EMPLOYMENT TRIBUNALS

Claimant: Lee Hopewell

Respondent: University Hospitals of Derby and Burton NHS Foundation Trust

Heard at: Nottingham

On: 19, 20 and 21 October 2019

Before: Employment Judge Jeram, Ms Howdle, Ms Lowe

Representatives:

Claimant In person

Respondent Mr C Bourne of Counsel

RESERVED JUDGMENT

1. The Claimant's claims of disability discrimination are not well founded and are dismissed.

REASONS

Background and Issues

1. By a claim presented on 12 April 2019, the Claimant complained of unfair dismissal and disability discrimination. On 19 March 2019 Employment Judge

Clark determined that the Tribunal had no jurisdiction to hear the unfair dismissal claim and struck it out. He made case management orders in respect of the disability discrimination claims.

2. The Claimant confirmed that his claims were for a failure to make reasonable adjustments contrary to ss. 20 and 21 Equality Act 2010 and discrimination arising from disability contrary to s.15 of the Act. At the outset of the case, the Tribunal discussed with the Claimant the substance of his complaint and whether his reasonable adjustments complaints were more appropriately framed as a s.15 Equality Act complaint; he confirmed that he wished to pursue the causes of action as per the issues agreed between the parties.

3. The issues for the Tribunal are set out below.

Disability

The Respondent accepts that at all material times, that the impairments below amounted to disabilities within the meaning of s.6 EqA 2010:

a. Irritable Bowel Syndrome ('IBS');
b. Nerve damage to the right wrist.

The Respondent accepts that it knew or ought reasonably to have known of the nerve damage to the right wrist at all material times;

Did the Respondent know or ought reasonably to have known of the IBS at any stage during the Claimant's employment?

Reasonable Adjustments Claim

The parties agree that the Respondent applied the following PCPs:

a. Not to have more than 4 absences in a 12-month period and that those absences must not exceed 10 days in duration[1];
b. Not to attend work in the 48 hours after suffering from diarrhoea.

The Claimant relies upon the substantial disadvantage of: the Claimant was unable to attend work due to his disabilities.

Did the PCPs put the Claimant to the substantial disadvantage relied upon?

Did the Respondent know, or ought it reasonably to have known that the Claimant is likely to be placed at the substantial disadvantage (identified below)?

Whether the Respondent took such steps that as were reasonable to avoid the disadvantage.

The Claimant contended that the following amounted to reasonable adjustments of the PCPs;

a. Discounting disability related absences;
b. Adjusting trigger levels under the absence management policy;
c. Relaxing the 48 hour / diarrhoea policy so he could return to work within 48 hours of a bout of diarrhoea.

Discrimination Arising in Consequence Claim

The Respondent accepts that dismissal amounts to unfavourable treatment.

Was the dismissal because of something arising in consequence of the disability/ies?

Can the Respondent can show that the dismissal was a proportionate means of achieving a legitimate aim? The legitimate aim relied upon is: managing staff absences in order to maintain an appropriate level of service in respect of patient care.

[1] The issues submitted to the Tribunal, we note record the PCP to be one where 'each absence must not exceed 2 weeks in duration'. In fact, both parties in their written and oral evidence as well as their submissions proceeded by reference to the Respondent's absence management policy and so we have adopted the appropriate wording here.

Evidence

4. We had before us an agreed bundle comprising of 736 pages and a further bundle prepared by the Claimant comprising of 27 pages that the Respondent did not object to.

5. We heard from oral evidence from the Claimant; and for the Respondent, Rebekah Devitt (Training and Development Superintendent, and the Claimant's line manager for the majority of his employment), Julie Campbell (Matron, and dismissing officer) and Mike Carr (General Manager, Cancer Business Unit and appeal officer).

Application to strike out

6. At the outset of the hearing, the Claimant made an application to strike out the response. The Respondent was late in complying with the direction requiring it to provide a paginated bundle for use at the final hearing, although on the Claimant's own account it had been sending to him indexes with a view to agreeing the final bundle. A paginated bundle that the Respondent considered to be final was provided to the Claimant a week before the hearing. The Claimant had produced a full witness statement; the Claimant's concern that his statement omitted references to page numbers could have been met if he had accepted the Tribunal's offer to provide him with time to include such references.

