 1000, whereas 1 10-day absence would be 10.

22. Intermittent absences are periods of less than 28 days. The policy records that intermittent sickness absence becomes problematic when a Bradford score reaches 128 or more or absences that follow a pattern for example frequently start on the same day or immediately before/after off days. Sickness absence will remain problematic until it falls below this score or the pattern is redressed (280).

23. Under paragraph 4 of the policy, the process for *Problematic Intermittent Sickness Absence* ('PISA') is set out (285):

    23.1 once the absence record reaches the PISA trigger (Bradford score or the pattern) then there is an informal meeting of concern;

    23.2 targets can be set for attendance (typically no absence in next 3 months where there is no underlying condition);

    23.3 if the target is not met, then a formal stage 1 meeting is held at which a further target can be set;

    23.4 if the target is not met (in the rolling 12 month period) then a final stage is reached with some possible outcomes including dismissal;

    23.5 where targets are met but only for a short time, then the process can continue from the last stage that was undertaken (286);

    23.6 the absence is assessed on a rolling 12 month basis; consideration must be given to any underlying condition and whether adjustments are needed.

24. Under paragraph 5 of the policy the process for long-term sickness absence ('LTSA') is set out (287). In the definition section of the policy a LTSA is described as 28 days

or longer.

24.1 after 28 days a stage 1 meeting is held, consideration given to OH advice, whether any other policy needs to be applied, making a plan for return to work or keeping in contact;

24.2 if the employee does not return after 56 days of absence then a stage 2 meeting is held: an include a plan for return to work or a plan for keeping in contact;

24.3 if the employee does not return then, after 84 days of absence a stage 3 meeting is held. There can be several outcomes to this meeting: more time given for a return; a return to work; a return with adjustments; redeployment; ill health retirement; or dismissal;

24.4 the policy states that the return to work is regarded as unsuccessful if there is a return with gaps of less than 3 months between the periods of long term sickness and management of the absence will start at the prior last stage;

24.5 the policy is silent as to whether targets can be set.

25. In its definition section '*discounted absences'* are described as '*absences that are confirmed by OH as being … that arise in consequence of an employee's disability*'. All absences will still be recorded as such. The definition goes on to state: *'Where reasonable adjustments and support are exhausted and absences resulting from disability do not improve, it may be appropriate to address these absences in line with this policy following advice from HR and OH. A case conference may be appropriate at this stage.'* The policy does not say in what way the absences are to be discounted. Mrs Hewitt thought that it meant deduction from the LTSA periods of absence. Ms Senyard did not agree. OH suggested at least one disability-related absence should not be counted towards a Bradford Score.

26. A case conference is described in the policy as a '*constructive discussion to identify helpful and implementable measures for rehabilitation which contributes to, but is not part of, the formal management of sickness absence… This will normally be arranged by the manager with the following attendees: individual +/- representative; manager; OH doctor or nurse; +/- human resources'* (292).

27. The redeployment process (297) starts when the employee fills out a form and includes a search for suitable alternative vacancies.

2015/16

28. The most recent absence for symphysis pubis began on 4 September 2015, after Mrs Carter exacerbated her symptoms with an introversion injury after slipping in a swimming pool on holiday (101). She remained off work for about 10 months, during which time the Trust held meetings under Stage 1 and 2 of the Long Term Sickness Absence (LTSA) part of the policy. (During this period Mrs Carter was also

hospitalised with gastro-intestinal problems in November-December 2015.)

29. During this absence, the Trust extended the recovery times beyond those advised in the policy by 4 months (76). The Trust also obtained regular updates from OH. In December 2015 the OH physician stated his opinion that the condition was likely to be considered a disability under the EA (64C, 65). In April 2016, at the Stage 2 meeting, the prognosis was for a further 6-8 week period before a return to work and the Trust agreed to wait for that period before reviewing the matter.

30. On 23 June 2016, Mrs Hewitt invited Mrs Carter to a Stage 3 meeting for 6 July 2016, warning that one of the outcomes might be dismissal (98). At that stage the fit note, dated 21 June 2016, recorded unfitness for work until 5 July 2016 (100); however, Mrs Carter replied to Mrs Hewitt on 24 June 2016 that she was actually fit for work (99).

31. The Trust sought OH advice on 28 June 2016 to advise on a phased return and any adjustments. In the meantime Trust managers had a discussion by email about Mrs Carter's case. Mrs Hewitt wanted to know, if OH cleared her for a phased return, whether the Stage 3 meeting should still go ahead. In her reply, copied to Mrs Hewitt and Ms Butler, Ms Senyard, Associate Director of Nursing, said '*This is a very frustrating case whereby Mrs Carter has habitual periods of long term sickness over many years. She is well versed in the processes and systems in place, which leaves us as a leadership team in a very difficult position in terms of her management. OH has now deemed her fit for a phased return. I would certainly question her suitability for returning to a role given the 10 months' sickness signed off by her GP with no real evidence of what is wrong with her apart from a back injury with all tests normal (that was the sick certificate from February). I have no doubt she will do this again and use the system to her advantage. I am very concerned about the morale of the band 7 team on ACCU if she returns to the unit given this is habitual behaviour. Is there anything we can do in terms of redeployment?'* (106).

32. Ms Senyard, who was due to be on the Stage 3 panel, stated that she ought not to have been involved in this email exchange, that she was newly appointed and had learned now not to do so and thought this email '*poorly worded*'. She said it was a difficult position because Mrs Carter had been off so long. She observed that the only information that they had was sick certificates and there were no hospital letters. She disputed that she had a poor opinion of Mrs Carter's integrity and that they got on well. She had forgotten about the email.

33. We find her explanation of the email weak. Ms Senyard expressed plain views in this email. She doubted Mrs Carter's integrity and suggested she was playing the sickness absence system. We acknowledge, however, the timing of Mrs Carter's statement that she was fit to return (on the receipt of the stage 3 invitation) contrary to the then fit note might have caused managers some surprise. And we understand Ms Senyard's frustration at the impact of so much absence. But it was up to management to obtain evidence if they felt any absence was unexplained. They had not done so. We note, on the other hand, that Ms Senyard was not calling for a dismissal, but asking about redeployment. And despite these views, the Trust allowed Mrs Carter to return to work. Nor did her views stop her from having a good working relationship with Mrs Carter.

34. Mr Lowe, (Interim) Assistant Director of Workforce Development responded that he understood the stage 3 meeting was going ahead. He advised that the phased return should be accommodated. And he was unsure what grounds the Trust would have on redeployment if Mrs Carter was now fit. He went on '*I think if there is a future period of long-term absence we need a case conference with OH and fully explore options available for continuation of her employment or redeployment in line with the policy.'* (106) Although there was another period of long-term sickness absence, this was for migraines and not the disability-related illness, which may explain the absence of a case conference in the later chronology. In any event a case conference was not an absolute requirement.

35. On 18 July 2016 OH advised a phased return, which would inform Mrs Carter whether she could do the physical aspects of the job. In answer to the question: '*Is the condition likely to cause increases sickness absence in the future?*' Dr Maqsood replied, '*The best predictor of future attendance is past sickness absence record*.' (102D)

36. In accordance with OH advice, a back assessment was done on 4 August 2016 (113). All agree that, in the main, Mrs Carter could adopt the advice without being instructed formally to do so or requiring a change to her job description: for example, taking the least active role in turning patients like holding the ET tube; asking other members of staff to assist with carrying 5l dialysis bags; calling for assistance with aggressive or confused patients and taking micro breaks where that was possible.

37. The back assessment identified that standing for long periods of time would be challenging but possible (114-115).

38. The back assessor recommended that Mrs Carter trial a special chair. In her report she set out the details of how such a trial could be achieved with the type of chair, its cost and name and contact details of a supplier.

39. We agree that it was not the responsibility of an individual member of staff to spend money on her own behalf. We find that it was the employer's responsibility to organise this trial. This was not done. Mrs Carter did not ask for it to be done or follow it up or complain about it. On balance, we find on the basis of her oral evidence overall, that she only had one conversation about the chair during the review with Mrs Hewitt.

40. At that stage the pelvic problems meant that Mrs Carter could not stand or sit for long periods of time. We find that her job was one requiring a mix of standing and sitting during the day. No two days were the same but there was usually administrative work requiring sitting and a ward round that was sometimes lengthy and during it the team generally stood.

41. In relation to the ward round, Mrs Carter said she could sit down on the nearest chair for a short time to relieve her pelvic problems. We find a specialist chair situated somewhere on the ward would not have helped with this, as the ward round necessarily moved between patients.

42. In relation to the administrative work and sitting we find on balance that the job was a mixture of sitting and standing and there were therefore no lengthy periods of sitting that could not be relieved by walking about doing other work. We are supported in this conclusion by the lack of complaint at the time (about the chair) and that Mrs Carter had no further absences for back/pelvic problems that might have been brought on by the need to sit for long periods. Nor was this a point made during the Stage 3 or appeal meetings.

43. If a chair was going to be ordered then the time in which reasonably to expect that it was done was before the end of the 6 week review period set out in the back assessment and at the latest by the end of the year 2016.

