EMPLOYMENT TRIBUNALS

Claimant: Ms V Earle

Respondent: The Chief Constable of North Yorkshire Police

HELD AT: Middlesbrough **ON:** 19-21 and 24-26 February 2020

BEFORE: Employment Judge Aspden
Mr S Hunter
Mrs D Newey

REPRESENTATION:

Claimant: Ms J Callan, counsel
Respondent: Ms R Mellor, counsel

JUDGMENT having been sent to the parties and written reasons having been requested in accordance with Rule 62(3) of the Employment Tribunals Rules of Procedure 2013, the following reasons are provided:

REASONS

The claims and issues

1. By a claim form presented on 22 November 2018, the claimant brought complaints under the Equality Act 2010 of disability discrimination, relying on sections 39 and sections 15 (discrimination arising from disability) and 20/21 (failure to make reasonable adjustments).

2. The respondent denied all liability to the claimant.

3. In her grounds of claim, the claimant said that a consultant psychiatrist confirmed, on 11 January 2018, that she was suffering from work-related stress, an acute stress reaction, an adjustment disorder and symptoms of post-traumatic stress disorder and that, in a report dated 5 October 2018, that same psychiatrist confirmed that the 'claimant's mental impairments were revised as being a complex post-traumatic stress disorder, a clinical depressive disorder and an obsessive compulsive disorder.' The claimant contended in her grounds of claim that her 'conditions (either individually and/or cumulatively) are mental impairments, which have a substantial and long-term adverse effect on [her] ability to carry out normal day-to-day activities' and that the claimant was at all material times disabled within the definition in section 6 of the Equality Act. The respondent conceded, in its grounds of resistance, that the claimant was a disabled person, within the meaning of that term in the Equality Act 2010, at all relevant times.

4. In response to questions from the Tribunal on the second day of this hearing (the first day having been set aside for reading by the Tribunal in the absence of the parties) Ms Callan said that the impairments on which the claimant relies as constituting a disability at the relevant time(s) are those referred to in the grounds of claim as having been set out in the consultant psychiatrist's report of 11 January 2018 ie work-related stress, an acute stress reaction, an adjustment disorder and symptoms of post-traumatic stress disorder. Ms Callan also confirmed that the matters about which the claimant complains in these proceedings all occurred after 11 January 2018. Ms Mellor confirmed that the respondent accepts that the claimant was disabled by virtue of those impairments from no later than 11 January 2018, that the respondent knew, or could reasonably have been expected to know, that she had that disability from the date the respondent's Force Medical Adviser (FMA) received the report of 11 January 2018 and that it is no part of the respondent's case that the FMA was independent of the respondent or that the FMA's knowledge could not be properly imputed to the respondent.

5. At a preliminary hearing before Employment Judge Morris on 28 February 2019, the issues arising for determination by the Tribunal were identified. The list of issues set out in the note of the case management hearing suggested that the claims being made by the claimant are as follows.

6. **Allegations of Failures to make Reasonable Adjustments: sections 20/21 of the Equality Act**

   6.1. The claimant alleges that the respondent applied the following provisions, criteria or practices (PCPs) which put her at a substantial disadvantage in comparison with persons who are not disabled:
   (a) the respondent's policy/practice in relation to acting upon the medical advice from an independent medical practitioner regarding the medical treatment required by any particular officer;
   (b) the respondent's policy/practice relating to the procurement of medical treatment;
   (c) the respondent's policy/practice relating to the extension of pay where the absences are disability-related;

(d) the respondent's policy/practice relating to the extension of sick pay where the officer's absences are prolonged because of a failure to make earlier reasonable adjustments;
(e) the respondent's policy/procedure relating to sick pay where an officer is seeking referral to the SMP for ill-health retirement.

6.2. The claimant alleges that the respondent was, therefore, under a duty to make reasonable adjustments to avoid that disadvantage and that it had discriminated against her by failing to comply with that duty.

7. **Allegations of Discrimination arising in consequence of disability: section 15 of the 2010 Act**

7.1. The claimant alleges that the respondent treated her unfavourably by:
(a) failing to provide adequate or any medical treatment;
(b) refusing to provide the recommended number of sessions of EMDR;
(c) refusing to provide monthly one-hour appointments with a consultant psychiatrist;
(d) delaying the provision of six sessions of EMDR and appropriate medical treatment.

7.2. The claimant alleges this was discrimination within section 15 of the Equality Act on the basis that the respondent did these things because:
(a) she required medical treatment identified by Dr Beaini in his report dated 11 January 2018 because of her disability;
(b) she needed to take ongoing sick leave because of her disability, which triggered half and possibly nil pay; and/or
(c) she was receiving half pay due to her continuing absence from work.

8. We discussed the claims and the list of issues set out in the case management order with the parties at the start of the second day of this hearing.

9. In relation to the complaint that the respondent discriminated against the claimant by refusing to provide the recommended number of sessions of EMDR, the claimant alleged in her grounds of complaint, at paragraph 20, that 'in or around late January/early February 2018 HR indicated that they were only prepared to provide six sessions of EMDR…' We asked Ms Callan if this allegation was still being pursued, as the claimant's own evidence in her witness statement (at paragraph 35) appeared to be at odds with the allegation (the claimant saying, 'On 8 March 2018 I received email confirmation from OH that the Force had approved funding for 6 EMDR sessions (as I understand is the Force's standard practice) with interim approval being granted for further sessions 'once the therapy is believed to be being effective.' Ms Callan said that the allegation concerns the decision to sanction the provision of, and fund, six sessions of EMDR with the proviso that more sessions could be provided and funded. We asked if it is the claimant's case that this was a refusal to fund more than six sessions of EMDR as alleged in the claim form. Ms Callan's reply was that it is.

10. In relation to the complaint that the respondent discriminated against the claimant by refusing to provide monthly one-hour appointments with a consultant

psychiatrist, we noted that the grounds of complaint do not clearly identify when this refusal was alleged to have occurred but that the claimant alleges in her grounds of complaint, at paragraph 23, that 'The Claimant queried with ADI Kirk the lack of monthly consultations with a psychiatrist. ADI Kirk informed the Claimant that she would only be referred back to Dr Beaini after six sessions of EMDR.' We asked Ms Callan when, on the claimant's case, the respondent refused to provide monthly one-hour appointments with a consultant psychiatrist. Ms Callan's response was that the respondent had, in or around early March, approved funding for six sessions of EMDR. We asked if she is saying this constituted a refusal to provide monthly one-hour appointments with a consultant psychiatrist. Ms Callan replied that she is.

11. During the course of the discussion about the section 15 claims it became apparent that the list of issues set out in the case management order did not reflect the way in which Ms Callan was now seeking to put the claim. Specifically, Ms Callan said it was the claimant's case that the respondent also treated her unfavourably by reducing her pay to half pay with effect from 1 September 2018 and that the respondent did so because she was absent from work on sick leave, which was something arising in consequence of her disability. That is not how the claim was set out in the list of issues in the case management order, which list was based on – and reflected - a draft prepared by the claimant's representatives for the case management hearing.

12. Ms Callan referred us to paragraph 35.2 of the grounds of claim. That paragraph, however, did not allege that the respondent treated the claimant unfavourably, and thereby discriminated against her, by reducing her pay. Nevertheless, Ms Mellor said the respondent had understood the claimant to be making the complaint under section 15 now raised by Ms Callan, notwithstanding that it had not been included in the list of issues discussed during the case management hearing. Ms Mellor referred us to paragraph 38 of the grounds of claim in which the claimant had said that the respondent's 'treatment in respect of the reinstatement of the sick pay cannot be justified.' Ms Mellor said the respondent had inferred, based on paragraphs 35 and 38, that the section 15 claim now raised by Ms Callan was included in the claim form. We asked the parties' representatives if they were now suggesting that the list of issues discussed at the case management hearing and set out in the case management order was incorrect. They both agreed that it was. That being the case, we permitted the claimant to add to the complaints identified in the list of issues a further allegation of discrimination arising in consequence of disability under section 15 of the Equality Act ie that the respondent treated her unfavourably by reducing her pay to half pay with effect from 1 September 2018 and that th erespondent did so because she was absent from work on sick leave, which was something arising in consequence of her disability.

13. The Tribunal noted that it was not clear from the grounds of claim, grounds of resistance or the list of issues what the parties' respective positions were on certain issues. We, therefore, provided the parties with a revised list of claims and issues which included the additional section 15 claim and reflected further information provided by the parties during discussion. We asked the parties to clarify their position on certain matters, which they did following a break. The list

of issues below sets out the matters which it was then agreed that the Tribunal would need to decide in order to determine the claimant's claims.

List of issues

Allegations of Failures to make Reasonable Adjustments: sections 20/21 of the Equality Act

14. Did the respondent apply PCPs as alleged by the claimant? ie

(a) the respondent's policy/practice in relation to acting upon the medical advice from an independent medical practitioner regarding the medical treatment required by any particular officer;
(b) the respondent's policy/practice relating to the procurement of medical treatment;
(c) the respondent's policy/practice relating to the extension of pay where the absences are disability-related;
(d) the respondent's policy/practice relating to the extension of sick pay where the officer's absences are prolonged because of a failure to make earlier reasonable adjustments;
(e) the respondent's policy/procedure relating to sick pay where an officer is seeking referral to the SMP for ill-health retirement.

In this regard:

14.1. In response to a request for better particulars of the alleged policy/practice 'in relation to acting upon the medical advice from an independent medical practitioner regarding the medical treatment required by any particular officer', Ms Callan explained that, by this, the claimant means specifically 'the handling of various stages between line manager, occupational health, FMA, the report going back to Occupational Health to HR, the approval of recommendations to seek independent psychiatric assessment and then, once obtained, the handling of that advice within occupational health, including the FMA, and from the FMA to HR and referral to the provider i.e. the practices within the organisation in dealing with the referral for advice and handling of that advice through to implementing that advice.'

14.2. Ms Mellor confirmed that:

14.2.1. The respondent accepts that the application of regulation 28 of the Police Regulations 2003, and the exercise of discretion, amounted to a PCP.

14.2.2. The respondent does not accept that there is a PCP in relation to the extension of sick pay where the officer's absences are prolonged because of a failure to make earlier reasonable adjustments ie (d) above.

14.2.3. It is not accepted that the respondent applied any other PCPs as alleged.

15. Did the PCP(s) in question put the claimant at a substantial disadvantage in relation to employment by the respondent, in comparison with persons who are not disabled? If so, what was the disadvantage?

15.1. In response to a request that the Claimant identify the disadvantage she alleges the PCP(s) put her at in comparison with persons who are not disabled, Ms Callan provided the following further particulars:

15.1.1. 'The delay in the provision of EMDR therapy affected the claimant's mental health so that it deteriorated to the extent that she had complex PTSD and two new diagnoses of OCD and clinical depressive disorder, which led to her permanent inability to perform the duties of a police officer.'

15.1.2. 'In relation to the pay issue, from 1 September 2018 to 21 November 2018 the substantial disadvantage was financial and also the psychological impact on the claimant's mental health.'

16. Did the respondent know that the PCP in question was likely to place the claimant at a substantial disadvantage in relation to employment by the respondent, in comparison with persons who are not disabled, or could the respondent reasonably have been expected to know that?

17. Would any of the following steps have avoided that disadvantage in relation to employment by the respondent:

17.1. facilitating medical treatment where advised to do so by the medical practitioner;
17.2. expediting medical treatment where advised to do so by the medical practitioner;
17.3. varying the procurement policy to ensure medical treatment is provided as recommended by the medical practitioner;
17.4. varying the procurement policy to ensure medical treatment is provided within a timeframe recommended by the medical practitioner;
17.5. varying the procurement policy to ensure there is no exacerbation of an officer's ill-health due to a failure to provide medical treatment;
17.6. varying the procurement policy to ensure there is no exacerbation of an officer's ill-health due to a failure to provide medical treatment within a timeframe recommended by the medical practitioner;
17.7. continuing full pay where there is evidence of a delay in the provision of medical treatment and/or in the making of earlier reasonable adjustments;
17.8. continuing full pay where there is evidence of disability -related absences;
17.9. continuing full pay where there is evidence that the reduction in pay will exacerbate the officer's ill-health;
17.10. expediting an application for ill-health retirement and the referral to the SMP;
17.11. expediting an application for ill-health retirement and the referral to the SMP to ensure an officer is reinstated to full pay?