7. The Claimant sought to include further documents to the bundle. Of the 5 pieces of additional documentary evidence he sought to admit in evidence, 3

had been sent to the Respondent's solicitors with a view to their inclusion. Whilst the Respondent maintained that all were irrelevant to the issues for the Tribunal to decide, it did not object to the Claimant adding them to the bundle.

8. The Claimant pursued his application to strike the response out for the Respondent's failure to comply with the orders of the Tribunal to provide a paginated bundle. We dismissed the application because it was a disproportionate sanction since a fair trial was still possible.

Policies

Absence Management Policy

9. The Respondent has in place Management of Health and Attendance Policies. Its Short Term Absence Procedure (for absences of fewer than 4 consecutive weeks) provides for two periods of formal absence monitoring if trigger points are met. The trigger points relevant to this claim are either four periods of absence in a rolling 12-month period or 10 working days absence in a rolling 12-month period (2.1 of the policy).

10. If employee meets the triggers above, a formal absence review meeting is required (3.1 of the policy). The manger is required to consider a number of matters, including whether a common theme or apparent link is present that could indicate an underlying health condition (3.2.1 and 3.3.2 of the policy). A number of potential outcomes are available to the manager, including at Stage 1, a period of formal monitoring of absences for 3 months (1.2 of the policy), during which zero absences are allowed. At the end of the monitoring period, the employee is invited to a further review meeting.

11. In the event of successful completion of the Stage 1 period of monitoring, the formal monitoring process is halted, but if an employee hits the same triggers within one year of the review meeting, he or she will, absent exceptional circumstances, proceed to formal monitoring at Stage 2 of the procedure (5.3). In the event that an employee fails to successfully complete the Stage 1 monitoring period, then the manager is required to consider the matter should be progressed to Stage 2 (5.4).

12. Stage 2 requires an employee to be monitored for a period of 6 months, during which time, one episode of absence for up to 4 days is permitted (1.2). A successful completion of the Stage 2 halts the monitoring process but hitting the triggers within 12 months of the review meeting requires a further formal monitoring at Stage 2 (7.4). If an employee exceeds the level of absences permitted at Stage 2, the manager is required to explore the reasons for the absences. If the absence is felt to be unsustainable, or all appropriate adjustments have been exhausted, the employee's case is presented to a Formal Absence Management Panel, who may, if they consider the levels of absence to be unsustainable, dismiss the employee (7.5).

13. At each review stage, the manager is required to keep under review the need for adjustments. The policy provides guidance to seek assistance from Human Resources and Occupational Health in circumstances where a disability is either known of (2.1.3) or suspected (3.4.4). The policy requires 'consideration is given as to whether reasonable adjustments have been made which may provide for or require a different set of triggers to be agreed' (12.3.1)

48-hour Policy

14. In addition to the written policy above, the Respondent operates (non-written) a '48-hour' policy which requires employees who are in contact with to remain off work for 48 hours after a period of vomiting or diarrhoea, in order to reduce the risk of infection to cancer patients or other immunocompromised patients.

Findings of Fact

15. The Claimant was employed as a therapy radiographer at the Royal Derby Hospital from 19 October 2015 until his dismissal on 14 December 2018 on grounds of ill health capability.

16. In a pre-employment occupational health questionnaire, the Claimant had he had an impairment, which was a reference to an impairment to his left shoulder following a road traffic accident in 2011.

17. On Tuesday 1st December 2015 the Claimant was absent from work one day.

18. The Claimant was able to see his GP the same day as his absence; he GP noted: *"History: epigrastic cramping pains. Radiates to shoulders on and off . History: had for years. Pre appendix and gallbladder removed. History: adv -IBS no rx helps, getting worse, gets every few weeks, getting more intense".*

19. We accept his evidence that it was he who was advising his doctor during that appointment that it was not IBS he was suffering from; having conducted his own research, he believed he was suffering from some other, undefined,

gastrointestinal issue. We accept that the reason for the Claimant's absence on this occasion was likely to be symptoms associated with his IBS.