44. On 16 August 2016, a Stage 3 meeting took place. Mrs Carter was supported by her Trade Union representative. The outcome (118) was that Mrs Carter would return to work on a 6 week phased return, redeployed to a supernumerary role on a different ward with a mentor. It was stated that further sickness absence in 6 months would lead to reconvening the stage 3 meeting. In an email setting out arrangements, Mrs Hewitt informed Mrs Carter that she was required to have no further sickness absence in the next 6 months (122). No complaint was made about this target.

45. Mrs Carter returned on this phased return on 5 September 2016. Mrs Carter was unhappy about the delay in returning after she had self-reported fitness to work at the end of June. But she acknowledged in her oral evidence that, as a manager, she would have to obtain OH advice after a LTSA once an employee reported fitness to work. This is merely what happened in her case. The delay was reasonable in order to obtain the back assessment, discuss it and decide what the return should look like.

46. Mrs Carter was unhappy about not going straight back into the ACCU, albeit that the supernumerary role was designed to be less physical. This suggests to us that she felt fit enough for the demands of the ACCU.

47. After this return, and from then on, the symphysis pubis settled and was being managed successfully by pain relief. She had no further absences because of it. Mrs Hewitt also agreed in evidence that this return to work had been successful.

48. At this point, although Mrs Carter noticed her foot deformity in the summer 2016, nothing was said about it at these meetings and we infer therefore it was not causing more than minor problems at that stage.

Migraine Absence

49. On 31 July 2017 Mrs Carter began what turned out to be 2 months' sick leave with a viral illness that triggered migraines.

50. On 1 September 2017 she was invited to a Stage 1 meeting, which was ultimately held on 18 September (141). The sick certificate ran out on 22 September. It is not the case that Mrs Carter stated she was fit to return the following week as she suggests in her witness statement. We find the notes of the meeting are likely to be an accurate record because they are detailed and because they are consistent with

the subsequent fit note. They record that she had hoped to have been fit but now was not (141). The outcome was that the matter would be kept under review and moved to Stage 2 after 56 days of sickness. The next fit note, dated 21 September, was that Mrs Carter was unfit for work until 29 September 2017 (274).

51. On 25 September 2017 Mrs Hewitt informed Mrs Carter there would be a stage 2 meeting on 29 September i.e. after 56 days of absence (145).

52. The next fit note of 29 September advised fitness for a phased return until 29 October 2018. On 29 September 2017, the Trust placed Mrs Carter on paid leave pending obtaining OH advice, which was the appropriate procedure. In the referral Mrs Hewitt pointed to a pattern of high sickness absence as set out in a breakdown of sickness over the last 14 years.

53. On 9 October 2017 the Trust invited Mrs Carter to a stage 2 sickness absence review meeting. It was rescheduled to the 18 October 2017 and again to 1 November 2017.

54. OH reported the day before on 31 October 2017 (152), which report was provided to Mrs Hewitt at the meeting. Dr Easmon advised:

    54.1 the pelvic pain (symphysis pubis) problem 'now seems to be resolved'. Although later in the letter he indicated that Mrs Carter had low-level 2-3/10 pelvic pain occasionally made worse by activities and that there was an element of unpredictable future absence because of this;

    54.2 the gut problem was a one off;

    54.3 the virus and migraine were now resolved. Although later he refers to a follow up neurology appointment. (Mrs Carter now disputes this part of his opinion. Her view is that the migraines were not resolved and could recur, although she did not inform the Trust of this at the time);

    54.4 for the future that there were predictable and unpredictable elements:

        54.4.1 the predictable element was that there was a '*painful foot deformity*' for which an operation on each foot was required in the next 24 months with recovery time for each at least 3 months.

        54.4.2 the unpredictable element was how Mrs Carter coped with her pelvic pain (which required intermittent use of oramorph) and her 'more recent painful foot deformity'.

    54.5 a phased return. And if Mrs Carter was off sick for more than 14 days or accumulated another 14 days in 12 months that she was to be immediately referred back.

55. Mrs Hewitt knew therefore at this stage that Mrs Carter had a painful foot deformity.

She had not been made aware that it caused any difficulties at work. She knew it was going to be corrected by surgery and was aware that it might cause unpredictable absence.

56. Outcome of Stage 2 was that a phased return was agreed to start on 6 November 2017 (155). (Thus there was 1 month and 1 week after which Mrs Carter's GP had recorded her fit for a phased return during which there was paid leave.) A review was to take place at the end of the period 'in order to set sickness targets going forward' (158).

Further OH referral

57. The phased return ended on 27 November 2017. Thereafter Mrs Hewitt sought another OH opinion (158B) in order to check progress and '*ability to sustain full time work with rotation to night duty'*. She informed Mrs Carter of this on 14 December and referred to the agreement that the matter be reviewed at the stage 2 meeting (161). She indicated after the opinion she would '*reconvene a formal sickness meeting so we can review any suggestions made from a health perspective'* (161). Mrs Carter queried this because '*I have not been off sick and have not experienced any problems since September'* (160). She attended a further OH appointment on 19 December 2017.

58. The OH opinion was provided in virtually the same wording as the 31 October opinion (161B).

59. By a letter of 12 January 2018 Mrs Hewitt reconvened the Stage 2 sickness absence meeting for 29 January 2018.

60. Mrs Carter had two days of emergency annual leave on 20 and 21 due to family ill-health (her father's health had significantly deteriorated). And she had planned annual leave on 27 and 28 January. On 28 January she emailed her managers to state she would not be in work for the next 2 days as she had flu and vomiting. She saw the urgent care team at her GP on 28 January and was diagnosed as having a flu-like illness (see GP notes, 350). The GP issued a fit note until 5 February. She rang in again on 31 January to say should not be working that day or 1 February as she was still unwell.

61. In the meantime the Trust had decided to go ahead with the 29 January 2018 sickness absence review meeting in her absence and set targets for sickness. She was to have '*no sickness over the next 12 months apart from the elective surgery*' and '*no episodes of sickness either directly preceding or directly after any annual leave, as this has been a recognised pattern to your previous episodes of sickness*' (163). She was informed that should she breach the target then they would reserve the option to proceed immediately to Formal Final Stage Sickness Panel as set out in the policy and that such a panel could consider dismissal. They informed her of this by letter of 30 January (163) sent to her on 31 January 2018.

62. Mrs Hewitt explained that she set the target on advice from HR. She said targets were needed for the future because of the significant absences in the past and

Maqsood's opinion that past absences were a good indicator of likely future absences. She was not referred to the policy and did not refer to it herself.

63. On 2 February 2018 (while still absent with flu) Mrs Carter queried what part of the policy allowed targets to be set (168). No response to this in the reply (171). The reply from Ms Rudkin did inform her that the flu absence would be discounted from the target. She informed the nurse in charge on 5 February that she would be fit for her next shift on 9th February.

64. On 5 February (the last day of flu sickness) Mrs Carter's father had a cardiac arrest and was hospitalised. On 6 February Mrs Carter's daughter was also hospitalised. She informed Mrs Hewitt of this and requested some leave to deal with this. She was given an emergency annual leave for neurology appointment on 7 February and because her father had been hospitalised. And she was given emergency leave on the other day she was rostered to work that week, 9 February 2018.

65. On 12-18 February 2018 Mrs Carter was off work with planned annual leave.

66. On 27 February 2018 OH reported that she '*is enjoying work and has no significant problems to report. She has seen the consultant neurologist and has had diagnostic and medication reassurance*.' OH advised there were no restrictions to her full time role including nights. Dr Easmon advised the elective surgery (for the foot) will have a planned 3 months' absence and that it would be fairer not to include that in her Bradford score (185).

Further Sick Leave

67. Mrs Carter sent the last OH report to Mrs Hewitt on 7 March 2018. Confirming that the surgery would be on 19 April 2018.

68. She reported that the week before she had walked to work through the heavy snow and that she had '*started to have pain in my feet after walking part of the route to work …due to snow disruption*' (186). She asked to change a shift in order to attend a medical meeting with her father. Mrs Hewitt allowed this.

69. On 9 March 2018 she saw her GP and was instructed to take antibiotics and elevate her right foot as she had a soft tissue injury over the bunion area, which had started as blistering during the walk to work. She was given a fit note to expire on 16 March, which stated 'bunion'. Mrs Carter informed the Trust she would be back the following day but may have to elevate her foot on breaks (188).

70. At this point the Trust knew of the painful foot deformity via the OH report. At some point Mrs Carter had shown Mrs Hewitt her feet. She knew also that there was planned surgery to correct it on both feet. She understood it to be a bunion. She may have underestimated its seriousness.

Stage 3 Process

71. On 16 March Mrs Hewitt wrote a management case in respect of 'long term continuous absence' and decided to take the matter to a Stage 3 meeting. We find that her main reason for doing so (as she confirmed in her evidence WS para 47) was that the last period of sickness had breached the target she had set of no absence except for the elective surgery. She also explained that overall the level of sickness absence had had an impact on ACCU for some time for the reasons we have set out in our findings above.

72. In the management case conclusion Mrs Hewitt relied on the period of long term sickness absence from 31 July 2017 (migraines), from which there had been a successful return, and 2 periods of intermittent sickness, the latter for 5 days being in breach of the sickness targets set on 30 January 2018 (194). She also referred to the long-term sickness absence history over a period of years since appointment and the calendar diaries from 2015 (260-262), which included the symphysis pubis absence as well as those set out above. She stated this had had a '*detrimental effect on the service which relies heavily on clinical band 7 leadership. Sarah's long periods of absence have also affected her team in terms of their leadership and development. This amount of absence from work is unsustainable from an operational and team leadership perspective.*' She relied both on the history and the recent absence to move to Stage 3 (195). But we find on balance that she would not have moved to stage 3 without the target having been triggered.