18. Would it have been reasonable for the respondent to take any of those steps?

19. Did the respondent fail to take such steps?

Complaints of discrimination arising in consequence of disability: section 15 of the 2010 Act

20. Did the respondent:
    20.1. fail to provide adequate or any medical treatment;
    20.2. refuse to provide the recommended number of sessions of EMDR;
    20.3. refuse to provide monthly one-hour appointments with a consultant psychiatrist; and/or
    20.4. delay the provision of six sessions of EMDR and appropriate medical treatment?

21. If so, was this unfavourable treatment?

22. If so:

    22.1. Did the respondent treat the claimant unfavourably in this way because she required medical treatment identified by Dr Beaini in the report dated 11 January 2018? If so was the requirement for that treatment something that arose in consequence of her disability?

    OR

    22.2. Did the respondent treat the claimant unfavourably in this way because she needed to take ongoing sick leave? If so was the claimant's need to take ongoing sick leave something that arose in consequence of her disability?

    OR

    22.3. Did the respondent treat the claimant unfavourably in this way because she was receiving half pay? If so was the fact that the claimant was receiving half pay something that arose in consequence of her disability?

23. If so, was the unfavourable treatment in question a proportionate means of achieving a legitimate aim? ie

    23.1. Was the alleged aim legitimate?
    23.2. Was the treatment a proportionate means of achieving that aim?

    23.3. In response to a request that the respondent identify the aim relied on, Ms Mellor said the respondent's position is as follows:
        23.3.1. If the Tribunal finds the respondent failed to provide adequate or any medical treatment, the respondent does not contend that there was an objective justification for this treatment.
        23.3.2. If the Tribunal finds that the respondent refused to provide the recommended number of sessions of EMDR, the respondent's aim was to ensure treatment was effective at the six-session mark and ensure appropriate use of public funds at the six-session mark.
        23.3.3. If the Tribunal finds that the respondent refused to provide monthly one-hour appointments with a consultant psychiatrist, the aim was the appropriate use of public funds by not using the Force's public funds, and oversight of healthcare should be with the individual's treating physician and not the Force.

23.3.4. If the Tribunal finds that the respondent delayed the provision of six sessions of EMDR and appropriate medical treatment, the aim was to enable the provision of a more local practitioner.

Additional complaint of discrimination arising in consequence of disability: section 15 of the 2010 Act (not set out in list of issues in CMO)

24. The Respondent accepts that:
    24.1. the respondent reduced the claimant's pay to half pay with effect from 1 September 2018
    24.2. the claimant's pay was reduced because of her continuing absence from work
    24.3. the claimant's absence from work arose in consequence of her disability.

25. Was the reduction in pay unfavourable treatment?

26. If so, was the reduction in pay a proportionate means of achieving a legitimate aim? Ie
    26.1. Was the alleged aim legitimate?
    26.2. Was the reduction in pay a proportionate means of achieving that aim?

    In response to a request that the respondent identify the aim relied on, Ms Mellor said the aim was 'to apply the discretion in the guidance to ensure a consistent and fair application of the rules across the Force.'

Time points

27. If any of the claims are well founded, does the Tribunal have jurisdiction to determine them?

Relevant legal framework

28. It is unlawful for an employer to discriminate against an employee in the way it affords him or her access, or by not affording him or her access, to opportunities for transfer or for receiving any other benefit facility or service, by dismissing him or her or by subjecting him or her to any other detriment: section 39(2) of the Equality Act 2010.

Discrimination arising from disability

29. An employer discriminates against a disabled employee if it treats that person unfavourably because of something arising in consequence of his or her disability and the employer cannot show either (a) that it did not know, and could not reasonably have been expected to know, that the employee had the disability; or (b) that the treatment was a proportionate means of achieving a legitimate aim: Equality Act 2010 s15.

30. 'Unfavourably' must be interpreted and applied in its normal meaning; it is not the same as 'detriment' which is used elsewhere but a claimant cannot succeed by

arguing that treatment that is in fact favourable might have been even more favourable: Williams v Trustees of Swansea University Pension and Assurance Society [2018] UKSC 65, [2019] IRLR 306.

31. Simler P in Pnaiser v NHS England [2016] IRLR 170, EAT, gave the following guidance as to the correct approach to a claim under Equality Act 2010 s 15:
    - A tribunal must first identify whether there was unfavourable treatment and by whom: in other words, it must ask whether A treated B unfavourably in the respects relied on by B.
    - The tribunal must determine what caused the impugned treatment, or what was the reason for it. The focus at this stage is on the reason in the mind of A. An examination of the conscious or unconscious thought processes of A is likely to be required, just as it is in a direct discrimination case. Again, just as there may be more than one reason or cause for impugned treatment in a direct discrimination context, so too, there may be more than one reason in a s.15 case. The 'something' that causes the unfavourable treatment need not be the main or sole reason, but must have at least a significant (or more than trivial) influence on the unfavourable treatment, and so amount to an effective reason for or cause of it.
    - The tribunal must determine whether the reason/cause (or, if more than one), a reason or cause, is 'something arising in consequence of B's disability'. That expression 'arising in consequence of' could describe a range of causal links. The causal link between the something that causes unfavourable treatment and the disability may include more than one link. In other words, more than one relevant consequence of the disability may require consideration, and it will be a question of fact assessed robustly in each case whether something can properly be said to arise in consequence of disability.

Failure to make reasonable adjustments

32. Under section 39(5) of the Equality Act 2010 a duty to make reasonable adjustments applies to an employer. A failure to comply with that duty constitutes discrimination: Equality Act 2010 s21.

33. Section 20 of the Equality Act 2010 provides that the duty to make reasonable adjustments comprises three requirements, set out in s 20(3), (4) and (5). This case is concerned with the first of those requirements, which provides that where a provision, criterion or practice of an employer's puts a disabled person at a substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled, the employer must take such steps as it is reasonable to have to take to avoid the disadvantage. Section 21(1) provides that a failure to comply with this requirement is a failure to comply with the duty to make reasonable adjustments.

34. In considering whether the duty to make reasonable adjustments arose, a Tribunal must consider the following (Environment Agency v Rowan [2008] IRLR 20):

34.1. whether there was a provision, criterion or practice ('PCP') applied by or on behalf of an employer;
34.2. the identity of the non-disabled comparators (where appropriate); and
34.3. the nature and extent of the substantial disadvantage in relation to a relevant matter suffered by the employee.

35. The concept of a 'provision, criterion or practice' is a broad one, which is not to be construed narrowly or technically. Nevertheless, as the Court of Appeal said in Ishola v Transport for London [2020] EWCA Civ 112, [2020] IRLR 368:

'[t]o test whether the PCP is discriminatory or not it must be capable of being applied to others because the comparison of disadvantage caused by it has to be made by reference to a comparator to whom the alleged PCP would also apply. However widely and purposively the concept of a PCP is to be interpreted, it does not apply to every act of unfair treatment of a particular employee. That is not the mischief that the concept of indirect discrimination and the duty to make reasonable adjustments are intended to address. If an employer unfairly treats an employee by an act or decision and neither direct discrimination nor disability related discrimination is made out because the act or decision was not done/made by reason of disability or other relevant ground, it is artificial and wrong to seek to convert them by a process of abstraction into the application of a discriminatory PCP. In context, and having regard to the function and purpose of the PCP in the 2010 Act, all three words carry the connotation of a state of affairs indicating how similar cases are generally treated or how a similar case would be treated if it occurred again. 'Practice' connotes some form of continuum in the sense that it is the way in which things generally are or will be done. That does not mean it is necessary for the PCP or 'practice' to have been applied to anyone else in fact. Something may be a practice or done 'in practice' if it carries with it an indication that it will or would be done again in future if a hypothetical similar case arises.'

36. A duty to make reasonable adjustments does not arise unless the PCP in question places the disabled person concerned not simply at some disadvantage viewed generally, but at a disadvantage which is substantial (ie more than minor or trivial) and which is not to be viewed generally but to be viewed in comparison with persons who are not disabled: Royal Bank of Scotland v Ashton [2011] ICR 632, EAT.

37. Simler P in Sheikholeslami v Edinburgh University [2018] IRLR 1090 held:

'*The purpose of the comparison exercise with people who are not disabled is to test whether the PCP has the effect of producing the relevant disadvantage as between those who are and those who are not disabled, and whether what causes the disadvantage is the PCP. …*

The Equality Act 2010 provides that a substantial disadvantage is one which is more than minor or trivial: see s 212(1). The EHRC Code of Practice states that the requirement that an effect must be substantial reflects the general understanding of disability as a limitation going beyond the normal differences in ability which might exist among people: see para 8 of App 1. The fact that both groups are treated equally and that both may suffer a disadvantage in consequence does not eliminate the claim. Both groups might be

disadvantaged but the PCP may bite harder on the disabled or a group of disabled people than it does on those without disability. Whether there is a substantial disadvantage as a result of the application of a PCP in a particular case is a question of fact assessed on an objective basis and measured by comparison with what the position would be if the disabled person in question did not have a disability.'

38. The substantial disadvantage must be 'in relation to a relevant matter'. Schedule 8 of the Equality Act 2010 makes it clear that, in this context, a 'relevant matter' means employment by the respondent.

39. An employer is not subject to a duty to make reasonable adjustments if it does not know, and could not reasonably be expected to know, that the employee is likely to (ie could well) be placed at the substantial disadvantage.

40. The predecessor to the Equality Act 2010, the Disability Discrimination Act 1995, contained guidance as to the kind of considerations which are relevant in deciding whether it is reasonable for someone to have to take a particular step to comply with the duty. Although those provisions are not repeated in the Equality Act 2010, the EAT has held that the same approach applies to the 2010 Act: Carranza v General Dynamics Information Technology Ltd [2015] IRLR 43, [2015] ICR 169. This is also apparent from Chapter 6 of the Code of Practice on Employment (2011), issued by the Equality and Human Rights Commission, which repeats, and expands upon, the provisions of the 1995 Act. The 1995 Act provided, as does the Code of Practice, that in determining whether it is reasonable for an employer to have to take a particular step in order to comply with a duty to make reasonable adjustments, regard shall be had, in particular, to—
    - 40.1. whether taking any particular steps would be effective in preventing the substantial disadvantage;
    - 40.2. the practicability of the step;
    - 40.3. the financial and other costs of making the adjustment and the extent of any disruption caused;
    - 40.4. the extent of the employer's financial and other resources;
    - 40.5. the availability to the employer of financial or other assistance to help make an adjustment; and
    - 40.6. the type and size of the employer.

41. It is clear from the cases of O'Hanlon v Comrs for HM Revenue & Customs [2007] EWCA Civ 283, [2007] IRLR 404, and Meikle v Nottingham County Council [2004] EWCA Civ 859, [2004] IRLR 703 that paying money, such as enhanced sick pay, to an employee who is absent sick is, in principle, capable of falling within the duty to make adjustments. However, as the EAT made clear in O'Hanlon, it would be a rare and exceptional case in which an employer would be expected to enhance an employee's sick pay entitlement. As Elias P said in that case:

    'First, the implications of this argument are that Tribunals would have to usurp the management function of the employer, deciding whether employers were financially able to meet the costs of modifying their policies by making these enhanced payments. Of course we recognise that tribunals will often have to

> have regard to financial factors and the financial standing of the employer, and indeed s.18B(1) requires that they should. But there is a very significant difference between doing that with regard to a single claim, turning on its own facts, where the cost is perforce relatively limited, and a claim which if successful will inevitably apply to many others and will have very significant financial as well as policy implications for the employer. On what basis can the tribunal decide whether the claims of the disabled to receive more generous sick pay should override other demands on the business which are difficult to compare and which perforce the tribunal will know precious little about? The tribunals would be entering into a form of wage fixing for the disabled sick.
>
> Second, … the purpose of this legislation is to assist the disabled to obtain employment and to integrate them into the workforce.'