20. At his return to work interview, however, the Claimant reported to his employer that the reason for the absence was *'nausea / bug'.* He declined an offer of a referral to Occupational Health. He did not tell his employer that he suffered from IBS or from any gastrointestinal impairment. We accept his evidence that he believed Occupational Health could not assist him in circumstances where he disagreed with his own GP's diagnosis, but in light of his clinical experience we reject his evidence that he did not understand the 'remit' of Occupational Health.

21. In fact, the Claimant had suffered from gastrointestinal problems since having his gallbladder removed in 2010; he was referred to a gastroenterologist in 2011.

22. We reject the Claimant's evidence that his failure to mention to the Respondent on this and on subsequent occasions, his previous referral to a gastroenterologist, was due to a *'memory issue'* caused by a motorcycle accident in 2011, there being no medical evidence before us that the Claimant suffered memory issues at all, and it being inherently unlikely that any such loss of memory was confined specifically, on this and on future occasions when discussing his health with his employer and Occupational Health, to his referral to a gastroenterologist.

23. The Claimant in his evidence described a pattern of symptoms whereby he would tend to experience a flare up at a weekend, and that, because of the 48-

hour policy, which requires him to remain away for 48 hours after an episode of diarrhoea and/or vomiting, he was required to incur an absence early the following week. He contended that, unlike a stomach bug, his IBS symptoms do not create an infection risk to patients and it was not therefore necessary for him to remain away from work. The policy is therefore said to cause him incur (at least) one more days' absence than was necessary.

24. We reject the Claimant's case that he was adversely affected by compliance with the 48-hour policy on this occasion; his absence was for one day only.

25. On Monday 11 January 2016, the Claimant was unwell and absent for a day. The Respondent accepts that the absence is attributable to his IBS, rather than, for example, a stomach bug; it has recorded nothing of substance in the Claimant's return to work interview and the Claimant's own evidence was that he 'as always, tried to deal with this on my own'. We accept the Claimant's unchallenged oral evidence that he suffered IBS symptoms over the weekend and was required to remain absent on this day because of the operation of the 48-hour rule.

26. Between 27 January and 1 March 2016, the Claimant was off work for a total of 34 days with an injury, sustained at home, to his ring finger on his left hand. He was referred to Occupational Health and attended an appointment on 29 February 2016. The nurse supported the 4-week administration duties that the Respondent had arranged for the Claimant on his return. The Claimant did not mention to Occupational Health that he had a gastrointestinal problem.

27. On Monday 16 May 2016 the Claimant was again absent, this time for three days, by reason of 'nausea/bug'. In his return to work interview the Claimant told the then manager that he was uncertain of the cause of his illness and queried whether it was something that he ate. The Claimant does not suggest that this absence was disability related.

28. On Thursday 28 July 2016, the Claimant was again absent from work for one day which the Respondent accepts is attributable to the Claimant's IBS. We do not accept the Claimant's contention that it was caused by reason of the 48-hour rule; the period of absence was for one day only, on a Thursday.

29. In August 2016, Rebecca Devitt ('RD') became the Claimant's line manager. This was the first occasion when she had been required to follow and apply the Respondent's sickness absence procedure.

30. By August 2016, the Claimant had been absent on 5 occasions for a total of 40 days in the previous 12 months; he was therefore invited to a formal absence review meeting on 18 August 2016. The Claimant did not share his medical history with RD, but since 4 of the 5 absences were gastrointestinal related, a referral to Occupational Health was agreed. That appointment took place on 28 September 2016. The Occupational Health nurse summarised the Claimant's medical issues as being a long-term issue with his left shoulder (for which he had had no absences but for which adjustments to duties were recommended), four episodes of sickness absence with gastrointestinal symptoms since December 2015 and the right hand finger injury which had required surgery.