73. On 17 March 2018, at the return to work interview, the Bradford Score was calculated as 3 x 3 x 74 = 666. (The last absence was counted as 7 calendar days, which would be correct according to the fit note and first day back.) At this meeting Mrs Carter informed Mrs Hewitt that the surgeon the day before had thought that the soft tissue injury was a '*bursitis as a result of the deformity*' (196). Mrs Hewitt did not add this reason into the management case.

74. By letter of 27 March 2018 the Trust invited Mrs Carter to a Stage 3 meeting '*to discuss your long term and recent intermittent sickness absence'* and warned her one of the outcomes could be dismissal. The management case was enclosed. She had the opportunity to be represented. The meeting was scheduled for 6 April and then rescheduled to 10 April 2018.

75. On 4 April Mrs Hewitt held a 1:1 with Mrs Carter who alleges she suggested her mental health was suffering and things were getting on top of her and she informed Mrs Hewitt that would be a good idea for her to go part time or take more time off. This was not put to Mrs Hewitt in the evidence we heard. Nor was it relied upon at the Stage 3 meeting. Nor is it recorded in the 1:1 minutes. Nor is it the recommendation of OH. We find that Mrs Carter may well have sought some compassionate leave (which is not an issue in this case) because of her father's illness and the stress it was causing, but that, on balance, she did not seek a reduction in her hours as alleged. In fact submissions were made on her behalf based on the assertion that Mrs Carter was well and capable of full-time work.

76. On 9 April 2018, the day before the Stage 3 meeting at which her future might be decided, Mrs Carter emailed Ms Senyard to inform them that her father was critically unwell and admitted to hospital on 7 April with chest sepsis. She did not expressly ask for a postponement of the meeting. Ms Senyard expressed her regret. She

informed Mrs Carter that the meeting would go ahead as it had already been rescheduled.

77. At the Stage 3 meeting Mrs Hewitt outlined the impact of Mrs Carter's sickness absences fully (208).

78. Mrs Carter explained she had moved surgery to accommodate team development work that had to be done. She stated she was fully committed to her team and work. That she had wanted to come back sooner than 29 September. She argued that the patterns of absence (near holidays) were coincidental. Her TU rep argued that it was inappropriate to look at 16 years of absence. She was concerned that short and long term absence had been brought together, given that there had been a successful return to work since September 2017 and that the no sickness target was unfair given this. That the 2 short periods of absence since would not usually have been sufficient to warrant setting targets and they should have been dealt with at Stage 1 of the PISA, not stage 3.

79. Ms Senyard and her panel decided to dismiss. She announced this at the meeting. She sent a letter confirming the dismissal. It spends several pages reciting the long chronology. At the end of the letter a brief reason for the dismissal is given as follows: '*the panel carefully considered all of the evidence presented … as outlined above, in addition to the detrimental effect that your continued sickness absence has had on the service and team members which can no longer be sustained. Therefore the panel made the decision … to dismiss you on grounds of capability*.'

80. Ms Senyard made further written remarks in the response to the appeal about the reasons for dismissal. We have also considered her written and oral evidence. In our judgment, taking all of this into account, we find the reason for dismissal was for the following factors:

    80.1 the most recent sickness from 2015 (375 days since September 2015) against a background of historical absence as a pattern;

    80.2 the panel had no assurance that there would improved attendance in the future. Ms Senyard relied in particular on OH's view that past absence is the best predictor of future absence;

    80.3 the significant detrimental impact of the absences on the ACCU;

    80.4 redeployment would not improve attendance: it would simply pass the problem of poor attendance on to another area.

81. The panel were satisfied that the procedure had been followed. They felt that there were aspects of both long-term and short-term absence here and that neither procedure fitted neatly. As to targets Ms Senyard acknowledged this influenced whether Stage 3 meeting was called. She stated that custom and practice was for targets to be used in both types of absence. This is consistent with the target previously set in Mrs Carter's case, which was not objected to.

82. We find, on balance that, while Ms Senyard had suggested two years before that Mrs Carter was playing the system to her advantage, this was probably not a factor in the decision of the panel to dismiss. Time had moved on. There had been other significant absences for different reasons. The most important factor in their mind at the time was the likelihood of future absences based on past absences.

83. On balance, we also accept on its face the dismissal panel's assertion that it did not take into account the future planned 6 months of absence in respect of elective surgery. While its main concern was future absence, this was logically separate because of OH's advice that it should be discounted.

84. The dismissal was immediate and 12 weeks' notice was paid in lieu.

85. At the end of the Stage 3 meeting Mrs Carter was told not to worry about her belongings at that stage (210).

86. The letter of dismissal included the following paragraph: '*At the close of our meeting you provided me with your Trust ID badge. However I must remind you [sic] must not contact any member of Trust staff or visit any Trust premises without explicit consent unless this is for the purpose of emergency medical treatment…*' We find this letter was drafted by HR on behalf of Ms Senyard, mistakenly using a template for misconduct dismissals. We do not find that Ms Senyard said words to this effect at the meeting, contrary to Mrs Carter's evidence. This is because this was not the allegation made in the appeal grounds, rather the letter was objected to. Nor did she state this in her written evidence, as she is likely to have done if it had been said. We find it likely that Mrs Carter has, in hindsight, mistakenly conflated the letter with the meeting.

87. The letter was signed by Ms Senyard, who had responsibility for its contents. A dismissal letter is obviously a very important letter. It affects the future of the recipient. All the more reason for both Ms Senyard and HR to check carefully the contents of the letter. They obviously did not do so in this case.

88. The Trust now accepts that this was an entirely inappropriate paragraph to include in a capability dismissal. This is because the paragraph suggests that Mrs Carter was guilty of wrongdoing and was not to be trusted in the future. This was not the case. Although she made complaint about it in the appeal grounds (220), HR did not make an immediate apology or withdraw the paragraph. When Ms Senyard was asked about it by the appeal panel she explained a template had been used and said *'if necessary we are happy to offer an apology but were using a trust template'* (245). While a mistake may have explained the paragraph, it did not excuse it and this seems to us a begrudging response. When the appeal panel telephoned Mrs Carter during the appeal, Ms Butler did not immediately apologise and withdrawn the paragraph, but only did so when Mrs Carter raised it orally at the meeting (247).

Appeal Grounds and Appeal

89. The grounds of appeal were as follows:

89.1 The penalty was too severe because the last period of illness had ended and there had only been two short intermittent absences since.

89.2 A further OH referral should have happened.

89.3 Redeployment and/or reduced hours should have been considered.

89.4 The Trust failed to follow its own procedure. The LTSA and the PISA procedures had been conflated. There had been a successful return from the last period of long term sickness. The two shorter periods off sick were not long enough to trigger a stage 3 meeting and it was inappropriate to set a target: there was nothing in the policy allowing that after 3 months of fitness for work. The target itself was wholly unreasonable. If the target had not been set, there would have been no Stage 3 meeting and dismissal would not have taken place. The whole period of sickness absence should not have been considered.

89.5 The foot deformity itself should have been regarded as a disability and OH should be asked to advise at the appeal stage whether that was the case. The RCN provided evidence to rebut the management case that the final sickness absence was not connected to the foot deformity (236) namely: the sick certificate stating 'bunion'; and the Return to Work interview in which Mrs Carter had stated that the absence was '*a bursitis as a result of the deformity'* (196); and an email from Mr Louette, consultant orthopaedic surgeon, dated 20 June 2018 which states '*I note also that when she was seen in the pre-assessment clinic on 16 March 2018 that she had inflammation around her bunion on the right side, where it had been rubbing in shoes. She required some antibiotics and anti-inflammatories to help this local inflammation settle down. … Her pre-op situation made her prone to pain, including pain at work, and rubbing of her bunions into her shoes…* (232).

89.6 The upcoming surgery and recovery time were improperly taken into account.

90. In the appeal management case Ms Senyard stated that her panel had considered that:

90.1 the patterns of absence, which were significant and for a variety of reasons, together with OH advice, gave no assurance that Mrs Carter would be able to sustain improved attendance in the future (bottom, 227). (It appears to us, from the evidence, that it was the amount and variety of sickness absence that was the pattern rather than the sickness after holidays);

90.2 Mrs Carter' s absence had had a detrimental effect on the service and team members (this was set out in detail at 228);

90.3 there had been both long-term and intermittent absence and neither of the processes set out in the policy fitted the circumstances neatly (228) and that

both processes were used at different times. Stage 3 was the same for both;

90.4 the targets were set '*in view of a previous record of poor attendance over a number of years.'* (230) The target was reasonable bearing in mind the absence for surgery had already been allowed;

90.5 in relation to redeployment, the problem was the difficulty of sustaining attendance not the role. There was no evidence that redeployment would help because any other service would be impacted by absence;

90.6 there was no advice that reduced shift patterns would assist (229).