42. Following these cases, in G4S Cash Solutions (UK) Ltd v Powell [2016] IRLR 820, EAT, HHJ Richardson held that, whilst not anticipated to be 'an everyday event for an Employment Tribunal to conclude that an employer is required to make up an employee's pay long-term to any significant extent', there could be cases where this may be a reasonable adjustment for an employer to have to make as part of a package of adjustments to get an employee back to work or keep an employee in work. In Tameside Hospital NHS Foundation Trust v Mylott UKEAT/0352/09 (11 March 2011, unreported), the EAT observed 'The whole concept of an adjustment seems to us to involve a step or steps which make it possible for the employee to remain in employment and does not extend to, in effect, compensation for being unable to do so.' This is consistent with the fact that the duty to make adjustments only arises if a PCP puts an employee as a substantial disadvantage in relation to employment with the respondent.

Burden of proof

43. The burden of proof in relation to allegations of discrimination is dealt with in section 136 of the 2010 Act, which sets out a two-stage process.

    43.1. Firstly, the Tribunal must consider whether there are facts from which the Tribunal could conclude, in the absence of an adequate explanation, that the respondent has committed an unlawful act of discrimination against the claimant. In deciding whether the claimant has proved such facts, it will usually depend on what inferences it is proper to draw from the primary facts found by the tribunal. If the Tribunal could not reach such a conclusion on the facts as found, the claim must fail.

    43.2. Where the Tribunal could conclude that the respondent has committed an unlawful act of discrimination against the claimant, it is then for the respondent to prove that it did not commit or, as the case may be, is not to be treated as having committed, that act.

Police regulations

44. The Police Regulations 2003 provide, at regulation 28, as follows: The Secretary of State shall determine the entitlement of members of police forces to pay during

periods of sick leave taken in accordance with a determination under regulation 33(5), and in making such a determination the Secretary of State may confer on the chief officer discretion to allow a member of a police force to receive more pay than that specified in the determination.

45. The Secretary of State's determination made pursuant to regulation 28 says

    45.1. Subject to paragraph (2), a member of a police force who is absent on sick leave, in accordance with Regulation 33(5), shall be entitled to full pay for six months in any one year period. Thereafter, the member becomes entitled to half pay for six months in any one year period.

    45.2. …

    45.3. The chief officer of police may, in a particular, case determine that for a specified period

    a) a member who is entitled to half pay while on sick leave is to receive full pay, or

    b) a member who is not entitled to any pay while on sick leave is to receive either full pay or half pay,

    and may from time to time determine to extend the period….

Evidence and findings of fact

46. We heard evidence from the claimant. For the respondent we heard evidence from Mrs Kirk, a Detective Inspector (formerly Temporary Inspector) who became the claimant's line manager during the course of events with which we are concerned, Miss Colclough, an HR adviser for North Yorkshire Police, Mrs Consett, the HR Support Unit manager for North Yorkshire Police, and Ms Winward, who has been the Chief Constable of North Yorkshire Police since August 2018 (and was Acting Chief Constable from April 2018).

47. In addition, we were referred to a number of documents in a bundle comprising over 1100 pages. We explained to the parties at the outset of the hearing that we would only take into account the documents that we were referred to.

48. The claimant joined the respondent's police force as a police constable in August 2003. During the summer of 2017 the claimant's mental health deteriorated and, following observations by colleagues, the claimant was referred to the force's occupational health department. The claimant had some meetings with occupational health and was then referred to the force medical advisor (FMA).

49. The claimant reported in sick on 18th September 2017 with anxiety. She did not return to post after that date. An occupational health report records that the claimant's GP had made a provisional diagnosis of Post-Traumatic Stress Disorder (PTSD) and a full recovery was expected.

50. The claimant met the FMA in October 2017. The FMA determined the claimant was not medically fit to return to the workplace at that time and that was likely to remain the case for at least a further three months. On the FMA's recommendation the claimant was referred to an independent psychiatrist, Dr Beaini, for an assessment.

51. The consultation with the FMA was on 9th October 2017. The FMA's report was dated 16th October and was e-mailed to HR on 27th October. An appointment was arranged for the claimant to see Dr Beaini on 10th January 2018. At the time the claimant expressed her unhappiness that the appointment was so long after the FMA had recommended the referral. However, one of the reasons that date was chosen is that the claimant had not wanted an appointment in the lead up to Christmas.

52. Dr Beaini saw the claimant on 10th January and prepared a report dated 11th January. In that report he said the claimant was suffering from increased anxiety and depression, work-related stress, acute stress reaction, adjustment disorder and post-traumatic stress disorder. He referred to events going back as far as 2006 and said that over the years the claimant has suffered from acute stress reaction and adjustment disorder and, over recent years, post-traumatic stress disorder. In a section headed 'treatment' he said:

    a. *intensive EMDR course is strongly indicated*
       i. twelve to twenty-four sessions in the first instance then reassess
    b. *Self-help; sensible diet… and regular physical and relaxation activities, with a view to a CBT course once the EMDR is finished*
    c. *Leave from work; 12 weeks in the first instance in order to initiate the above treatment plan*
    d. *Anti-depressants which are indicated in PTSD should be considered …if the above psychological interventions are not sufficient*
    e. *One-hour appointment per month with a consultant psychiatrist to monitor mental state and response to treatment and consider additional medical treatment.*

53. In a section of the report headed prognosis Dr Beaini said this:
    a. *Every attempt should be made to encapsulate the PTSD and treat it in order to prevent irreversible personality change*
    b. *Re-assessment in 12 months' time will be required in order to review the treatment and prognosis of Ms Earle*
    c. *Should Ms Earle require, I would be happy to treat her in my private outpatient clinic on a schedule advised above…I would be in a position to prescribe any treatment or medication indicated following discussion with her GP*

54. In his conclusions Dr Beaini said:
    a. *Ms Earle should remain on sick leave from the police force for 12 weeks in the first instance, to allow for her intensive psychological interventions can be initiated*
    b. *Ms Earle's sick leave should be reviewed on a 12 week basis by her GP accompanied by consultant psychiatrists monthly input and feedback from psychological therapies*
    c. *I can confirm that Ms Earle, providing the above treatment plan is carried out, following re-assessment and continued support; holds a firm possibility of returning to her duties as a police officer within the next 12 to 15 weeks.*

55. The acronym EMDR stands for Eye Movement Desensitisation Reprogramming therapy. CBT stands for Cognitive Behavioural Therapy.

56. The usual process followed by the respondent when an external independent expert recommends EMDR or CBT was described in evidence by the respondent's witnesses and in particular by Miss Colclough. At the time of the events with which we are concerned that process was as follows:
    1. The consultant writes a report and sends it directly to the force's occupational health and welfare department for consideration by the FMA. The FMA is part of the force's occupational health and welfare department; he or she is not a permanent fixture in the department but someone who comes in approximately one day a week to deal with force matters.
    2. The individual then has an appointment with the FMA. To avoid delay, the appointment is pre-arranged by HR before the independent medical report is obtained, based on what HR has been told by the independent consultant or their secretary about when the report could be expected.
    3. After the appointment the FMA dictates a report.
    4. An admin officer within occupational health types the report and sends it to the FMA to check.
    5. The FMA checks the report.
    6. The individual is then given the opportunity to see the report and comment on it.
    7. If the individual approves the report they then say so. Occupational health then e-mail the FMA's report to the individual's line manager and HR contact.
    8. If the FMA has recommended EMDR or CBT an administrative officer sends the report to a welfare advisor.
    9. The welfare advisor sends the report to the head of HR, who decides whether to approve funding.
    10. If funding is approved the head of HR tells the welfare advisor.
    11. The welfare advisor then approaches the two contractors that the force has in place for the provision of this kind of treatment to ask if they can provide the treatment.
    12. If one or other of the contractors agrees to the referral the welfare advisor puts the supplier in contact with the individual. It is then for the provider to contact the individual to make arrangements for treatment.

57. Miss Colclough also described the normal (prior) process followed by the respondent in deciding whether an officer should be referred to an independent medical practitioner. We accept Miss Colclough's description of that process. However, there is no need for us to describe those stages of the process here as the claimant's complaint concerns the process adopted by the respondent in relation to acting upon the medical advice from an independent medical practitioner, which is the process described above.

58. Returning to that process, the external consultant's report is not sent to HR or the individual's line manager, for confidentiality reasons. The role of the FMA is to consider and interpret the external consultant's report and form their own view on recommendations as to what steps the organisation should consider taking, no doubt taking into account matters such as whether the treatment is practicable

and likely to be effective. The independent consultant, whilst an expert in their field, will not necessarily have any knowledge of police work. In contrast, the FMA will be familiar with police activities and able to consider the advice of the independent consultant in the context in which the individual works. Neither the FMA nor occupational health decide whether any potential adjustments will in fact be made. They do not control the budget for such matters. Nevertheless, we infer that the FMA will have some familiarity with the force's general approach to funding in such matters.

59. Funding decisions are a matter for HR. In particular, when therapy is recommended and where that therapy is EMDR or CBT it is for HR to decide whether that will be funded. At the time of these events the respondent did not have therapists in-house who could provide EMDR. Instead, where it considered it appropriate to do so, the force would provide funding and arrange for such therapy to be provided by an external supplier. The force would also, in some cases, provide funding and arrange for CBT to be provided by an external supplier. Mrs Consett said that she was unaware of the force having provided funding for other kinds of therapy or treatments and that the reason EMDR and CBT have been singled out for special treatment is that it has been recognised within the force that individuals can struggle to obtain such therapy on the NHS; so a decision was taken that the force would provide funding in appropriate cases.

60. When procuring services from third parties, the force is subject to procurement rules on best value. It used to be the case that where such therapy was recommended and the force was willing to fund it the respondent would approach three separate providers for quotes on an individual ad-hoc basis. However, a decision was taken to change that regime and instead put in place contracts with certain suppliers. In 2017, following a procurement exercise the previous year, contracts were entered into with two suppliers for the provision of EMDR therapy and CBT.

61. In this case, the independent consultant, Dr Beaini, dated his report 11th January 2018. We infer it was sent to the force's occupational health department around about that time and received by the FMA soon after. On 29th January, when the claimant had not heard anything regarding the treatment plan recommended by Dr Beaini the claimant spoke to Mrs Kirk to ask for the treatment plan to be expedited. There was a discussion then about Mrs Kirk taking over as the claimant's line manager. That was something the claimant was in favour of and that change took effect at that time.

62. The claimant had an appointment with the FMA on 8th February, as pre-arranged by HR. On 21st February the claimant submitted an application to the Chief Constable to extend her full sick pay entitlement. On 23rd February the report from the FMA was chased up. On 1st March the claimant told Mrs Kirk that the fact that she had not yet had the FMA's report was causing concern as she said she needed to send it to the Chief Constable in connection with her pay appeal.

63. The FMA's report was in fact sent to the claimant on 1st March 2018. The FMA's report is dated 20th February. The claimant approved the report on that same day and it was sent to Miss Colclough in HR that day.

64. In her report, the FMA set out in a series of bullet points a summary of what Dr Beaini had said. That bullet point list, which was introduced by the words 'According to the psychiatrist', included the following:

    '-PC Earle should remain on sick leave from the police force for twelve weeks in the first instance to allow her to have intensive psychological interventions in the form of CBT and EMDR.
    - Some recommendations have been made which her GP will be implementing.
    -Her expected time of recovery and return to work will be over the next twelve to fifteen months.
    -She should be reviewed every three months by her GP and monthly by the psychiatrist if indicated.
    -He should reassess her in another twelve months in order to review her treatment and prognosis.
    …
    -As she is not taking any medication presently, it has been recommended that her GP should look at this if and when indicated.'

65. In her report, the FMA expressed the following opinions:
    '1. PC Earle is unfit for work and this is likely to be the case for the next three to six months at least.
    2. Expected time for recovery and return to full policing duties will be no fewer than twelve to fifteen months.
    3. This will also be dependent on her accessing the treatment and support interventions recommended by the psychiatrist and her response to the treatment.
    4. Treatment with EMDR and CBT is required as soon as possible and I will be happy to facilitate a referral to the force psychologist in order to access this treatment, with your permission.'