31. The nurse continued, in response to a query about any long term underlying health conditions:

"In addition, Lee has been diagnosed with an underlying medical condition which may account for the sickness episodes with gastro-intestinal symptoms. On the basis of our discussions today, I have suggested that he return to his GP to discuss things further. . his gastrointestinal symptoms are infrequent but ongoing and may result in further absence".

32. We found the Claimant's evidence about what he told the nurse on this occasion to be inconsistent. We are not persuaded that he told her that he had been diagnosed with IBS and that that had caused his absences; if that were the case, we would have expected that to be reflected in the wording in the report.

33. The Claimant did not visit his GP as advised by Occupational Health. His reason for not doing so, he told us, was that his GP had advised that s/he needed to examine the Claimant at the very moment he was suffering from gastrointestinal symptoms, and that since they tended to be both occasional and fleeting, sometimes lasting for a matter of only minutes at a time, and often appearing months apart, to attempt to seek an appointment during an onset of symptoms was unrealistic. We are not satisfied, as he suggests, that he told Occupational Health of his GP's requirement; had he done so, we consider that the Occupational Health nurse would not, without further comment, have persevered with advice that the Claimant was suggesting was, to all intents and purposes, impossible to follow.

34. The Claimant met again with RD on 5 October 2016 to discuss the Occupational Health report. RD noted the Occupational Health nurse had advised the Claimant to visit his GP. The Claimant did not tell RD that the advice to visit his GP was unrealistic, given that his GP wished to see him when he was symptomatic; had he done so, we would have expected further comment in the outcome letter of that meeting.

35. RD informed the Claimant that Stage 1 of the absence management policy was triggered and that he was subject to a 3-month period of formal absence monitoring; because of the delay in obtaining the Occupational Health report, however, during which time the Claimant had had no further absences, that period of monitoring was to be reduced from 3 months to 2 months.

36. On 28 November 2016, RD confirmed to the Claimant that, having had no further absences, the Stage 1 period of formal monitoring had been successfully completed in accordance with the short-term monitoring policy and that he was no longer subject to formal monitoring.

37. On 6 December 2016 the Claimant underwent surgery to his right wrist in order to correct an ongoing problem caused by the motorcycle accident in 2011. He was absent from work for 42 days.

38. The Claimant saw Occupational Health on 19 January 2017, who advised that he had good strength, grip and range of movement and had been discharged after physiotherapy; the Respondent was advised that after a phased return to work on adjusted duties, the Claimant would be fit to perform the demands of

his role, save for leading in manual handling activities. No further review appointment was considered necessary.

39. On Monday, 20 March 2017 the Claimant was again absent from work for two days, he told his employer, on account of diarrhoea and vomiting. We are not satisfied that these were symptoms of IBS and that he was therefore, required to stay away from work because of the 48-hour policy for a further day than was necessary. He did not describe to us vomiting as being a symptom of his IBS. This was the Claimant's fifth absence due to gastrointestinal problems, four of which, on his case, were unnecessarily extended due to the operation of the 48-hour policy. We consider that, having been told by RD in terms that he faced escalation to Stage 2 monitoring if he incurred any further absences, it is likely he would have told her of the effect of the 48-hour rule on his absence record, had this absence been attributable to his IBS.

40. On Monday 26 June 2017 to Wednesday, 28 June 2017, the Claimant was absent from work by reason of IBS for three days. We reject his oral evidence that that period of absence was as a result of the 48-hour policy; in his own statement, the Claimant describes being increasingly unwell on each of those days, which is consistent with a contemporaneous log of his daily calls to the Respondent.

41. On 4 July 2017 until 31 July 2017, the Claimant was absent for 27 days on sick leave, by reason of work related stress. The stress was linked to an incident whereby the Claimant had been spoken to about personally messaging a student. On 27 July 2017 when the Claimant spoke to Occupational Health, he advised them that the reason for his absence was a *"one-off event at work due*

to a misunderstanding/miscommunication" and that *"everything was sorted";* Occupational Health advised the Claimant was likely to return to work without further issue or concern. The Claimant was asked to complete a stress risk assessment but declined to do so.