90.7 they asserted the dismissal did not relate to her foot deformity: the future anticipated absence for the foot deformity was not taken into account. Mrs Carter had not requested other adjustments in relation to her foot nor had OH. And the periods of sickness absence leading up to the Stage 3 meeting were asserted to be not related to the foot condition. (We note that the reason for the second period of short-term absence was not explored by the panel at the Stage 3 meeting. Nor was it stated in the original management case. It is odd therefore, in the absence of this exploration or information, that the panel could assert that the second absence was <u>not</u> related to the foot deformity. By the time of the appeal it was identified as 'pain from an injured foot' (226)).

91. The appeal was rescheduled from 5 June 2018 to allow for Mrs Carter's father's funeral. It was relisted for 17 July 2018. At this stage the Trust knew Mrs Carter was unable to travel to Trust premises due to recent surgery that had resulted in an extended period of recuperation. Mrs Carter had agreed that it would take place in her absence because of this. The panel then decided to reschedule again to 24 July 2018 for the reasons given in the letter of 19 July 2018, which was only sent to the RCN and Mrs Carter on 23 July (238, 240), namely that there were a number of points in the correspondence that '*need to be fully understood. I do not think it is in your best interests that this is via correspondence*.' Ms Butler gave Mrs Carter a further opportunity to attend if she were able and if not that it would be heard via correspondence. Mrs Carter's RCN representative replied by email on the same day stating that due to the short notice she was unable to attend. The RCN invited the panel to telephone Mrs Carter during the course of the hearing and this was done. Mrs Carter reiterated that her last period of absence was related to her foot deformity (247) and complained again about the paragraph in the dismissal letter, which prohibited her from not being allowed to come to the Trust or to speak to anyone.

92. Ms Butler chaired the appeal panel, which considered the grounds of appeal only. By letter 1 August 2018, appeal panel rejected the appeal deciding that:

92.1 the sanction was not severe. They referred to 375 days of absence since 7 September 2015;

92.2 the most up to date OH report was 27 February 2018 and that was sufficient, albeit that they would have preferred the OH advice to be very recent '*i.e.*

one week'. (The appeal panel did not get to grips with whether OH could have advised on the nature of the last absence, and whether it related to the foot deformity, which was one of the grounds of appeal.)

92.3 On procedure the appeal panel decided that the '*clearly the issue in question was the lengthily [sic] spells of absence'*. It decided the absence period was not intermittent. They decided that it was appropriate under the LTSA procedure to manage such absence with targets (250). The target was not for zero absence because it took into account the elective surgery absence of 6 months.

92.4 The appeal panel decided that Mrs Carter was making an '*assumption/statement'* that the final absence was disability-related. Mr Louette's email confirmed the absence for a bunion. They observed that no reference was made in the OH reports that the final absence was disability-related. (The difficulty with this is that OH did not see Mrs Carter after the final absence. Nor did it deal with the ground of appeal that OH should have been asked to advise especially if Mrs Carter's statement that she was disabled was to be rejected as assumption. If the operation absence was to be discounted there was a logical argument for this short absence to be discounted if it was connected and the appeal panel therefore did not deal with this either. The statement also disregards the evidence that Mrs Carter had provided: in particular Mr Louette's advice that the pre-op situation in relation to her deformity made her prone to pain and rubbing.)

Bradford Scores

93. As 29 January 2018, when the target was set, the Bradford score for the 12 month period prior to it was: 61 i.e. 1 x 1 x 61. (1 absence of 61 days including all the certified days) or 56 (if the 5 days after Mrs Carter indicated on 24 September her willingness to return).

94. By 16 March (the management case) or 27 March (the invitation to the stage 3 meeting) the Bradford Score had been increased by the flu absence to, at least 2 x 2 x (56+7) = 252, even if the foot-related absence was not included.

Redeployment

95. We have not heard any evidence that there were suitable alternative vacancies. The redeployment procedure proceeds on the basis that vacancies are considered.

Since dismissal

96. Mrs Carter had surgery on 10 April 2018. It was complicated by a post-operative infection. By 26 July 2018 (after the hoped-for 3 month recovery period) she was given a sick certificate as being unfit to work until 13 August 2018. There had been mal-alignment of the joint post-operatively. The metal had migrated, the swelling would not go down and Mrs Carter experienced more pain so it was decided that the foot had to be redone. She was then not able to fully weight bear. She was referred

to a pain clinic. With this evidence in mind we find it unlikely that Mrs Carter was walking miles in the summer shortly thereafter. In any event, she is likely to have been absent from work with the other difficulties of oncoming migraine, see below. We find there is no likelihood of her having returned to work from 13 August to the beginning of September 2018.

97. At the beginning of September 2018 Mrs Carter's migraine is recorded as having returned (345). On 5 October 2018 she was diagnosed with depression.

98. We find it 100% likely that Mrs Carter would have experienced migraine at this time regardless of the dismissal: first, because her evidence is that migraine was always likely to recur; second, because this migraine was triggered by a food bug/dehydration (310) which had nothing to do with the dismissal, and third there were other significant stressors in her life, in particular the inquest over her father's death, which would have been present in any event and the unsuccessful surgery. We find therefore even removing the stressor of dismissal from this equation, there were plenty of triggers for migraine to recur as they did. We find the migraine would have kept her off work in September and October 2018.

99. The fit note in November 2018 recorded unfitness for work referring to the foot problem and depression. We find, on the evidence we have heard and for the reasons above, sickness absence would have occurred despite the dismissal. The later report notes that pelvic pain had worsened since the operation. The two being interconnected. In relation to depression, we have not heard any medical evidence as to its cause. Plainly dismissal might well have been a contributing factor to it. But, we find it likely Mrs Carter would have been absent anyway as the other factor of unsuccessful surgery was significant.

100. The medical report dated 18 December 2018 records that: the initial foot surgery may need to be redone. Mrs Carter was experiencing pain in her feet and in the left pelvic region. It was worse on the left and was continuous. Her pelvic pain had worsened since her last operation. On this evidence, plainly the difficulties of her feet meant she could not have worked in any event in November and December 2018 and January 2019.

101. During 2018 Mrs Carter received Employment Support Allowance a benefit, which is only paid to those who are assessed by the DWP as having a limited capability for work.

102. The first foot was operated on again in February 2019. It would have been only by about June 2019 that Mrs Carter would have been in a position to return to work.

Submissions

103. Mr Dilaimi set out his summary of the law in a useful written skeleton to which we refer but do not repeat.

104. Mr Dilaimi made well-structured and persuasive submissions.

105. In relation to unfair dismissal, in summary, he argued:

105.1 where there was a cumbersome and inflexible policy, as this arguably was, we should not determine the 'reasonableness' question on the basis whether the policy had been followed. The policy flow charts envisage 2 separate situations and did not allow for the situation here where there had been long term and intermittent absence. Here, in order to act reasonably, the Trust had to find a middle route.

105.2 It was reasonable to hold the Stage 1 meeting and the Stage 2 meeting before the return to work. The reconvened stage 2 meeting was to discuss absence targets for the future. This was reasonable, bearing in mind the history of absences. The target was also reasonable given that the managers had already discounted 6 months of absence for elective surgery. It was reasonable to discount the flu sickness.

105.3 There was then, within 6 weeks, a further absence. It was reasonable therefore to move to stage 3. He reminded us that stage 3 did not inevitably lead to dismissal, as Mrs Carter knew from her previous history.

105.4 It was reasonable to dismiss at that point, because the facts pointed to the likelihood of further absence in the future: OH had advised that past sickness absence was the best predictor of the future. It was unrealistic only to look at the last 12 months. OH referred to unpredictable factors in the future. And, even discounting 2015/16, there had been the viral illness, migraines, flu, and the foot problem – significant absences for different conditions.

105.5 Issue 4.2 was not reasonable because redeployment would not have been effective, to reduce sickness absences. Mrs Carter had said in evidence that, if she could physically attend work, she could do 100% of the work.

105.6 We should find a significant Polkey reduction in any event. In as unfortunate a case such as this, on the basis of the medical notes together with Mrs Carter's evidence, it is clear that from April 18 until May/June 19, she would have been able to attend work for very little, if any of that period. As of April 19 Mrs Carter would have been off sick for almost an entire year. Even if we found that the policy required all absence to be discounted, there came a point when such a step was no longer reasonable.

106. In relation to disability he submitted, in summary, as follows:

106.1 Mrs Carter was a disabled person at all relevant times because of symphysis pubis. She was not disabled person because deformity of the feet until roughly the summer of 2017.

106.2 Issue 4.4. Clearly the Trust knew of the foot condition from 31 October 2017, where Dr Easmon refers to the painful foot deformity. Knowledge was not about whether it was a disability but about whether the condition now admitted to be a disability was first known.

106.3 Then, in relation to the section 15 claim. Taking issues 4.5 ii, iii, v together: plainly this amounted to unfavourable treatment.

106.4 Issue 4.5 iv was fact specific. It was a mistake by Ms Senyard. He queried whether treatment arising from a mistake could amount to unfavourable treatment. He agreed we should apply the Shamoon test of whether it was a detriment.

106.5 As to Issue 4.6 ii iii v, he accepted that the dismissal and appeal were caused by something arising in consequence of the disabilities, in part because the Trust took into account time off work for the pelvis and foot.

