EMPLOYMENT TRIBUNALS (SCOTLAND)

5 **Case Number: 4102143/2017**

Hearing held in Edinburgh on:
7th-9th and 12th-14th March 2018, 22nd- 25th and 29th-30th October 2018,
31st October, 2nd and 22nd November 2018 (deliberations).

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Employment Judge M Whitcombe
Mr S Gray
Mr A Ross

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Dr A	**Claimant** **Represented by:** **Mr D Northall (Counsel)**

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NHS Education for Scotland	**First Respondent** **Represented by:** **Mr I Truscott QC (Counsel)**

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Lothian Health Board	**Second Respondent** **Represented by:** **Mr D Fairley QC (Counsel)**

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JUDGMENT

The unanimous judgment of the Tribunal is as follows.

(1) All of the following disability discrimination claims brought against the first respondent fail and are dismissed:

a. discrimination arising from disability, contrary to section 15 of the Equality Act 2010;

b. indirect discrimination, contrary to section 19 of the Equality Act 2010;

c. failure to make reasonable adjustments, contrary to sections 20 and 21 of the Equality Act 2010.

(2) The second respondent did not breach sections 20 and 21 of the Equality Act 2010 by failing to make reasonable adjustments.

(3) The claim for unfair dismissal against the second respondent succeeds.

(4) The second respondent discriminated against the claimant for a reason arising from disability, contrary to section 15 of the Equality Act 2010.

(5) As previously ordered, questions of remedy will be dealt with, if necessary, at a further hearing.

Contents

Our reasons have been drafted with the intention that they should be read as a whole but this table of contents is intended to aid navigation.

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REASONS

Introduction

1. This case concerns claims of disability discrimination and unfair dismissal brought by a doctor in relation to her anaesthetic training, her removal from that training programme and the termination of her employment on 16th May 2017.

2. As a consequence of previous orders the claimant will be known simply as "Dr A" in the title of this judgment. If, having read these reasons, the claimant or her representatives consider that further steps need to be taken in order to prevent "jigsaw identification" and to preserve anonymity then they should make an application as soon as possible, and in any event within 14 days of the date on which these reasons are sent to the parties. The use of gender-neutral pronouns was not feasible given the need also to refer to maternity leave.

3. In broad terms, the first respondent is responsible for the postgraduate training of doctors in Scotland. The second respondent was the employer of the claimant at the relevant times. The detailed position is set out below.

4. It was common ground at the hearing that the claimant is and was a disabled person for the purposes of section 6 of the Equality Act 2010 by reason of a recurrent depressive disorder.

5. As a result of a prior direction, the hearing was concerned with matters of liability only.

Representation

6. The claimant was represented by Mr Northall. The first respondent was represented by Mr Truscott QC and the second respondent was represented by Mr Fairley QC. We want to thank all of them for their skill, considerable help and hard work during this hearing. That included responding to the Tribunal's requests for additional summaries and other documents as the hearing progressed. We are grateful for their help in ensuring that evidence and

submissions were completed on schedule at the end of the second portion of the hearing. We extend the same thanks to the many others with a non-speaking role who worked hard to progress the case in accordance with the overriding objective.

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Case Management

7. A number of case management issues arose during the hearing. On each of them we gave oral reasons for our rulings in the presence of the parties and there was no request for written reasons. We therefore record those issues only briefly below.

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8. At the outset we discussed with the parties a number of connections between the tribunal panel and others involved with the case. Although our preliminary view was that none of them gave rise to a risk of actual or apparent bias we nevertheless disclosed all the relevant details and sought the parties' views. The matters discussed were briefly as follows.

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8.1. Mr Fairley QC once sat as a salaried employment judge in Scotland and was primarily based in Edinburgh. He left that post in order to return to private practice at the bar. Employment Judge Whitcombe's appointment has not overlapped with that of Mr Fairley QC and they have never been judicial colleagues in Scotland. Employment Judge Whitcombe had previously met Mr Fairley QC just once, on a course in 2009. Mr Gray thought that he had been a member of a tribunal panel including Mr Fairley QC just once or twice in the past. Mr Ross did not recall sitting with Mr Fairley at any point in the past and is more often based in the Glasgow ET.

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8.2. Mr Truscott QC was once a member of the barristers' chambers in England at which Employment Judge Whitcombe practised for about 20 years. However, Mr Truscott QC's practice was always primarily in Scotland and he and Employment Judge Whitcombe never met during that period.

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8.3. About 25 or 30 years ago Mr Truscott represented Lothian Regional

Council while Mr Gray was one of the officers of that local authority. Mr Gray remembers him from that time.

9. The parties were given time to reflect and to consider their positions. None of them had any objection to the panel continuing to hear the case and there were no applications for recusal.

10. The hearing took place over six days in March 2018 and six further days in October 2018. The members of the tribunal then deliberated together for three further days. The lengthy interval between the two main portions of the hearing was caused by the restricted availability of the parties, their witnesses and their representatives. With the cooperation of the parties (for which we are very grateful) the second portion of the hearing was timetabled so as to ensure that the evidence and submissions were completed without a further lengthy adjournment. The representatives relied upon written as well as oral submissions.

11. On 16th March 2018 we made a number of orders intended to ensure that the second portion of the hearing was fair, efficient and conducted at proportionate cost. We are very grateful to the parties for their hard work in producing the following documents.

    11.1. A chronology of key dates, which was mostly agreed.
    11.2. A list of the key individuals mentioned in evidence.
    11.3. A list of issues, which was mostly agreed.
    11.4. The parties' respective calculations of the duration of the claimant's ST3 and ST4 training periods.

12. Additionally, during the first portion of the hearing, the parties were able to produce the statement of agreed facts first discussed during a preliminary hearing for case management conducted by EJ Garvie on 26th January 2018.

13. On 26th February 2018 Employment Judge d'Inverno made a restricted reporting order and an order under rule 50(3)(b) of the ET Rules of Procedure 2013

preventing the identification of all of the parties and witnesses in this case. By consent, we varied those orders so as to delete from their scope the identification of all persons and bodies other than the claimant, who will continue to be known as “Dr A”, or simply as “the claimant”. The reasons are set out in our order dated 16th March 2018.

14. At the commencement of the second portion of the hearing the parties’ efforts to agree a list of issues highlighted a dispute as to whether or not the first respondent should be allowed to raise an argument under section 53(7) of the Equality Act 2010. We heard submissions before ruling that the argument could be raised by way of an amendment to the first respondent’s case, which we allowed in accordance with well-known “***Selkent***” principles. We gave fuller oral reasons for our decision in the presence of the parties at the time.

Evidence

15. The joint bundle of documents filled 4 lever arch files and some additional documents were added during the hearing.

16. The claimant gave evidence but did not call any other witnesses.

17. The first respondent called the following witnesses in the following order:

    17.1. Dr David Semple, Consultant in Anaesthetics and Intensive Care Medicine, NHS Lothian. Appointed by the first respondent as Training Programme Director for Specialty Trainees in Anaesthesia for South East Scotland 2007-2013.

    17.2. Professor David Bruce, Director of Postgraduate GP Education, East of Scotland. Lead Dean/Director Paediatrics, Obstetrics and Gynaecology for the first respondent. His role, so far as relevant to this case, was that he chaired the claimant’s appeal against the ARCP Outcome 4.

    17.3. Dr Kirsteen Brown, Consultant Anaesthetist, Department of Clinical Neurosciences, NHS Lothian. Appointed by the first respondent to be the

Training Programme Director for Speciality Trainees in Anaesthesia for South East Scotland from August 2013 (the successor in that role to Dr David Semple).

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17.4. Professor William Reid, until recently Dean of Post Graduate Medicine, South East Scotland. The role of the postgraduate dean is explained below.

18. The second respondent called the following witnesses in the following order.

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18.1. Dr Michael Gillies, an Associate Medical Director and Consultant in Critical Care, NHS Lothian. As Associate Medical Director he has responsibility for consultants and non-consultant career grades (i.e. doctors not in training). A major part of his role is to manage medical staff. He has responsibility for clinical governance, patient safety and to some degree, finances.

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18.2. Janis Butler, at the relevant time Interim Director of HR and Organisational Development, NHS Lothian. She was a member of the panel considering the claimant's appeal against dismissal and also offered HR advice to that panel.

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19. All of the witnesses listed above gave their evidence on oath or affirmation and were cross-examined. Witness statements were not used.

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Issues

20. The parties were able to produce a list of issues which was very nearly agreed by the conclusion of the hearing. The remaining contentious aspects were as follows.

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21. There was a dispute as to the extent to which it was either necessary or legitimate for us to enquire as to "the precise nature and effect of the claimant's disability". The claimant regarded the *effect* of the illness as being an issue for expert

medical evidence rather than fact finding. Our observation at the time was that it was certainly necessary for us to explore that issue to some extent in order to address issues of particular (individual) disadvantage and substantial disadvantage in the claims for indirect discrimination and failure to make reasonable adjustments. That is still our view.

22. One of the issues originally agreed concerned an accessory liability argument that the first respondent knowingly helped the second respondent to commit a basic contravention of the Equality Act 2010, as defined by section 112 of that Act. On behalf of the claimant Mr Northall abandoned that argument during closing submissions.

23. In closing, Mr Northall also relied on an additional PCP numbered "(g)" in the lists below.

24. By agreement following the hearing, a correction was also made to a typographical error in issue 24(e).

25. Allowing for those various changes, the agreed issues were as follows (set out in italics, retaining the numbering used by the parties, with contentious aspects underlined).

<u>Against the First Respondent</u>

Qualifications Body

2. *Did R1 apply a competence standard or standards to C in terms of section 53(7) of the Equality Act 2010?*

If the answer to (2) above is yes, did R1 indirectly discriminate against C as described in (3) – (8) below, and was the claim brought in time as per (9) below?

Indirect Discrimination

3. *Did R1 apply the following PCPs to C?*

   a. *A provision, criterion or practice requiring the completion of ARCP procedures on a 12 month cycle.*
   b. *A provision, criterion or practice requiring the demonstration of core competencies within the ARCP process.*
   c. *A provision, criterion or practice requiring C to complete her training and/or show adequate progress within a set timeframe;*
   d. *A provision, criterion or practice preventing the issue of two Outcome 3s in respect of the same period of training;*
   e. *A provision or criterion requiring C to show progression in the development of "non-technical skills".*
   f. *A provision or criterion requiring C to complete her then current phase of training unsupervised.*
   g. *A provision, criterion or practice meaning that a period spent on an Outcome 3 should not exceed 12 months within the intermediate training period.*

4. *Did each of the PCPs put persons sharing C's disability <u>and its nature and effect</u> at a particular disadvantage when compared with persons who are not disabled?* [The underlining shows the contentious aspect.]

5. *Was C placed at that disadvantage?*

6. *If the answers to (3), (4) & (5) above are yes,*

7. *Was the PCP a means of achieving a legitimate aim, namely to ensure that all trainees who achieve consultant status have satisfactorily progressed through a nationally agreed training curriculum. The curriculum is implemented in such a way as to ensure that, on completion, the doctor has the necessary qualifications, aptitude,*

skill set (including non-technical skills) and experience to practise competently, without supervision, so ensuring patient safety?

8. *Was the PCP a proportionate means of achieving the aim?*

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(R1's position on proportionality is set out in an email to the ET dated 16.2.18)

[We add at this point the way in which the proportionality argument was expressed, at some length, in that email.]

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Legitimate Aim

To ensure that all trainees who achieve consultant status have satisfactorily progressed through a nationally agreed training curriculum. The curriculum is implemented in such a way as to ensure that, on completion, the doctor has the necessary qualifications, aptitude, skill set (including non-technical skills) and experience to practise competently, without supervision, so ensuring patient safety.

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Proportionate Means

The proportionate means of achieving the above aim is to ensure satisfactory progression through the nationally agreed curriculum, or to discontinue the training of a trainee, when that trainee has not been able to demonstrate to suitably qualified assessors, satisfactory progression through the nationally agreed training curriculum. The first respondent's position is that, despite the various steps taken over the length of time the claimant had been in training, she had not demonstrated, to suitably qualified assessors, satisfactory progression through the nationally agreed curriculum, including in relation to non-technical skills. Patient safety could not be assured were she to continue progress through the program as trainees are required to work on a progressively less supervised basis as they build towards safe autonomous practice.

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9. *Has the above claim been brought before the end of the relevant 3 month period?*

If the answer to (2) above is no, did R1 indirectly discriminate against the claimant as per (3)-(8) above; discriminate against C as described in (10)-(24) below; and were the claims brought in time?

Discrimination arising from disability

10. *Did R1 know or could [R1] reasonably be expected to know that C had a disability <u>and is likely to be placed at the disadvantage referred to hereafter</u> prior to 27 June 2016?*

If the answer to (10) above is yes,

11. *Did R1 treat C unfavourably by issuing her with an Outcome 3 in June 2014?*

12. *Was the treatment because of something arising in consequence of C's disability, namely her disability-related absence and missed training time?*

If the answers to (11) & (12) above are both yes,

13. *Was the Outcome 3 a means of achieving a legitimate aim, namely to ensure that all trainees who achieve consultant status have satisfactorily progressed through a nationally agreed training curriculum. The curriculum is implemented in such a way as to ensure that, on completion, the doctor has the necessary qualifications, aptitude, skill set (including non-technical skills) and experience to practise competently, without supervision, so ensuring patient safety.*

14. *Was the Outcome 3 a proportionate means of achieving the aim?*

(R1's position on proportionality is set out in an email to the ET dated 16.2.18)

[We have already set out above the relevant passages of that email on legitimate aim and proportionality.]

15. Has the above claim been brought before the end of the period of 3 months, starting on 3 June 2014?

16. Did R1 treat C unfavourably by issuing her with an Outcome 4 on 14 June 2016?

17. Was the treatment because of something arising in consequence of C's disability, namely,

17.1 The risk to patient safety caused by the "intermittent and unpredictable situation" resulting from C's ill-health which, in the view of both Rs, could not be mitigated against, or at least not to an acceptable extent; and

17.2 A concern over a lack of progression in acquiring "non-technical skills".

If the answers to (16) & (17) above are both yes,

18. Was the Outcome 4 a means of achieving a legitimate aim, namely to ensure that all trainees who achieve consultant status have satisfactorily progressed through a nationally agreed training curriculum? The curriculum is implemented in such a way as to ensure that, on completion, the doctor has the necessary qualifications, aptitude, skill set (including non-technical skills) and experience to practise competently, without supervision, so ensuring patient safety.

19. Was the Outcome 4 a proportionate means of achieving the aim?

(R1's position on proportionality is set out in an email to the ET dated 16.2.18)

5 [We have already set out above the relevant passages of that email on legitimate aim and proportionality.]

20. *Has the above claim been brought before the end of the relevant 3 month period?*

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Failure to make reasonable adjustments

21. *Did R1 know or could [R1] reasonably be expected to know that C had a disability and is likely to be placed at the disadvantage referred to*
15 *hereafter prior to 27 June 2016?*

22. *Did R1 apply the following provisions, criteria and practices (PCPs) to C:*

a) *A provision, criterion or practice requiring the completion of ARCP*
20 *procedures on a 12 month cycle.*

b) *A provision, criterion or practice requiring the demonstration of core competencies within the ARCP process.*

25 c) *A provision, criterion or practice requiring C to complete her training and/or show adequate progress within a set timeframe;*

d) *A provision, criterion or practice preventing the issue of two Outcome 3s in respect of the same period of training;*

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e) *A provision or criterion requiring C to show progression in the development of "non-technical skills".*

f) *A provision or criterion requiring C to complete her then current phase of*
35 *training unsupervised.*

g) A provision, criterion or practice meaning that a period spent on an Outcome 3 should not exceed 12 months within the intermediate training period.

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23. Did each of the PCPs put the C at a substantial disadvantage in comparison with persons who are not disabled?

24. Was it reasonable for R1 to take the following steps to avoid the disadvantage:

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a) Not issuing C with an Outcome 3 in June 2014;

b) Deferring the June 2014 ARCP until such time as C had been provided with an opportunity to complete the required period of training;

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c) Providing C with remedial training at ST3;

d) Providing its expectations to C of the outcomes and objectives in training in a manner that was clear and effectively communicated;

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e) Not issuing C with an Outcome 4 in June 2016;

f) Issuing C with an Outcome 3 in June 2016 or subsequently;

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g) Otherwise extending C's period of training in June 2016 or subsequently;

h) Permitting or facilitating C to continue her training and employment in a supervised environment (for which R1 needed to ascertain the extent to which supervision was necessary);

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i) Implementing a system of monitoring or self-reporting so as to identify the occurrence of mental ill-health;

j) Allowing C to attend a period of further training in relation to "non-technical skills", the content of which was specifically designed to assist the Claimant in overcoming the effects of her depression.

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25. If the answers to paragraphs (21) - (24) above are yes; has the above claim been brought before the end of the relevant 3 month period?

Against the Second Respondent

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Unfair dismissal

26. What was the reason or, if more than one, the principal reason for C's dismissal?

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27. Was the reason a potentially fair reason within s.98(2) ERA?

28. Was the dismissal reasonable in all the circumstances, having regard to equity and the substantial merits of the case?

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Discrimination arising from disability

29. Did R2 treat C unfavourably by dismissing her?

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30. Was the dismissal because of something arising in consequence of C's disability, namely those matters identified at (12) above?

31. Was the dismissal a proportionate means of achieving a legitimate aim; namely, that of employing trainee doctors only if they were in a position to participate in a recognised training programme and, through that aim, furthering the legitimate aims of R1 as described at (13) and (18) above, by ensuring that all doctors acquired the necessary qualifications, aptitude, skill set (including non-technical skills) and experience to practise competently, without supervision, so ensuring patient safety?

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Failure to make reasonable adjustments

32. Did R2 apply to C those PCPs identified at (3) above?

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33. Did each of the PCPs put the C at a substantial disadvantage in comparison with persons who are not disabled?

34. Was it reasonable for R2 to take the following steps to avoid the disadvantage:

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a. Not dismissing C;

b. Permitting or facilitating C to continue her training and employment in a supervised environment (for which R2 needed to ascertain the extent to which supervision was necessary);

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c. Implementing a system of monitoring or self-reporting so as to identify the occurrence of mental ill-health;

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d. Allowing C to attend a period of further training in relation to "non-technical skills", the content of which was specifically designed to assist C in overcoming the effects of her depression?

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Findings of Fact

26. The following findings of fact were either agreed between the parties or else proved on the balance of probabilities.

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The role of the first respondent, NHS Education for Scotland

27. The first respondent is a Special Health Board established by statutory instrument. It exercises the functions of the Scottish Ministers in respect of providing, coordinating, funding and advising on education and training for persons providing services under the National Health Service (Scotland) Act

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1978. It provides education, training and lifelong learning for the NHS workforce in Scotland. It is responsible for the management of delivery and governance of postgraduate training to standards required by the General Medical Council ("GMC") as regulatory body.

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28. The first respondent's Scotland Medical Deanery operates in four regions centred on Aberdeen (north), Dundee (east), Edinburgh (southeast) and Glasgow (west). Each of those regions has a Postgraduate Dean. The Deanery is responsible for managing the delivery of postgraduate training through
10 approved training programs, and for managing the quality of those programs for the GMC.