42. The Claimant was notified that his absences had triggered Stage 2 of the Respondent's absence policy and he was invited to attend a meeting with RD and Human Resources. The meeting took place on 23 August 2017 when the Claimant was accompanied by his trade union representative.

43. At this meeting, the Claimant told his employer that he had had his gallstones removed in 2010 after which time he had suffered cramping and vomiting. He told them that the pain had returned and that he had visited his GP on several occasions, who had diagnosed IBS, since all other investigations had been to no avail. He said that he had tried several medications, to no avail. The Claimant suggested that the next step should be referral to gastroenterologist. He was advised return to his GP. The Claimant did not tell RD that his GP had told him that s/he could only assist him if he presented at the very moment he was suffering symptoms.

44. The Claimant stated that he believed he may have asthma, although it was noted that that was not causing any difficulties at work. He confirmed that he was due to have further surgery to his wrist to reduce pain and improve sensation. A workplace assessment was arranged. The Claimant confirmed that the most recent episode of stress had now been resolved.

45. A referral to Occupational Health was arranged and the Claimant was again encouraged to attend his GP about his gastrointestinal problems, but he did not do so.

46. The Claimant attended an Occupational Health appointment with Dr Macherides on 26 September 2017.. He told Dr Macherides that he had attended the emergency department the day before in relation to his breathing difficulties, but agreed that that condition did not affect his work. He told Dr Macherides that his left arm and his stress problems were no longer causing any functional difficulty.

47. Dr Macherides reported that the main barriers to attending work were the Claimants right wrist and occasional abdominal pain. In relation to his right wrist the Claimant complained of ongoing pain and pins and needles.

48. The Claimant told Dr Macherides in relation to his abdominal pain, that he experienced severe pain several times a year lasting from 30 to 60 minutes from which he usually recovers so as to carry on his daily activities.

49. Dr Macherides advised the Respondent that the *'right wrist and abdominal problems'* were likely to be long-standing problems and caused significant difficulties on a day-to-day basis and are likely to fall *'under the remit of the Equality Act'*. He advised that adjustments were made to the triggers in the Respondent's absence management policy.

50. At around the same time, an Occupational Health Nurse carried out a workplace assessment for the Claimant. He said that he did not feel any discomfort riding

a motorcycle, but did complain generally of pain and discomfort in the right wrist / forearm, and reduced grip strength. He was given a vertical mouse to try and advised to reduce the use of motorcycle with a view to stopping altogether as its use could have an ongoing impact on his reported symptoms. He was advised, and agreed, to visit his GP in order to be referred to the Hand team at Derby hospital, for further support.

51. On 25 October 2017 the Claimant was absent from work again, for 10 days, in relation to his right arm, which was injured in a recent road traffic incident 518 C70. During his absence, the Claimant told his employer that his hand consultant was of the view that it was ‘too early to tell’ if the injury to his right arm would affect his right wrist; on his return to work, the Claimant told his employer that they were ‘separate issues’. This was not a disability related absence.

52. On 28 November 2017, the Claimant and his trade union representative met with RD and another Human Resources colleague. The Claimant said he had not visited his GP as he had not suffered any symptoms since the last meeting.

53. RD told the Claimant that whilst it was unnecessary to discount the absence in December 2016 in relation to the operation to the right wrist, his absence for his future operation on the same wrist would be discounted.

54. In relation to the abdominal symptoms, RD had raised further questions of Occupational Health, in respect of which she was awaiting a response. In the meantime, she did not consider it appropriate to extend any future triggers. She

advised the Claimant that if future abdominal symptoms occur, he should return to his GP to seek a referral to a gastroenterologist.

55. The Claimant's workplace assessment was discussed. The Claimant had not visited his GP for a referral to the Hand Team at the Derby Royal Hospital because, he told RD, he had been on annual leave and because he felt conflicted given that he was expecting to undergo an operation. The Claimant told RD that the reduction or stopping use of the motorcycle was a '*sensitive issue'* because he considered driving to be more troublesome, but he would consider using a more upright bike which would put less pressure on his wrist. He did not tell her, as he told us in evidence, that the motorcycle was his only means of transport.