106.6 As to issue 4.6 iv, he did not accept that the wording of the letter was because of something arising in consequence of the disability. It happened because of an HR error in using the wrong template and Ms Senyard's failure to notice that error. It was a leap of logic, he contended, to suggest otherwise.

106.7 Thus he argued that the section 15 claim came down to whether dismissal was objectively justified. He submitted maintaining adequate attendance at work was a legitimate aim. Was dismissal a proportionate means? He contended that it was *reasonably necessary* and *appropriate*. There was no reasonable adjustment that could be made to improve attendance and there was huge disruption to the Trust: long periods of absence had had a detrimental effect on the unit, team, other employees, and finances of the trust. The disruption caused by the absence of a band 7 nurse in ACCU was particularly significant. The Trust was a publicly funded body and did not have unlimited financial resources. It was time to say enough was enough.

106.8 He argued there was no failure to make a reasonable adjustment here: he agreed that the first PCP led to the substantial disadvantage of dismissal. But he disagreed that Issue 4.10 ii had been made out: it was not that Mrs Carter was unable to perform physical requirements leading to dismissal. The back assessment had been complied with.

106.9 He accepted that, as to issue 4.11, there was knowledge in relation to the disadvantage he had conceded (risk of dismissal due to absences).

106.10 That left issue 4.12 i: Mrs Carter suggested three steps: disregarding disability related absence and/or more time to get OH advice and/or not dismissing. He suggested it was not reasonable for the Trust to put out of its mind the fact of the absence: it was not practicable for an employer to disregard that much absence because of the large amount of disruption it had caused; the particular circumstances of ACCU and the fact that the Trust did not have unlimited financial resources. He submitted the policy really meant discounting for the Bradford Score, as OH had advised. He argued, here, that would not have made any difference because the migraine, flu and foot absences maintained a high Bradford Score. The suggestion that another OH report should have been obtained, he submitted, would not have

changed anything.

107. In her submissions Ms Brown dwelt wisely up on her best points.

108. She argued it was not within the range of reasonable responses to dismiss and therefore unfair:

108.1 The Tribunal should first look carefully at what actually was the reason for dismissal. Different witnesses have concentrated on different aspects and appeared unclear as to what, at the time, was the problem.

108.2 As illustrated in the cases, there is an important distinction between intermittent and long-term sickness absence.

108.3 Ms Butler had agreed there was no evidence here of problematic, intermittent sickness absence. That would have been shown by a Bradford Score of 128, which she argued Mrs Carter did not have at the point when Stage 3 was triggered. If there had been two types then a blended approach to policy might have been appropriate but here it was wrong to do so.

108.4 It was unreasonable to set a target: this was to depart from the long-term sickness absence policy, which witnesses accepted had no provision for the setting of targets; there had been insufficient intermittent sickness absence; and Mrs Carter was not on long-term sickness absence and much of the previous absence should have been discounted in any event as it was disability-related.

108.5 If so, then it was unreasonable to consider dismissal at all because it was only the breach of the target that landed Mrs Carter at a Stage 3 meeting.

108.6 It was unreasonable to dismiss, in any event, because the sickness absence for symphysis pubis was counted when the policy required that it should not have been. Ms Senyard knew this is what the policy meant.

108.7 While we might consider the policy was strict, or even unworkable in some cases, it is not for us to re-write it and it is unreasonable for an employer to depart from its own policy.

108.8 The decision was unreasonable because Mrs Carter was back at work. The OH advice at the time was that the return to work from pubic symphysis had been successful; the migraines were resolved; and so far as the foot deformity was concerned, the Trust had already agreed to discount the future 6 months' sickness absence for the operations and that would resolve them. Thus, so far as the future was concerned, what else was the problem? The recent short sickness, which broke the target, was plainly related to her foot condition.

109. In relation to section 15 and objective justification, Ms Brown contended the

dismissal was wholly disproportionate in that:

109.1 the setting of the target was not an appropriate means. The target triggering the stage 3 should not have been set under the policy and therefore cannot have been appropriate means.

109.2 In relation to its breach, the last two absences were unavoidable: it was vital for a sister in ACCU to stay off for flu; and the foot injury followed from the foot condition and was evidently genuine. The Trust would have known that this was part of an ongoing issue, which would soon be resolved (196).

109.3 And for the same reasons dismissal was not reasonably necessary: in particular given that the Trust had already accepted the future 6 months of absence for surgery of which the foot injury was a part.

110. In relation to many adjustments, all accept many were for Mrs Carter to manage herself, but there was a failure to make adjustments here in relation to redeployment. It was discounted out of hand. It should have been considered according to the policy at 297.

111. It would also have been a reasonable adjustment to discount for the period of illness related to her foot condition. At the appeal (236) the connection was made crystal clear.

Law

112. We refer to Mr Dilaimi's opening skeleton, which set out the relevant principles.

Unfair Dismissal

113. It is agreed here that the reason for dismissal was capability. We must consider therefore whether the employer acted reasonably in treating it as a sufficient reason for dismissal.

114. Whether an employer acted reasonably was considered in Spencer and Paragon Wallpapers Ltd [1977] ICR 301 EAT, which held that, in the case of a long-term sickness absence, it is essential for the Tribunal to consider whether the employer can be expected to wait any longer for the employee to return. There are a number of relevant factors including: whether other staff available to do the work; the likely length of the absence; the cost of continuing to employ; the size of the organisation; and the unsatisfactory situation of having an employee on very lengthy sickness absence.

115. In the case of intermittent sickness absence: Lynock v Cereal Packaging Ltd [1988] IRLR 510 EAT is still a useful authority. There is no principle that the mere fact that an employee is fit at the time of dismissal makes the dismissal unfair. In determining whether to dismiss an employee with a poor record of intermittent sickness absence the factors which may be important include: the nature of the illness; the likelihood of

it recurring or of some other illness arising; the length of the various absences and the periods of good health between them; the need of the employer to have done the work of the employee; the impact of the absences on those who work with her; the adoption and carrying out of policy; the emphasis on a personal assessment in the ultimate decision; the extent to which the difficulty of the situation and position of the employee have been explained to her.

116. We were referred to the decision in O'Brien v Bolton St Catherine's Academy [2017] IRLR 547 CA and the later clarification of it in City of York Council v Grosset [2018] IRLR 746 CA. The principle is that the tests of what is reasonable in unfair dismissal and what is objectively justified under section 15 of the EQA are different and, while sometimes the outcome will be the same, this is not necessarily so. The test under section 15 requires us to make our own objective assessment, whereas the range of reasonable responses requires us to review the employer's decision against the range of responses we consider were available to a reasonable employer.

117. Procedurally in sickness dismissals, section 98(4) reasonableness generally requires: consultation with the employee; medical investigation including of the prognosis; and consideration of other options including alternative employment. Sainsbury's Supermarkets v Hitt [2003] ICR 111 reminds us that the test is whether the employer's procedure was one a reasonable employer could have adopted bearing in mind there will be a range, some employers adopting a more exacting approach than others. We must not apply our own view of what we would have done but consider whether the Respondent's procedure fell within a reasonable range of procedures.

Equality Act 2010

118. Under section 120 of the EQA the Tribunal has jurisdiction to determine a complaint relating to employment under Part 5. The complaint here is that the Respondent discriminated against Mrs Carter: by subjecting her to a detriment and/or dismissing her contrary to section 39; or by failing to comply with a duty to make reasonable adjustments, contrary to section 39(5), section 20-21, as read with Schedule 8.

119. 'Detriment' under section 39 is broadly defined. We must ask whether, *'by reason of the act or acts complained of, a reasonable worker would or might take the view that he had thereby been disadvantaged in the circumstances in which he had thereafter to work*', see Shamoon v Chief Constable of the Royal Ulster Constabulary [2003] IRLR 285 HL. An unjustified sense of grievance cannot amount to 'detriment' but nor is it necessary to demonstrate some physical or economic consequence.

Section 15 EQA

120. Mrs Carter argues that she was subject to unfavourable treatment because of something arising from her disability contrary to section 15 EQA.

121. Section 15 recognises that a disabled employee may be adversely treated for something that other employees would be adversely treated for but where that something arises '*in consequence of their disability'* the disabled employee is

afforded greater protection. Grosset confirms that the employer does not need to know of the connection, just of the disability.

122. Section 15 does not give the disabled employee in these circumstances complete protection: the employer can avoid liability if it can 'objectively justify' the treatment.

122.1 First, it must identify that the treatment was in order to pursue a legitimate aim: a real, objective consideration or real need on the part of the business.

122.2 Second, it must satisfy us that treatment was a proportionate means of achieving this aim: both an '*appropriate means'* of achieving it and '*reasonably necessary'* (not the only possible way but we should ask whether lesser measures could have achieved the same aim). This requires an objective balancing exercise between the discriminatory effect of the treatment and the importance of the aim. This is an objective test and does not matter if employer did not have these reasons in its mind at the time.

123. We have had regard to the Equality and Human Rights Commission Code of Practice on Employment 2011 ('the Code') para 5.21: '*if an employer has failed to make a reasonable adjustment which would have prevented or minimised the unfavourable treatment, it will be very difficult for them to show that the treatment was objectively justified*.'