The role of health boards, including the second respondent

15 29. The role of Health Boards such as the second respondent is probably well-known. They are responsible for the protection and improvement of their population's health and for the delivery of frontline healthcare services.

30. Health boards, such as the second respondent, also have a role in medical
20 education and governance. They support the delivery of multi-professional education and training and provide for supervised training across the whole range of medical education. Health boards employ almost all postgraduate trainees. Those trainees ordinarily deliver healthcare services as part of their training. Through their consultant, other specialist and general practitioner staff
25 health boards enable the supervision of training required by the first respondent and its postgraduate deanery to standards set by the relevant regulatory body.

31. The details are described in "A Reference Guide for Postgraduate Specialty Training in the UK", generally known as "The Gold Guide". The 6th edition of the
30 Gold Guide was in force at the relevant times and formed part of the evidence before us. We will refer to some of the key passages later in these reasons.

32. Service level agreements exist between the first respondent and relevant health boards, including the second respondent, which set out the educational and
35 financial obligations between them in relation to medical education and

governance. Those service level agreements reflect the governance arrangements set out in "The Governance of Postgraduate Medical Education and Training - The Arrangements for Scotland".

5 *Postgraduate medical specialty training*

33. Doctors who have successfully completed both foundation and core training can apply for a place on a training programme for a medical specialty, such as anaesthetics.

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34. The programme of training in a given specialty or sub-specialty takes the form of a formal alignment or rotation of posts. The GMC is responsible for approving programmes of training in particular locations. There are currently nearly 200 GMC approved training programmes covering over 50 specialties which, if 15 successfully completed, lead to a trainee receiving a Certificate of Completion of Training (CCT) and entry onto the specialist register held by the GMC. Entry onto that specialist register allows doctors to apply for a consultant post in their given specialty or general practice.

20 35. All programs of postgraduate training have an identified Training Programme Director ("TPD"). TPDs are employed by the first respondent on a "sessional" basis, in other words for a defined proportion of their overall working time.

36. Within each programme, each training location requires at least one Educational 25 Supervisor ("ES"). Educational Supervisors are employed by health boards, such as the second respondent. Typically, they are consultants or other suitably trained specialists employed by the relevant health board who directly supervise the training of the trainee concerned.

30 *Entry to a training programme*

37. Entry to a training programme is through open competition. There are four regional programmes available in anaesthetics in each of the four Deanery regions referred to above.

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38. A trainee who is successful in obtaining a place on a programme is awarded a National Training Number ("NTN") by the first respondent. The number is unique to the trainee concerned and will be held by them for as long as that trainee remains in specialty training, or is out of that program on a basis agreed by the Postgraduate Dean. A doctor who is not on a training programme, or who has not completed a training programme, can accumulate experience sufficient to attain entry to the specialist register in other ways.

Employment during a training programme

39. A training programme is made up of a number of placements in various hospitals. Those hospitals are likely to be in more than one health board area. Fixed term contracts of employment are offered by the relevant health boards for each placement. The contract of employment for a placement which is part of a specialty training programme is dependent upon the employee holding an NTN.

Assessment of progression through a training programme

40. The basis upon which progression through a training programme is to be assessed is set out in the "Gold Guide", already referred to above. At paragraph 7.11 it states that, "a trainee's progress in their training programme is assessed using a range of defined and validated assessment tools, along with professional and triangulated judgments about the trainee's rate of progress. A review (ARCP) results in an "outcome" following evaluation of the written evidence of progress and determines the next steps for the trainee. A satisfactory outcome confirms that the required competences, together with ongoing conformance with the GMC's good medical practice have been achieved." "ARCP" is an acronym standing for "Annual Review of Competence Progression".

41. The ARCP considers evidence provided by the trainee and from those involved in their training. It can include direct observation of procedural skills, case note reviews, case-based discussions, multi-source feedback (commonly abbreviated to "MSF"), observed video assessment, assessment in clinical skills facilities, clinical evaluation exercises, direct observation of non-clinical skills, self-reflective learning logs and consideration of logbooks, audit projects, and any

publications and research carried out by the trainee.

42. Where an unsatisfactory outcome has been indicated as a possibility by the TPD or ES then the trainee is to be informed of that prior to the meeting with the ARCP panel. The purpose of the meeting is to discuss the recommendation which is to be made. That may be for additional training, additional training time, or for removal of the national training number ("NTN").

43. The ARCP can lead to 8 possible outcomes, and each of them is commonly abbreviated to, for example "Outcome 1". The details are listed in a box immediately following paragraph 7.80 of the Gold Guide. We will list each of them in order:

43.1. Satisfactory progress – achieving progress and the development of competences at the expected rate.

43.2. Development of specific competences required - additional training time not required.

43.3. Inadequate progress – additional training time required.

43.4. Released from training programme – with or without specified competences.

43.5. Incomplete evidence presented – additional training time may be required.

43.6. Recommendation for completion of training – gained all required competences – will be recommended as having completed the training programme and for the award of a certificate of completion of training ("CCT") or equivalent.

43.7. Outcomes for trainees in fixed term training posts and OOP. This is subdivided into four parts, but since none of them are relevant to this case we will not list them.

43.8. Out of programme for clinical experience, research or career break. We will not list further details since this has no relevance to the present case.

Recommendation by ARCP of Outcome 4 – removal from training programme

44. When an ARCP recommends the removal of a trainee from a training programme that is confirmed to the trainee and the Postgraduate Dean is notified. The national training number ("NTN") will be removed on the date of notification to the Postgraduate Dean unless there is an appeal. Where the trainee appeals the Postgraduate Dean will refrain from signing off the outcome documentation from the original ARCP panel until after the appeal process has been completed.

The role of the Anaesthetist

45. The statement of agreed facts included more than a side of facts concerning the role of an anaesthetist, all of which derive from "Who is the anaesthetist?" (fifth edition) published by the Association of the Anaesthetists of Great Britain and Northern Ireland. We will set them out in detail because they are part of the essential background to the assessment of the claimant's competence and progress during training.

    a. The core activity is providing anaesthesia for surgery, which straddles ages and pathologies.
    b. Safe care of patients in theatre starts with a thorough preoperative assessment.
    c. Pre-assessment enables the anaesthetist to establish a rapport with the patient and to identify any potential anaesthetic difficulty or pre-existing medical conditions. Some patients will require further investigation and optimisation pre-operatively and may involve anaesthetic-led advanced physiology testing or expert advice from other specialities. Having ascertained the necessary information, it is possible to quantify the risks of surgery and therefore formulate an appropriate management plan to provide the safest possible care. This may be very straightforward for healthy individuals having minor operations but can be extremely complex for unwell patients undergoing major surgery. Anaesthetists are responsible for explaining such risks to a patient and outlining the proposed management

plan.

d. The choice of anaesthetic management for a particular case is often not clear-cut and there may be a number of possible options available to safely facilitate surgery.

5 e. In theatre the anaesthetist becomes the patient's carer and safety is paramount. Control of the patient's airway, breathing and circulation are of particular importance. Close attention is paid to the patient's condition during surgery and the anaesthetic tailored to each individual.

f. At the end of the procedure the anaesthetist is responsible for ensuring full 10 recovery from anaesthesia in a safe environment and ensuring adequate analgesia.

g. Anaesthetists are responsible for planning and facilitating effective and safe post-operative care. This may require post-operative ventilation on the intensive care unit, topping up an epidural, or planning discharge medications 15 for a day case patient.

h. The majority of anaesthetists are responsible for a wide variety of theatre cases, from fit people to major complex vascular surgery in sick elderly patients. Many anaesthetists also have one or more sub-specialty interests, which further enhances the breadth of their clinical work.

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Anaesthesia training programme

46. In order to achieve a Certificate of Completion of Training ("CCT") an anaesthetic trainee must complete a programme of training which is prescribed by the Royal 25 College of Anaesthetists and approved by the GMC. The requirements in place when the claimant began specialty training are set out in a document titled, "Anaesthesia Training Programme 2010" issued by the Royal College.

47. The program is split into Basic, Intermediate, Higher and Advanced training.

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a. In order to progress from Basic to Intermediate training a trainee must complete a number of units of training and pass the primary FRCA exam and be issued with a Basic Level Training Certificate.

b. Intermediate training requires further units of training to be successfully completed and for the trainee to pass the final FRCA exam and be issued with an Intermediate Level Training Certificate.

c. Higher and advanced training requires successful completion of further units of training.

48. Successful progression through training requires a trainee to develop both technical and non-technical skills.

The claimant's placements

49. The claimant's placements throughout core and specialty training are listed in the statement of agreed facts. NHS employment is deemed to be continuous in the claimant's case from 5th August 2009. The placements undertaken were mainly within the NHS Lothian Health Board area but also on one occasion with NHS Fife and on another occasion with NHS Borders.

a. 25th July 2007 until 4th August 2009: foundation training, Yorkshire.
b. 5th August 2009 until November 2009: intensive care medicine, Western General Hospital (Edinburgh), NHS Lothian.
c. 4th November 2009 until 3rd August 2010: anaesthetics, Western General Hospital (Edinburgh), NHS Lothian.
d. 3rd or 4th August 2010 until 1 February 2011: rotated to NHS Fife.
e. 2nd February 2011 to 2nd August 2011: CT2 anaesthetics, NHS Lothian.
f. 28th March 2011 until 13th December 2011: maternity leave.
g. 13th December 2011 until 3rd June 2012: anaesthetics, NHS Lothian.
h. 1st August 2012 until 5th February 2013: CT2+, NHS Borders.
i. 2nd or 7th January 2013 until 31st March 2013: STR paediatric anaesthesia the Royal Hospital for Sick Children (Edinburgh), colloquially known as "the Sick Kids", NHS Lothian.
j. 7th August 2013 until 6th August 2014 SP trainee at Royal Infirmary of

Edinburgh, NHS Lothian.

k. 11th September 2014 until 12th April 2015, maternity leave.
l. 5th August 2015 until 3rd January 2016 rotated to St John's Hospital (Livingston), NHS Lothian.
m. 5th January 2016 until 1st May 2016 rotated to Royal Infirmary of Edinburgh, NHS Lothian.
n. 3rd May 2016 until 2nd August 2016: rotated to Western General Hospital (Edinburgh), NHS Lothian.
o. 3rd August 2016 until 4th December 2016: Western General Hospital (Edinburgh), NHS Lothian.
p. 5th December 2016 until 14th August 2017: Western General Hospital (Edinburgh), NHS Lothian.

Chronological progress of the claimant's training

50. It is not necessary for us to set out every detail of the claimant's progression as a trainee anaesthetist. We will confine ourselves to the most important events for the purposes of the claims we have to decide.

51. On 10th August 2012 Anne McCrae, consultant anaesthetist at the Royal Infirmary of Edinburgh, sent an email of concern to David Semple. Her view was that the claimant was not cut out for a career in anaesthesia. The concern centred on the claimant's clinical competence and attitude. The claimant had approached Dr McCrae for MSF comments but had not pursued that approach once Dr McCrae had indicated that she would feel obliged to put negative comments in that document. Dr McCrae also referred to the experience of another anaesthetist who had felt obliged to intervene when the claimant had struggled to intubate a patient causing that patient to desaturate. Dr McCrae was concerned that the claimant appeared easily stressed and/or distracted, and lacked awareness of the urgency of emergency situations. She found the claimant strange to talk to in that the claimant either closed her eyes looked at the ceiling behind the speaker's head. Dr McCrae had noted multiple scars of self-harm on the claimant's forearms.

52. In the months that followed the claimant re-sat and passed a required exam, gained a basic level certificate of competence and on 21st November 2012 received an ARCP outcome 1, indicating that she had achieved progress and competences at the expected rate.

53. Carolyn Smith, placement supervisor, prepared a report on the claimant's placement between January and March 2013. It is noted an improvement in clinical knowledge, a general improvement in technical skills but a mixed picture so far as feedback on non-technical skills was concerned. Some theatre staff expressed concerns that they did not feel confident of the claimant's ability to cope in a crisis or when things did not go according to plan. Communication skills were felt, on occasion, to be sub-optimal. Two critical incidents were documented. The first was felt to demonstrate a failure by the claimant to appreciate the nature of the problem causing a delay in the appropriate management of that problem. Although it could have resulted in a more serious outcome there were no untoward consequences. The second incident concerned a decision in relation to an injection which was probably inappropriate, not discussed with the consultant on-call, not properly documented and not checked by other staff. However, once again there were no adverse consequences. In summary, the suggestion was that the claimant needed to work at improving her spatial awareness and her planning for the unpredictable, that she needed to ensure clear logical communication with theatre staff, and that she needed to ask for help when she encountered the unfamiliar. She needed to gain the confidence and skills required to deal with any unexpected crisis.

54. The claimant nevertheless completed her unit of training in paediatric anaesthesia successfully, gaining a sign off on 12th April 2013. The narrative sections noted that the claimant had initially been quite apprehensive but had gradually improved in confidence. She was felt to be a pleasant trainee who interacted with patients and parents well. It was felt that her situational awareness needed to improve by being more aware of what was happening and by planning for the unexpected. In unusual situations communication in advance with senior colleagues was recommended.

55. On 7th June 2013 the claimant received an ARCP Outcome 5 – incomplete evidence presented, additional training time may be required.

56. The claimant satisfactorily completed training in cardiothoracic anaesthesia on 2nd August 2013. Assessor comments stated that clinical skills and knowledge were at a level appropriate for the stage of training. There were no criticisms of non-clinical skills.

57. On 12th September 2013 Dr David Swann, consultant anaesthetist at the Royal Infirmary of Edinburgh, sent a letter highly critical of the claimant to Carl Moores who had then recently been appointed as the claimant's Educational Supervisor. Dr Swann wished to document his concerns about the claimant's clinical abilities since he felt that the system of trainee assessment had some selection bias towards positive reporting. He gave an example of working with the claimant on an operating list on 11th September 2013 (the previous day) on which the claimant had failed to check important details relating to cardiac medication and had acted on assumptions. Throughout the day the claimant had performed tasks well below the standard Dr Swann expected from a third year specialist trainee. Her assessment of patients' anatomy, positioning and needle approach during lumbar punctures was felt to be poor. She failed to connect a breathing circuit adequately after transferring a patient to theatre and failed to notice a disconnect. Later, she failed to notice another disconnect.

58. In evidence at the tribunal hearing the claimant stated that she attended an appointment with Dr Steel, her treating consultant psychiatrist, on 2nd October 2013. He advised the claimant to stay at work. Given that a critical incident occurred two days later (see below) this was understandably explored in cross-examination. The claimant did not accept the suggestion that this demonstrated that she was unable to recognise when she should not be working due to illness. During cross-examination by Mr Truscott QC the claimant said that she *could* identify when she was ill or potentially ill and that in those situations she sought appropriate advice, which she had done in this case and had followed that advice. When the same topic was explored further in cross-examination by Mr

Fairley QC the claimant eventually accepted that Dr Steel must simply have failed to identify the risk to patients caused by her condition.

59. On 4th October 2013 the claimant was involved in a critical incident which resulted in Dr Heidemann, Clinical Director Anaesthesia, Theatres and Pain Medicine, deciding that she should be removed from unsupervised training slots. That decision was based on the concerns of two different consultant colleagues (confirmed in evidence to be Drs Swann and Leeson-Payne) as well as undocumented anecdotal evidence of a near miss in obstetric anaesthesia.

60. The incident on 4th October 2013 concerned a patient in Dr Leeson-Payne's list. He returned to the anaesthetic room of a particular operating theatre to start the provision of anaesthesia for that day's orthopaedic trauma list. He observed that the claimant had already begun anaesthetising the first patient. The patient was severely centrally cyanosed with an oxygen saturation of less than 70%. The patient was evidently inadequately anaesthetised. A new locum consultant was also present purely in an observational capacity and was not involved in the care of the patient. Dr Leeson-Payne took over and regained control by administering another drug and managing the airway. The condition of the patient very quickly improved and oxygen saturation returned to above 95% very quickly. There were no further difficulties.

61. Dr Leeson-Payne concluded that by a series of actions the claimant had severely compromised the safety of a high-risk patient undergoing trauma-related surgery. She had also put several other members of theatre staff and the visiting locum consultant present in an observational capacity in an extremely awkward position. They had felt unwilling to contradict the claimant's suggestions. Dr Leeson-Payne stated that the greatest concerns with implications for the claimant's continued practice in anaesthesia were:

61.1. a failure to communicate with him as the consultant anaesthetist, with other theatre staff or with the patient;

61.2. a lack of insight regarding communication, patient assessment and potential difficulties, interactions with staff and failure to use the immediate

opportunity to offer any personal reasons for gross omissions or lapses of reason or logic;

61.3. inadequate assessment or processing of information collected from the patient.

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61.4. In summary, he considered all of that to be totally inadequate at the ST3 level of training in anaesthesia.

62. The incident was investigated and the report concluded that the claimant had failed to identify patient risk factors during pre-anaesthetic assessment, had commenced anaesthesia without adequate awareness of potential complications, and had failed to communicate effectively with the nominated consultant for the list, the staff in the anaesthetic room and the patient. The main recommendation was that the claimant had not performed at a level appropriate to her grade and had potentially caused harm to a patient. The investigation team did not consider that she should work at that grade unsupervised until "her competency could be confirmed and any mitigating factors redressed". The investigation team also noted that use of the departmental pre-list briefing, introduced since the incident, might have prevented it. One of the recommendations was for individual support for the claimant.

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63. The claimant does not accept that Dr Leeson-Payne's account of the incident is entirely accurate. She also contends that she wanted to do exactly what Dr Leeson-Payne eventually did but found it difficult to tell the observer, Dr Snell, that she thought he was wrong. However, the claimant accepted in cross-examination by Mr Truscott QC that she "did not perform at all well". She agreed that the situation had been very serious and that the patient could have died. She agreed that aspects of her judgment were called into question. When cross-examined by Mr Fairley QC on the same incident the claimant acknowledged that her performance had been adversely affected by a lack of confidence and assertiveness, which she attributed to her illness.

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64. The claimant commenced a period of sick leave immediately after the critical incident on 4th October 2013. The subsequent occupational health referral dated

30th October 2013 notes the reason for absence as "depression". That reason was confirmed by the claimant in her evidence. The referral asked a number of questions arranged in tick box format, one of which was, "does a condition exist that could be referred as a disability under the DDA?".

65. The occupational health report subsequently obtained from Dr Kalman was dated 28th November 2013. It noted that the critical incident had left the claimant very distressed. The report also observed that the author would be, "*very surprised if [the claimant's] colleagues and co-workers had not recognised that her health had been below optimum for some time before this incident actually occurred.*" The claimant was not fit for work at the time of writing but Dr Kalman was optimistic regarding the chances of improvement. The report conspicuously fails to answer the question posed in the referral regarding disability.

66. On 16th December 2013 Dr Brian Cook, Associate Medical Director, Critical Care, Anaesthesia and Theatres, NHS Lothian, wrote to the claimant to describe the processes that would be followed in order to resolve a number of outstanding issues. It dealt with the claimant's absence, a disciplinary investigation into allegations of inappropriate access to the claimant's daughter's medical records, a grievance and employment tribunal claim regarding the claimant's banding while working at the Royal Hospital for Sick Children, concerns over competence and the need to develop an appropriate action plan and, finally, an investigation into the incident which had occurred on 4th October 2013. As regards the competence concerns, Dr Cook wished to meet with the claimant and her Educational Supervisor upon her return to work in order to establish the background to the concerns and to develop an action plan in order to move forward. Dr Cook had also requested the assistance of Dr Rhiannon Pugh, Associate Postgraduate Dean, in developing that action plan.