56. On 27 December 2017, the Claimant was absent from work for 6 days with a cold.

57. A Stage 1 formal absence meeting was held between RD and the Claimant on 4 January 2018. At that meeting, the Claimant agreed to visit his GP in order to have his IBS symptoms investigated further. On that basis, RD agreed to take no formal action at this stage although she told him that that decision could be reviewed in the event of further absences. The Claimant did not wish to be appraised of trigger points. He did not visit his GP.

58. Between 5 February and 14 May 2018, the Claimant was off work for 96 days on the first day for pain, and thereafter for an operation to his right wrist.

59. Dr Macherides reported on 19 March, 2 May and finally on 24 July 2018. In his final report, he advised that the *'abdominal problem'* continued to cause sporadic episodes of diarrhoea, sickness and nausea, but that they were normally infrequent and require no specific medical input. He stated *'as I have previously recommended, [the Claimant's] sickness absence attributed to his musculoskeletal problems if operationally feasible be dealt with as a disability related absence for attendance management purposes'* and that the Claimant's *'musculoskeletal problems'* were such that the Claimant was *'likely to continue to fall under the remit of the Equality Act'.*

60. The Claimant returned to work on a phased basis, over a 4-week period.

61. On 16 May 2018, RD met with the Claimant to review the end of the Stage 1 monitoring period. The absences in respect of the wrist having already been discounted, and although the Claimant had not seen his GP about his gastrointestinal problems as discussed at the meeting on 4 January 2018, RD confirmed that the Claimant had successfully completed the Stage 1 monitoring period and reminded the Claimant that if he hit the absence management triggers in the next 12 months, he would automatically commence a period of formal monitoring at Stage 2 of the procedure.

62. For three days between 9 and 12 July 2018, the Claimant was absent from work with *'nausea/bug'.* We are not persuaded that this absence was due to the Claimant's IBS symptoms; he told his employer at the time that he was unsure whether his absence was related to previous abdominal symptoms or was a bug, and the length of the absence is inconsistent with the fleeting presentation of symptoms that the Claimant described to us. The Claimant had contacted

his GP on this occasion; he explained to RD his GP was unwilling to provide any documentation with regard to ongoing abdominal symptoms without a 'private fee'.

63. In a further workplace assessment carried out on 12 July 2018, the Claimant, who was on modified duties, was still suffering from the same symptoms in his wrist as before.

64. RD met with the Claimant on 25 July 2018. The Claimant was still using his motorcycle to travel to and from work. There was discussion about whether the Respondent had adjusted triggers as recommended by Dr Macherides; the Claimant believed that had he not been absent with his wrist operation, he would not be at Stage 2 of the absence monitoring procedure. RD reminded him that formal action could have been taken sooner, but was not. The Claimant said he felt stressed about being monitored whilst off sick but declined to complete a stress risk assessment. He was told that he would enter a 6-month period of formal monitoring at Stage 2 of the procedure, from 12 July 2018 until 12 January 2019, during which time, he should not incur more than 1 period of absence of up to 4 days. The Claimant was advised to take a flu jab for the winter period.

65. For 12 days between 1 August 2018 and 13 August 2018, the Claimant was absent from work by reason of stress arising out of an incident in which he texted a student. The Claimant reported that he was unable to complete a stress risk assessment that was posted to him, as it had been removed from the envelope before it reached him. Another copy was given to him to complete.

66. The Claimant and RD met on 30 August 2018. The Claimant was asked about his most recent episode of absence, which the Claimant initially refused to discuss because of a complaint he had submitted to the General Manager, Mike Carr (MC), General Manager Cancer Business Unit, in the week commencing 20 August 2018, but subsequently explained was attributable to the loss of his dog. As in March 2018 and again in July 2018, the Claimant was offered counselling and signposted to other means of mental health support. He was referred to Occupational Health.