Failure to make adjustments

124. The duty to make reasonable adjustments arises:

'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. …' (section 20, EQA)

125. The duty does not arise if the employer did not know Mrs Carter was disabled; and did not know or could not be reasonably expected to know that Mrs Carter was likely to be placed at that disadvantage compared to non-disabled people. Mrs Carter is not required to suggest the steps that should have been taken, but a failure to do so could however be relevant to the question of the employer's knowledge of the disadvantage.

126. The Tribunal must first identify the PCP applying to all. Then whether it put Mrs Carter to a comparative substantial disadvantage.

127. It must then consider how the proposed adjustment would have addressed the substantial disadvantage in question. This is an objective question, the focus being on the practical result. It does not require a definitive answer. What must be shown is 'a' prospect or a 'real prospect'. A mere opportunity to avoid the disadvantage is insufficient.

128. The Tribunal considers a wide variety of factors in deciding reasonableness: the size

and resources of the employer; what proposed adjustments might cost; the availability of finance or other help in making the adjustment; the logistics of making the adjustment; the nature of the role; the effect of the adjustment on the workload of other staff; the other impacts of the adjustment; the extent it is practical to make (see 7.29 of the Code).

129. Failure to consult about adjustments does not itself constitute a breach of the EQA, although obviously it is good practice to do so. We also note that just because the employer has already made adjustments does not mean in theory that there are others that might have to be made.

130. Section 123 of the EQA provides that all claims of work related discrimination must be brought before the end of the period of 3 months starting with the date of the act complained of or such other period as the Tribunal thinks '*just and equitable'*.

131. According to the Court of Appeal in Hull City Council v Matuszowicz [2009] ICR 1170, in a claim based on a failure to make reasonable adjustments, it is the employer's failure to do something that is at issue and this is a continuing omission **not** an act extending over a period.

132. Often in reasonable adjustment cases failure to make reasonable adjustments is not a deliberate omission but an inadvertent one. In Matuszowicz the court held that for time to start running in such a case a somewhat artificial date had to be found. It held that the employer is treated as having decided on omitting to make reasonable adjustments at the time when it might reasonably have been expected to make them. (And we note, that the duty only arises once the Tribunal finds the employer knew or ought reasonably to have known about the disadvantage.)

133. If 3 months has expired, the Tribunal can extend time according to what it thinks is just and equitable. A tribunal cannot hear a complaint unless the applicant persuades us it that it is just and equitable to extend time. The Tribunal has a wide discretion but must only take into account relevant factors.

Application of facts and law to issues

134. We do not need to decide the issue of disability because two have been conceded and the others withdrawn.

135. We therefore begin with the issue of whether there was a duty and a failure to make reasonable adjustments because, if there was, then that may affect our judgment in relation to the section 15 claim. We deal with each PCP in turn.

Adjustments

Issue 4.9(i) Did the Respondent have the PCP: a requirement for satisfactory and regular attendance.

136. This issue is conceded.

137. We note that the Respondent's sickness policy apprehended that some employees would take sick leave from time to time and it had a policy for managing this. Ms Senyard's clear evidence was that the Respondent expected satisfactory attendance.

Issue 4.10(i) Did the PCP (of regular and substantial attendance) put Mrs Carter at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled at any relevant time in that she had an increased need to take sickness absence?

138. We have taken into account that substantial (in relation to disadvantage) means more than minor or trivial. It does not mean very large.

139. Mrs Carter was plainly put to a substantial disadvantage compared to non-disabled persons as at the date of dismissal by this PCP in relation to the foot deformity because of her future need to take anticipated absences of two times 3 months for surgery to her feet. (We note below, however, in this respect an adjustment had been made.)

140. But in addition to this:

140.1 in relation to her foot deformity and symphysis pubis OH had indicated, they both presented the likelihood of unpredictable absences;

140.2 the final sickness absence was plainly, on the evidence we have heard, connected to the foot deformity and it was this that triggered the Stage 3 meeting;

140.3 OH had also advised there was ongoing, low-level pain relation to the pelvic problem.

141. We have decided these factors are just enough to put Mrs Carter over the threshold of substantial disadvantage in relation to the need to take absences in addition to the absence for elective surgery. We have taken into account that non-disabled people are also at risk of unpredictable absence (for the normal vicissitudes of life, colds, flu and the like) but Mrs Carter had two conditions that made such absences more likely. While the pelvic problems had not caused any absence in the recent past, the foot deformity had grown. Mr Louette had advised it was a significant deformity. It was significant enough to warrant corrective surgery to both feet. Furthermore, Mr Louette anticipated that pre-operatively there were likely to be problems with rubbing and pain. All of these factors, in our view, put the likelihood of more absence as more than minor or trivial. This is not an easy assessment, but the weightiest factor in our decision is that OH had specifically identified the unpredictability of the future by reference to the two conditions. On the other side of the balance, the recent absences for each condition had only been 5 days, which is arguably minor, but the law requires us to assess the comparative need to take more absences and it is this that we consider is more than minor or trivial. Someone without the problems would have been in a much stronger position to meet the Respondent's requirement of regular attendance that Mrs Carter.

142. As at the date of dismissal, therefore, her disabilities meant that Mrs Carter had an increased need to take sickness absence and this put her to a substantial disadvantage in relation to the PCP of substantial and regular attendance.

Issue 4.11 If so, did the Respondent know or could it reasonably have been expected to know Mrs Carter was likely to be placed at such disadvantage

143. The issue here is not whether the Trust knew of the foot deformity. It plainly did.

144. But it is knowledge of the disadvantage we have found namely that she had an increased need to take sickness absence.

145. We have based our finding, in the main, on the OH report that the Trust had seen. They knew there was the prospect of unpredictable absence because of the pelvic pain and/or foot deformity. In our judgment, this meant they reasonably ought to have known that the final absence was related to the foot-deformity (as we set out below). And taking these points together they therefore reasonably ought to have known of the disadvantage we have found.

Issue 4.12(i) If so, did the Respondent take reasonable steps to avoid any such disadvantage. The Claimant says that the Respondent should have disregarded disability-related absence and/or allowed more time to enable it to obtain OH advice and/or not dismissed her.

146. At the time of dismissal, the dismissing panel may not actually have known that the final absence was connected to the foot deformity: this is because it is not set out specifically in the management case and was not explored at the Stage 3 hearing. We are very surprised about this. Any reasonable employer, before dismissing, would have enquired about the reason for the absence that triggered the breach of the target that led to the Stage 3 meeting. As Mrs Hewitt confirmed, it was the final absence that breached the target. Without that absence the Stage 3 meeting would not have occurred when it occurred and Mrs Carter would not have risked dismissal. Had the Trust enquired as to the reasons for the final absence at the Stage 3 meeting, they would have discovered that it was related to the foot deformity. We therefore find they reasonably ought to have known this at the Stage 3 stage.

147. In any event, by the time of the appeal, the Trust knew the final absence was foot-related because of the evidence in Mr Louette's email. And the appeal grounds raised the issue specifically that the last absence was disability-related. Before rejecting such a ground any reasonable employer would have investigated it by either referring to the evidence provided or, if not satisfied with it, by some further investigation. The Trust did not do so. It follows that before dismissal was confirmed at appeal the Trust had actual knowledge that the last absence was disability-related, or reasonably ought to have known that.

148. We have considered the factors at paragraph 7.29 of the Code. In our view it would have been a reasonable step in this case to disregard the short of foot-related absence in March 2018 so far as the target set by Mrs Hewitt was concerned. This is because:

148.1 the Trust had already decided to discount 6 months of future absence in respect of the foot problem and this was a relatively short additional period;

148.2 while it came at a cost (the 5 days of disruption to the staffing cover on the ACCU, and the cost of that cover), this was relatively small in comparison to that already agreed to be accepted by the Trust in the form of the 3 months for each recovery period;

148.3 the absence was plainly connected to the reason for the elective surgery and, at that stage, it was anticipated that foot-related problems would be resolved by the surgery and those 3 month recovery periods;

148.4 it was practicable in the sense that it simply required the trigger point to be delayed;

148.5 the step was effective in that it gave Mrs Carter a prospect of avoiding the comparative disadvantage of not being able to meet as easily the Trust's standards of attendance (as we set out below), essentially because it meant she avoided the trigger for the Stage 3 meeting;

148.6 another factor going to reasonableness is what the Trust's policy stated. At the very least, the definition of 'discounted absence' would suggest that the Trust anticipated discounting absence for some purposes if it was disability-related. We do not consider the Trust policy necessarily requires all disability-related absence to be disregarded: in different circumstances, it might be unreasonable, impracticable and have a huge impact on the Trust's finances and organisation of its work. Nevertheless, and for the above reasons, in these circumstances, it would have been a reasonable step to disregard this particular short absence for the purposes of whether it breached the target set.

149. The LTSA policy is silent on targets. In our view this does not mean that they were 'prohibited' by the policy (as Mrs Carter submits). On the contrary, targets, in the right circumstances can be a reasonable tool to manage long-term sickness and had been used in her case in the past without objection. But the question here, in our view, is not therefore whether the target should have been used but whether the final absence should have been allowed to breach it and trigger the Stage 3 meeting.

150. In our view, the reasonable step of discounting the short March 2018 absence would have meant that Stage 3 was not triggered by this final absence. Mrs Hewitt's clear evidence was that this absence was the main reason for triggering the Stage 3 meeting. Mrs Carter therefore had a real prospect of avoiding the Stage 3 meeting and dismissal if this absence had been discounted from the target. We find that dismissal is not likely to have followed at this stage if the absence had been discounted.