67. On 19th December 2013 the claimant contacted Dr Rhiannon Pugh seeking a meeting. The claimant said that she was currently on sick leave but desperate to return to work. She felt fit enough to attend a meeting and that the resolution of issues might be of benefit to her health. She was concerned to develop a plan to meet concerns expressed about her clinical competence. Dr Pugh's reply dated

23rd December 2013 was to the effect that she did not think it would be helpful to meet at that stage. Dr Cook's letter of 16th December 2013 (see above) had outlined a number of actions for the claimant to take and Dr Pugh recommended that the claimant followed through those suggestions.

68. A further occupational health report was obtained from Dr Kalman dated 7th January 2014. Dr Kalman had reviewed the claimant, a little later than planned, that day. A "very real improvement" in the claimant's condition was noted over the previous six weeks or so. Dr Kalman endorsed the cancellation of arrangements for the claimant to move to St John's as "a sensible way forward". Dr Kalman considered that some assessment of competence upon return to work would be of assistance to the claimant as well as to NHS Lothian, stating, "*I would be very surprised if the extent of her ill-health over the last two months had not affected you and her colleagues' perception of her.*" The claimant was considered fit enough to meet with the second respondent to discuss a return to work programme and to return to work once that program had been identified. A continued improvement in health over the next few weeks and months was expected. A phased return to work was recommended.

69. A return to work meeting was held on 4th February 2014. It was attended by the claimant, Dr Brian Cook (Associate Medical Director, Critical Care, Anaesthesia and Theatres), Dr Carl Moores (the claimant's Educational Supervisor) and Mrs Jackie Houston (head of the relevant section of HR). The key points discussed are noted in a subsequent letter dated 6th February 2014.

70. The meeting discussed not only the concerns about the claimant's practice but also the support structures and programmes which could be put in place to assist her. The findings of the investigation into the critical incident were discussed with the claimant. So was the occupational health opinion of Dr Kalman. A phased return to work programme was agreed. The claimant would be working under the supervision of a small group of consultants appointed to support her. The four consultants concerned were identified in the letter. There would be a period of assessment based around "back to basics" and the beginning of the ST3 training programme. There would be workplace assessments and reviews of those

workplace-based assessments, communications, decision-making and planning as well as the use of the online assessment system. It was stressed that it would be vital for the claimant to engage with that process and it was noted that an ARCP was due in May or June. There would be a significant amount of assessment prior to that date. The claimant stated that she had not been informed about the issues of concern in detail and it became clear that she had not received a copy of Dr Swann's letter of 12th September 2013 (above). A copy was therefore enclosed with Dr Cook's letter of 6th February 2014. Mrs Houston expressed a concern that the claimant did not appear to be engaging with the process. When the claimant asked for clarification Mrs Houston explained that she was not making eye contact with any of the others present, her body language was closed and she was not participating in the discussions about the process being put in place. In her evidence to us the claimant said that she probably displayed those characteristics because although well enough to be back at work, she was not completely well. A return to work date of 11th February 2014 was agreed (the reference to 2013 is clearly an error).

71. The claimant replied to that letter and its enclosures in a lengthy email sent on 16th February 2014. She made a number of points in relation to the investigation report. In the final line of the first long paragraph the claimant stated, "*it became clear to me on that day that my ill-health was clearly having an impact on my performance at work, which made me seek immediate advice from suitably qualified colleagues, as advised in the GMC's Good Medical Practice Domain 2 paragraph 28*". The claimant went on to make certain comments in relation to Dr Swann's letter. On the second page of the email the claimant stated, "*particularly because of this disability, I would very much appreciate discussion of any performance that is viewed as below satisfactory as soon as possible, so I can be aware of this, and consider if health, or other issues need addressing. The first I knew of any details of Dr Swann's letter (or who indeed had raised concerns) was when I met with Dr Moores, at my request, in December 2013*". It is not necessary for present purposes to summarise any of the rest of the email.

72. A further occupational health review took place on 4th March 2014 and Dr Kalman

produced a report of the same date. The claimant had by then been back at work for about three weeks. The opinion was that the claimant's health had continued to improve and that the return to work had been of real benefit to the claimant. The expectation was that the claimant's health would continue to improve. Dr Kalman nevertheless emphasised that, "*there is absolutely no doubt that her health was substantially impaired for some months before the incident, and I would be very surprised if colleagues had not noticed this. I think this undoubtedly has a bearing on her work performance during that time.*" Dr Kalman asked for a managerial report of the claimant's performance prior to the next review in 8 to 10 weeks' time.

73. Dr Heidemann met with the claimant on 12th March 2014 to carry out an informal review of the phased return to work. He subsequently noted in an email to Dr Semple a concern that the claimant had not made eye contact at any stage during that meeting.

74. In March 2014 the claimant failed the final FRCA written exam and therefore needed to retake it.

75. On 25th March 2014 a meeting took place to review formally the claimant's progress since her return to work. The minutes are effectively contained in a subsequent letter from Dr Brian Cook (Associate Medical Director) dated 11th April 2014. He was accompanied at that meeting by Dr Carl Moores (the Claimant's educational supervisor) and Mrs Jackie Houston head of HR. The claimant was accompanied by a colleague Dr Stuart.

76. The claimant's view was that she had been doing "fine" and that there was nothing else she could think of to say. About a dozen workplace assessments had been carried out. The claimant had only taken one day of sick leave in addition to some study leave. The claimant had, as planned, been working with a small group of consultants including Dr Moores. Dr Moores observed that he would expect someone at the claimant's level to be able to work unsupervised and that he had asked the consultants for feedback on the claimant's performance. While everyone had positive things to say about the claimant's

manner with patients and punctuality there were some negative issues. One of them was a consistent report that the claimant's airway skills were not at the expected level. Another was a concern about situational awareness and a lack of engagement. Dr Moores emphasised the importance of progressing matters bearing in mind the forthcoming ARCP in May or June. He did not think that the claimant could be put on the on-call rota at that time but would give consideration to early evening work and trauma in order to enable the claimant to achieve competences for the ARCP, including airway type lists. Dr Moores emphasised the "duty of safety", which we take to mean the duty to ensure patient safety. It was agreed that there would be a further meeting to review progress prior to the ARCP.

77. On 4th April 2014 a further meeting took place between the claimant and Dr Carl Moores. The purpose was to review the claimant's progress in the six weeks or so which had passed since her return to work following sick leave. The claimant said that she did not like working in the Royal Infirmary Edinburgh but did not know why that was. Dr Moores pointed out that because of the restrictions on the claimant's practice, and the fact that she was not allowed to work alone or therefore on the on-call rota, she would not be permitted to work at a smaller hospital. He had spoken to all of the consultants involved in supervising the claimant and all had said that they would not be happy with her working without immediate supervision. Two particular areas of concern were highlighted: airways and non-technical skills. In relation to the latter, there was a consistent report from supervising consultants of a lack of engagement on the claimant's part. She appeared to take no interest in the operating list or the current operation. Dr Moores gave an example from his own experience, pointing out that the claimant tended not to speak or even to look at other members of the theatre team which he felt could be an issue for patient safety. He also noted on one occasion a lack of motivation to rescue the situation when a line failed to insert quickly. Dr Moores was concerned whether the claimant would have enough situational awareness during an operating list and whether she would respond appropriately to an emergency situation if she were working alone. Given her stage of training he regarded that as a worrying situation and asked

the claimant whether she had considered training in another medical specialty. The claimant made it very clear that she would rather give up medicine than switch specialty. The claimant asked how she could in future show that she was engaging fully with the theatre list and theatre team. Dr Moores pointed out some of the behaviours normally expected of a trainee at the claimant's level although they are not listed in the summary of the meeting.

78. On 9th April 2014 the claimant telephoned Dr Semple. The claimant wanted to change hospital to move away from the Royal Infirmary Edinburgh. She also wanted to change deanery. Neither was possible. The claimant made it clear that she wished to stay in anaesthesia. The claimant's view was that everyone at the Royal Infirmary thought that she was "rubbish" and would not let her progress. That is why she wished to change location and mentioned that she would "go off sick before ARCP".

79. On 15th April 2014 Dr David Semple sent an email to (among others) Dr Rhiannon Pugh, Professor Reid and Dr Kirsteen Brown with the subject "[Claimant] – confidential". In it he stated a view that there was, "*little point in revisiting previously tried remedial efforts and it is difficult to see how she can progress with a career in anaesthesia (her stated wish and not willing to consider alternatives)*". He went on to state that, "*the Service will be approaching us very soon with lists of 'difficulties' some of which are irremediable*".

80. On 16th April 2014 the claimant emailed Carl Moores taking issue with a number of criticisms of her technical skills but also asking, in relation to non-technical skills, "*if you could please give me any further suggestions of behaviours I should be displaying*". The claimant also stated that although she was well enough to return to work, she was "*not 100% well*". Although the claimant said in her evidence to us that she was intending to make a link between perceived shortcomings in her performance and her ill health, we do not think that is obvious from the terms of the email.

81. At around that time the claimant took a week of annual leave followed by a period of compassionate/sick leave as a result of the tragic and unexpected death of

her brother-in-law.

82. On 2nd May 2014 a meeting took place between Dr Kirsteen Brown, Dr David Semple and Dr Rhiannon Pugh. Notes effectively appear in subsequent emails between the three of them dated 6th May 2014 and 19th June 2014. The purpose was to discuss a training support plan for the claimant. It was as follows. The claimant should complete a piece of reflective practice every week detailing what she had learned or gained from that week. There should be no change in clinical or educational supervisors and the claimant was not allowed to request a change. The supervisors should complete regular assessments of the claimant's performance. The claimant should undergo very regular MSFs at a monthly frequency. SESSA should be giving the claimant specific plans for training and the competences to be achieved. The claimant should go to the "simulator centre" for assessment, probably after return from maternity leave, and should take an independent support consultant as a mentor. The claimant should attend a specific communications course run by Kirsty Boyd on behalf of the first respondent. The claimant should also meet with Jane Montgomery for careers advice. There should be continued involvement with occupational health regarding the claimant's ability to undertake work and to perform her job as required.

83. On 14th May 2014 the claimant was seen by Dr Kalman of Occupational Health, who considered the claimant fit enough to return to her previous duties. The claimant remained under specialist care and her health was "reasonable" overall.

84. On 16th May 2014 Dr Cook emailed Dr Semple to inform him of "actions in support of [the Claimant]." Drs Cook, Moores and Semple would meet with the claimant in the next couple of weeks to outline plans of support ahead of an ARCP at which the outcome would be 3 (failure to progress). Plans were in place for further close support and assessment after that including a simulator session to examine situational awareness. It was possible that the claimant would be moved onto another part of the rotation in the coming months with a clear brief, advice and support.

85. The simulator session referred to was never arranged.

86. The anticipated ARCP was conducted on 12th June 2014. The claimant was awarded an Outcome 3, although it appears that Outcome 1 had originally been ticked but had then been scribbled out. We are satisfied that this alteration must have been because of a simple mistake, given that an Outcome 3 had been anticipated in the email of 16th May 2014. The detailed reasons for the Outcome 3 were, "*currently off training programme due to patient safety concerns*" and "*awaiting paperwork*". The recommended actions were that the claimant should return to the intermediate training rota, conduct frequent MSFs and reflective practice, attend a communication course and also an airway course. The box for "recommended additional training time" was left blank. So was the box for "mitigating circumstances", which were not discussed. The paperwork was signed by Dr David Semple as chair of the panel. Other panel members were Dr Kirsteen Brown and three others.

87. The claimant believes that although the purpose of an Outcome 3 was to give her additional training time, she did not in fact receive any additional training time.

88. Once the result of the ARCP was known Dr Kirsteen Brown emailed Dr Semple on 19th June 2014, copied to Dr Rhiannon Pugh, referring to the training support plan agreed on 2nd May 2014 and asking whether some of that plan should be commenced immediately or whether it should wait for the claimant's return from maternity leave.

89. An action plan was issued on 26th June 2014 along the lines anticipated in previous emails. It had 11 numbered points.

    89.1. The claimant should return to the on-call rota immediately, probably on Tuesday to Thursday nights having regard to the presence of the resident consultant, or weekend days.

    89.2. The claimant should organise some days at particular hospitals to refresh core skills in airways and obstetrics.

    89.3. The claimant would remain at the Royal Infirmary Edinburgh both prior

to and immediately after maternity leave. After that she would undertake intermediate level training at 80% of whole time equivalent. Progress would be reviewed monthly.

89.4. Attempts would be made to organise a communication course such as that organised by Dr K Boyd.

89.5. The claimant should meet Dr Montgomery for careers advice and mentoring as required.

89.6. Dr Moores would maintain the educational supervisor relationship, nominating supervising consultants and so on.

89.7. The claimant would maintain a brief reflective log for each week's training, recording what had gone well, what had gone less well, useful training and experience.

89.8. The claimant would complete a MSF prior to going on maternity leave and once settled on her return would complete MSFs regularly every one or two months.

89.9. The claimant would have an ARCP arranged upon return from maternity leave.

89.10. The Scottish Simulator Centre would organise a day's course in relation to the evaluation of non-technical skills once the claimant was comfortable upon her return to clinical practice.

89.11. The Anaesthesia Service via Dr Heidemann would remain fully involved in these developments.

90. On 2nd July 2014 Dr Ashish Satapathy set out in email form concerns that he had already communicated orally to Dr Moores. He had supervised the claimant a few times in the previous few months. His areas of concern were that while the claimant performed acceptably with straightforward procedures she struggled when the primary plan failed. He found her unreceptive to suggestions and had seen her make the same mistake again, probably having not paid attention when corrected the first time around. On one occasion the claimant had ignored Dr Satapathy's instructions and had proceeded to perform a difficult procedure without supervision with potentially disastrous complications. The claimant had good days when she interacted with people and did everything right but on other

days she could be a complete recluse. Her level of confidence varied dramatically from day to day. Theatre staff had found her to be rude and unpredictable. The email concludes, "*I don't know if she has any personal issues but certainly something is affecting her work and demeanour whilst at work. I hope whatever issues she has gets sorted soon*."

91. In cross-examination the claimant acknowledged that she had not been progressing especially well at that time and attributed the difficulties to her inability to take her normal anti-depressant medication due to pregnancy. We find that Dr Satapathy's concerns were well-founded.

92. On 15th July 2014 Dr Kalman produced a further occupational health report based on an assessment of the claimant carried out on 11th July 2014. Dr Kalman continued to believe that the claimant was fit for work. He suggested that her on-call commitment should be limited to a maximum of 48 hours per week during the remainder of her pregnancy.

93. In September 2014 the claimant once again failed the final FRCA written examination.

94. The claimant's maternity leave commenced on 11th September 2014. Shortly after that, on 18th September 2014, the claimant emailed Dr Semple asking him to give specific details of the reasons why she was perceived not to be working at an appropriate level.

95. The claimant returned to work from maternity leave on 25th May 2015 on an 80% of whole-time equivalent basis. Another ARCP was due in November. The claimant was considered ready to return to on-call work.

96. The claimant successfully completed her obstetric placement in early August 2015. Dr Arlene Wise said in an email to the claimant, "*we have all been impressed with how you have conducted yourself and performed clinically – a big well done!"*

97. The assessor comments in the sign off document noted that the claimant had consolidated the improvement seen and made the previous year. That was contrasted with initial concerns dating back to 2013 about poor decision-making, poor situational awareness and poor engagement with staff and patients. By 2015 the claimant was "much improved" to the point that there were no longer concerns about signing off her training. The claimant had been extremely proactive in her approach to getting things sorted out. She had been open to all suggestions and comments and had done her best to remedy what had been a difficult situation. During the most recent attachment in 2015 the consultant body had found her to be functioning at a level appropriate for her stage of training and in particular demonstrating good communication skills and being much more engaged with the clinical team. Specific significant improvements were noted in terms of eye contact, mood and confidence. The claimant had regained clinical confidence and needed to retain that.

98. The claimant then rotated to St John's Hospital with effect from 5th August 2015. Consultant feedback was largely positive but more than one person suggested that she seemed to be lacking in confidence and to have low self-esteem. One consultant added that she should not lack confidence since there was no evidence to justify that lack of confidence. The claimant had failed the most recent exam resit in September 2015 and was running out of opportunities to retake it. It was hoped that she would pass at the next and final opportunity to re-take.

99. The claimant attended a communication course called "communication challenges in clinical practice" on 2nd and 3rd September 2015.

100. The intended ARCP on 17th November 2015 was changed in status to an "interim review", signed off later that month. Dr Moore's comments were that the claimant's main aim should be to pass the FRCA exam. He noted that while concerns had been raised about the claimant's performance prior to her maternity leave, since the claimant's return from maternity leave he had noticed a considerable improvement. He thought the claimant had been very much more focused, much more willing to help with the list and very much more

communicative. The positive feedback from St John's Hospital was also noted. The comments of college tutor Clare Gardner were that the claimant seemed very under confident and apologetic. It was noted that she was preparing to sit the exam for the final time.

101. On 6th January 2016 the claimant began a rotation in intensive care medicine at the Royal infirmary Edinburgh.

102. In March 2016 the claimant was successful in the final FRCA written examination.

103. The period of training in intensive care medicine was successfully completed by 22nd April 2016. The comments section stated that the claimant had demonstrated adequate competencies for her stage of training. There had been a considerable time since the previous attachment to intensive care medicine and the claimant's confidence had improved over the duration of the latest attachment.

104. In the meantime, on 13th April 2016, a meeting had taken place between Dr Kirsteen Brown, Professor William Reed, Dr Marson and Dr Semple to discuss the "lack of progression in training of [the claimant]". That meeting is minuted in an email of the same date. The claimant had not been invited. It was noted that the claimant had been on an Outcome 3 since June 2014. That remedial extension to her training would continue until her ARCP on 14th June 2016. The meeting discussed "attached evidence" of the claimant's career timeline, portfolio evidence, non-technical reasons for a lack of demonstrated progression and other issues. It was agreed during the meeting that in the absence of other new evidence being presented the claimant would receive an Outcome 4 from the ARCP panel in June and would lose her training number. That would be due to a lack of demonstrated progression towards an acceptable completion of intermediate training. The claimant would not be supported in a return to anaesthetic practice (including locum work) should she pass the FRCA exam.

105. On 7th June 2016 a meeting took place between the claimant, Dr Kirsteen

Brown (Training Programme Director) and Dr Debbie Morley (consultant anaesthetist and the claimant's previous college tutor). We have seen handwritten notes of that meeting and it was also briefly summarised in an email to the claimant of the same date.

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105.1. Dr Kirsteen Brown told the claimant that the ARCP in November 2015 had been treated instead as an interim review because it was neither possible to give her an Outcome 1 nor to extend her Outcome 3.