67. The Claimant was seen by Occupational Health on 6 September 2018, who reported that the Claimant attributed the stress to his work circumstances, in respect of which he had submitted a grievance; the Claimant felt that adjustments had not been made as advised by Dr Macherides. It was suggested that this matter was one for management to resolve, rather than a medical issue.

68. The parties reconvened on 24 September 2018, when after summarising the absences in the last 12 months, and the workplace adjustments and support offered, it was confirmed to the Claimant that he would be referred to the Formal Absence Management Panel.

69. By the time of the referral to the Formal Absence Management Panel, the Claimant had been absent on sick leave on 16 occasions for a total of 282 days and during which time, the Respondent arranged 13 appointments with Occupational Health and had accommodated his attendance at 33 medical appointments during working hours.

70. The Claimant was off sick with stress for a further 41 days between 25 September 2018 to 7 November 2018. He was referred to Occupational Health for review.

71. The Claimant asked MC, and MC agreed, to arrange for the Claimant to be temporarily redeployed in an administrative role away from the radiotherapy team as a step to assist his stress levels during the ill health capability process. He commenced this arrangement on 5 November and, on 7 November 2018 the Occupational Health nurse reported stating in response to her understanding that she was being asked whether it was a suitable role for the him *"Lee will need more time to see whether this should be a permanent recommendation; I suggest at least 6 months with review with his line manager after this*". The report reiterated that the issues causing the Claimant's stress were for management to resolve and that further referral or review by Occupational Health was *'not indicated'.*

72. The Claimant was absent from work in early December 2018. We reject the Claimant's evidence that those absences were caused by a flare up of his IBS that was caused by stress and that, again, he was prevented from returning to work by operation of the 48-hour policy; we find it more likely that it was a stomach bug, since he told JC that his diarrhoea had occurred after using a public toilet.

73. The Claimant attended a meeting with the Formal Absence Management Panel on 14 December 2018, that was chaired by Julie Campbell (JC), Matron.

74. The Claimant acknowledged that he was taking too much time off work and that he didn't like it and that he was disappointed.

75. They discussed his interactions with students, as well as his motorcycle riding; the Claimant acknowledged that he had not followed the advice given but it had not been his intention to make things difficult. We reject the Claimant's explanation, suggested for the first time in cross-examination, that he told JC that he had received consultant advice, contrary to that given by the Occupational Health nurse during his workplace assessment, to the effect that he was capable of riding his motorcycle without affecting his wrist.

76. He had not completed stress risk assessments, he said, because he did not feel he needed to and that his stress-related absences were because he felt the Respondent had not handled matters fairly, although he told us in evidence that the reason was that it was not for him to complete them, but for the Respondent to complete them.

77. His most recent episode of diarrhoea was due to using a public toilet, he told JC, and that sometimes the 48-hour policy prevented his return to work sooner. He said that he had not yet been referred to a gastroenterologist because his GP wanted to observe the symptoms for himself. He said he had tried to arrange medical appointments outside work time where possible.

78. The Claimant did not respond directly to the question as to whether he was fit to continue in his role. He stated that he was now on medication regime which, despite being one that his GP had not recommended and that his consultant was not happy with, he believed would ensure continued attendance at work.

79. JC considered whether alternatives to dismissal, but she was aware that the Claimant had incurred a further period of absence, notwithstanding the fact that the redeployment was arranged in order to help him cope with the stress of the absence management procedure. She decided to dismiss the Claimant because of the high level of absenteeism, despite the amount and variety of measures the Respondent had put into place to support the Claimant. Furthermore, she concluded that the Claimant had failed to follow specialist medical advice that could have affected his attendance record, and that, in relation to amended triggers to the attendance policy, management had not progressed as quickly though the process as they could have. She decided that the Respondent could not sustain further persistent absences and therefore dismissed the Claimant.

80. The Claimant appealed his dismissal, contending that the Respondent was guilty of disability discrimination, unfair dismissal and breach of contract, but did not seek reinstatement or reengagement, rather he sought an apology, an exemplary reference (there was no issue about the Claimant's performance) and compensation.