151. Was the obtaining of a further OH report also a reasonable step in these circumstances? We think so. We do not accept that the OH report would not have made a difference here, as Mr Dilaimi submits. It would have highlighted that the final

absence was foot-related. It might well have cast light on whether the foot-deformity was a disability. And it would have led to a proper consideration of whether, therefore, it was reasonable under the EQA or the Trust's own policy to discount it. A further OH referral gave Mrs Carter a prospect of avoiding the disadvantage by ensuring that the Trust understood which of her absences were disability-related and therefore considering whether they should be discounted from the target it had set. In our judgment this would have been a reasonable step at the dismissal stage because it would have enabled Ms Senyard to investigate the final absence. In any event, it was far more obviously a reasonable step by the appeal meeting because there was specific ground of appeal that the final absence was disability-related and it would have plainly been reasonable to seek the advice of OH about this.

Issue 4.9(ii) Did the Respondent have the PCP: performance of the full contractual duties.

152. In our view there was a requirement to perform full contractual duties. This was part and parcel of being a Band 7 nurse. The Trust does not contend otherwise.

Issue 4.10(ii) Did the PCP put Mrs Carter at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled at any relevant time in that she was unable to perform some of the physical requirements of her job? The Claimant relies upon the symphysis pubis and foot deformity as the causes of her physical pain.

153. We have found that, consequent upon the back assessment in 2016, Mrs Carter knew to adjust her role to avoid doing the physical aspects of the job she could not, from time to time do, because of her symphysis pubis. For example handling 5 litre bags and the more energetic roles in turning and CPR. Mrs Carter was senior enough manage these aspects of the report herself in her own role or by directing other nurses on the ward. When pain became problematic, Mrs Carter took sickness absence, but she confirmed that if she could get to work then she could do the work, presumably with these self-controlled adjustments.

154. We have heard some evidence that Mrs Carter found sitting for long periods difficult. The evidence is also clear that the nature of the job was mixed sitting and standing over the day. We do not consider, therefore, that in her role Mrs Carter was put to a substantial disadvantage by this in comparison with non-disabled persons because the role did not require long periods of sitting and/or if some nurses chose to do it in that way, Mrs Carter did not have to and could mix her day with periods of standing, walking and sitting.

155. We have also heard some evidence that long periods of standing was challenging for Mrs Carter. We have heard that sometimes the ward round could be very long and Mrs Carter would be in attendance. We find that this could be self-managed by the Claimant by the easy process of sitting down from time to time during the ward round on the chairs situated in and about the ward. Mrs Carter herself identified in her evidence that this was the solution. In our judgment therefore the long ward rounds did not *require* standing for long periods and therefore the Claimant was not subject to a disadvantage by them.

156. In respect of full time hours, in our judgment, these did not put Mrs Carter to a

disadvantage. This is not a case where she is saying she could do the job but the hours were a problem. Her pain was managed sufficiently that when she was fit for work she could attend full-time (save for the phased periods after long-term absence that were granted to her). When she experienced problems, they were problems that required time off work.

157. Mrs Carter has latterly suggested she required specialist shoes. We have had to do some retrospective work to work out what disadvantage is claimed in respect of this proposed adjustment. There was plainly, as part of the physical nature of the job, a requirement to be on her feet for some of the day. Latterly, as her painful foot deformity increased, this created the difficulties that we have described in normal shoes: discomfort, pain, rubbing. This probably put her to a substantial disadvantage in comparison to non-disabled persons.

Issue 4.11(ii) If so, did the Respondent know or could it reasonably have been expected to know Mrs Carter was likely to be placed at such disadvantage

158. As to the disadvantage of difficulty standing for long periods of time, and lifting and carrying the Trust knew this from the back assessment (114-115).

159. As to the disadvantage of wearing normal shoes, we are less sure that the Trust was aware of this. Mrs Carter was using inserts in her shoes to relieve the problem. And while, at one point, Mrs Carter had shown Mrs Hewitt her bunions, it does not necessarily follow that Mrs Hewitt ought to have known that her normal shoes were creating a difficulty. There is no medical advice suggesting specialist footwear. The Trust was aware that the walking through the snow had caused rubbing at the bunion, but this was a particularly unusual day and it would not follow that wearing normal shoes was a problem generally. We are of the view, therefore, that the Respondent did not know and ought not reasonably to have known this.

Issue 4.12(ii) If so, did the Respondent take reasonable steps to avoid any such disadvantage:

160. As to standing, lifting and carrying, we have found that Mrs Carter could make the adjustments herself of avoiding the heaviest work and finding chairs to sit on from time to time during a lengthy ward round. There was no need for any further adjustment.

161. If we are wrong about knowledge in relation to the disadvantage of normal shoes, we have found that Mrs Carter herself found a reasonable solution to the problem of normal shoes, namely inserts that she bought at the chemist. This was an effective adjustment except on the exceptional day when she had to walk into work during the snow.

162. In those circumstances there was no further physical limitation on the job that demanded the adjustment of redeployment. It is her case is she can do the job she loves and, that at the point of dismissal, there was not a problem that prevented this. A less physical job would have created the difficulty of long sitting periods. Nor have we seen any evidence of appropriate vacancies (or appropriate vacancies with

adjustments) that she could have been redeployed into.

Section 15 Claim

Issues 4.5 and 4.6 Did the Respondent treat Mrs Carter unfavourably: ii (stage 3 meeting), iii (dismissal), v (appeal rejection) because of something arising in consequence of her disability? The Claimant relies upon time off work caused by her disabilities.

163. It is conceded that points ii, iii, and v of the list of issues are unfavourable treatment because of something arising in consequence of her disability namely time off work caused by disabilities. Issue i is no longer pursued.

164. That leaves the question whether issue iv (*10 April 2018 instruction by Ms Senyard that Mrs Carter must not contact any of the Respondent staff and/or visit its premises*) is unfavourable treatment.

165. In our judgment the instruction in the dismissal letter was plainly an act of less favourable treatment. It was an entirely inappropriate instruction to include in a capability dismissal. The strong implication in this instruction is that Mrs Carter is not to be trusted. Her upset at this implication is understandable and that of a reasonable employee. She had not been dismissed for misconduct or dishonesty but for capability. There was no reason therefore why she should be excluded in the future from Trust premises. We consider that to be subject to this instruction did subject the Claimant to a detriment because she reasonably felt disadvantaged by it.

166. The more difficult question is whether the instruction was because of something arising in consequence of her disabilities (the absences). We have found that the inclusion of this passage was an error. It was an error that should not have been made. Ms Senyard plainly did not take the time she should have taken to check this important letter: a letter ending a long-standing nurse's employment. We roundly criticise her for it but we have found it was genuinely an error: that of HR for using the wrong template and Ms Senyard for not picking it up. This error was not logically connected to the absence but to carelessness. We therefore find that it was not because of something arising in consequence of the disabilities.

Issue 4.7 if so, has the Respondent shown that the unfavourable treatment was a proportionate means of achieving a legitimate aim? The Respondent's legitimate aim is managing sickness absence to ensure adequate attendance levels and seeking to improve Mrs Carter's attendance in order to meet the needs of the organisation.

167. We find that the aims set out in the statement of the issue were held by the Trust and legitimate. The Claimant did not contend otherwise.

168. We do not find, however, that the Stage 3 meeting; dismissal and appeal rejection were reasonably appropriate means of achieving that aim in this case. This is because we have found that the Trust failed to make the reasonable adjustment here of disregarding the final sickness absence. If they had done so then the main reason for the Stage 3 meeting would have fallen away. The meeting was not reasonably necessary *at that* stage because the lesser measure of disregarding the final

absence was a reasonable adjustment the Trust did not make. Therefore the move to Stage 3 was inappropriate and disproportionate.

169. It follows from this that dismissal, too, was not objectively justified at that point because it would not have been considered without the Stage 3 meeting. Nor would there have been an appeal.

170. While this might appear to be a very short conclusion to this part of the claim, paragraph 5.21 of the Code supports us in our view that where there was a reasonable adjustment to be made that would have avoided the measure then it will be very difficult to justify objectively.

171. We emphasise again that the setting of the target was probably appropriate and reasonably necessary given the long history of very high absence. But for us it is the decision that this final absence triggered the next stage of the procedure that is the problem here.

172. Nor should our decision be taken as somehow disregarding the significant impact of Mrs Carter's absence history. We have set out above how much the absence of a Band 7 nurse affects the running of the ACCU both in terms of cost, quality of care and morale. The question under section 15 is not a matter of overall reasonableness, but of whether the measure was 'reasonably necessary', which we consider is a higher threshold. The logical scheme of the Act in relation to disability would also be undermined if on the one hand we were to find there was a failure to make a reasonable adjustment that would have avoided Stage 3 and dismissal but on the other find that Stage 3 and dismissal were objectively justified.

Unfair Dismissal

Issue 4.2 Was the dismissal fair or unfair in accordance with ERA section 98(4), and, in particular, did the Respondent in all respects act within the so-called 'band of reasonable responses'? The Claimant says it was not as she should have been redeployed or other reasonable adjustments made to enable her to remain in employment.