66. Because the FMA recommended EMDR and CBT, Miss Colclough sent the report to the welfare advisor, Ms Bailey. This happened on 1st March, three weeks after the claimant had met with the FMA. Ms Bailey sent her report to the head of HR to approve funding; we infer that was done on 1st March as we were referred to an e-mail from Ms Bailey in which she said she would be seeking approval that day. On 6th March the claimant spoke to Mrs Kirk and asked for her treatment to be expedited.

67. The head of HR approved funding for EMDR treatment and told the welfare advisor she had done so. That appears to have happened on 8th March, ie a week after the funding request was referred to the head of HR. In her email to Ms Bailey confirming that funding was approved for the referral, the head of HR said 'in principle I understand and support your initial assessment that possibly 12 sessions may be needed and I am happy to approve the initial 6 sessions with a confirmation from yourself that at the 6 session point you have been able to liaise with the supplier to ensure that the treatment is believed effective and then

perhaps you will have a better idea of the exact number of sessions that will be required so that I can support that further recommendation.' The initial approval of six sessions as opposed to the full series of sessions recommended is standard practice for the force. There was no suggestion in this e-mail that further approval would not be forthcoming for future sessions and nor was the claimant told at the time that she would not get funding for future sessions.

68. The welfare advisor then approached the two suppliers with whom the force had contracts for the provision of EMDR therapy. We were referred to an e-mail of 8th March to the claimant saying the providers were asking for consent forms and we infer from that that Ms Bailey had been in touch with the contractors as early as 8th March. One of the contractors said it could not provide the treatment and suggested that was a matter for the NHS. The other, Alliance, said it could. It is not clear to us when it indicated it could provide the treatment but a formal referral was made on 22nd March which is just less than two weeks from funding approval. When she made that referral, Ms Bailey said in an email to Alliance '6 sessions have been approved in the first instance as is NYP's standard practice; however I have already made the fund-holder aware that the number of sessions recommended by the psychiatrist is 12-24 and she assures me that she will be ready to approve further sessions promptly on receipt of confirmation that the therapy is proceeding effectively. Should further sessions be needed after the maximum funded by NYP I would approach the Blue Lamp Foundation'. The 'fund-holder' in this case was the head of HR. The Blue Lamp Foundation is a charity.

69. In accordance with regulations governing pay, the claimant's entitlement to sick pay was due to be reduced to half pay on 14th March. However, the Chief Constable exercised discretion and extended full pay from 14th March to June 2018.

70. One of the claimant's allegations in these proceedings is that the respondent refused to provide her with monthly sessions with a psychiatrist, which she contends were recommended by Dr Beaini. In her grounds of complaint, at paragraph 23, the claimant appears to suggest that it was Mrs Kirk who communicated that decision to her, saying 'The Claimant queried with ADI Kirk the lack of monthly consultations with a psychiatrist. ADI Kirk informed the Claimant that she would only be referred back to Dr Beaini after six sessions of EMDR.' The claimant addressed this point briefly in her statement at paragraph 27, saying that Dr Beaini had recommended she have monthly appointments with a psychiatrist but that when she asked Mrs Kirk about this she was 'informed that the Force were not going to implement that part of Dr Beaini's recommendation and that I should not expect to see him until after the initial treatment.' The claimant did not volunteer the context of that conversation or say when it happened and did not suggest that she raised that specific matter again with anybody on any later occasion. When we asked the claimant if she could remember what Mrs Kirk actually said to her, her evidence differed from what is in her statement: she said that Mrs Kirk had told her that she should not expect to see Dr Beaini again until after the initial treatment (which is what is alleged in the grounds of complaint). For her part, Mrs Kirk said she had no recollection of saying what was attributed to her by the claimant. Furthermore, she did not think

she would have said what the claimant claimed in paragraph 27 of her statement because it was not for her to make decisions about what sort of treatment will be provided or funded. Although it is clear that the claimant and Mrs Kirk had a lot of conversations about the treatment that was being arranged, we find it unlikely that Mrs Kirk said that the force was not going to implement Dr Beaini's recommendation that she have monthly psychiatric appointments, given that Mrs Kirk had not seen Dr Beaini's report (though she had seen the FMA's precis of it) and, more significantly, it was not her decision to make - she would have had to ask somebody else. Even the claimant, when asked what Mrs Kirk had actually said, did not suggest Mrs Kirk had said the force were not going to implement Dr Beaini's recommendation. Looking at the evidence in the round, we accept there may, however, have been a conversation between the claimant and Mrs Kirk in which the claimant asked about going to see Dr Beaini again and Mrs Kirk simply said that the claimant would see him after EMDR.

71. On or before 28th March, ie within a week of the referral, the claimant was telephoned by someone from administration in Alliance to make arrangements for her treatment. The claimant was offered an appointment in Middlesbrough. The claimant said she was anxious about travelling that far and the person from Alliance said she could look into the possibility of a provider nearer to the claimant and that they were in the process of appointing someone in the Yorkshire area.

72. On 28th March a doctor from Alliance e-mailed an update to Mrs Bailey saying the claimant was looking for something in the Leeds area and was unwilling to travel further afield. He also said 'we are currently in discussion with an EMDR therapist based in York and hope to update you on this status shortly.' That e-mail was forwarded to the claimant. She e-mailed Mrs Bailey to say the doctor's e-mail was not correct, that she had not refused to travel, that somebody had called her and said they were a practice based in Middlesbrough and asked if she was looking for somewhere closer to home, that she had replied that ideally she was and that the person she spoke to stated that she would look into the possibility of a provider in the claimant's area and would come back to her.

73. The claimant assumed at this point that the appointment of a therapist in the York area by Alliance was imminent. On 12th April Mrs Kirk spoke to the claimant on the phone. The claimant was upset that treatment had not yet been arranged. Mrs Kirk contacted Miss Colclough by email. In that email she said the claimant had told her she was upset because she had been led by Alliance to believe that they were recruiting a therapist in the York area 'at the minute' and that, had she known that was not the case, she would have travelled to Middlesbrough for treatment.

74. Miss Colclough, in turn, contacted Ms Usher, another Welfare Adviser, to ask if anything could be done to bring forward the treatment date. She asked if there was a different supplier that could be approached. Ms Usher replied on 13th April by email. In that email she said 'The agency that we have commissioned to work with Victoria has been identified as the one which should best meet their individual needs. I spoke with someone at the agency today and they advised me that they are waiting at the moment to ascertain the CRB status of their York

practitioner. If she already has DRB clearance then an appointment can be made as soon as next week. If not, it could take up to six weeks for this to be done. If it is likely to take longer than a further week to access the practitioner in York then Victoria has the option of going to Middlesbrough where an appointment can be made within the week. The agency advised that they have arranged with Victoria to call her next week to update her.'

75. By early May there had been no further news from Alliance regarding the appointment of a therapist in York. The claimant met with Mrs Kirk and expressed her unhappiness at how long it was taking to arrange treatment. At that meeting the claimant said she felt her condition was deteriorating. She also said she did not feel it was appropriate for her to travel to Middlesbrough for treatment. She asked if it was possible for her to be referred to Dr Beaini instead. Mrs Kirk put that question to Ms Bailey, who responded by e-mail. On the matter of treatment from Dr Beanini, Ms Bailey said: 'I have spoken with Janine Hall my line manager today and she has confirmed that unfortunately it would not be possible to fund Victoria's undertaking this work with Doctor Beaini. This is a procurement rule - the two external providers that Welfare Advisors refer to have gone through a procurement process and met certain criteria, and HR cannot agree to fund a provider who hasn't gone through this process. I understand this will be disappointing to Victoria but this is the situation in relation to NYP rules.' Regarding Alliance she said 'the provider Alliance have undertaken to recruit a suitably qualified therapist based in York and when I spoke to them last week this process was underway with a timescale of '6-7 weeks'. I have spoken with Alliance today and they are now expediting this process. I will keep you both updated as I hear (and definitely before 30 May)..'

76. During the meeting with Mrs Kirk, the claimant had said that Ms Bailey had assured her that all of her treatment would be funded as there is an additional funding stream that can be accessed. Mrs Kirk recorded this in a note of the meeting, which she sent to Ms Bailey at the claimant's request. In her emailed reply, Ms Bailey said: 'I'd like to add one more thing in terms of managing Victoria's expectations. …I did mention to the claimant that once the NYP allocation of funding has been used up there is a police charity to which we can apply for additional funding. However, this is not unlimited and it may well be the case, given the number and severity of Victoria's issues, that not all of the issues can be dealt with through NYP's provision.'

77. The question of referring the claimant to Dr Beaini, or elsewhere, for treatment was raised again later in May and managers did start looking into it.

78. In the meantime, on 1st June, the Chief Constable exercised her discretion to extend the claimant's full pay to the end of August when it was to be reviewed at the September case conference. The reason she gave at the time for extending pay was the claimant had been unable to access treatment due to organisational delays and appeared to be suffering as a result of a longstanding work-related event. The Chief Constable said in her decision 'please extend full pay as per the rationale above but the treatment must be expedited so that this case can make progress. Full pay cannot be extended for a protracted period if there is no

anticipated return to work and treatment is anticipated as being for a protracted period with no recuperative duties being undertaken during this period.'

79. On 5th June the claimant was contacted by Alliance and she was told they now had appointed a therapist in York. An appointment was made for the claimant to see the therapist on 25th June for what turned out to be an introductory session.

80. The claimant went to her meeting with the therapist in York on 25th June. There then followed three sessions of EMDR, the last one on 20th August. Those sessions could not begin until 24 July 2018 because the therapist was on leave for three weeks, which the claimant says she found disappointing. After three sessions, the claimant and her therapist agreed that she should not have any more sessions of EMDR. The therapist prepared a discharge report in which she recorded the following 'I had explained to the client…that EMDR works to lessen the strength of negative feelings associated with past events to help her to be able to recall incidents without the strength of feeling attached. The client felt that even if she was more able to deal with her feelings she was still 'going to have to carry on being exposed to an environment which was physically and emotionally distressing to her.' The client told me that she felt 'poked and prodded' by the work. … We were both in agreement that she did not seem to be emotionally resilient enough to engage with therapy at this time.'

81. On receipt of that discharge report, the senior welfare officer at the force advised that the FMA would require an update report from Dr Beaini and funding for that consultation was obtained.

82. In the meantime, with effect from 1st September, the claimant's pay was reduced to half pay. The Chief Constable decided not to exercise her discretion to extend full pay at the September review of these matters. She gave her reasons at the time as follows: 'there has already been a protracted period of full pay beyond the regulations to take into account the work-related nature and allow for progress to be made. However treatment has been suspended and there is no realistic prospect of this matter being progressed to either return to work or SMP at this stage. I therefore agree half pay is the most appropriate decision in this case at this time until further information is available.' When she made that decision she knew that EMDR therapy had not been successful. She had been provided with a summary of the progress to date, including the medical report from the FMA that had been obtained earlier in the year. Her decision was that the claimant should receive half pay until 31 October 2018, whereupon the position would be reviewed again.

83. The claimant had a second consultation with Dr Beaini on 4th October and the following day he prepared a report. In that report he said:

> *1. It took several months until the claimant had EMDR. She became worse during that period, intrusive thoughts persisted, negative in content and purposeless. Occasionally telling herself 'stop it' helped but quite often the level of anxiety increased to the extent that she had to give way to the thoughts. This process amounts to obsessive compulsive disorder phenomenon (OCD).*

2. During the same period she became worse with poor sleep, inability to leave the house, negative thoughts and low mood. Her concentration became worse …Her the sense of enjoyment was reduced significantly... This supports clinical depressive phenomenon.

3. The EMDR was started around the end of June and stopped after four sessions because Ms Earle was experiencing headaches and vomiting, excessive sweating and upsurge of previous traumatic events. She was not able to articulate words and remembered more dormant traumatic incidents at work. This supports a complex post-traumatic stress disorder. The latter does not necessarily respond to EMDR. She was discharged from this therapy at the end of August 2018. Her salary was reduced by half and she perceived this as evidence of her unworthiness.