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105.2. Dr Kirsteen Brown's view was that the claimant had spent 20 months on an Outcome 3 (15 months at Specialty Trainee level and five months during Core Training) which could not be extended further given that the maximum in any program was normally 12 months, or up to 24 months at the discretion of the Postgraduate Dean.

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105.3. The claimant was told that she would need to get an Outcome 1 or an Outcome 4 the following week. In order to get an Outcome 1 she would have to show that she had completed intermediate training.

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105.4. The claimant was shown a timeline suggesting that she had then completed 23.5 months of Intermediate Training, which the claimant thought was correct. The claimant took away a copy of the timeline but did not refute any of the contents at the meeting. She subsequently confirmed that it was broadly accurate. However, the claimant observed that she would not have had any *additional* Intermediate Training time at all if the issue was whether she should or should not progress to Higher Training the following week. The claimant felt that an Outcome 3 ought necessarily to result in additional training time.

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105.5. There was some discussion of what the claimant would need to do in order to get an Outcome 1. In terms of curriculum requirements, there was no evidence that "Annex G" requirements had been fulfilled. There had not been any audit, presentation, quality improvement, publication or project activity either, and the claimant was told that the lack of that material might

make it difficult to give her an Outcome 1. The claimant subsequently replied saying that she did in fact have evidence of audits and quality improvement but that they were not recent because she had been focusing on exams. The claimant was prepared to do one in the near future if it would help.

105.6. The MSFs were both felt to be unsatisfactory in that there were insufficient returns and not enough returns from consultants. The amount of feedback was important as was the seniority of the sources of feedback. We find that the first respondent reasonably regarded the claimant's MSFs as deficient in those circumstances.

105.7. Concerns had been voiced that the claimant was not performing at the level of her peers. There were issues with communication, team working, prioritisation and anaesthetic plan formulation as well as situational awareness.

105.8. The claimant then stated that she could not attend the ARCP meeting for exam-related reasons. She was reminded of the importance of attendance given the possibility of an Outcome 4 but again said that she could not attend.

106. On 7th June 2016 Dr Deborah Morley emailed Dr Kirsteen Brown to raise a concern about the claimant. The email concerned an error in relation to vaporiser concentration which was not in itself unusual but which the claimant repeated on two more occasions during the same operating list. Dr Morley's concern was not the initial mistake or misjudgment but the fact that it was repeated despite intervention by Dr Morley.

107. On 8th June 2016 Dr Michael Robson emailed Dr Kirsteen Brown giving negative feedback on the claimant's handling of out of hours calls made to him as the on-call consultant. He was concerned that the claimant failed to articulate a clear account of the surgical management plan, timescale or anaesthetic requirements.

108. On 14th June 2016 the ARCP took place. The claimant received an Outcome 4, effectively recommending that she should be released from the training programme. The paperwork notes that the claimant had spent 20 months on an outcome 3 at the Postgraduate Dean's discretion and that despite multiple supportive interventions she had not progressed beyond the level of core training. There were serious concerns regarding situational awareness, a lack of communication skills and other non-technical skills which are vital to a career in anaesthesia. Those problems had been identified since starting core training and had persisted despite support. They were now regarded as "non-remediable". Under "recommended actions" the paperwork stated, "not suitable for a career in anaesthesia". Under "recommended additional training time (if required)" the report stated, "none".

109. On 21st June 2016 the claimant failed the final FRCA Structured Oral Examination.

110. On 24th June 2016 a meeting took place to inform the claimant formally of the award of an Outcome 4. Those present included Dr Lorna Marson (Associate Postgraduate Dean) and Professor William Reid (Postgraduate Dean). Professor Reid outlined the appeal process. Since the claimant wished to discuss the basis of the Outcome 4 decision Professor Reid decided that he would leave the meeting since he would be the first point of contact for any appeal.

111. The claimant took issue with the timings upon which comments in the ARCP form had been based. She disputed that she was at the end of intermediate training. The comment regarding communication skills and situational awareness did not tally with her own experience and feedback. The comments regarding an unsatisfactory MSF were not appropriate either because the number of assessors recommended by the Royal College had been provided and there was no rule that a minimum number of consultant assessors must provide evidence as part of an MSF. The MSF had also been approved by the claimant's Educational Supervisor prior to being sent. The claimant had taken part in audit, although not recently. The claimant felt that the form failed to reflect the progress she had made in the programme. The details of the placements noted in the form

were wrong. The claimant stated that she felt she had not had the requisite time on an outcome 3 to remedy her situation.

112. It was agreed that the claimant would submit an appeal to Professor Reid in due course. In the meantime, in the interests of the claimant and for patient safety, she could not work at ST4 level.

113. The claimant appealed under cover of a letter dated 27th June 2016. Briefly summarised, the grounds of appeal were as follows. The ARCP panel incorrectly proceeded on the basis that in order to award an Outcome 1 the claimant must have completed her intermediate training. The panel failed to consider the presented evidence. The panel failed to follow nationally agreed guidelines. There had been an inappropriate refusal to issue an ARCP outcome at the ARCP in November 2015. The claimant also advanced some potential explanations for slower progress than might have been expected. They included the serious ill-health and tragic death of her brother-in-law, her husband's diabetes and the fact that the claimant was a disabled person. The claimant said in a dedicated paragraph, "*As I am sure you are aware I have a disability as defined by the Equality Act 2010. Whilst I had three months of sick leave, I have also had to live with my disability throughout my training, which may have resulted in my training being slower than might have otherwise been expected.*"

114. In accordance with the procedure set out in the Gold Guide, the ARCP panel reconvened to review its own decision on 26th July 2016. The minutes are misleadingly headed "Outcome 4 ARCP Appeal Panel" but the appeal, properly so-called, came later. The panel appears to have considered whether an Outcome 5 could have been issued instead, before concluding that it would not have been an appropriate option given that the claimant had supplied evidence to the panel. Dr Kirsteen Brown also pointed out that the option of an Outcome 5 had not been suggested by Professor Reid during their April meeting. The panel also had patient safety concerns were the claimant to return to training.

115. There is only the briefest consideration of the claimant's disability. The notes state that "*KB was also unaware of [the claimant's] disability and was cleared fit*

for work by Occupational Health. It was agreed that it was the claimant's duty of care to inform Kirsteen Brown or David Semple of her circumstances to ensure she was not putting patients at risk which she did not." It therefore appears that the panel gave no real consideration to the question whether the claimant's disability might have been an explanation for slower progress than her peers and was instead focused on the claimant's obligation to inform others of her situation in order to avoid a risk to patient safety. In our judgment, those are two quite separate issues and the claimant's important argument about the relevance of disability to her rate of progression was overlooked.

116. The panel unanimously agreed that the Outcome 4 issued on 14th June 2016 should be upheld. In accordance with her entitlement under the procedure set out in the Gold Guide the claimant requested an appeal hearing before an independent panel. Her grounds are set out in a letter dated 6th August 2016 and included in the nine bullet points was, "*mitigating circumstances… and my disability*".

117. Dr Robby Steel, Consultant Psychiatrist, prepared a "to whom it may concern" letter dated 29th August 2016. The claimant had been under his care "on and off" since 2011. At her request he provided a summary of her psychiatric history, "*as this has undoubtedly had a bearing upon her progress through training.*" In summary, he describes depressive illness which had been regarded as a "recurrent depressive disorder" when the claimant was first referred to him in January 2011. In the penultimate paragraph he states,

"there is no doubt that [the claimant's] recurrent depressive disorder has had an impact on her progress through postgraduate training. It is well known that depression is associated with impairment of attention and cognition and some impact on academic performance is therefore inevitable. I strongly suspect that the depressive episode has played a role in [the claimant] failing postgraduate examinations. She has also had time off work with her illness and at other times has had to alter her work pattern on account of her depression. Taken together these will inevitably lead to slower progression through training. During the five years that [the claimant] was attending my clinic her depression varied from very

severe to complete remission. When [the claimant] was severely depressed her self-care was poor, she showed no eye contact and there was marked psychomotor retardation. When her depression was in full remission she was bright and cheerful and quite engaging with a sharp if somewhat dark sense of humour. There were other times when her depression was sufficiently mild that [the claimant], her occupational health physician Dr Chris Kalman and I all felt that she was clinically safe to work yet she came across as quiet and withdrawn, prone to self-criticism etc. I suspect that this will have been reflected in the feedback components of her E-portfolio."

118. During the employment tribunal hearing a specific issue arose regarding the redacted form in which Dr Steel's letter of 29th August 2016 was presented to the appeal panel. The claimant made the redactions. The appeal panel were unaware of the redacted content. We were shown a less redacted version, unavailable to the appeal panel. The remaining redactions in that version concerned the claimant's obstetric history and the respondents' representatives were happy to accept Mr Northall's assurance that nothing turned on them. For reference, the two versions were at pages 915-916 and 790-791 of volume 3 of the joint bundle of documents prepared for the employment tribunal hearing. The relevant redacted part is underlined in the following quotation:

> "*[the claimant] felt that she was being labelled as 'mentally ill' <u>and in a misguided attempt to disprove that label she discontinued her antidepressant medication and unilaterally discharged herself from my clinic</u>. Shortly after this her depression was sufficiently evident for her to be sent home from work and she contacted me requesting an urgent appointment.*"

119. We regard that as an extremely significant redaction which had an obvious bearing on the issues the appeal panel had to decide. By making that redaction, the claimant was seeking to prevent the appeal panel from learning that she had, several years earlier, made a "misguided" attempt to disprove her diagnosis of mental illness and had failed to adhere to her treatment regime, most likely to the detriment of her health and fitness to work. Not only did the incident itself call into

question the claimant's insight, judgment and ability to manage her own condition in accordance with expert advice, the much more recent decision to make the redactions called into question her candour and inclination to give a full, honest and accurate account of her history and state of health to the respondents. The claimant had put forward material which she considered helpful to her appeal but had suppressed material which tended to suggest poor decision making on her part, with implications both for her performance and patient safety. The fact that she suppressed that material also called into question whether she could be relied upon to give a full and accurate account of her state of health in the future. Honest and accurate self-reporting would be essential to the proper management of the claimant's recurrent depression and therefore to the avoidance of risks to patient safety.

120. We find that the claimant did all of that deliberately. Her initial response in cross-examination was that the letter might be interpreted inaccurately without further questioning. She appeared to think that it was the first respondent's responsibility to ask her about the redactions, or to seek that information in other ways. In fact, the panel did ask the claimant about the redactions but were misleadingly told that the redactions were all "personal matters" of no relevance to the appeal hearing (see internal page 7 of the appeal notes, page 844 in the tribunal bundle). We find that they certainly were personal matters, but they were also obviously relevant to the issues at the appeal hearing. That must also have been obvious to the claimant at the time. The claimant eventually agreed that she had kept information from the appeal panel and sought to justify that by alleging that the first respondent had been selective in their use of documents too.

121. Very similar points arise in relation to a redacted letter from Dr Steel to the claimant's GP Dr Buck dated 13th December 2013 (pages 920, 1554 and 1555). The whole of the second paragraph of the letter had been redacted and the second page was not provided to the appeal panel at all. The redacted paragraph related to the management and treatment of the claimant's mental health. The claimant's psychiatric history should have been fairly and squarely before the

appeal panel unedited. The claimant had raised the issue of disability as part of her appeal. The fact that it was "personal" did not justify its removal from the material before the panel. The second page of the letter also revealed that the claimant had decided to discontinue antidepressant medication during pregnancy against Dr Steel's advice. The claimant confirmed that this was not the same occasion as that referred to in Dr Steel's letter of 29th August 2016 (above). While it is right to observe that the claimant committed to more frequent psychiatric review while off that medication as a way of mitigating the impact of her decision, the quite separate decision to withhold that aspect of her history from the appeal panel suggests that the claimant could not be relied upon to give a full and candid account of her psychiatric condition and history.

122. Similar issues arise in relation to letters from Dr Steel to the GP Dr Buck dated 27th December 2013 (pages 917 and 1556) and 3rd February 2014 (pages 921-922 and 1557-1558). The claimant redacted passages concerning her psychiatric health and history.

123. The entirety of a letter from the GP Dr Buck to Dr Steel dated 22nd April 2014 (pages 901 and 1559) was obliterated save for "she said that she is currently working at the RIE and hating it as there is no support". The claimant removed all of the medical content, which included a note that she was showing many signs of low mood but did not wish to use a "sickline". Dr Buck therefore requested that Dr Steel should see the claimant urgently about her health and medication. All of that was redacted. We find that was most likely done deliberately in order to suppress evidence that the claimant was unwilling to be signed off sick at a time when her GP thought that an urgent referral to a consultant psychiatrist was necessary. Once again, the original incident suggests a lack of insight and judgment on the claimant's part, and the decision to redact references to it suggests that the claimant could not be relied upon to give a full account of her relevant medical history.

124. The first half of an email from Dr Steel to the claimant's GP dated 29th April 2014 (pages 913 and 1560) was also redacted. The redactions removed evidence that the claimant had taken annual leave rather than use a sick line

provided by the GP, and that there was clear evidence of a relapse of her recurrent depressive disorder. The claimant had agreed to recommence antidepressant medication, but the redaction of that passage hid the fact that she had previously ceased it.

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125. By this point in cross-examination the claimant accepted that she did not give a full explanation to the appeal panel for the redactions and had only given a full explanation at the tribunal hearing. Our finding mirrors the suggestion made by Mr Fairley QC in cross-examination that the claimant had sought to keep from
10 the first respondent that there were times when her condition had been unmedicated or unmanaged.

126. The appeal hearing took place on 15th September 2016 (the reference to 14th September 2016 is an error). At that hearing the claimant was represented by Mr
15 Rob Quick, National Officer, Hospital Consultants and Specialists Association. The appeal panel of seven was chaired by Professor David Bruce. Also present and described as “witnesses” were Dr Carl Moores (Educational Supervisor, NHS Lothian), Dr David Semple (Previous Training Programme Director, NHS Lothian) and Dr Kirsteen Brown (Current Training Programme Director, NHS
20 Education for Scotland).

127. Professor Bruce outlined the process for the hearing. The panel’s purpose was to look at the Outcome 4 decision and to consider any new information. In brief summary, the claimant’s points were that the alleged “widespread concerns”
25 were not documented in the e-portfolio or raised prior to the ARCP. The timing of placements recorded was inaccurate. The calculation of time spent in remedial training was also inaccurate and did not reflect the fact that the claimant had been working less than full-time. The claimant highlighted paragraph 6.124 of the Gold Guide. The claimant felt strongly that she had not had the full year of
30 remedial training. The claimant should have been given extra time as an ST3 rather than being assessed as an ST4. The claimant felt that Dr Moores, as Educational Supervisor, had failed to address issues as soon as possible in order to give the best chance of remedial training.

128. On behalf of the claimant Mr Quick referred to the Equality Act 2010 and advised that the claimant was seeking recognition of those issues. The claimant stated that she was aware of the impact of those things on her ability to do the job. She had previously been scared to let people know of the potential effect of her disability, although now everyone did know. The claimant stated that a relapse was unlikely since she was now taking the appropriate medication.

129. The claimant was asked why the psychiatry report had been redacted in certain parts. The claimant stated that the redactions concerned personal details which were not relevant to the appeal hearing. We have dealt with this matter above.

130. The claimant was specifically asked whether her disability affected her clinical working on a day-to-day basis. The claimant stated that it did to a degree during the times when she was unwell. The claimant was asked whether she could recognise when she was unwell and answered that she could. The claimant felt that she knew when she was having a bad spell and understood her limits. The claimant felt that when she was having a less bad spell she was often perceived as lacking confidence, enthusiasm and tended to avoid eye contact. The claimant was asked what reasonable adjustments could be made on a day-to-day basis. The claimant answered that suitable adjustments would be more feedback and, when she was unwell, more supervised practice so that she could remain at work. The claimant pointed out that although she would progress more slowly she would still be progressing.

131. On the issue of disability Dr Moores' position was that the claimant had not informed him of her disability. He had understood that she was cleared by occupational health as fit for work and that the claimant had not declared any health issues on her SOAR declarations. Dr Moores acknowledged that the claimant had made some progress during training but he did not believe that she was ready for higher specialist training. He believed that her airway skills had improved but that there was still concern regarding her interpersonal skills. Non-technical skills had not improved.

132. Dr Semple said that the main issue was with the claimant's non-technical skills, which were vital in anaesthetics having regard to patient safety. There was more variability in the claimant's performance than that of other trainees. The claimant would need to be able to communicate, respond and have multiple plans in place in an emergency situation. The claimant was not at the level of an ST4 trainee in those respects.

133. Dr Kirsteen Brown summarised concerns raised with her about the claimant's skills and practice. It had been reported to her that consultants were staying in the hospital overnight out of concerns about the claimant being left unsupervised. Feedback from ITU suggested that the claimant was unable to multitask and required a great deal of support and could not cope with the pressures as an intermediate trainee. At Western General Hospital similar concerns had been raised about leaving the claimant unsupervised. Dr Kirsteen Brown's view was that it would take more than six months of extended training for the claimant to be able to pass intermediate training. Simulator training had never in fact been arranged, but Dr Kirsteen Brown was not sure whether it would have benefited the claimant given that "she does not accept feedback".

134. The reasoning and conclusions of the panel are set out in the appeal notes and also in an outcome letter dated 19th September 2016. The panel reasoned that the claimant was a good and caring doctor. The panel also recognise that the claimant had significant health problems and had encountered two significant adverse events in her personal life. The panel regarded it as a difficult and complex case.

135. The panel recognised that the claimant had a disability and acknowledged a duty to consider reasonable adjustments, both in terms of training and also of employment. However, the panel also accepted that the disability was not known to those involved in the claimant's training and that it was new information presented to the appeal panel. Therefore there needed to be a management referral to occupational health to see if any reasonable adjustments could be recommended. If the report recommended further adjustments there would be

consultation with the service to see if those suggestions could reasonably be delivered.

136. The panel decided that the claimant had not made an adequate case that the evidence provided on behalf of the Deanery was inaccurate and agreed that the claimant was unable to demonstrate progress in key non-technical skills namely situational awareness, communication skills, leadership skills and multitasking.

137. The panel also felt that following the award of an Outcome 3 in June 2014 the recording of educational objectives, the plan to meet those objectives, milestones to measure progress and agreed educational outcomes were "less than satisfactory". The claimant was not told what the panel meant by that.

138. The panel expressed the view that continuing in anaesthetics was not in the claimant's best interests and that she might well excel in another branch of the profession. The claimant was advised to consider alternative career options. Patient safety was said to be a factor in that advice.

139. The final conclusion of the panel was that the claimant's disability (which it regarded as new information) needed to be taken into account. A specialist opinion on adjustments was necessary. NHS Lothian, as the claimant's employer, would be asked to initiate a referral to occupational health. Training would be paused while that opinion was sought. Higher anaesthetic training required trainees to be able to work independently and to show team working and leadership skills when faced with an acute medical crisis. If adjustments could not be made which would allow the claimant to progress in her training and to work independently and safely then the award of an Outcome 4 should be upheld.

140. The claimant's prospects of overturning the Outcome 4 therefore depended upon occupational health evidence and the possibility that reasonable adjustments could be made.

141. On 12th October 2016 a management referral to occupational health was made by Dr Michael Gillies, Associate Medical Director, Diagnostics, Theatres,

Anaesthesia and Critical Care, NHS Lothian. Dr Gillies posed six numbered questions.