The reason for dismissal

173. Our jurisdiction here is to review the Trust's decision and process through the lens of a reasonable employer. The ERA is a separate jurisdiction to the EQA and what is required under the latter may be more demanding of the employer than the former. The EQA puts positive obligations upon employers for the protection of disabled employees in particular. The ERA requires what is reasonable in general.

174. Here the reason for dismissal was that the Trust could not be assured that the Claimant's sickness absence was likely to improve: it relied on the prior history of long absence: 375 days since September 2015; the OH advice that the best predictor of future absence was past history; and the significant impact of absence on the ACCU. The reason was not that there was currently a long-term absence that could not be tolerated any longer. Nor was it that Mrs Carter had a problematic intermittent sickness absence.

175. Was that a reasonable conclusion to draw and, if so, was dismissal within the range of responses of a reasonable employer?

176. In our judgment the reason for dismissal was a reasonable one to reach on the facts.

177. First, the history was indeed of a very high level of absence. Mrs Carter herself has agreed this generally. While she disputed the figure of 375 days since September 2015, it is accurate. It does appear that the Trust concentrated on the period after September 2015. We would have been concerned if the Trust had relied on the entire history of absence going back 16 years. But, by the point of dismissal and appeal, the 375 figure is the one relied upon.

178. Second, the significant impact of this absence on the ACCU that we set out in full in our findings of fact, is also uncontroversial. There was an impact on other staff; a reduction in senior nurses on the ACCU for each day of absence; an impact therefore on other staff; and in particular on the quality of care that could be offered both by the absence of an experienced nurse and by the absence of a permanent member of staff and the absence of a nurse manager. The cost, equally, was significant, £364 per day plus sick pay running into tens of thousands of pounds. This would put a burden on any employer especially a publicly funded health service with limited funds. None of this is a criticism personally of Mrs Carter. She was unable to work for a variety of reasons. She is not at fault. But to disregard the significant impact of her absences because she is blameless would equally be wrong. It was reasonable to have regard to this impact.

179. Third, the latest OH advice did indicate unpredictable future absence. Taken together with the earlier OH report that suggested the Trust look at the history as a good predictor of the future, it was reasonable for Ms Senyard to be pessimistic about the future likelihood of improved attendance. This is despite that there had been some periods of good attendance and that she was not taking into account the anticipated periods of recovery for elective surgery.

180. Fourth, the Bradford score, at the point of dismissal, was high even discounting for the final absence and that would have meant, according to policy that the absence level was a cause for concern.

181. In our judgment, it was within the range of responses of a reasonable employer to dismiss for this reason. We have had in mind the factors set out in both Spencer (long term absence) and Lynock (intermittent sickness absence).

182. It was reasonable to consider at this point, even while Mrs Carter was not absent on long term sickness, whether the pattern of lengthy and varied absences was likely to improve. The past impact was so significant and conclusion as to the future a reasonable one to draw. For these two reasons for the employer to state that enough was enough at that point, under the ERA, was a decision a reasonable employer could have reached.

Procedure

183. We have more concern, however, about the reasonableness of the procedure adopted.

184. Here there was a mixture of prior long-term absences and some intermittent absence. In those circumstances, a blended approach to the procedures set out in the sickness absence flowcharts was probably reasonable because they anticipated either LTSA or PISA, when in this case there was a history of LTSA and some intermittent absence.

185. Some of the processes prior to dismissal followed good practice: there was adequate notification of meetings and the reasons for them. Mrs Carter had the opportunity to be represented.

186. We find it was probably acceptable under the policy to reconvene the stage 2 meeting. There had been 56 days of absence. It was reconvened to review future attendance. While this is not anticipated by the policy expressly, we find it was reasonable to do so, considering the history of absence.

187. As we have set out above, we consider it was reasonable to set a target. There was no prohibition in the long term absence process to do so and they can help in the management of absence by setting points at which the employer is showing it is concerned. Thus it was probably reasonable to reach the Stage 3 meeting when that target was breached.

188. We consider, however, any reasonable employer would have delayed the Stage 3 meeting upon hearing that the employee's father was gravely ill. We have all reached the view that a reasonable employer would have done this even without a request. A stage 3 meeting may determine an employee's future. She is unlikely to be able to attend as carefully to it if a close family member is gravely ill. There was no countervailing reason not to postpone other than that it had already been rescheduled. This is insufficient to outweigh the very real reason for postponement that a family illness represents and it seems to us to show a lack of compassion on the part of the Trust.

189. We are concerned about the approach of the Stage 3 panel. They failed to investigate the final period of absence either at the meeting or by way of an OH referral. Any reasonable employer would have done so: an enquiry into the nature of the illness and an emphasis on personal assessment are key factors going to reasonableness set out in Lynock.

190. We have a real concern about the drafting of the dismissal letter. It is really important for an employee to understand the reason for her dismissal. Here the Trust engaged in a long recitation of the chronology and then a one paragraph reason. It was only upon reading Ms Senyard's response to the appeal grounds and her evidence at the Tribunal that we fully understood why she had chosen to dismiss.

191. For the reasons we have already given, the instruction not to attend Trust premises

in the letter of dismissal was unreasonable as was the failure to apologise and withdraw the instruction immediately it was drawn to the Trust's attention.

192. We are also concerned by the short-notice of the final rescheduling of the appeal meeting. On the one hand Ms Butler had rescheduled because she was concerned that there were points in the appeal that it was not in Mrs Carter's interests to be dealt with by correspondence. The Trust knew that Mrs Carter would not be able to attend and also knew that she had RCN representation. Yet they gave only 24 hours notice of this rescheduling and then did not respond to the RCN's complaint that because of this they could not attend.

193. Finally the approach of the appeal meeting to investigating the appeal ground in relation to disability was unreasonable. Mrs Carter had provided Dr Louette's letter evidencing a connection with her foot problem. But the appeal panel failed to investigate this further and characterised Mrs Carter's ground as an 'assumption'. This was a wholly unreasonable way to approach the matter. It was an important aspect of the appeal: had the final absence been disability-related (or indeed related to the forthcoming surgery for which absence had been discounted) there was an argument according to the policy or logic that this short absence, too, should be discounted. Any reasonable employer would have needed to investigate this by either considering the evidence supplied by the employee or by a further OH referral. To reject that evidence as mere assumption or assertion was high-handed and unreasonable.

194. Stepping back, and looking at the overall procedure, taking all of our points of concern into account, we have concluded that it was not one a reasonable employer would have adopted. We are particularly concerned about the failure to investigate the final absence period at dismissal and appeal stage. And the failure to reschedule both Stage 3 and appeal meetings so that Mrs Carter had a real opportunity adequately to represent herself or be represented.

195. We have therefore found that this dismissal was unfair.

Issue 4.3 If Mrs Carter was unfairly dismissed and the remedy is compensation, should there be any Polkey reduction to reflect any possibility that Mrs Carter would have been fairly dismissed in any event?

196. Looking at the evidence of what occurred, we are satisfied that Mrs Carter would not have been fit for work from the date of her first foot operation until about June 2019. This is our finding even if there had been no dismissal.

197. Given this period of time of absence, we consider it undoubtedly the case that the Trust could have dismissed Mrs Carter fairly by the end December 2018. We consider that the considerable impact of such a lengthy absence would have again taken its toll on the Trust for the reasons we set out in our findings of fact above under the sub-heading *ACCU Unit/Impact of Absence*: briefly, the particular circumstances of the ACCU; the daily cost; the fact that the bank replacement was not a band 7; that band 7 nurses were critical to many aspects of the running of ACCU especially to the quality of care. These are all matters that are significant to

the critical care that takes place in the ACCU.

198. Even if the Trust had begun its LTSA procedure from the beginning, and excluded the 3 months it was to disregard after surgery, we find it would have taken until about the end of December 2018 to reach a stage 3 decision. We have added some time in this to allow for procedural delays.

199. We do not consider, because of the significant impact this length of absence would have had, that, at that stage, it would have been a reasonable step to discount for further disability-related absence beyond the 3 months already allowed (and further 3 months in the future) and the Trust would have been able objectively to justify a dismissal at this stage because it was appropriate and reasonably necessary. No lesser measure would have worked bearing in mind the nature of the illness and pain described.

Remarks of the 'Industrial Jury'

200. Managers must remember that they are accountable for their decisions. HR can give advice, but managers must be clear about the reasons for their decisions and be able to justify them. At this hearing, at times, the Trust's managers failed to 'own' some of their decisions.

201. The parties should note that we have not decided that the Trust must discount all disability-related absence in all circumstances, rather that it was a reasonable step for this short period of disability-related absence to be discounted here in relation to the target set.

202. We realise that our decision is made with the benefit of hindsight. What is or is not a disability and how the employer may then be obliged to adjust its approach are often subtle and very difficult questions to decide in real time. The threshold of what is a disability under the EQA can be a relatively low one. OH can advise but they do not finally decide this question. Whenever there is a potential sickness dismissal, managers should carefully consider, with the help of HR and OH advice, whether the definition of disability might be met. If they had done so in this case, then they may have been more alive to the positive obligations that they owed to Mrs Carter. It appears here that managers did not consider whether the foot deformity was a disability. If they had done so, undertaken a proper investigation and analysis, then this liability decision might have been avoided.

Employment Judge Moor

3 August 2019