4. It is unclear whether the OCD and the clinical depressive disorder were already in evidence prior to the assessment I carried out in January 2018 or whether they were secondary disorders to the PTSD. Either way bearing in mind a diagnosis of PTSD the revised diagnoses are:

- *complex post-traumatic stress disorder*
- *clinical depressive disorder*
- *obsessive compulsive disorder.'*

84. Dr Beaini went on to say 'EMDR should be avoided. The treatment of the clinical depressive disorder and the OCD should be given the priority first followed by the treatment of the complex PTSD.' He then went on to refer to other matters such as self-help, CBT and medication before saying 'This may take a good twelve months in the first instance and if successful the treatment of PTSD should be reconsidered. This step by step treatment plan is crucial. The prognosis is significantly worse than expected. The emergence of dormant PTSDs render its treatment more complex and the outcome uncertain. Furthermore, the overall treatment, if successful, may improve Ms Earle's quality of life and daily function without necessarily enhancing her fitness to resume work as a police officer. In my considered opinion her incapacity to work as a police officer is total and permanent.'

85. That report was sent to the OH department. The FMA reviewed the claimant's case on 26th October and expressed the following opinion: 'I am unable to think of any adjustments, either permanent or temporary, that are likely to facilitate a return to work and her ability to carry out the ordinary duties of a police officer and render regular and reliable service. …In my opinion the question of whether she is permanently disabled from performing the ordinary duties as a member of the police force as defined by the police pension regulations is one for the Selected Medical Practitioner. However, there is enough evidence for a referral to the SMP if requested.'

86. The claimant applied for ill-health retirement under the police pension regulations.

87. In early November, the Chief Constable decided that the claimant should be reinstated the claimant to full pay if and when the Deputy Chief Constable agreed that the claimant should be referred to the SMP to decide whether she was

permanently disabled. In her reasons for exercising her discretion she acknowledged that the claimant was highly unlikely to return to work.

88. On 19 November 2018, the Deputy Chief Constable agreed to refer the claimant to the SMP and the claimant was reinstated to full pay from that date. Up to that point, the claimant's pay remained at half pay.

89. The claimant's appointment with the SMP took place the following January and her retirement on ill health grounds was subsequently approved. She remained on full pay until the date of her retirement.

90. The Police Negotiating Board (PNB) has agreed guidance in relation to situations where it would be reasonable for chief constables to exercise their discretion favourably to resume/maintain paid sick leave. This is set out in a circular, to which we were referred. The guidance refers to the requirement to consider each case on its merits, saying 'the force cannot have a fixed policy that discretion always will or always will not be exercised in a particular kind of case.' It says that it is possible for forces to lay down guidelines 'to promote fairness and consistency in the decision-making process', however, and recommends forces have a written policy on the exercise of discretion. At paragraph 7, the circular goes on to say the PNB considers it generally would be appropriate for chief officers to exercise the discretion favourably in certain circumstances as set out there. Those circumstances include: where the chief officer is satisfied that incapacity is directly attributable to injury or illness sustained in execution of duty; where the case is being considered in accordance with guidance on improving the management of ill-health and the police authority has referred the issue of whether the officer is permanently disabled to a selected medical practitioner (SMP); or where the force medical advises that the absence is related to disability as defined in the Disability Discrimination Act (now the Equality Act of course) and the chief officer considers that it would be a reasonable adjustment to extend the sick pay, generally speaking to allow further reasonable adjustments to be made to enable the officer to return to work.

91. The North Yorkshire Police force's own policy largely reflects the guidance. It also emphasises that although each case will be considered on its own merits it is expected that only in exceptional circumstances will discretion be exercised in favour of the member of staff. It sets out examples of 'possible exceptional circumstances' that mirror the circumstances described in the PNB circular as those in which it would be appropriate for a chief officer to exercise discretion favourably ie (a) cases of injury or illness sustained or contracted in the actual execution/discharge of duty; (b) cases of life threatening illness where the prognosis is poor; (c) cases being considered in accordance with guidance on improving the management of ill-health where there has been a referral of the issue of whether the officer is permanently disabled to a selected medical practitioner (SMP); or (d) where the FMA advises that the absence is related to disability as defined in the Equality Act 2010 and it is considered that it would be a reasonable adjustment to extend sick pay, generally speaking to allow further reasonable adjustments to be made to enable the officer to return to work. With regard to referrals to an SMP, the force policy also says that where a decision is made to medially retire an officer after he or she has gone through the SMP

process then the officer's full pay will be restored to full pay, backdated to the date the Deputy Chief Constable referred the question regarding permanent disablement to the SMP and continuing to the retirement date.

Conclusions

Alleged failure to make reasonable adjustments in relation to PCPs (a) and (b)

92. We will deal first of all with the allegations that the respondent failed to make reasonable adjustments to avoid disadvantage caused by the alleged PCPs identified as: (a) the respondent's policy/practice in relation to acting upon the medical advice from an independent medical practitioner regarding the medical treatment required by any particular officer; and (b) the respondent's policy/practice relating to the procurement of medical treatment.

Did the respondent apply PCPs as alleged by the claimant?

93. As recorded above, in relation to PCP(a) Ms Callan explained that the alleged policy/practice 'in relation to acting upon the medical advice from an independent medical practitioner regarding the medical treatment required by any particular officer' that the claimant relies on is 'the handling of various stages between line manager, occupational health, FMA, the report going back to Occupational Health to HR, the approval of recommendations to seek independent psychiatric assessment and then, once obtained, the handling of that advice within occupational health, including the FMA, and from the FMA to HR and referral to the provider.'

94. At the outset of the hearing, Ms Mellor's position was that the respondent did not apply PCPs as alleged at (a) and (b). In her closing submissions, however, Ms Mellor acknowledged, in relation to PCP (a) that the respondent has an administrative process which might amount to a practice, although she submitted that it was not clear whether it was actually that process which was being relied on as a PCP, as opposed to what she described as 'the specific 'handling' of the 'various stages between'.' Ms Mellor submitted that the former may be a PCP, but the latter is not.

95. It is clear to us that the respondent did have a normal process for 'acting upon the medical advice from an independent medical practitioner regarding the medical treatment required by any particular officer'. That process was as described by Miss Colclough and is as set out in our findings of fact in 12 numbered stages. That process, with its various stages, requires a number of different people to take a series of steps in sequence. Ms Mellor conceded that this may be a practice falling within section 20. We are satisfied that it clearly was and that the practice was applied to the claimant.

96. With regard to PCP(b) concerning procurement, Ms Mellor accepted in her closing submissions that the respondent has a requirement to comply with contract regulations so that all contracts for services are procured in a transparent way and that there are rules that apply to using services outside those procured contracts; Ms Mellor accepted that these are PCPs applied by the

respondent. The application of those PCPs meant that the respondent would (usually) only facilitate and fund EMDR or CBT treatment from one or other of its two approved suppliers. We are satisfied that the respondent applied those PCPs in this case.

Did the PCP(s) in question put the claimant at a substantial disadvantage in relation to employment by the respondent, in comparison with persons who are not disabled? If so, what was the disadvantage?

97. As recorded above, in response to our request that the Claimant identify the disadvantage she alleges the PCPs at (a) and (b) put her at in comparison with persons who are not disabled, Ms Callan described the disadvantage as follows: 'The delay in the provision of EMDR therapy affected the claimant's mental health so that it deteriorated to the extent that she had complex PTSD and two new diagnoses of OCD and clinical depressive disorder, which led to her permanent inability to perform the duties of a police officer.' In her written closing submissions, Ms Callan put it slightly differently, saying the disadvantage was 'the deterioration in her mental health to the extent she was permanently unable to perform the duties of a police officer.'

98. It was apparent from the way Ms Callan described the alleged disadvantage at the start of the hearing that the claimant's case then was that the PCPs – or the 'delay' in the claimant receiving treatment, which was a consequence of the application of the PCPs - caused the claimant's mental health to deteriorate and, more particularly, caused her to have complex PTSD, OCD and clinical depressive disorder, and led to her being permanently unable to perform the duties of a police officer and that it was this deterioration that put the claimant at a substantial disadvantage in comparison with someone without a disability.

99. As noted above, Ms Callan described the disadvantage somewhat differently when it came to making closing submissions. She referred simply to the deterioration in the claimant's mental health to the extent she was permanently unable to perform the duties of a police officer. One could read into this a shift in approach, with the claimant's case now (or alternatively) being that the application of the PCPs (or, more specifically, the delay in receiving treatment as a consequence of their application) did not, in itself, cause the claimant's mental health to deteriorate, but its effect was that the claimant could no longer benefit from treatment (or at least could no longer benefit to the extent that her career could be saved) because her condition had, in the meantime, deteriorated, whatever the cause of that deterioration may be. Although Ms Callan did not suggest that the claimant's position had changed, we have considered the claimant's claim on both alternative bases.

100. Whichever of those two ways one looks at the claimant's case, the disadvantage to which she was put in comparison with those without a disability was said to be the deterioration in her mental health.

101. Ms Mellor submitted that any 'delay' in the provision of treatment was not a consequence of the application of the PCPs and, therefore, it cannot be said that the PCPs put the claimant at the claimed disadvantage. We do not agree that the

fact that some five months passed between the Dr Beaini recommending EMDR and the claimant starting to receive that therapy was unrelated to the PCPs relied on – or at least PCP(a), for the reasons that follow.

102. Dealing first with PCP (a), it is an inherent feature of the respondent's normal process for 'acting upon the medical advice from an independent medical practitioner regarding the medical treatment required by any particular officer' that that it is likely to take a period of time to progress through each of the stages. In this case the independent consultant, Dr Beaini, sent his report to the force's occupational health department on or around 11th January 2018; the claimant had an appointment with the FMA on 8th February, as pre-arranged by HR; the FMA's report, dated 20th February, was sent to the claimant on 1st March 2018 (three weeks after the claimant had met with the FMA); on that same day, the claimant approved the report, it was sent to Miss Colclough in HR and Ms Bailey referred the matter to the head of HR to approve funding; no more than a week later, on 8th March at the latest, the head of HR approved funding for EMDR treatment and told the welfare advisor she had done so; by 8th March Ms Bailey had contacted the external suppliers; and on 22nd March, some 10 weeks after Dr Beaini had sent his report to the force's occupational health department, a formal referral was made to the one supplier that said it could provide treatment.

103. The evidence before us did not suggest there was anything unusual about the claimant's case that meant it took longer than it typically would to progress through the stages of the respondent's usual process from receiving an independent consultant's report to formally commissioning treatment. Although Ms Mellor referred us to the case of *Ishola*, she acknowledged that the stages described above followed the respondent's usual process. We are satisfied that in taking the steps described in the previous paragraph, the respondent applied a PCP, namely its normal process in relation to acting upon the medical advice from an independent medical practitioner regarding the medical treatment required, to the claimant and that that process meant that 10 weeks passed between the date Dr Beaini recommended EMDR treatment and the date the respondent formally commissioned an external provider to provide the claimant with the recommended treatment.

104. As for PCP (b), as noted above, this PCP meant that the respondent would (usually) only facilitate and fund EMDR or CBT treatment from one or other of its two approved suppliers. In this case, some three months passed between the date the claimant was formally referred to Alliance for treatment and the date of the claimant's first appointment with the therapist arranged through Alliance. Ms Mellor contends that this delay was not a consequence of the PCP but was due to the Claimant preferring to wait for a local therapist rather than travel to Middlesbrough and the time taken by Alliance to recruit a local therapist. Ms Callan, on the other hand, submits that the delay was a consequence of PCP (b). We have not had to resolve that dispute. That is because even if the entirety of the 'delay' in securing EMDR treatment for the claimant was a consequence of the PCPs, we are not satisfied that these PCPs put the claimant a substantial disadvantage in comparison with persons who are not disabled. The reasons for that conclusion follow.