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141.1. Does [the claimant] have a health condition with the implications for training outlined in the letter?

141.2. Does [the claimant] always recognise that she is unwell so that she can excuse herself from training?

141.3. How does [the claimant's] health condition impact on her ability to train and safely care for patients?

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141.4. How does [the claimant's] health condition impact [on] her ability to work safely and effectively within a team?

141.5. What reasonable adjustments (beyond those which [the letter said had] already been implemented) could be made to allow [the claimant] to continue to work and maintain patient safety, yet satisfy the requirements to demonstrate a training level commensurate with independent (and often solo) practice as an anaesthetist?

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141.6. Could reassurance be given to NHS Lothian that [the claimant's] illness, even with "reasonable accommodation", would allow her to continue to train and practice without risk to patient safety?

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142. In December 2016 the claimant passed the final FRCA Structured Oral Examination. Consequently, she was admitted as a fellow of the Royal College of Anaesthetists about two weeks later.

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143. An occupational health review was carried out by Dr Funbi Ogundipe, Consultant Occupational Health Physician, on 9th December 2016. The claimant's health condition was described as "long-standing". It had been disclosed in occupational health questionnaires beginning with one completed in 2009. At the time of writing the claimant's health was "stable". The nature of the long-standing health condition was that when deterioration occurred it could have implications for the claimant's ability to attend work safely and undertake her duties. However, the claimant indicated that she was able to identify when her health began to deteriorate. She engaged with the appropriate healthcare

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providers and from the information she had provided to Dr Ogundipe she had complied with the advice given. It was difficult to state whether the claimant would always recognise when she was unwell to the level that she needed to stop work. However, when her health was significantly suboptimal she engaged with the appropriate healthcare providers in a timely manner and followed their recommendations. When suboptimal, the claimant's health could have an impact on her performance at work. It was therefore conceivable that during periods of significant suboptimal health the condition could impact on the claimant's ability to train and to provide safe care to patients. However, when health was stable there was no medical reason why the claimant would not be able to provide safe care commensurate with her level of training and skills. The claimant's presentation when her health dipped could affect how she related to others and consequently could have some impact on effective team working. At other times she would be able to work safely and communicate effectively within a team.

144. Suggested adjustments included providing clarity regarding expectations, outcomes and objectives, being provided with feedback in a constructive manner within safe boundaries and considering additional time to enable the claimant to make up for whatever she had missed in terms of training time when health deteriorated. The report also records but does not endorse the claimant's wish to move outside the South East Deanery to complete her training as a result of a deterioration in working relationships.

145. Dr Ogundipe considered that questions of patient safety and compliance with training requirements were decisions which should be made at service level based on the identification of relevant risks and an adequate assessment of those risks. It was not possible to provide any assurance that fluctuations in the claimant's health would not have an impact on her ability to practice or train without risk to patient safety.

146. On 1st March 2017 Dr Brian Cook wrote to Professor Reid summarising the occupational health evidence. Dr Cook was concerned by the claimant's potential lack of insight into her own health and the possible consequences of that for

patient safety. The suggested adjustments regarding outcomes, objectives and constructive feedback were already in place. It was difficult to see what further adjustments could be put in place. NHS Lothian's position as expressed by Dr Cook was that the combination of lack of insight into health fluctuations aligned with the potential impact on patient care and the fact that there are no identifiable further adjustments to the claimant's role, made it untenable for him to support the continuation of the claimant's current training post.

147. Professor Reid wrote to the claimant on 16th March 2017. His view was that the suggested adjustments in terms of communication of outcomes, objectives and feedback did not directly address concerns about the claimant's ability to continue to train safely. We agree with that observation.

148. Occupational health had described an intermittent and unpredictable situation which raised significant concerns in relation to the claimant's safety as well as that of patients. Occupational health highlighted that there might be times when the claimant herself failed to recognise that her health was compromised to the extent that patient care might be affected. The view of NHS Lothian as employer was that due to the fluctuating nature of the illness and the claimant's periodic lack of insight into its severity and impact, it would not be able to support the level of supervision necessary to ensure the claimant's safety and that of patients. Additionally, the Deanery remained concerned that the claimant had been unable to demonstrate progress in acquiring the key non-technical skills identified in Professor Bruce's letter of 19th September 2016 advising the claimant of the appeal outcome. The information available to the panel was that the claimant had been consistently unable to demonstrate those skills and that the lack of progress was not because competence in those areas had fluctuated due to ill-health or because a reasonable adjustment had not been made. So far as training time was concerned, it had been extended by 14.8 months and progress in the necessary areas had not been demonstrated during the additional training period. A further extension would not be likely to address the deficit. A transfer to a different deanery would not address the issues of a lack of satisfactory progress to date or patient safety concerns. For all of those reasons the deanery decided to confirm the decision to issue an Outcome 4.

149. On 10th April 2017 Dr Gillies wrote to the claimant following receipt of the letter dated 16th March 2017 from Professor Reid. In light of Professor Reid's decision NHS Lothian invited the claimant to a meeting on 19th April 2017 to discuss the impact of that decision on her continued employment.

150. Ultimately, that meeting took place on 16th May 2017. It resulted in the claimant's dismissal. The reasoning is set out in a letter dated 5th June 2017. Doctors in training had two contracts: a contract for training with the Deanery and, dependent on that contract, a contract of employment with an NHS employer. In the claimant's case that was the second respondent. The NHS employment contract was directly linked to the training contract and existed solely to facilitate training. If the training contract was terminated then the NHS contract was also terminated. Since the claimant had been released from the training programme the purpose of her contract with the second respondent no longer existed and unfortunately her employment would therefore be terminated. The reason for termination was framed with reference the wording of section 98 of the Employment Rights Act 1996 and was described as amounting to "Some Other Substantial Reason". The claimant was paid three months' notice and was notified of a right of appeal.

151. An appeal hearing took place on 30th August 2017. It took the form of a full rehearing of the case rather than a simple review of the appropriateness of the decision to dismiss. Janis Butler, Interim Director of HR and OD was one of the panel members. She was concerned that redeployment had not been considered.

152. The outcome and the reasoning of the panel was summarised in a letter dated 12th October 2017, just over 6 weeks after the hearing. We find that at least part of the reason for that delay was a desire to have discussions about alternative employment with the claimant's representative. Those discussions had not concluded by the time the appeal outcome was announced.

153. The appeal against dismissal was not upheld. The panel's decision was that

the termination of the claimant's employment had been fair and appropriate. The panel had no remit or authority to overturn the Deanery's educational governance process. As part of its deliberations the panel considered whether there would be any scope for the claimant to undertake other work for NHS Lothian. There had been some discussions following the hearing with the claimant's representative but the process had been delayed. Consequently, the panel provided an outcome while awaiting a response from Mr Quick on behalf of the claimant. At the time of writing the panel's understanding was that the claimant was prepared to consider alternative employment if a suitable non-training grade medical post within anaesthetics were available. There was believed to be just such a vacancy at St John's Hospital. The panel had therefore asked the Executive Medical Director to explore that further and to make contact with the claimant.

154. Tracey Gillies (no relation to the Dr Gillies referred to above) duly contacted the claimant in a letter dated 3rd January 2018. She proposed a further occupational health referral and a discussion of the post of Specialty Doctor in Anaesthetics at St John's hospital. We heard no evidence regarding the progress of matters after that.

Submissions

155. The bulk of the parties' submissions were set out in writing. The claimant's written submissions ran to 62 pages, the first respondent's submissions ran to 49 pages and the second respondent's submissions ran to 23 pages. We set aside a day in which to read them prior to hearing oral submissions and the process of reading and discussion took almost all of that day. We also referred to them regularly during our deliberations.

156. Little useful purpose would be served by a summary of the written submissions in this already lengthy judgment. Instead, we will refer to them as necessary in the course of expressing our reasoning and conclusions on each point. We will however add a brief summary of the additional oral submissions made on behalf of each party, since they would not otherwise be recorded in

writing.

Oral submissions on behalf of the claimant

157. On behalf of the claimant, Mr Northall dealt first with the issue of the redactions made by the claimant to certain documents, which he accepted was relevant only to the extent of dealing with the efficacy of the adjustments contended for. He accepted that the redacted medical records related to contemporaneous events and that they therefore had a potential relevance to the matters the tribunal had to decide. A party who owed a duty to make adjustments could not simply say that they were not going to make them because they felt they had been misled. That had no bearing on the statutory test, unless it also had a bearing on the efficacy of the adjustments, and whether they would have been efficacious to a sufficient degree.

158. Mr Northall made the equivalent submission in relation to the justification defence to the claims brought under sections 15 and 19 of the Equality Act 2010. The correct approach was to balance a range of relevant factors including the discriminatory effect of the PCP, its importance to the respondent (the legitimate aim) and also other more practical questions such as whether a different course of action could have been taken which had a less discriminatory effect but which preserved the legitimate aim. None of that had anything to do with whether a party felt that they had been misled. Mr Northall accepted on behalf of the claimant that the tribunal was entitled to take into account the redactions made but what it could not do was take into account whether the claimant had acted in good faith.

159. Mr Northall criticised the written submissions lodged on behalf of the first respondent on the basis that in large part they amounted to a lengthy proof of evidence which was no substitute for the Tribunal's own fact-finding process, and which included a number of matters which were not touched upon in the evidence heard by the tribunal.

160. Mr Northall made submissions in relation to each of the redacted documents

highlighting the context in which they were made and arguing that the respondent had overplayed their significance.

161. There was sufficient evidence of group disadvantage for the purposes of the indirect discrimination claim in the evidence of Dr Steel and the occupational health evidence.

162. In relation to section 53 of the Equality Act 2010 and competence standards, it was submitted that the first respondent's submissions failed to engage with the distinction between a competence standard and the process of assessing that standard. In this case the Royal College set the competence standards. Supervision was merely a means by which competence was assessed and a means of ensuring patient safety. It was a regulatory requirement flowing from GMC scrutiny of healthcare services.

163. In relation to the claims against the second respondent, the mere fact that the claimant had lost her training number did not absolve the second respondent of responsibility for considering what opportunities for alternative employment existed. While it could be accepted as a matter of principle that losing a training number would normally lead to the end of employment for training, that did not mean that employment could not continue on other terms. Redundancy was not a perfect analogy but it was an analogy of sorts. The concessions made by Janis Butler were fatal to the second respondent's case. She had accepted that the redeployment policy should have applied and that it should have been considered at the dismissal stage. The appeal process should not have been concluded until the alternative employment issue had been "bottomed out". Mr Northall relied on ***Taylor v OCS Group Ltd*** [2006] ICR 1602, CA in support of the argument that the dismissal was therefore substantively unfair. It was not fair to dismiss and to reject the appeal unless and until the parties had discussed whether the alternative job identified should be offered to the individual concerned. The appeal outcome was peremptory because alternative employment questions had not been determined before the appeal outcome was delivered.

164. On reasonable adjustments, the second respondent had adopted the PCPs of the first respondent and had not run any argument on practicability, cost or efficacy. Therefore, it could not discharge the burden of proof.

Oral submissions on behalf of the first respondent

165. On behalf of the first respondent, Mr Truscott QC first of all dealt with our request that he should clarify which, if any, of the PCPs he accepted had been applied to the claimant, and if so whether they were argued to be a competence standard. It was accepted that PCPs (b), the second half of (c) and (e) had been applied but no others. All seven PCPs were alleged to have been competence standards, if applied at all.

166. Mr Truscott QC placed heavy emphasis on the submission that the claimant had not been open, candid and honest in her health declarations. The claimant had a health condition which impaired her medical practice but she did not declare it. That point flowed through the entire case. The first respondent did not know up until the appeal stage that the claimant was disabled. It did not have access to the second respondent's health questionnaires. The first respondent could not know what it was dealing with unless the claimant was open and candid. Without that, the first respondent was unable to protect both the claimant and patients from the full effects of the claimant's depression when it was at its most severe.

167. Mr Truscott QC relied on an extract from the IDS Handbook to which we will refer below. In very brief summary, he argued that the claim was drawn in such a way that it became an individual claim which could not amount to indirect discrimination.

168. On time bar, Mr Truscott QC argued that any discrimination at the point of the 2014 ARCP must be out of time. Any discrimination at the point of the 2016 ARCP would also be out of time unless it could be linked with the appeal.

Oral submissions on behalf of the second respondent

169. On behalf of the second respondent, Mr Fairley QC first of all addressed the significance of the redactions. He said that they went to the efficacy of the adjustments and the proportionality of the dismissal for the purposes of section 15. That was in any event a fall-back position because his primary submission was that none of the PCPs were applied to the claimant by the second respondent at all.

170. While Mr Fairley QC did not disagree that the medical records and the redactions from them must be read in context, or that occasions could be found on which the claimant did take medication and follow medical advice, the claimant must nevertheless concede that within the redacted sections there are several examples of the opposite. It was sufficient for the second respondent to say that the claimant's management of her condition was sporadic, as was her honesty about that. The claimant had not really dealt with the context in which the redactions had been made. That context was her appeal against the decision of the ARCP panel in which she maintained that adjustments ought to have been made for her disability. Candour, honesty and openness on that issue were therefore paramount. The claimant had brushed over the fact that she had not been honest with the ARCP panel. She had cherry picked her medical records in order to remove all aspects which could conceivably have been seen to be damaging to her appeal. She extracted the bad and left the good, although she was also saying that reasonable adjustments should be made. Mr Fairley QC did not shrink from calling that dishonest. The claimant was also specifically asked by the appeal panel about the redaction in Dr Steel's report and lied about it. She accepted that she had lied on that occasion in cross-examination. She had then belligerently sought to justify making the redactions and had suggested that she had acted entirely appropriately by making them. In summary, Mr Fairley QC argued that the claimant had demonstrated a continuing course of conduct in which she repeatedly minimised, covered up, hid and lied about the management of a fluctuating and potentially dangerous condition.

171. Patient safety was on any view a legitimate aim. Mr Fairley QC agreed entirely with the claimant's submission that a depressive condition, recurrent or otherwise, was not inconsistent with a career in anaesthesia. However, the second respondent could not agree with the claimant's submission that there was no evidence to suggest that she was unmanageable. There was indeed evidence of that sort, in that there was a lack of candour and dishonesty. While the claimant occasionally mentioned depression she was also sporadically dishonest about it. Mr Fairley QC asked rhetorically, "how do you manage an acknowledged risk to patient safety created by someone who was not prepared to be honest about their condition". The suggested adjustment involving monitoring or self-reporting could not be efficacious if the claimant lied and deceived.

172. The claimant's dishonesty was relevant to the question of the proportionality of dismissal as a response to the loss of the claimant's training number if the tribunal concluded that there was a link between recurrent depression and the Outcome 4.

173. Mr Fairley QC highlighted the rather unusual nature of the contract of employment between the claimant and the second respondent. It was not a typical contract of employment in that there was a striking absence of control by the first respondent. It did not control who it employed for training purposes, or for how long. That was the context in which the fairness of the dismissal must be assessed. Bearing in mind all the unusual features of the contract, the dismissal was fair. The concessions made by Janis Butler in cross-examination were not decisive. It was for the tribunal to decide whether, on the facts of this case, there was a duty on the second respondent to consider redeployment. Mr Fairley submitted that whatever the second respondent might have thought, said or done, there was no such duty.

174. There was no evidence at all that any of the PCPs were applied by the second respondent to the claimant. There was no evidence that the second respondent had access to the health questionnaires completed by the claimant.

Applicable Law

175. Although it has become customary for employment tribunals to set out the legal principles applied in a separate section of their written reasons, in this case we have found it more convenient to do so as part of the section dealing with our reasoning and conclusions. By presenting it in that manner we can combine the statement of legal principle with its application. We think that is entirely compliant with rule 62(5) of the ET Rules of Procedure 2013, which requires a tribunal only to "concisely identify the relevant law". In total, the representatives referred to 68 authorities filling two lever arch files. It is not necessary for us to refer to all of them in order to give that concise statement.

Reasoning and Conclusions

Knowledge

176. We will deal first with the issue of the first respondent's knowledge of disability (issues 10 and 21). A lack of the requisite knowledge would constitute a complete answer to the claims against the first respondent of discrimination arising from disability (section 15 Equality Act 2010) and failure to make reasonable adjustments (sections 20 and 21 Equality Act 2010). The second respondent does not take any point about knowledge.

177. The two tests are slightly different. One focusses on actual or constructive knowledge of disability whereas the other focusses not only on that but also on actual or constructive knowledge of the disadvantage to which the claimant was put by the PCP.

177.1. Section 15(2) of the Equality Act 2010 provides that the preceding subsection defining discrimination arising from disability "does not apply if A shows that A did not know, and could not reasonably have been expected to know, that B had the disability".

177.2. Schedule 8, paragraph 20 of the Act provides that, "A is not subject to a duty to make reasonable adjustments if A does not know, and could not reasonably be expected to know…that an interested disabled person has a disability and is likely to be placed at the disadvantage referred to in the first, second or third requirement."

178. As for knowledge of disability itself, the question is whether the first respondent had actual or constructive knowledge of the facts constituting the disability for the purposes of section 6 of the Equality Act 2010 – the physical or mental impairment, and the substantial and long-term adverse effect on the ability to carry out normal day to day activities. It is not necessary for the first respondent also to have known that, as a matter of law, the consequence of those facts was that the employee was a 'disabled person'. The Court of Appeal endorsed that as a correct statement of the law in ***Gallop v Newport City Council*** [2013] EWCA Civ 1583, [2014] IRLR 211, at paragraph 36, before going on to hold that a respondent could not unquestioningly adopt unreasoned occupational health opinions that a person is not disabled. It is for the employer to make the necessary factual judgment.

179. As for the additional aspect of the test in Schedule 8, paragraph 20, Mr Northall emphasises the word "likely", which he submits in this context means "could well happen" rather than something which is more probable than not. No authority is cited for that proposition but we infer that Mr Northall may well take that from ***SCA Packaging Ltd v Boyle*** [2009] IRLR 746, a decision on the meaning of "likely" in a different provision. On that basis it would be sufficient for an employer to have constructive knowledge that an individual could well be placed at a substantial disadvantage. Whether Schedule 8, paragraph 20 should also be interpreted in that manner is an interesting question which it was ultimately unnecessary for us to decide.

180. In ***Department for Work and Pensions v Alam*** [2010] ICR 665 the EAT identified the questions as being (1) did the respondent know both that the employee was disabled and that their disability was liable to affect them in the relevant manner, and if not, (2) ought the respondent to have known both that

the employee was disabled and that their disability was liable to affect them in the relevant manner.

181. Mr Northall also referred us to ***Department for Work and Pensions v Hall*** (UKEAT/0012/05/DA) as an example of a case in which there were "red flags" or "warning signs" yet the employer failed to make further enquiries. The employer in that case had not seen the employee's health declaration, but the employer had seen very unusual behaviour which gave cause for concern. The employer had been aware of a claim for disability tax credit but had not made any follow up enquiries. There were also various colloquial references to mental health and medication. On that basis the ET held that the employer was "on notice". The findings of the ET at first instance are at paragraph 9 and the endorsement of the EAT is at paragraphs 23 and 24.