105. The claimant's case was that the disadvantage to which she was put in comparison with those without a disability to whom the PCPs might be applied (ie people whom an independent expert recommends would benefit from CBT or EMDR and whose treatment the force agrees to fund) was the deterioration in her mental health.

106. It appears to us that the claim, as put by the claimant, faces a fundamental problem. That is because, under section 20, the duty on an employer to make reasonable adjustments only arises 'where a provision, criterion or practice of an employer's puts a disabled person at a substantial disadvantage…'. If, as suggested by Ms Callan, the claimant's case is that the disadvantage to her was the actual deterioration in her mental health to the point that she was permanently unable to perform her duties, then by the time the duty to make reasonable adjustments arose (ie when she was put at that disadvantage) it was too late for any adjustment to be made to avoid that disadvantage in relation to her employment. As Dr Beaini said in his second report, although further treatment at that point might have improved the claimant's quality of life and daily function, her incapacity to work as a police officer was total and permanent.

107. We consider, however, that notwithstanding the way in which Ms Callan articulated the claimant's claim, the claimant's case – in substance - could be said to be that the disadvantage to her was the risk that her condition would deteriorate. We have, therefore, considered the claim on that basis.

108. The claimant's case essentially rests on the proposition that the evidence shows that the EMDR treatment recommended by Dr Beaini was required by her urgently. Ms Callan suggested in her submissions that this was accepted by the respondents' witnesses. We do not accept that it was. What the witnesses accepted was that the FMA had said in her report that treatment should be provided 'as soon as possible.'

109. The advice that the claimant be provided with treatment in the form of EMDR came from Dr Beaini and was set out in his original report of February 2018. It is clear from that report that the EMDR was advised as a means of treating the claimant's PTSD. In our judgement, the only part of Dr Beaini's report that may lend support to the claimant's case that there was some urgency to the need for treatment is his statement that '*Every attempt should be made to encapsulate the PTSD and treat it in order to prevent irreversible personality change.'* That statement implies that the claimant's PTSD could lead to permanent personality change but that EMDR therapy might avert that outcome. It is notable, however, that Dr Beaini did not give any timescale as to when, in the absence of treatment, such a personality change could occur. It is not implicit in the statement that such a change was imminent, or that to forestall it EMDR was required urgently. Indeed, there are other aspects of Dr Beaini's report that imply that treatment was not urgent. For example, the report referred to the claimant having suffered from PTSD 'over recent years' and other mental health difficulties for even longer. Notwithstanding that the claimant had been suffering from PTSD for some considerable period, Dr Beaini believed that it was amenable to treatment with EMDR. He was clearly not suggesting that time is of the essence generally when treating PTSD with EMDR. Furthermore, Dr Beaini envisaged the 'treatment plan'

being 'initiated' within 12 weeks. One could infer that he had in mind that the treatment plan might be got under way within those 12 weeks. The treatment plan identified by Dr Beaini comprised a number of elements, however, only one of which was EMDR. We do not consider it implicit that Dr Beaini was suggesting that the claimant's EMDR should start within 12 weeks, still less that the EMDR should start even sooner than that. Most significantly of all, Dr Beaini did not actually say in his report that that there was an element of urgency to the claimant's need for treatment or that time was of the essence. That would be a surprising thing to omit if he did believe that the need for EMDR treatment was urgent or that time was of the essence in the way the claimant suggests.

110. We turn now to the FMA's interpretation of that report. In support of her claim, the claimant leans heavily on the fact that the FMA said in her report 'Treatment with EMDR and CBT is required as soon as possible.' The FMA does not, in her report, say what she means by that. Again, as with Dr Beaini, we would expect the FMA to have been much more explicit if she was of the view that time was of the essence. The phrase 'as soon as possible' is the sort of wording a medical expert might use in any case when recommending treatment. We bear in mind the FMA was likely to have some familiarity and understanding of force processes, including the need for funding third party providers. The FMA did not suggest the usual processes should be short-circuited or sped up in any way, which, again, is surprising if the FMA believed that is what should happen. The FMA saw the claimant on 8th February and her report was sent to the claimant and HR around three weeks later. If the FMA had felt time was of the essence it seems to us very unlikely that she would have taken so long to get her report out. We consider it highly likely that she would have expedited the report if she had believed any delay in providing treatment might be injurious to the claimant. The fact that she did not tends to suggest she did not hold that belief. It is our judgement that the words 'as soon as possible' cannot bear the weight of meaning attributed to them by the claimant.

111. We have also considered the therapist discharge letter from August. She referred to the claimant being not ready for the work and not being emotionally resilient enough to engage enough 'at this time.' She did not say, as is asserted in the claim form, that the claimant could not engage due to the delay.

112. We turn now to Dr Beaini's second report. We note he records that 'it took several months until Ms Earle had EMDR' immediately before going on to describe a deterioration in her condition and diagnosing OCD and clinical depressive phenomenon. One could read into that reference that he considered the delay to have some significance in relation to the deterioration of the claimant's condition. Alternatively, Dr Beaini may simply have been recording in his report something that it was clear to him the claimant felt strongly about (as he did by referring to the reduction in the claimant's pay). We consider the latter to be more likely given that Dr Beaini himself says he cannot say that the OCD and depression were not already present in January 2018.

113. Dr Beaini also, in his report, diagnoses complex PTSD which, he says 'does not necessarily respond to EMDR'. He expresses the opinion that EMDR is still possible at this point but it is less likely to succeed because the PTSD is

complex; and, even with treatment, because the claimant's PTSD is complex she is unlikely to return to work. This is the first time that a diagnosis of complex PTSD is made. He refers to the 'emergence of dormant PTSDs' and the claimant having experienced an 'upsurge of previous traumatic events' and 'remembered more dormant traumatic incidents at work' during her EMDR therapy.

114. It is clear that Dr Beaini's opinion of the nature of the claimant's PTSD had changed since his original opinion in January 2018. At the start of the year he considered she had PTSD that was amenable to EMDR treatment and that she was likely to return to work. Now he was of the opinion that she had complex PTSD that was harder to treat and, in any event, meant the claimant could never return to work as a police officer. The claimant invites us to infer from this that her PTSD deteriorated and became complex because of the time it took for her EMDR to begin, or that her PTSD became complex in the period between him seeing the claimant for the first time and her EMDR starting, and that this in turn supports her case that she was at risk of such deterioration all along.

115. Considering this report in the round and alongside the other evidence we have referred to above, we are not persuaded that Dr Beaini's report does support the claimant's case. We think it more likely that Dr Beaini was suggesting either that the claimant's existing PTSD became complex because of the claimant's reaction to EMDR or that, through the process of undergoing EMDR, it became apparent that the claimant's PTSD was more complex than he originally thought. We do not accept that it was Dr Beaini's opinion that the claimant's PTSD became complex because of the time it took for her EMDR to begin or that her PTSD became complex in the period between him seeing the claimant for the first time and her EMDR starting. For our part we are not persuaded that the claimant's PTSD became complex because of the time it took for her EMDR to begin or that her PTSD became complex in the period between Dr Beaini seeing the claimant for the first time and her EMDR starting. Nor do we find that there was a risk that the claimant's PTSD would deteriorate, to the extent that the claimant would no longer be able to work as a police officer, if EMDR treatment was not provided sooner than it in fact was.

116. Considering the evidence in the round, we are not satisfied that the PCPs relied on – or any 'delay' in the claimant receiving treatment consequent on the application of the PCPs – put the claimant at the disadvantage claimed, either by causing the claimant to deteriorate and have complex PTSD, OCD and clinical depressive disorder and leading to her being permanently unable to perform the duties of a police officer, or by putting the claimant at risk of experiencing such a deterioration or such conditions. Therefore, we are not persuaded that the PCPs relied on put the claimant at a substantial disadvantage in comparison with persons who were not disabled, as alleged. That being the case, this aspect of the claimant's claim fails.

117. Even if we had found that the PCPs did put the claimant at that disadvantage, we would have been persuaded that the respondent did not know, and could not reasonably have been expected to know, that the claimant could well be at risk of that disadvantage and that, therefore, no duty to make reasonable adjustments to avoid the disadvantage arose. As noted above, the only part of Dr Beaini's report

that could be construed as implying that there was some urgency to the need for treatment was his statement that 'Every attempt should be made to encapsulate the PTSD and treat it in order to prevent irreversible personality change.' That statement must be read in the context of the report as a whole. As noted above, although the statement implied that the claimant's PTSD could lead to permanent personality change but that EMDR therapy might avoid that outcome, Dr Beaini did not give any timescale as to when, in the absence of treatment, such a personality change could occur. The FMA (who was the only person -other than the claimant - to whom the report was provided) could not reasonably be expected to infer from the statement that such a change was imminent, or that to forestall it EMDR was required urgently, and as we note above, there were other aspects of Dr Beaini's report that implied that treatment was not urgent. For reasons already explained, we do not accept that the FMA in fact believed time was of the essence or that the claimant's mental health was at risk of deteriorating if she did not receive EMDR quickly.

118. Before considering the claimant's complaints in respect of pay, we shall address the claimant's further claims about how the respondent dealt with the treatment Dr Beaini recommended. These are complaints of discrimination falling within section 15 of the Equality Act.

Allegation of discrimination arising in consequence of disability: section 15 of the 2010 Act: allegation (a) - failing to provide adequate or any medical treatment

Did the respondent fail to provide adequate or any medical treatment?

119. The allegation that the respondent failed to provide any medical treatment is totally without merit. The respondent facilitated and funded access to EMDR as recommended by the independent consultant and FMA. That course of treatment was terminated by mutual agreement between the claimant and her therapist as it was not working. There is no suggestion by the claimant that she should have thereafter been provided with further treatment.

120. If and to the extent that the claimant alleges the treatment was not 'adequate' because the respondent refused to provide the recommended number of sessions of EMDR, failed to provide monthly appointments with a psychiatrist, or delayed treatment we deal with those matters in the context of allegations (b), (c) and (d).

Allegation of discrimination arising in consequence of disability: section 15 of the 2010 Act: allegation (b) - refusing to provide the recommended number of sessions of EMDR

Did the respondent refuse to provide the recommended number of sessions of EMDR?

121. The claimant's own evidence in chief does not support this allegation. The respondent agreed to fund EMDR sessions for the claimant from the outset and it provided those sessions up until the point at which the claimant and her therapist

agreed the claimant was not benefiting from them. The initial funding approval was for 6 sessions. The claimant accepted in her own evidence that this was in line with the force policy. At no point was she told the respondent would not fund more than that. The suggestion that the respondent refused to fund more than six sessions is contradicted by the e-mail confirming funding from the head of HR and also the e-mail from Ms Bailey of 22nd March to Alliance in which Ms Bailey said the Head of HR was aware that the number of sessions recommended by the psychiatrist is 12-24 and had assured her that – having approved the initial 6 sessions - she would be ready to approve further sessions promptly on receipt of confirmation that the therapy was proceeding effectively. The clear inference from the correspondence we were referred to is that the force may have been willing to fund potentially between 12 and 24 sessions of therapy directly provided the therapy was proving beneficial. That was not a guarantee that as many as 24 sessions would be funded by the force but it was certainly not a refusal to fund those sessions. By referring to the Blue Lamp foundation, Ms Bailey was saying that if more sessions were needed than the force could fund directly, charitable resources may be available. Again, that was not evidence of a refusal to fund the recommended sessions.

122. As events transpired, the claimant only undertook three sessions of EMDR. The reason for that was that the claimant and her therapist agreed the sessions were not beneficial. The curtailment of those sessions was in no way connected with any funding decisions by the respondent.

123. We reject the allegation that the respondent refused to provide the recommended number of sessions of EMDR. This claim, therefore, fails.

Allegation of discrimination arising in consequence of disability: section 15 of the 2010 Act: allegation (c) - refusing to provide monthly one-hour appointments with a consultant psychiatrist

Did the respondent refuse to provide monthly one-hour appointments with a consultant psychiatrist?

124. In his report, Dr Beaini recommended that the claimant have a '*One-hour appointment per month with a consultant psychiatrist to monitor mental state and response to treatment and consider additional medical treatment.'*

125. It is not in dispute that the respondent did not provide (or arrange for the claimant to be provided with and fund) regular appointments with a consultant psychiatrist.

126. The claimant's case is not simply that the respondent omitted to provide such treatment but that the respondent refused to do so. That implies that someone made a conscious decision that the respondent would not provide such treatment.

127. We have rejected the claimant's evidence that Mrs Kirk told her that the force was not going to implement Dr Beaini's recommendation that she have monthly psychiatric appointments. We have accepted that there may, however, have been

a conversation between the claimant and Mrs Kirk in which the claimant asked about going to see Dr Beaini again and Mrs Kirk simply said that the claimant would see him after EMDR. But even if she did say that, that was not a refusal to provide monthly one-hour appointments with a consultant psychiatrist.

128. When we asked Ms Callan when, on the claimant's case, the respondent refused to provide monthly one-hour appointments with a consultant psychiatrist, Ms Callan's response was that it was implicit in the communication, in or around early March, approving funding for six sessions of EMDR that the respondent was refusing to provide funding for monthly one-hour appointments with a consultant psychiatrist.

129. On the evidence before us, we find that the respondent, or -more accurately- those acting on the respondent's behalf, did not contemplate the possibility of arranging or funding monthly sessions with a psychiatrist. Ms Consett's evidence, which we accept, is that the force does not consider it appropriate for it to fund that kind of provision as it would, in effect, entail trespassing on the day to day care of the individual, which is and ought to remain the responsibility of an individual's GP who would, in appropriate, arrange psychiatric referral if needed. It is notable that, although the FMA referred to the force arranging EMDR and CBT, she did not suggest in her report that the recommendation for monthly psychiatrist appointments was one for the force to implement. When she refers to the recommendation of monthly psychiatric appointments she does so after observing that 'some recommendations have been made which her GP will be implementing', saying 'she should be reviewed every three months by her GP and monthly by the psychiatrist if indicated.' This suggests that she too felt that a referral to a psychiatrist was for the claimant's GP to arrange.

130. In light of the above, we do not accept that anyone acting on behalf of the respondent made a conscious decision that the respondent would not provide or fund regular psychiatric appointments. We, therefore, reject the allegation that the respondent refused to provide such treatment.

131. However even if we are wrong about that, or even if the claimant's case should be interpreted as an allegation that the respondent treated her unfavourably by omitting to provide or fund such treatment, the claim fails in any event for the reasons that follow.

The reason for the treatment

132. The claimant's claim is that she was treated unfavourably (a) because she required the medical treatment or (b) because she needed to take ongoing sick leave or (c) because she was receiving half pay. The claim can only succeed if the respondent refused/omitted to provide the treatment for one of those reasons.

133. The suggestion that the respondent refused or omitted to provide the claimant with psychiatric treatment because she needed the treatment is unsustainable. If there was an omission or refusal to provide treatment it was not <u>because</u> the claimant needed it but <u>despite</u> the fact that she needed it. The claimant's need for treatment was not part of the reason the respondent did not provide it – had she

no need for the treatment then obviously she would not have been provided with it either. As for the other bases on which this claim is put, there is no evidence at all to suggest that if the respondent did refuse or omit to provide the treatment that they did so because the claimant needed to take ongoing sick leave or was receiving half pay.

Was this unfavourable treatment?

134. Furthermore, we doubt that the omission to provide or fund psychiatric treatment could properly be described as unfavourable treatment. However, as the claim fails for the reasons already stated, we have not had to reach a concluded view on this.

Allegation of discrimination arising in consequence of disability: section 15 of the 2010 Act: allegation (d) - the respondent delayed the provision of six sessions of EMDR and appropriate medical treatment

Did the respondent delay the provision of six sessions of EMDR and appropriate medical treatment

135. In complaining that the respondent failed to make reasonable adjustments, the claimant submitted that the respondent applied the force's normal process for acting upon medical advice from an independent medical practitioner regarding the medical treatment. We have accepted that was the case. That process meant that 10 weeks passed between the date Dr Beaini recommended EMDR treatment and the date the respondent formally commissioned an external provider to provide the claimant with the recommended treatment. We do not accept that it can properly be said that the respondent thereby 'delayed' the claimant's medical treatment.

136. Some three months then passed between the date the claimant was formally referred to Alliance for treatment and the date of the claimant's first appointment with the therapist arranged through Alliance but that was not due to any delay on the part of the force.

137. What the claimant is really complaining about is that the respondent (or rather, those acting on the respondent's behalf) applied – and did not depart from – the force's usual policies for acting on medical advice that an individual should receive treatment and for procuring such treatment.

138. We have accepted that the application of those policies meant that it took 10 weeks to commission an external provider to provide the claimant with the recommended treatment. The claimant contends that the application of the force's procurement policies led to a further delay of several months. As we understand the respondent's position, she does not accept that was the case, Ms Mellor submitting that the delay was a consequence of the claimant's preferences as to where she received treatment and the time it took the provider to recruit someone local to the claimant. We have not felt it necessary to decide the extent to which any delay might have been caused by the force's own procurement

policies as opposed to decisions made by the claimant and/or Alliance because, as we now explain, the claim fails for other reasons.

Was this unfavourable treatment?

139. If and to the extent that the respondent caused a delay in the claimant receiving treatment by applying – and not departing from – the force's usual policies, the claimant's claim can only succeed if that was unfavourable treatment. The respondent was seeking to secure medical treatment for the claimant because of her disability. That was favourable, not unfavourable treatment. The claimant's complaint is that the respondent failed to provide that favourable treatment (by funding recommended therapy) in the optimal way. Bearing in mind the case of Williams v Trustees of Swansea University Pension and Assurance Society [2018] UKSC 65, [2019] IRLR 306, we do not accept that the respondent's application of the force's usual policy can properly be described as unfavourable treatment.

The reason for the treatment

140. Even if the respondent can be said to have caused a delay in the claimant receiving treatment by applying – and not departing from – the force's usual policies, and even if that could be considered unfavourable treatment of the claimant, the claim as put by the claimant can only succeed if the respondent treated the claimant unfavourably in that way (a) because she required the medical treatment or (b) because she needed to take ongoing sick leave or (c) because she was receiving half pay.

141. As with allegation (c), there is no basis for concluding that, if the respondent did delay providing treatment for the claimant, it was because she needed such treatment or because she was on sick leave or receiving half pay. If the respondent caused delay in the claimant receiving EMDR, that was not because the claimant needed it but despite the fact that she needed it. Had the claimant no need for EMDR she would not have been provided with it at all. As for the other bases on which this claim is put, there is no evidence at all to suggest that if the respondent delayed providing treatment they did so because the claimant needed to take ongoing sick leave or was receiving half pay.

142. For all of those reasons this claim fails.

Allegation of discrimination arising in consequence of disability: section 15 of the 2010 Act: - the respondent reduced the claimant's pay to half pay with effect from 1st September 2018

143. The respondent accepts that the respondent reduced the claimant's pay to half pay with effect from 1st September and that the claimant's pay was reduced because of her continuing absence from work and that the claimant's absence arose in consequence of her disability.

Was this unfavourable treatment?

144. Ms Mellor submitted that it was not unfavourable treatment for the respondent to reduce the claimant's pay to half pay when she did. She referred to the fact that the Chief Constable had, because the claimant's absences were disability related, already exercised discretion on two occasions to pay to the claimant more than she was entitled to under paragraph (1) of the determination issued by the Secretary of State pursuant to the Police Regulations. Accordingly, the claimant had received full pay rather than half pay from March to the end of August 2018. Then, with effect from 1 September 2018, the respondent exercised her discretion to pay the claimant half pay rather than nil pay and, therefore, the claimant continued to receive more than she was entitled to under paragraph (1) of the Secretary of State's determination. Referring to Williams v Trustees of Swansea University Pension and Assurance Scheme and another, Ms Mellor submitted that the respondent did not treat the claimant unfavourably by reducing her pay but rather chose to exercise her discretion to increase the claimant's pay from nil pay to half pay rather than exercising her discretion to increase the claimant's pay (or continue to increase her pay) to full pay. Ms Mellor's submission was that the claimant's complaint, in reality, is not that the respondent treated her unfavourably but that the respondent did not treat her as favourably as she could have done and the claimant wished her to.

145. We do not accept Ms Mellor's analysis. The case of Williams concerned the award of a pension. There was nothing intrinsically 'unfavourable' or disadvantageous about that given that the only basis on which the claimant was entitled to any award at that time was by reason of his disabilities: had he been able to work full time he would have been entitled not to an enhanced entitlement, but no immediate right to a pension at all. Here, the 'treatment' the claimant complains of is the reduction in her pay. Ms Mellor suggests that if the claimant had not been disabled then she would have been on nil pay. The problem with that argument is that it assumes that if the claimant had not been disabled she would nonetheless have been absent from work. We do not accept that is the correct approach to take. Had the claimant not been disabled there is no reason to think she would have been absent from work; and had she not been absent from work she would have been in receipt of full pay. We find that the reduction in pay from full pay to half pay was unfavourable treatment of the claimant by the respondent.

Was the reduction in pay a proportionate means of achieving a legitimate aim?

146. In response to a request from the Tribunal at the outset of the hearing to identify the aim that the reduction in pay sought to achieve, Ms Mellor said the aim was 'to apply the discretion in the guidance to ensure a consistent and fair application of the rules across the Force.' In her closing submissions Ms Mellor refined the point, saying that reducing the claimant's pay was a proportionate means of achieving the legitimate aim of 'proper adherence [to] and application of guidelines to ensure consistency across the Force to ensure the efficient [efficiency] and cost effectiveness of NYP.' We accept that this was clearly a legitimate aim for the respondent to pursue.

147. The guidelines to which Ms Mellor refers are those contained in the Police Negotiating Board (PNB) guidance and the respondent Force's own policy

covering the exercise of discretion by chief constables to pay an officer more than their entitlement under the Police regulations. The PNB circular encourages forces to have their own policy and says a force can have guidance 'to promote fairness and consistency in the decision-making process'. The respondent's force does have such guidelines, contained in a written policy. We are satisfied that, in accordance with the PNB circular, the force does not have a fixed policy that discretion always will or always will not be exercised in a particular kind of case. The respondent's force's policy is that, although each case will be considered on its own merits, it is expected that only in exceptional circumstances will discretion be exercised in favour of the member of staff. The policy sets out a list of what it describes as 'possible exceptional circumstances' in which discretion might be exercised. That list is in line with examples given at paragraph 7 of the PNB circular, which we refer to in our findings of fact above.

148. In line with those guidelines, the Chief Constable considered the claimant's case on its merits in deciding not to continue full pay but rather to reduce it to half pay.

149. The force's policy provides for extension of sick pay only in exceptional cases. The policy highlights certain circumstances in which discretion might be exercised. One of those is where extending the entitlement to full or half pay may be a reasonable adjustment to enable other reasonable adjustments to be made or continued to enable the individual to return to work. Ms Callan did not suggest to us that there were any adjustments that could have been made at this stage that would have enabled the claimant to get back to work; indeed the claimant's case is quite the opposite: that she was permanently unable to return to work as a police officer. Nor was there any evidence before the Chief Constable at the time she made her decision to suggest that further adjustments were possible. The Chief Constable knew that EMDR had failed; no other treatment had been suggested; and there was no sign of the claimant returning to work. It is clear from the reasons she gave at the time that the Chief Constable was mindful of this when she decided to exercise her discretion to pay the claimant half pay from September rather than full pay.

150. One of the other circumstances recognised by the force policy as being one in which discretion might be exercised is where the question of whether the individual is permanently disabled has been referred for determination to a Selected Medical Practitioner. That had not occurred in this case at this stage (and, later, when it was agreed a referral would be made, full pay was reinstated).

151. Another potential exceptional circumstance identified in the force policy is where the Chief Constable is satisfied that incapacity is directly attributable to an injury or illness sustained in executing of duty. It is clear from the reasons she gave at the time that, in deciding to exercise her discretion to extend the claimant's full pay for as long as she did, the Chief Constable took into account the 'work-related nature' of the claimant's illness, although under questioning it appeared that she had not formed a settled opinion that the claimant's ill health had in fact been caused by work, which was not an unreasonable position for a lay person to take on the limited evidence available to her.