182. The current EHRC Code (paragraph 6.19) states that employers must do all that they can reasonably be expected to do to find out whether an employee has a disability, giving the example of an employee who cries at work and the suggestion that it might be reasonable to discuss whether that crying was related to a disability.

183. Applying those principles to the facts of the present case, we are satisfied that the first respondent had the requisite knowledge of disability by mid-December 2013 at the latest. We base that finding on the following key pieces of evidence, all of which are referred to in more detail in our findings of fact.

183.1. On 10th August 2012 Dr Anne McCrae emailed Dr David Semple (then the first respondent's Training Programme Director for Speciality Trainees in Anaesthesia) referring to the claimant being "easily stressed and/or distracted" and lacking awareness of the urgency of emergency situations. Dr McCrae also referred to the claimant's habits of closing her eyes or looking at the ceiling behind the head of the speaker. In the same paragraph Dr McCrae says that she had noticed scars of self-harm on the claimant's forearms. We find that those factors, especially when read together, constituted "red flags" which should have triggered further enquiries. In his

evidence in chief Dr Semple said that it was “extremely unusual” to receive an email of that sort. That rather underlines the point. He accepted in cross-examination that the scars of self-harm “would be a marker for some sort of illness in the past”. They could equally be a marker of an illness which was continuing. The first respondent ought reasonably to have enquired whether those were signs of a disability, acting in conjunction with the second respondent as the claimant’s employer if necessary.

183.2. On 30th October 2013, during the claimant’s sickness absence following the critical incident, Dr Brian Cook of the second respondent made an occupational health referral specifically asking whether the claimant was a disabled person for statutory purposes. The reason for absence had been given by Dr Cook as “depression”. The report dated 28th November 2013 prepared by Dr Kalman did not address that question and did not supply an answer one way or the other. However, if it was important enough for the second respondent to raise the question in the first place then it was also important enough to make enquiries of occupational health when the report failed to answer the question.

183.3. However, what Dr Kalman’s reports of 28th November 2013 and 4th March 2014 did say was that it would be surprising if the claimant’s colleagues had not noticed that her health was “sub-optimal” or “substantially impaired” for some months prior to the incident.

183.4. On that basis we find on the balance of probabilities that there had for many months been sufficient visible signs of illness and impairment for both respondents to have asked the question whether the claimant might be a disabled person for the purposes of the Equality Act 2010. That ought reasonably to have triggered a chain of enquiries on both their parts to establish, with the assistance of appropriate expert advice if necessary, whether or not the claimant might be a disabled person, potentially owed duties under the Equality Act 2010.

183.5. The fact that occupational health referrals were normally made by the

second respondent does not weaken that conclusion in respect of the first respondent. The first respondent could and did ask the second respondent to make occupational health referrals when necessary, as it did in the course of the claimant's appeal against the ARCP Outcome 4. If the reports generated by those referrals had been silent or ambiguous on the issue of disability, then further questions ought reasonably to have been asked given the many months for which visible signs of illness and impairment had been present.

183.6. If appropriate follow-up questions had been asked of occupational health, then we have little doubt that the eventual answer would have been that the claimant was likely to be a disabled person for the purposes of section 6 of the Equality Act 2010. Similarly, if reasonable enquiries had been made then the respondents would each have been informed of the likelihood of the claimant being placed at a substantial disadvantage by the PCPs. We reach that conclusion whether the appropriate test of "likelihood" is the "could well happen" test submitted by Mr Northall or the ordinary civil standard of likelihood on the balance of probabilities. Either way, the answer is the same, and the first respondent would have been aware of it had reasonable enquiries been made.

184. We therefore find that the first respondent had the requisite knowledge from mid-December 2013 at the latest. By "requisite knowledge" we mean knowledge that the claimant had a disability, and that she was likely to be placed at a substantial disadvantage as a result of the application to her of the PCPs considered below. The date of knowledge of mid-December 2013 allows for time to ask follow-up questions in the event of incomplete medical evidence.

185. Seen in that context, we do not think that the claimant's failure to make a formal annual "SOAR" declaration in relation to disability or ill-health is a factor of decisive importance. The first respondent could not reasonably rely on the lack of any reference in some of those declarations given the visible signs of the claimant's illness. In any event, the question posed by the SOAR forms is narrow – whether the practitioner concerned had suffered from any illness or physical

condition which had resulted in them "restricting or changing [their] professional activities". Activities might be impaired by disability even if the claimant had not "restricted" or "changed" her professional activities in a formal way. Further, the declaration in 2014 expressly referred to illness requiring 3 months' sick leave.

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The PCPs

186. In this section we will deal with three questions arising in relation to each of the provisions, criteria or practices ("PCPs") relied upon by the claimant for the purposes of claims under sections 19 and 20-21 of the Equality Act 2010.

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186.1. The first question is whether they were applied by the first respondent. As Mr Northall rightly reminds us, we are concerned with the PCPs applied as a matter of fact, and not with the PCPs which could or ought to have been applied as a matter of the first respondent's own policies and procedures.

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186.2. To the extent that they were applied, the second question concerns the extent to which they amounted to "competence standards" for the purposes of section 53(7) of the Equality Act 2010, which provides that "The application by a qualifications body of a competence standard to a disabled person is not disability discrimination unless it is discrimination by virtue of section 19."

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186.3. The third question is whether they were applied by the second respondent. Since the second respondent was not a qualifications body section 53(7) has no application.

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187. The first respondent accepts that it applied PCPs (b), the second half of (c) and (e) only. The application of the others is not admitted.

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188. Our finding is that all of the PCPs relied on by the claimant were applied to her by the first respondent.

188.1. As for PCP (a), generally, ARCPs were indeed carried out on a 12 month cycle, although annual ARCPs could be conducted at more than one time of year. The “A” in ARCP stands for “annual”.

5 188.2. The application of PCP (b) is admitted by the first respondent.

188.3. Both parts of PCP (c) were applied by the first respondent. Plainly the claimant was required to complete her training. That was the only alternative to leaving training, and the completion of units and particular elements and 10 stages of training was a requirement applied to her. The first respondent required the demonstration of competence within the time allowed for the completion of each stage. Intermediate training (ST3 and ST4) was intended to last for 2 years on a whole-time basis.

15 188.4. As for PCP (d), it became increasingly clear from the oral evidence as well as the documents that the first respondent proceeded on the basis that only one Outcome 3 could be awarded during a particular period of training, and that a second could not follow at the next ARCP. Dr Semple and Dr Kirsteen Brown each said in evidence that a maximum of 12 months 20 (presumably based on whole time working) could be spent on an Outcome 3, save for exceptional circumstances with the Dean’s permission. That implies that a consecutive Outcome 3 could not be awarded at the next annual review. It is consistent with Dr Kirsteen Brown’s email of 11th March 2016 which refers to an Outcome 3 having “run out”, and her email of 26th 25 March 2016 which refers to the claimant having “already spent 13 months on outcome 3”, implying that a threshold had been crossed. Even more explicitly, Dr Kirsteen Brown said in cross-examination that her understanding at the time was that a trainee who had already received an Outcome 3 could only then receive an Outcome 1 or an Outcome 4. She said 30 that was her belief but accepted that her understanding might have been wrong. Although Professor Reid said that the possibility of a further Outcome 3 was “left on the table” for the ARCP panel in 2016, it was a matter for them. Dr Kirsteen Brown’s understanding that it was not an option is therefore

important. Dr Kirsteen Brown stated on 9th June 2016 that the Outcome 3 could not be extended further. The weight of all of that evidence means that we are quite satisfied that PCP (d) was applied to the claimant.

5 188.5. The application by the first respondent of PCP (e) to the claimant is admitted.

188.6. We are also satisfied that the first respondent applied PCP (f) to the claimant. Correctly understood, the degree of supervision was not, in fact, 10 absolute. It was not "all or nothing". All trainees below consultant level are and were supervised to some extent, but the level and type of supervision was expected to change and to diminish with successful progress through training. An ST4 trainee was expected to require less supervision and less direct supervision than a ST3 trainee. Understood in that way, intermediate 15 trainees would not be expected to complete ST4 (still less ST3) working *wholly* unsupervised. In truth, the issue was whether the claimant would require additional supervision over and above that which would normally be expected at the completion of training. It was an aspect of the requirement to make satisfactory progress by the end of the defined training period and 20 was closely related to PCP (c).

188.7. We also find that PCP (g) was applied by the first respondent to the claimant. Our reasons are the same as those set out above in relation to PCP (d) since the two points are very closely related. We agree with Mr 25 Northall's submission that this lay at the heart of the first respondent's approach to the selection of outcomes at ARCPs after June 2014.

189. We find that those alleged PCPs are each capable of amounting in law to a PCP for the purposes of the claims under sections 19 and 20 of the Equality Act 30 2010. ***United First Partners Research v Carreras*** [2018] EWCA Civ 323 shows that the concept is sufficiently flexible to include expectations. There is need to categorise each one as a provision, a criterion or a practice if it could be all or any of those labels (***Harrod v Chief Constable of West Midlands Police*** [2017] ICR 869, CA).

190. Since we have found that more than one PCP was applied, it is relevant to note that we should assess their effect in combination (***Ministry of Defence v DeBique*** (UKEAT/0048/09) paragraphs 162-170).

5 *PCPs as "competence standards"*

191. Of those PCPs we find that only PCPs (b), (e) and (f) were "competence standards" for the purposes of section 53(7) of the Equality Act 2010. The term "competence standard" is defined by section 54(6) as an academic, medical or
10 other standard applied for the purpose of determining whether or not a person has a particular level of competence or ability.

192. PCP (a), requiring the completion of ARCP procedures on a 12 month cycle, has nothing to do with competence. It is an administrative arrangement. It is not
15 a competence standard.

193. In ***Burke v College of Law*** (UKEAT/0301/10) the EAT held that the requirement that legal exams be completed under timed conditions was itself a competence standard, and not merely part of the process by which competence
20 was assessed. In that case the College of Law produced evidence to the effect that one of the things being assessed was whether work could be produced under constraints of time (see paragraph 25 of the ET judgment, quoted by the EAT at its own paragraph 3, and paragraphs 20, 21 and 22 of the EAT judgment). Although there was a further appeal to the Court of Appeal it was decided on
25 other grounds which made it unnecessary to consider the reasoning of the EAT on this point.

194. We have concluded that PCPs (c), (d) and (g) were not competence standards. They all relate to the time within which a particular level of
30 competence should be achieved, or rules about extensions of that period. They can be contrasted with the ability to prepare accurate legal research or advice within 3 hours in ***Burke***. In our judgment PCPs (c), (d) and (g) were part of the process of assessment rather than competence standards. On the evidence led

by the College of Law in ***Burke*** a trainee lawyer needed to show an ability to prepare work under pressure of time. In contrast, the timescales inherent in PCPs (c), (d) and (g) do not relate to any particular clinical task, nor do they relate to the simulation of such a task. ***Burke*** is readily distinguishable on its facts.

195. PCPs (b), (e) and (f) are of a very different nature. We find that they are competence standards. That was conceded on behalf of the claimant so far as PCPs (b) and (e) are concerned. We find that (f) was also a competence standard because the need for supervision was rooted in concerns about the claimant's competence and the implications for patient safety. For that reason, a requirement that training should be completed "unsupervised" (which in practice meant with only minimal, indirect supervision rather than totally unsupervised) was a competence standard. We remind ourselves that the statutory definition is broad, including academic, medical or "other" standards. They are not limited to academic aspects of competence and we conclude that PCP (f) also fell within the definition.

196. Finally in this section, we turn to the question whether any of the PCPs were applied to the claimant by the <u>second</u> respondent. We find that they were not for the following reasons.

197. All of the PCPs were connected with training, qualification and assessment. None of them were connected with the claimant's employment in any other or more general sense. The first respondent was the training and qualifications body whereas the second respondent employed the claimant to train and to provide service while doing so. However, while the second respondent certainly *facilitated* training and assessment it did not *control* or *manage* that training or assessment. It is therefore difficult to see how it could ever have applied the relevant PCPs to the claimant or to any other trainee. The second respondent did not determine ARCP outcomes or the range of possible outcomes. The second respondent did not determine when ARCPs should be held. The second respondent did not decide the indicators of satisfactory progress. Those things were all done by the first respondent.

198. While we agree with Mr Northall's submission that the application of a PCP should not be conflated with its origin, nor does the mere existence of a degree of cooperation between the first and second respondent mean that the PCPs of one can properly be attributed to the other too. In our judgment the separation of powers and functions of each respondent was clear and distinct. We find that the application of the PCPs considered above lay solely with the first respondent. When individual employees of the second respondent became involved in determining (for example) ARCP outcomes they did so solely in their capacity as (for example) Training Programme Directors. In other words, they did so on behalf of the Deanery, the first respondent, and in our judgment on behalf of that respondent only. We note that TPDs are employed by the first respondent on a sessional basis, but even if that were not the case it is clear that they act on behalf of the first respondent when discharging that role. While Mr Northall highlighted Dr Cook's involvement in the ARCP appeal and his letter to Professor Reid of 1st March 2017 we are unable to interpret that letter as amounting to the second respondent applying any of the relevant PCPs to the claimant. We do not accept Mr Northall's submission that the second respondent was in that letter adopting and repeating the requirements of the first respondent. Dr Cook was merely expressing an opinion "from the service point of view" on the claimant's appropriateness to continue in a training post. He had no power or control over the outcome of the appeal against the ARCP Outcome 4.

Potential claims against qualifications bodies

199. The first respondent's submission was that the effect of section 53(7) of the Equality Act 2010 was that the only available type of discrimination claim in respect of the application a competence standard by a qualifications body of was indirect discrimination contrary to section 19 of the Equality Act 2010. On that basis, as a matter of law, no claim for a failure to make reasonable adjustments could arise. Mr Truscott QC cites an extract from the IDS Handbook in support of that interpretation.

200. In contrast, Mr Northall on behalf of the claimant submitted that a finding of

indirect discrimination in such a case could also constitute a "gateway" to findings of other types of discrimination. Mr Northall also noted that section 14B(1) of the Disability Discrimination Act 1995 effectively exempted qualifications bodies from the duty to make reasonable adjustments if the PCP concerned was a competence standard. Section 14A(3) provided a particular justification defence to claims of "disability related discrimination" (now obsolete). There was however no evidence before us that Parliament had intended the differently worded provisions of the Equality Act 2010 to achieve a different result.

201. There is apparently no authority on this question. It is easy to think of other forms of wording which would have led less ambiguously to each of the rival interpretations suggested to us. The adoption of a purposive interpretation is not a neat solution, since the provision has a mixed purpose and is clearly intended to balance the rights of disabled people against the aims and purposes of qualifications bodies. The search for parliamentary intention is not straightforward. It was not suggested to us that EU law and the associated interpretative duties weighed in favour of one or other interpretation.

202. On either view, proof of indirect discrimination is a necessary first step where the allegation concerns the application of a competence standard by a qualifications body, whether or not it can also lead onto findings of other forms of discrimination.

203. Of the seven PCPs identified by the claimant, we have found that only three amounted to competence standards. Clearly section 53(7) of the Equality Act 2010 has no application to the others. Given our further findings below the question becomes academic, so it has not been necessary for us to reach a conclusion on the rival interpretations of section 53(7).

The indirect discrimination claim against the first respondent

204. Section 19(1) of the Equality Act 2010 provides that a person (A) discriminates against another (B) if A applies to B a provision, criterion or practice ("PCP") which is discriminatory in relation to a relevant protected characteristic

of B's.

205. Section 19(2) defines "discriminatory" for the purposes of section 19(1). It is when:

205.1. A applies, or would apply, it to persons with whom B does not share the characteristic,

205.2. it puts, or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it (an issue often summarised as "group disadvantage"), and

205.3. it puts, or would put, B at that disadvantage (an issue often summarised as "individual disadvantage");

205.4. A cannot show it to be a proportionate means of achieving a legitimate aim (often referred to as "the justification defence").

206. The Supreme Court in ***Essop v Home Office*** [2017] IRLR 558 summarised matters as follows. Indirect discrimination is meant to avoid rules and practices which are not directed at or against people with a particular protected characteristic but have the effect of putting them at a disadvantage. Indirect discrimination assumes equality of treatment – the PCP is applied indiscriminately to all – but aims to achieve a level playing field, where people sharing a particular protected characteristic are not subjected to requirements which many of them cannot meet but which cannot be shown to be justified. The prohibition of indirect discrimination aims to achieve equality of results in the absence of such justification. It is dealing with hidden barriers which are not easy to anticipate or to spot.

207. We have already set out our findings in relation to the various PCPs. We are satisfied that the first respondent applied them to the claimant and also that the first respondent applied them to people who did not share the relevant protected

characteristic. Those PCPs represented the first respondent's approach to training, and to trainees who were struggling to demonstrate the necessary rate of progress. They were not, or would not have been, applied solely to the claimant.

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The first respondent's argument based on ***Eweida***

208. Turning to the question of group disadvantage, Mr Truscott QC argues on behalf of the first respondent that none can be established. He says that it is necessary to identify the precise nature of the claimant's disability and its effects because section 6(3)(b) of the Equality Act 2010 requires that, in relation to disability, a reference to persons who share a protected characteristic is a reference to persons who have the same disability. Mr Truscott QC goes on to argue that "this means, in essence, that indirect discrimination cannot be established in this case".

209. Mr Truscott QC also relies on an extract from the IDS Handbooks (Vol 4, 16.150) in which the author refers to ***Eweida v British Airways plc*** [2010] ICR 890, CA, in which Sedley LJ said that a claimant could not construct an entirely hypothetical peer group to whom the disadvantage is to be attributed, although the author acknowledges that in some cases it would be relatively simple, and in keeping with the purpose of the legislation, to aggregate a solitary employee with others known to have the same characteristic and to be potentially affected in the same way (for example, a loan female worker could claim indirect discrimination on the basis of the way in which a policy would affect a hypothetical group of female staff). Sedley LJ considered that it would be "forensically difficult, even impossible" to do the same for a solitary believer whose fellow believers, if they existed, might accord different degrees of importance to the same manifestation of faith.

210. The argument is one of principle, rather than one based on an analysis of the evidence of group disadvantage in this particular case. As an argument of principle, we reject it.

211. We think that it is, in principle, entirely possible for a disabled person to establish group disadvantage for the purposes of section 19 of the Equality Act 2010. It will all depend on the disability and the evidence. In the present case, it would be sufficient for the claimant to rely on the group of trainees with recurrent depression (the claimant's disability), and to invite the tribunal to make findings as to whether the application to that group of the relevant PCPs puts the group at a particular disadvantage.

212. In our judgment there is no need to construct a group of actual or hypothetical people whose experience of recurrent depression is *precisely* the same as that of the claimant. To interpret section 19 in that way would rob the concept of indirect disability discrimination of much of its useful meaning, since it could often be argued that no two disabled people have *precisely* the same experience of its effects.

213. The point made in paragraph 16.151 of the IDS Handbook, that people who have the same disability cannot easily be treated as a homogenous class, is sound as far as it goes but it must also be recognised that there may be a proper evidential basis for a finding that people with a particular disability face a disadvantage as a group. That group may not be entirely homogenous even though it necessarily shares a protected characteristic. A group of women, or men, or people over a certain age is not entirely homogenous either. While disadvantage cannot be assumed, it might be established by evidence. That is clearly what Sedley LJ had in mind in paragraph 19 of ***Eweida*** when he contrasted the "forensically difficult" exercise in that case with the far less problematic aggregation of a single female employee with the hypothetical group of other female staff.

214. We have concluded that the situation can easily be distinguished from the "forensically difficult" one in ***Eweida***. While Sedley LJ had concerns about the construction of a group whose members "might accord different degrees of importance to the same manifestation of faith" we are in the present case dealing with a well-known and well-studied disability affecting a great many people in the

UK. It should be possible to obtain medical or other evidence regarding the disadvantages to which the group of individuals with recurrent depression were (or would be) put by the relevant PCPs. If it were impossible to draw proper conclusions in respect of that group because the nature of the disability varied so greatly from member to member, then the evidence could be expected to say so. If on the other hand the evidence suggested that the PCPs would put the group at a disadvantage, then the tribunal could act on that. Ultimately, we think that this is an issue of evidence rather than principle.

215. We do not think that the analogy with the facts of ***Eweida*** is sound. We return to the passage in the IDS handbook in which it was acknowledged that in some cases it would be relatively simple, and in keeping with the purpose of the legislation, to aggregate a solitary employee with others known to have the same characteristic and to be potentially affected in the same way. That is the approach we adopt. We aggregate the claimant with others with recurrent depression. We do not think it would be a "forensically difficult, even impossible" exercise as Sedley LJ feared in ***Eweida***.

Medical evidence regarding recurrent depressive disorder

216. Having rejected Mr Truscott QC's argument on matters of principle, we turn to the evidence of group disadvantage put before us.

217. We agree with Mr Northall that the appropriate pool for comparison contains the anaesthetic trainee cohort undertaking intermediate training. The comparison is between the members of that group who have a recurrent depressive disorder and those who do not. The question is whether the former suffer a "particular disadvantage".

218. The evidence of disadvantage relied upon consists of Dr Steel's report of 29th August 2016 and the Occupational Health report of Dr Ogundipe dated 9th December 2016. Mr Northall is quite right to observe that neither respondent has commissioned medical evidence in response, but nor are they obliged to. While we find that the medical evidence relied on by Mr Northall is mostly focussed on

the claimant's own experience it does also support some findings on group disadvantage.

218.1. Dr Steel's report of 29th August 2016 begins with a summary of the claimant's own psychiatric history. It is focussed primarily on her condition, dealing with referrals, diagnosis, medication and progress. The report generally does not deal with the experience of the relevant group - those with recurrent depressive disorder. The penultimate paragraph begins with the impact of the condition on *the claimant's* progress through training. However, evidence of group disadvantage is contained in the sentence reading "*it is well known that depression is associated with impairment of attention and cognition and some impact on academic performance is therefore inevitable*". The rest of the paragraph is once again concerned with the claimant's own experience.

218.2. Dr Ogundipe's report of 9th December 2016 is based on a meeting with the claimant. It mainly focusses on matters personal to the claimant and their occupational health implications. While there is on the second page a sentence beginning "*the nature of the condition*" it is focussed on the effect of that condition on the claimant's work, rather than the effect of the condition on the group in general, and reads in full "*the nature of the condition is that when deterioration occurs, it could have implications on [sic] her ability to attend work and safely undertake her duties*". However, the third paragraph on the same page begins, "*based on the nature of the diagnosis itself*…", which we regard as a reference to the relevant group. It goes on to describe an adverse effect on the way in which the claimant related to others and an impact on effective team working. Read fairly, we regard that as evidence of group as well as individual disadvantage.

219. In his written submissions on behalf of the claimant Mr Northall has extracted 11 effects of recurrent depressive disorder which he says are supported by the medical evidence referred to above. Our finding is that the evidence only supports a much shorter list of effects of recurrent depressive disorder, the others being effects experienced by the claimant, and not necessarily by the group in

general. As far as group disadvantage is concerned, the relevant effects are:

219.1. impairment of attention and cognition;

219.2. impact on academic performance;

5 219.3. relations with others;

219.4. effective team working.

Group disadvantage

10 220. The next question is whether, against that background, the relevant PCPs in this case placed the group at a particular disadvantage. For this purpose we consider all of the PCPs since we are concerned with the indirect discrimination claim under section 19 of the Equality Act 2010. We find that they did put the group at a particular disadvantage. Those with recurrent depression would face 15 a particular disadvantage in the assessment of competence because they would be more likely to have difficulty in developing the necessary "non-technical skills" at the required rate, especially if competence were assessed on a fixed 12 month cycle, if there was an expectation of no more than normal levels of supervision, or if the Gold Guide were applied in a way which meant that an Outcome 3 did 20 not necessarily result in an extension of training time at all. Non-technical skills include matters such as team working, communication and situational awareness. The group disadvantage identified above has an obvious impact on the development of those sorts of skills. The application of the PCPs therefore put the group at the particular disadvantage of increased likelihood of an adverse 25 ARCP Outcome (in particular Outcomes 3 and/or 4) and failure within the training process.

Individual disadvantage

30 221. Turning to individual disadvantage, we are satisfied that the claimant was also put at that "particular disadvantage" by the PCPs. While the first respondent suggested that the claimant's difficulties in the training process were caused by a lack of ability rather than by any disadvantage to which she was put by the

PCPs, we note the striking similarity between the effects of recurrent depression listed above and the claimant's perceived shortcomings. That strikes us as more cogent evidence than the first respondent's generalised assertion that feedback in the workplace suggested that problems were unrelated to disability. That assertion was not supported by evidence from the claimant's clinical or educational supervisor. Applying the usual standard of the balance of probabilities we find that the claimant's difficulties were most likely a manifestation of the particular disadvantage to which she was put by the PCPs.

The justification defence

222. The next question is whether the PCPs were a proportionate means of achieving a legitimate aim. We have already set out the aim above, so we will not do so again. We readily accept that the first respondent genuinely had that aim. We also accept that it was legitimate, given the first respondent's purpose and remit. Mr Northall conceded both of those points on behalf of the claimant.

223. The real issue between the parties is proportionality, and the question whether the application of the PCPs was a proportionate means of achieving the aim. In order to be proportionate the measure has to be both an appropriate means of achieving the legitimate aim and also reasonably necessary in order to do so (***Homer v Chief Constable of West Yorkshire*** **Police** [2012] IRLR 601). It is often said that a measure will not be considered reasonably necessary if the respondent could have used less discriminatory means of achieving the legitimate aim (***Kutz-Bauer v Freie und Hansestadt Hamburg*** [2003] IRLR 368).

224. This is a balancing exercise in which we must evaluate whether the first respondent's business needs were sufficient to outweigh the impact of the measures in question on the protected group in general and on the claimant in particular. We must strike an objective balance between the reasonable needs of the first respondent and the discriminatory effects of its actions (***Allonby v Accrington & Rossendale College*** [2001] IRLR 364).

225. On this issue we are required to carry out a fair and detailed analysis of the working practices and business considerations involved. We must reach our own decision as to whether the treatment complained of was justified. There is in this context no “margin of discretion” or “band of reasonable responses” afforded to respondents (***Hardys & Hansons v Lax*** [2005] IRLR 726, CA).

226. It was common ground between the parties that the first respondent is entitled to rely on “after the event” matters which were not actually considered at the time (***Cadman v HSE*** [2005] ICR 1546, CA). We must balance the discriminatory effect of the PCP(s) against the legitimate aim pursued by the employer.

227. The burden of proving on the balance of probabilities that a measure was a proportionate means of achieving a legitimate aim rests with the respondent so asserting.

The proportionality of the means used to achieve the aim

228. There can be little argument that the need to control risks to patient safety, or to avoid them altogether where possible, are critically important considerations for a medical training and qualifications body such as the first respondent. It is therefore a consideration which carries very considerable weight in the proportionality assessment. That merely reflects the priority rightly given to patient safety throughout the medical profession and the NHS.

229. However, it is a matter of great concern to the tribunal that the first respondent misapplied the requirements of the Gold Guide and failed to give the claimant the full extended training period envisaged by that Guide. The first respondent failed even to allow the claimant to complete the standard period of intermediate training once allowance is made for fractional working. It is necessary to set out some of the figures.

230. At our request the parties prepared rival calculations of the total time spent on each stage of training, and the total time spent on an Outcome 3. We prefer the claimant’s calculation and adopt it as a finding of fact. It reflects the fact that

an Outcome 3 becomes effective from a date slightly later than the date on which it is notified to the trainee concerned. We think that the first respondent's calculation overstates the time spent on an Outcome 3 for that reason. The claimant spent a total of 11.4 months on an Outcome 3 (9.9 months during intermediate training and 1.5 months during earlier core training, all figures whole time equivalent). The Gold Guide requires that allowance should be made for fractional working (see internal page 64).

231. The claimant's total time in intermediate training was 16.2 months (whole time equivalent) if a locum post was included, or 11.5 months (whole time equivalent) if it was excluded. Although competence was assessed on an annual cycle, the standard duration of the relevant training period was 24 months. On that basis the claimant had not come close to finishing the *standard* period of training when issued with an Outcome 4, still less an *extended* period of training. Even on the first respondent's figures the claimant had 4 months of standard training time remaining when issued with an Outcome 4.

232. The maximum period of additional training time was normally 1 year within the total duration of the training programme, or exceptionally a maximum of 2 years at the discretion of the Postgraduate Dean (Gold Guide, internal page 64). The first respondent wrongly thought and stated that the maximum period of 12 months had been exceeded in the claimant's case.

233. The Gold Guide envisages that some trainees might struggle to show sufficient progress within the assessment regime and it provides for that possibility. Issuing an Outcome 3 is one way in which a failure to show sufficient progress can be addressed in accordance with the Guide. It also is clear from the terms of the Guide that one Outcome 3 might be followed by a further Outcome 3 (see internal page 69). In contrast, Dr Kirsteen Brown thought that once an Outcome 3 had been given the only possible options at the following ARCP would be an Outcome 1 or an Outcome 4. That was a fundamentally flawed understanding.

234. The first respondent equated time spent on an Outcome 3 with additional

training time, even if it resulted in no overall extension of the normal training period. Interpreted in that manner it was simply not “additional” time at all, and that interpretation could even shorten the overall duration of training. Dr Kirsteen Brown thought that an Outcome 3 would only result in an extension of training if awarded towards the end of the training period. That is not faithful to the wording of the Gold Guide which states that an Outcome 3 “extends the duration of training” and discusses “additional training time” (internal pages 64 and 68). Dr Semple was clear in his view that an Outcome 3 did not necessarily extend the overall training period, but we find that to be a misunderstanding of the terms of the Gold Guide. The Gold Guide specified the maximum duration of an extension of the overall training period but did not set a maximum time that could be spent on an Outcome 3. The first respondent mistakenly proceeded on the basis that no more than 12 months could be spent on an Outcome 3, and that the issue of an Outcome 3 set a clock running on a finite period of additional training.

235. The first respondent’s marked departure from the detailed and well-publicised terms of the Gold Guide, the definitive reference guide for postgraduate specialty training throughout the UK, is a serious matter which carries significant weight in the proportionality assessment. The Gold Guide anticipates that some trainees may require extra time to demonstrate the required level of competence and also provides a structure for the management of that situation. The whole point of an Outcome 3 was to grant additional training time on a formal and defined basis. Subject to overriding considerations of patient safety, any trainee (whether disabled or not) was reasonably entitled to expect that the qualifications body would grant at least the training periods set out in the Guide.

236. Mr Northall is also correct to point out that the first respondent has not led evidence to the following effect:

236.1. that a 12 month assessment cycle is a necessary and appropriate component of a competence assessment process and that any alternative would undermine patient safety;

236.2. that intermediate competencies must be demonstrated within 2 years

of commencing intermediate training otherwise patient safety would be undermined;

236.3. that an Outcome 3 must run concurrently with standard training time such that it does not necessarily provide additional training time at all, otherwise patient safety would be undermined;

236.4. that providing additional supervision to a disabled trainee as they move towards completion of their intermediate training would undermine patient safety.

237. We think that all of those points have force. The necessity and appropriateness of the PCPs to achieving the aim of patient safety have not really been addressed in the first respondent's evidence. Nor does the first respondent appear to have contemplated exceptions to those PCPs for the group with the relevant protected characteristic, or to have articulated why no exceptions could have been made without prejudicing the aim of patient safety. More generally, the first respondent has not explained why alternative measures having less adverse impact on the protected group (or no adverse impact at all) would have compromised the aim. In the absence of clear evidence on the point, we find it difficult to see why it should have been unduly expensive, difficult, burdensome or unsafe for the first respondent to have allowed exceptions to the rigidity of the PCPs given the particular disadvantage to which they put the protected group.

238. The provision of increased support, including but not limited to temporary additional supervision, might often be expected to control any risk to patient safety during a period of additional training time. That would give a trainee with recurrent depression additional time to develop the necessary level of competence without compromising patient safety. No doubt that broad principle would have its reasonable and proportionate limits in terms of cost, disruption and duration of extensions, but the first respondent has not called evidence to establish those limits as a matter of general principle.

239. We also bear in mind the first respondent's own finding during the ARCP

appeal process that the recording of educational objectives, the plan to meet them, the identification of milestones by which to measure progress and agreed educational outcomes following the ARCP Outcome 3 had been “less than satisfactory”. That too weighs in favour of the claimant in the proportionality assessment because her opportunity to improve during the period spent on an Outcome 3 was hampered by those failures on the part of the first respondent.

240. However, and despite those points in the claimant’s favour, we find that for reasons which were not apparent to the first respondent at the time the claimant *did* present a risk to patient safety. We also find that the risk she presented was not manageable, such that the strict application of the relevant PCPs was proportionate *in her particular case*. The points weighing in favour of the claimant in the proportionality assessment are outweighed by considerations of patient safety.

241. We refer back to the findings of fact set out earlier in these reasons in relation to redactions made by the claimant to important pieces of medical evidence placed by her before the appeal panel. We found that the decision to make those redactions, the material redacted and the explanation given to the appeal panel for making those redactions demonstrate a lack of candour regarding the claimant’s own state of health and medical history. For present purposes the issue is not the claimant’s honesty, save to the extent that it impacted on patient safety. We find that it did have that impact. The redactions would have revealed the claimant making “misguided” attempts to disprove a diagnosis and ceasing medication against expert advice. Her decision to keep those matters from the appeal panel called into question her candour and judgment in matters of health, disability and the implications for patient safety. The decision to make the redactions, and the false assurance given to the panel that the redactions did not contain relevant material, each demonstrate that the claimant could not be relied upon to give a full, accurate and honest account of her depressive illness and its effects. Since the claimant concedes that her depression could impair her non-technical skills to an extent sufficient to give rise to a risk to patient safety (see for example her email of 16th February 2014 in relation to the critical incident on

4th October 2013), the lack of insight and candour made that risk unmanageable.

242. In order for the first and second respondent to be able to manage any risk to patient safety resulting from the claimant's disability the claimant would need to be honest and open with each of them about the symptoms and other consequences of recurrent depression that she was experiencing at any particular time. The respondents both needed to be able to assess and respond appropriately to the risk. That necessarily depended on full and accurate information being supplied by the claimant. We find that the claimant could not be relied upon to do that. Consequently, the risk to patient safety could not be managed adequately. The respondents could not manage a risk to patient safety that was obscured by a lack of insight, candour or even deliberate attempts to suppress information on the claimant's part.

243. We add two points.

243.1. First, it does not make any difference that the full extent and implications of the redactions and associated matters only came to light at this hearing (***Cadman v HSE*** [2005] ICR 1546, CA, ***City of York Council v Grosset*** [2018] ICR 1492 at paragraph 54 onwards). We are entitled to take them into account at this stage when deciding whether there was indirect discrimination at the relevant dates. The redactions issue has an obvious bearing on matters pertaining as at those dates. Mr Northall accepted that proposition in his oral submissions. We have of course been careful to focus on what the redactions and associated matters reveal about patient safety as at the dates of the alleged acts of discrimination, rather than at the date of this hearing. We make no findings regarding the claimant's candour, insight or the implications of those things for patient safety as at the date of the employment tribunal hearing, or this judgment.

243.2. Even though the events described in the redacted sections occurred up to several years prior to the appeal against the ARCP Outcome 4, the lack of insight, judgment and candour were also demonstrated at the time of

that appeal and were ongoing. On that basis we find that the implications for patient safety applied up until the end of the claimant's employment. They did not arise simply from issues which were, by then, firmly in the past. They arose also from the claimant's deliberate actions during the appeal process.

5

244. In summary, having considered the first respondent's aim, the means of achieving that aim and the impact of the PCPs on the claimant, we find that the PCPs were proportionate to the aim. The first respondent's disinclination to relax, modify or disapply any of the PCPs was proportionate to its legitimate aim of
10 safeguarding patient safety, even though the first respondent was not aware of the claimant's lack of insight, judgment and candour at the time. The strict application of the PCPs was reasonably necessary, since no less discriminatory means could have achieved the objective of maintaining patient safety. No extension of training time or increase in supervision could have taken place
15 without also prolonging an unmanageable and unacceptable risk to patient safety.

245. The claim for indirect disability discrimination against the first respondent therefore fails because although the claimant has established the necessary
20 group and individual disadvantage, the first respondent has satisfied us that the relevant PCPs were a proportionate means of achieving a legitimate aim.

246. It is unnecessary in those circumstances to consider the jurisdictional time limit points identified in the list of issues. We can nevertheless indicate that our
25 decision on the time point would have been to rule the claim out of time. Our reasoning would have been the same as is set out below in relation to the claim brought against the first respondent under section 15 of the Equality Act 2010.

247. No claim for indirect discrimination was brought against the second
30 respondent.

First respondent - discrimination arising from disability (s.15 EqA 2010)

248. The definition is as follows. A person (A) discriminates against a disabled
35 person (B) if A treats B unfavourably because of something arising in

consequence of B's disability and B cannot show that the treatment is a proportionate means of achieving a legitimate aim. We have dealt with the issue of knowledge elsewhere in these reasons.

5 249. We have also followed the guidance in ***Pnaiser v NHS England*** [2016] IRLR 170, EAT, paragraph 31.

250. The first question is whether the issue by the first respondent of an ARCP Outcome 3 in June 2014 and an Outcome 4 in June 2016 amounted to
10 unfavourable treatment for the purposes of section 15(1) EqA 2010. We find that both of those acts amounted to unfavourable treatment.

251. The Supreme Court has recently stated in ***Williams v The Trustees of Swansea University Pension & Assurance Sceheme*** [2018] UKSC 65 that
15 there is probably little difference between "unfavourable" treatment and other phrases such as "disadvantage" or "detriment" found in other provisions.

252. The unfavourable nature of an Outcome 4 is obvious since it results in the termination of training. While the effect of an Outcome 3 is (or should be) to offer
20 additional time for training and improvement, that is not favourable merely because it represents a better outcome from the trainee's point of view than an Outcome 4. The trainee's position under an Outcome 3 is more precarious than that prior to the issue of that outcome, and it is still properly regarded as "unfavourable" treatment overall.