152. The respondent's decision to exercise her discretion to reduce the claimant's pay to half pay was consistent with the force's policy. It does not follow from that that the reduction in the claimant's pay was necessarily justified. It is, however, a relevant factor in determining that issue, particularly as the respondent's case is that one of the aims of the pay reduction was to ensure consistency of treatment across the Force.

153. We must weigh against that the impact of the reduction in pay on the claimant. We do not doubt that the impact of having her pay reduced from full pay to half pay was significant and must have caused the claimant a great deal of anxiety.

154. On the other hand, the claimant had already been absent from work on full pay since the previous September. In that time, the respondent had exercised discretion to extend the claimant's full pay entitlement for some six months whilst arrangements were made for the claimant to have treatment in the form of EMDR, treatment that it was hoped would enable her to return to work. That treatment had been unsuccessful and, by early September 2018, there was no sign of the claimant being in a position to return to work. No adjustments had been suggested that might enable the claimant to return to work at some point in the future and nor would paying her full pay instead of half pay have done so. The claimant had not been able to provide any service to the force for almost a year and there was no sign that she would be able to in the future. The Force does not have unlimited resources and cannot be expected to continue, indefinitely, to pay officers who are unable to perform their duties. That being the case, at some point a line must be drawn. We have referred above to the case of O'Hanlon. Although that was a case on the duty to make reasonable adjustments, the EAT's conclusion that that it would be a rare and exceptional case in which an employer would be expected to enhance an employee's sick pay entitlement is apposite. The cost to the Force of increasing the claimant's pay may have been manageable. However, it the Force were to apply that same approach consistently, that would have very significant implications.

155. In all the circumstances, we are satisfied that the decision of the Chief Constable not to exercise her discretion to maintain the claimant's pay at full pay, and thereby reducing the claimant's pay to half pay was a proportionate means of achieving the legitimate aim relied on.

156. Ms Callan also suggested that once the FMA's report of 26 October 2018 was received, in which the FMA suggested that the claimant may be permanently disabled, the respondent should have increased the claimant's pay to full pay at that point. That is not how the claim was put in the agreed list of issues at the outset but nevertheless we have considered it. The claim appears to be that the respondent treated the claimant unfavourably by failing to reinstate her to full pay from 26 October 2018. Ms Mellor's argument that this was not unfavourable treatment may be stronger here than in relation to the September decision given that the claimant is, in effect, arguing for her pay to be increased. But, in any event, even if this was unfavourable treatment, we are satisfied that the failure to increase pay from 26 October was a proportionate means of achieving a

legitimate aim for the reasons as already explained in relation to the decision made in early September.

157. The claim that the respondent discriminated against the claimant by reducing her pay to half pay with effect from 1st September 2018 is not made out.

Alleged failure to make reasonable adjustments in relation to PCPs (c) to (e)

158. That brings us on to the allegations that the respondent failed to make reasonable adjustments to avoid disadvantage caused by the alleged PCPs identified as:
(c) the respondent's policy/practice relating to the extension of pay where the absences are disability-related;
(d) the respondent's policy/practice relating to the extension of sick pay where the officer's absences are prolonged because of a failure to make earlier reasonable adjustments;
(e) the respondent's policy/procedure relating to sick pay where an officer is seeking referral to the SMP for ill-health retirement.

Did the respondent apply PCPs as alleged by the claimant?

159. On officer's sick pay could only be extended beyond those entitlements set out in the Police Regulations if the respondent exercised her discretion to increase pay. We accept that the respondent's force had a policy as to how that discretion should be exercised. In line with that policy, it was the practice of the respondent only to exercise discretion to increase pay above entitlements in exceptional circumstances. The respondent's practice was to determine whether circumstances were exceptional in line with the examples set out in its policy. Normal practice was to consider extending pay entitlements in the four circumstances listed at (a) to (d) in the force policy ie (a) cases of injury or illness sustained or contracted in the actual execution/discharge of duty; (b) cases of life threatening illness where the prognosis is poor; (c) cases being considered in accordance with guidance on improving the management of ill-health where there has been a referral of the issue of whether the officer is permanently disabled to a selected medical practitioner (SMP); or (d) where the FMA advises that the absence is related to disability as defined in the Equality Act 2010 and it is considered that it would be a reasonable adjustment to extend sick pay, generally speaking to allow further reasonable adjustments to be made to enable the officer to return to work.

160. In relation to PCP (c), we accept that the respondent operated a practice relating to the extension of sick pay where the absences are disability-related. That practice was that it would consider extending sick pay beyond an officer's statutory entitlement in those circumstances. It is implicit in the reference to 'further adjustments to enable the officer to return to work' that an extension of sick pay was more likely to be considered a reasonable adjustment if there were other adjustments that could be made during the period of absence that might enable the officer to return to work at a future date.

161. In relation to PCP (d), we do not accept there was a specific policy/practice relating to the extension of sick pay where the officer's absences are prolonged because of a failure to make earlier reasonable adjustments: the respondent's practices were those set out in the previous two paragraphs ie that pay would only be increased above entitlements in the Secretary of State's determination in exceptional circumstances; that the fact that absences are disability related may be considered an exceptional circumstance warranting extending sick pay but that was more likely to be the case if there were other adjustments that could be made during the period of absence that might enable the officer to return to work at a future date.

162. In relation to PCP (e), we accept that the respondent operated a practice relating to the extension of sick pay where an officer is seeking referral to the SMP for ill-health retirement. That practice was that the force would consider extending sick pay where there had been a referral of the issue of whether the officer is permanently disabled to an SMP. It was also the Force's practice that even discretion was not exercised to pay the officer full pay at that point, if the decision was subsequently taken to medically retire an officer after going through the SMP process, full pay would be reinstated with retrospective effect from the date on which the referral to the SMP was made.

Did the PCP(s) in question put the claimant at a substantial disadvantage in relation to employment by the respondent, in comparison with persons who are not disabled? If so, what was the disadvantage?

163. The claimant's case is that these PCPs disadvantaged her in two ways, firstly financially (in that they resulted in her pay being reduced) and secondly – consequent on this – because the reduction in her pay had a psychological impact on her mental health.

164. Ms Mellor submitted that the claimant's claim must fail because the PCPs relied on did not put the claimant at a substantial disadvantage in comparison with persons who are not disabled. We accept that if the PCP is viewed narrowly that is the case:

164.1. In relation to PCPs (c) and (d), the respondent's practice was to consider extending sick pay beyond an officer's statutory entitlement when a claimant's absences were disability related. This was an exception to the usual practice of not exercising discretion to increase sick pay beyond the entitlements guaranteed by the Police regulations and was only capable of being applied to those with a disability. This meant that an officer who was absent from work because of a disability, such as the claimant, was at an advantage, not a disadvantage, in comparison with an officer who was absent from work due to sickness but who did not have a disability.

164.2. Similarly, in relation to PCP (e), the respondent's practice was to consider extending sick pay where there had been a referral of the issue of whether the officer is permanently disabled to an SMP. Again, this was an exception to the usual practice of not exercising discretion to increase sick pay beyond the entitlements guaranteed by the Police regulations and meant that an officer who was absent from work because of a disability, such as the

claimant, was at an advantage, not a disadvantage, in comparison with an officer who was absent from work due to sickness but who did not have a disability and would, therefore, not qualify for a potential increase in sick pay entitlements under this provision.

165. However, the concept of a 'provision, criterion or practice' is a broad one, which is not to be construed narrowly or technically. Whilst the way the PCPs have been described in the claim form refers to the practices in relation to disabled officers, it is important not to lose sight of the fact that those practices form part of a wider practice of limiting pay for those officers who were unable to work due to illness to that which was provided for in the Police Regulations, except where the respondent considered the circumstances to be exceptional. We accept that it was the operation of that practice that led to the claimant's pay being reduced to half pay between 1 September 2018 and 19 November 2018. The claimant's circumstances must be compared with someone who did not have a disability and who, therefore, was much less likely to have suffered the loss of pay since he or she was less likely to have been absent for a prolonged period. We accept, therefore, that this practice put the claimant at a substantial financial disadvantage in comparison with persons without a disability and that this disadvantage, in the form of reduced pay, was a disadvantage in relation to employment by the respondent.

166. Ms Callan also submitted that the claimant was put at a substantial disadvantage because the reduction in her pay had a psychological impact on her mental health. The duty to make reasonable adjustments is triggered only if a PCP puts an employee at a substantial disadvantage in relation to a 'relevant matter'. In relation to the duty towards disabled employees, a 'relevant matter' means 'employment by the employer'. We do not accept that that the possible psychological impact of the reduction in pay was, in itself, a disadvantage in relation to employment by the respondent in this case as the evidence demonstrates, and we find, that there was, by the time the claimant's pay was reduced, no prospect of the claimant ever returning to work. That being the case, we do not find that the PCP put the claimant at that further substantial disadvantage in relation to a relevant matter in comparison with persons who are not disabled.

Did the respondent know that the PCP in question was likely to place the claimant at a substantial disadvantage in relation to employment by the respondent, in comparison with persons who are not disabled, or could it reasonably have been expected to know that?

167. The consequences of the respondent's policy were clear. It led to the claimant's pay being reduced. The respondent undoubtedly knew that this was likely to disadvantage the claimant in comparison with someone who did not have a disability and who, therefore, was much less likely to have been absent for a prolonged period.

Would any of the steps identified by the claimant have avoided that disadvantage in relation to employment by the respondent and would it have been reasonable for the respondent to take any of those steps?

168. The claimant's case is that the respondent should have taken the following steps to avoid the disadvantage caused by its pay policy:
    168.1. continued full pay from 1 September; or
    168.2. expedited her application for ill-health retirement and the referral to the SMP to ensure she would be reinstate to full pay.

169. For the same reasons that we gave for concluding that reducing the claimant's pay to half pay was a proportionate means of achieving a legitimate aim, we do not accept that continuing to pay the claimant full pay would have been a reasonable adjustment to expect the respondent to make. This is not one of the rare and exceptional cases envisaged by the EAT in O'Hanlon in which the employer should be expected to enhance an employee's sick pay entitlement. It is not a case in which maintaining the claimant at full pay could have formed part of a package of adjustments to get the claimant back to work: the claimant does not suggest there were any adjustments that could have been made from September that would have got her back to work. Rather, what the claimant is seeking in effect is compensation for being unable to work. That the financial hardship could exacerbate the claimant's poor mental health does not lead us to conclude that the claimant's case warranted special treatment. As the EAT said in O'Hanlon 'It would be wholly invidious for an employer to have to determine whether to increase sick payments by assessing financial hardship suffered by the employee, or the stress resulting from lack of money; stress which no doubt would be equally felt by a non-disabled person absent for a similar period.'

170. As for expediting the application for ill-health retirement and the referral to the SMP, the claimant's position is that if the Deputy Chief Constable had agreed to refer her to the SMP more quickly, then she would have been returned to full pay a few weeks earlier than she was under the Force's usual policy. Many of the reasons for rejecting the claimant's argument that her pay should have remained at full pay from September also apply here: maintaining the claimant's pay at full pay was not step it was reasonable for the respondent to have to make in September 2018 and the fact that medical retirement was being contemplated did not change that. The adjustment sought would not have enabled the claimant to return to work: if anything, it could have accelerated her departure. In effect, the claimant is seeking to be compensated for being unable to work. Furthermore, the claimant appears to be suggesting that, in order to achieve that end, the respondent should be required to short circuit its usual processes for dealing with applications for ill-health retirement. We consider it would be unreasonable to expect the respondent to do that. If the force had considered it appropriate, as a general rule, to pay somebody full pay once an FMA had suggested that a referral to the SMP might be appropriate that would be set out in the various policies that are applied in relation to pay. It is not and it would not be reasonable to expect the respondent to have made an exception for the claimant in this case.

171. For the reasons set out above, we reject the claimant's claim that the respondent failed to comply with a duty to make reasonable adjustments.

172. The claimant's claims fail.

Employment Judge Aspden

Date 11 June 2020