25

253. The next question concerns the reason for the impugned treatment. In order to establish the reason, the focus is on the ARCP panel's thought processes. If there is more than one reason then the reason allegedly arising from disability need only be a significant (in the sense of more than trivial) influence on the
30 unfavourable treatment, it need not be the main or sole reason. See generally ***City of York Council v Grosset*** [2018] EWCA Civ 1105 at paragraph 53. Applying that test, we are satisfied that the following were reasons for the adverse outcomes in the ARCP process.

253.1. On both occasions, and in general terms, the first respondent's belief that the claimant had failed to demonstrate sufficient progress in the development of "non-technical skills".

253.2. In relation to the Outcome 3 awarded on 12th June 2014, specific concerns about the non-technical skills of "situational awareness" or "situational judgment" and teamworking (see for example [436] and [453]). We do not accept the claimant's submission that the reason was simply the time she had spent out of training. That would have been irrelevant if the required skills had nonetheless been demonstrated.

253.3. In relation to the Outcome 4 awarded in June 2016, specific concerns about situational awareness, a lack of communication skills and other unspecified non-technical skills (see [708]).

254. The next question is whether the reason for that unfavourable treatment was something "arising in consequence of" the claimant's disability. It was held in ***Pnaiser*** that the expression "arising in consequence of" could describe a range of causal links. More than one relevant consequence of the disability may require consideration and whether something can properly be said to arise in consequence of disability is a question of fact in each case. It is an objective question unrelated to the subjective thought processes of the respondent, and there is no requirement that the respondent should be aware that the reason for treatment arose in consequence of disability (see once again ***Pnaiser*** and more recently ***Grosset*** at paragraphs 50-52).

255. We find that the unfavourable treatment did indeed arise in consequence of the claimant's disability on both occasions. We make that finding in light of the medical evidence from Dr Steel and Dr Ogundipe, referred to above. Their reports identify consequences of recurrent depression which hampered the claimant's development of non-technical skills. Those consequences included a lack of eye contact, psychomotor retardation, impairment of attention and cognition, and coming across as quiet, withdrawn and prone to self-criticism. It is easy to see how those symptoms of depression could have impaired the development of non-technical skills and we find on the balance of probabilities that they did so.

256. We therefore turn to justification, and the question whether the treatment complained of was a proportionate means of achieving a legitimate aim for the purposes of section 15(1)(b) EqA 2010. Although the test of justification is legally identical to that arising under section 19, the factual context is different, since it is the unfavourable treatment which must be shown to be a proportionate means of achieving a legitimate aim for the purposes of section 15(1)(b), whereas it is the PCPs which must be shown to be a proportionate means of achieving a legitimate aim for the purposes of section 19(2)(d).

257. We are satisfied that the award of the Outcome 3 and the Outcome 4 were each proportionate means of achieving a legitimate aim when they were decided upon. The first respondent relies on the same aim as is relied upon for the purposes of the indirect discrimination claim. It is set out in full in the list of issues, reproduced above. A key element of that aim was patient safety.

258. Our reasoning is essentially same as is set out above in relation to the indirect discrimination claim and we refer back to that section of our reasons. The claimant presented a risk to patient safety. That risk could not be controlled adequately given her lack of insight, openness, candour and judgment when monitoring and reporting her own state of health. It follows that the Outcome 3 and the Outcome 4 were both proportionate means of achieving the legitimate aim. They represented an escalation of the controls necessary to ensure that only safe and competent trainees progressed to the next stage, which was a less supervised form of training. No lesser measures would have achieved the patient safety aspect of the aim. The lesser measure was in fact an Outcome 3, a precursor of an Outcome 4, which gave the claimant clear warning of the need to improve and of the consequences of a failure to do so. While the Gold Guide would have granted the claimant more time on an Outcome 3 if it had been applied correctly, the termination of the claimant's training by an Outcome 4 in June 2016 was nevertheless proportionate to the need to maintain patient safety, given that the claimant's own actions had made the risk unmanageable. That would be the case however much additional training time or supervision the claimant was granted. Although, as before, the first respondent's handling of the

ARCP process is open to criticism and several factors weigh in the claimant's favour in the proportionality assessment, they are ultimately outweighed by considerations of patient safety.

5 *Jurisdictional time limits*

259. Since we have rejected those claims on their merits the jurisdictional time points taken in relation to each of them are academic. We can nevertheless indicate the findings we would have made, if necessary.

10

260. We would not have found the allegations relating to first respondent's decision to award the Outcome 3 in June 2014 and the Outcome 4 in June 2016 to be part of the same "conduct extending over a period" as the dismissal by the second respondent on 16th May 2017 for the purposes of section 123(3)(a) of the
15 Equality Act 2010. The actors were different, even if the dismissal was in some ways a consequence of the Outcome 4. The nature of the decision, the decision maker and the body responsible were all different and so the "continuing act" argument would fail in so far as it represents an attempt to construct a single act ending on 16th May 2017.

20

261. Further, we would have regarded the two relevant ARCP Outcomes as separate events for time limit purposes too. Even though in a general sense both decisions were part of the ARCP process, they were distinct decisions made two years apart on the basis of the material available at the time of each decision.
25 We are unable to regard both of them as part of the same "conduct extending over a period".

262. Had it been necessary to make a finding, we would not have found it just and equitable for the complaints against the first respondent to be heard out of time.
30 The claim in relation to the ARCP Outcome 4 should have been presented within 3 months beginning with 14th June 2016. The claim in relation to the Outcome 3 should have been presented within 3 months beginning with 12th June 2014. The ET1 was received on 17th July 2017. That delay is very significant when seen in the context of a 3 month time limit, and all the more so in relation to the claims

regarding the Outcome 3. We are not persuaded that the decision to pursue an internal appeal process makes it just and equitable to hear the complaint late. The claimant was not under any misapprehension that she was *obliged* to pursue matters internally before bringing a tribunal claim, still less a reasonable misapprehension to that effect. She had contemplated bringing a tribunal claim about unrelated matters earlier in her employment and was aware of her right to do so. It was clear to us throughout the hearing that the recollections of witnesses had been impaired by the delay. The extensive volume of documentation only partially mitigated that difficulty. Delay diminished the cogency of the evidence we heard. The claimant had access to specialist advice from her representative organisation. She had access to advice on time limits and could easily have submitted a claim within the primary time limit. Weighing all those factors, we are not persuaded that the claims were presented within a just and equitable further period after the expiry of the normal time limits in accordance with section 123(1)(b) of the Equality Act 2010.

Failure to make reasonable adjustments against the first respondent

263. Although a claim for failure to make reasonable adjustments was brought against both respondents, the claim against the second respondent fails because we have found that none of the PCPs were applied to the claimant *by the second respondent*. The following paragraphs deal with the claim against the first respondent.

264. Our interpretation of sections 20 and 21 EqA 2010 has been guided by ***Environment Agency v Rowan*** [2008] IRLR 20, EAT, with necessary modifications to reflect the differences between the DDA 1995 and the EqA 2010. ***Secretary of State for Work and Pensions v Higgins*** [2014] ICR 341, EAT, is the equivalent post-Equality Act 2010 authority.

265. The first step is to identify the relevant PCPs. We have already set out our findings in relation to the PCPs applied to the claimant. We bear in mind that on Mr Truscott QC’s interpretation, but not Mr Northall’s, we should disregard for

present purposes those which constituted the application of competence standards.

266. Even on the basis of the reduced list of PCPs (excluding those which we have found to be the application of a competence standard), we are satisfied that they put the claimant at a substantial (in the sense of more than minor or trivial) disadvantage. The disadvantage was the greater likelihood of an Outcome 3 and ultimately an Outcome 4 and removal from the training programme. That was because the claimant's disability was likely to, and did, make it harder for her to develop and demonstrate the required non-technical skills *at the required rate*. The remaining PCPs are all concerned in one way or another with the maximum duration of training, or the timetable for assessment. The causal connection required by ***Nottingham City Transport Ltd v Harvey*** (UKEAT/0032/12 at paragraph 17) is therefore established. The claimant faced a substantial disadvantage when compared to a trainee who did not have a recurrent depressive disorder.

267. We therefore turn to the reasonableness of the proposed adjustments. The suggested adjustments were set out in the list of issues and were reproduced earlier in these written reasons. Adjustments are potentially reasonable if they would *or might* remove the substantial disadvantage caused by the PCP (***Griffiths v Secretary of State for Work and Pensions*** [2016] IRLR 216, paragraph 65, and ***Leeds Teaching Hospitals NHS Trust v Foster*** [2010] UKEAT/0552/10, paragraph 14). An adjustment does not have to be completely effective in order to be reasonable (***Noor v Foreign & Commonwealth Office*** [2011] UKEAT/0470/10, paragraph 33).

268. On the facts of this case we can deal with them globally. We have concluded that none of them would have been reasonable because none of them would have been sufficiently efficacious. The proposed adjustments would not be reasonable if they caused or failed to control a risk to patient safety, even if they alleviated some or all of the disadvantage faced by the claimant as a result of the application to her of the relevant PCPs. Put another way, it would not be reasonable to offer additional time or support, or to alter techniques and cycles

of assessment, in order to assist the development certain skills if there would be an ongoing risk to patient safety anyway for other reasons.

269. We have already set out similar reasoning in the context of the claims under sections 15 and 19 of the Equality Act 2010. In the context of reasonable adjustments, our essential finding is that the claimant's lack of judgment, candour and insight into her condition would have caused an unmanageable risk to patient safety regardless of adjustments. None of the adjustments proposed would have addressed that risk, because the claimant could not be relied upon to give a full and accurate account of her symptoms when too unwell to practise. Therefore, it was not reasonable to make the adjustments.

270. We should highlight one proposed adjustment since we understood Mr Northall to argue that it could deal with any risk to patient safety. The suggested system of monitoring and self-reporting could not succeed if the claimant was not honest and open about her state of health. The dependence of such a scheme on the claimant's own candour and insight is amply demonstrated by the redactions made by the claimant in the course of the appeal. The first respondent needed to be able to assess any risk arising and to decide upon appropriate measures to control that risk. Without full and accurate disclosure by the claimant of her symptoms the system would fail, and the claimant could not be relied upon to do that. The proposed system of monitoring and self-reporting was not a reasonable adjustment.

271. While our reasoning necessarily depends on matters which were not known to the respondent at the time, that is no objection to their admissibility or relevance. We must make an objective assessment (***Morse v Wiltshire County Council*** [1998] IRLR 352) and our assessment is not limited to the facts known to the respondent at the time. Mr Northall accepted that in paragraph 175 of his written submissions.

272. For those reasons, we find that neither respondent was in breach of the duty to make reasonable adjustments. So far as the first respondent was concerned, the suggested adjustments could not reasonably have been made. So far as the

second respondent was concerned, no duty to make adjustments arose.

Dismissal by the second respondent (section 15 of the Equality Act 2010 and section 98 of the Employment Rights Act 1996)

273. It is convenient to deal with two distinct legal claims in a single section of our reasons since both of them concern the claimant's dismissal by the second respondent. The claimant alleges that her dismissal was not only unfair having regard to section 98 of the Employment Rights Act 1996, but also that it amounted to discrimination arising from disability contrary to section 15 of the Equality Act 2010.

274. So far as the claim under section 15 is concerned, the second respondent concedes that dismissal amounted to unfavourable treatment.

275. As for the "something" arising in consequence of disability, that "something" was the claimant's removal from training and the loss of her training number following the Outcome 4. That was why the second respondent decided to dismiss.

276. As for whether that reason arose "in consequence of the claimant's disability", we find on the balance of probabilities that the claimant's removal from training arose in consequence of her disability. We have already set out above in the context of "substantial disadvantage" for the purposes of the reasonable adjustments claim the ways in which the claimant's progress through training was impeded by the symptoms of her disability. The medical evidence establishes the broad causative test at the heart of section 15(1)(a) of the Equality Act 2010 since dismissal arose from the claimant's removal from training, which in turn arose from disability for the reasons set out above.

277. The remaining issue is whether dismissal was a proportionate means of achieving a legitimate aim for the purposes of section 15(1)(b) of the Equality Act 2010. We will return to this issue after considering unfair dismissal.

278. The second respondent relies on "some other substantial reason" as its potentially fair reason for dismissal. It has satisfied us on the balance of probabilities that it had an honest belief in such a reason. The claimant had been removed from training as a result of the first respondent's processes and had lost her training number. Although we would not accept that the sole purpose of the claimant's employment was to train, we do accept that it was the primary or predominant purpose, with the delivery of service a necessary and welcome consequence. The claimant's removal from training was a substantial reason of a kind which might justify the dismissal of an employee holding the position which the claimant held (a training post) and the test in section 98(1)(b) of the Employment Rights Act 1996 is satisfied.

279. Since a potentially fair reason for dismissal has been established we therefore turn to the test of fairness in section 98(4) of the Employment Rights Act 1996. It is well established that on this issue we must not substitute our view for that of the employer. The issue is not what we would have done if we were the employer. We must instead apply a "range of reasonable responses" test. If some reasonable employers would have dismissed then the dismissal is fair. If no reasonable employer would have dismissed then the dismissal is unfair. That "range of reasonable responses" test applies just as much to procedural points as it does to the decision whether dismissal was the appropriate option.

280. To some extent the claimant's arguments on the fairness of dismissal reiterated arguments made in relation to discrimination claims which we have rejected (see paragraph 213 of Mr Northall's submissions).

281. The sole additional issue in relation to section 98(4) was that of alternative employment. The second respondent argues that there was no duty to search for alternative employment, given the unusual features of the employment relationship. The claimant was employed primarily to train, rather than primarily to deliver healthcare services. The second respondent played no part in the recruitment or selection of the claimant and did not decide where or for how long she would carry out her duties while in the second respondent's employment. The claimant argues that the end of employment for training should not preclude

the continuation of employment on other terms, if suitable vacancies exist.

282. We prefer the claimant's argument. We acknowledge that the employment relationship had somewhat unusual features but our finding is that all reasonable employers in the second respondent's position would have explored the possibility of alternative employment for an employee such as the claimant, who had been removed from speciality training. By alternative employment in this context we mean "staff grade" (i.e. non-training) posts since the claimant clearly could not return to another training post in the short term. We understood Mr Northall to accept that on the claimant's behalf.

283. While we agree with Mr Fairley QC that the employment relationship was unusual we do not think that makes a difference to the principle. The claimant was not a beginner in anaesthetics and had completed part of her speciality training. While her non-technical skills were considered deficient and a barrier to progression there was no dispute that she was competent in many respects and had successfully completed many units of intermediate training as well as core training and necessary exam passes. While the ARCP process looked forward to a time when a trainee would work with far less supervision, and asked whether they were ready for that, non-training posts do not assume progression in that manner. It *could* be that staff grade vacancies offered a type or level of work, or a degree of supervision, which would allow the claimant to work without presenting a risk to patient safety. We heard no evidence on that issue one way or the other. The second respondent had a vacancy which appeared to be potentially suitable. Clearly the viability of such a post, and the claimant's potential to give safe and effective service in that alternative role, would require careful evaluation, but we find that such an evaluation would have been carried out by all reasonable employers.

284. In submissions it was debated whether the duty to search for alternative employment in redundancy dismissals was a proper analogy in this case. We think that frames the issue too narrowly. The obligation to consider alternative employment is not limited to redundancy situations. No doubt it could also apply,

in an appropriate case, to dismissals made as part of a business reorganisation which did not meet the definition of redundancy. An obligation to consider alternative employment has been considered in capability dismissals too (***British Gas Services Ltd v McCaull*** [2001] IRLR 60). Mr Fairley QC referred us to ***Royal Surrey County NHS Foundation Trust v Drzymala*** (UKEAT/0063/17) but in that case the EAT declined to lay down firm rules in what it regarded as a fact sensitive area in which there was no substitute for applying the wording of section 98(4) ERA 1996.

285. Further, Janis Butler accepted at the appeal stage that the redeployment policy should have been applied prior to dismissal. Her opinion was authoritative given her very senior HR role. Having reached and announced that conclusion, it was incumbent on the second respondent to correct the unfairness which Janis Butler had identified. It did not do so. The error was identified and acknowledged but not corrected by the appeal. A letter dismissing the appeal was issued before a potentially suitable staff grade post had been fully explored with the claimant. The undertaking to do so in the future was insufficient to avoid an unfair dismissal. The fairness of a dismissal is judged at the time of that dismissal, or at the time of an appeal where there is an appeal (***West Midlands Cooperative Society Ltd v Tipton*** [1986] ICR 192). The tribunal must look at the fairness of the dismissal process as a whole (***Taylor v OCS Group Ltd*** [2006] ICR 1602). What a tribunal cannot do is to take into account undertakings or promises to correct a defect at some point in the future, after the conclusion of all internal processes and the rejection of the appeal.

286. We find that in this situation all reasonable employers would have completed the investigation of alternative employment before issuing the appeal outcome, or else would have upheld the appeal pending that investigation of alternative employment. No reasonable employer would have highlighted the need for a consideration of alternative employment in order to correct a failure at the dismissal stage, but nevertheless dismissed the appeal before alternative employment could be fully investigated. The dismissal therefore fell outside the reasonable range and we find that the claimant was unfairly dismissed.

287. Returning to the claim for discrimination arising from disability, we find that the confirmation of the claimant's dismissal on appeal was disproportionate to the second respondent's aim. The aim of dismissing the claimant is set out above in the reproduced list of issues. In part it is said to be "employing trainee doctors only if they were in a position to participate in a recognised training programme". We do not accept the legitimacy of that aspect of the aim where there was a potentially suitable *non-training* vacancy which the former trainee doctor might have filled competently and safely, despite their removal from training. We have no difficulty in accepting the legitimacy of the aspects of the aim concerned with competence and patient safety.

288. In any event, the second respondent has failed to satisfy us that the means used to achieve the competence and patient safety aspects of the aim were proportionate given that there remained an unexplored possibility that the claimant could have given satisfactory service in a staff grade role. At the time of the dismissal and the appeal outcome the claimant's suitability for the role had not been assessed. Suitability had at least two parts: competence and safety. The claimant's competence to discharge the responsibilities of the role had not been assessed and the risk to patient safety had not been explored and assessed either. Dismissal and the confirmation of that dismissal on appeal were therefore disproportionate means of achieving the stated aim.

289. For those reasons we find that the second respondent discriminated against the claimant for a reason arising from her disability contrary to section 15 of the Equality Act 2010.

<u>Summary of outcome</u>

290. All of the disability discrimination claims brought against the first respondent (under sections 15, 19 and 20-21 of the Equality Act 2010) fail and are dismissed.

291. The claim for failure to make reasonable adjustments brought against the second respondent fails and is dismissed.

292. The claims brought against the second respondent for unfair dismissal and discrimination arising from disability contrary to section 15 of the Equality Act 2010 both succeed.

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293. As previously ordered, questions of remedy will be dealt with at a separate hearing. The parties should write to the tribunal as soon as practicable, and in any event within 56 days of the date on which these reasons are sent to them, suggesting directions for the determination of the remaining issues, which should
10 be agreed if possible. We also remind the parties of our direction in paragraph 2 of these reasons regarding any necessary further anonymisation.

Date of Judgment: 17 January 2019
15 **Employment Judge: Mark Whitcombe**
Entered Into the Register: 24 January 2019
And Copied to Parties