81. MC chaired the appeal hearing on 21 March 2019 at which the Claimant reiterated that the other adjustments offered in respect of his wrist worked well, but that he was aggrieved about the attendance triggers applied by the Respondent. He complained about the effect of the 48-hour policy on his absenteeism due to IBS. JC had noted in her management statement of case that the Claimant had been asked on 5 occasions for evidence of a diagnosis of IBS, and it was only on the day of the capability hearing that he provided

information about a possible diagnosis by his GP had been provided. Further discussion was had about this issue and the Claimant agreed to submit after the hearing, further evidence; he did so. The panel decided to take time to deliberate and the parties agreed to reconvene on 25 March 2018 to provide a decision. The Claimant did not attend that hearing. A letter was sent to him on 26 March 2018 with the reasons for rejecting his appeal and upholding the original decision to dismiss. MC agreed with the Claimant that his use of his motorcycle was a matter of personal choice.

82. The radiotherapy department operated in the 2018/19 financial year at a staffing level of 15-20% above the bare minimum required to perform patient facing tasks; that additional allowance was to enable staff to undertake non patient-facing, but nevertheless patient-impacting activities, such as taking annual leave and professional development training.

The Law

<u>The Duty to Make Reasonable Adjustments</u>

83. With regard to the claim for a failure to make reasonable adjustments, we have had regard to the provisions of s.20 and 21 of the Equality Act 2010 as well as the correct approach to their interpretation as set out in <u>Environment Agency v Rowan</u> [2008] IRLR 20 EAT.

84. The duty to make reasonable adjustments does not arise if the employer does not know and could not reasonably be expected to know that the employee is disabled: Schedule 8 paragraph 20(1)(a).

85. The employer must have actual or constructive knowledge of the facts constituting the disability for the purposes of s.6 Equality Act 2010; it need not be aware of that, as a matter of law, the consequence of such facts is that the employee is a disabled person: Gallop v Newport City Council [2013] EWCA Civ 1583 [2014] IRLR 211 at para 36.

86. The EHRC Code (paragraph 6.19) states that employers must do all that they can reasonably be expected to do to find out whether an employee has a disability.

87. Employers are entitled to attach weight to the opinion expressed in the report of an Occupational Health report but must not unquestioningly rely on unreasoned reports: Donelien v Liberata UK Ltd [2018] EWCA Civ 129, [2018] IRLR 535.

88. Any modification of, or qualification to, the PCP in question which would or might remove the substantial disadvantage caused by the PCP is in principle capable of amounting to a relevant step, including the discounting of absences: Griffiths v SoS for Work and Pensions [2015] EWCA Civ 1265 at paras 65, 67.

89. What is reasonable is to be determined objectively: Griffiths at para 73.

Discrimination Arising in Consequence of Disability

90. Section 15(1) of the Equality Act concerns discrimination arising out of disability and provides:

(1) A person (A) discriminates against a disabled person (B) if—

(a)A treats B unfavourably because of something arising in consequence of B's disability, and

(b) A cannot show that the treatment is a proportionate means of achieving a legitimate aim.

(2) Subsection (1) does not apply if A shows that A did not know, and could not reasonably have been expected to know, that B had the disability

91. If there is more than one reason then the reason allegedly arising from disability need only be a significant (in the sense of more than trivial) influence on the unfavourable treatment, it need not be the main or sole reason; City of York Council v Grosset [2018] EWCA Civ 1105 at paragraph 53.

92. A legitimate aim is one that can encompass a real need on the part of the employer's business: Bilka-Kaufhaus GmbH v Weber von Hartz, Case 170/84 [1987] ICR 110. It is one that is legal, should not be discriminatory in itself and must represent a real, objective consideration: EHRC Code of Practice at 4.2.8.

93. To be proportionate, the treatment must be an appropriate means of achieving a legitimate aim and reasonably necessary in order to do so. Homer v Chief Constable of West Yorkshire [2012] UKSC 15 at [20-25].

94. The principle of proportionality requires an objective balance to be struck between the discriminatory effect of the measure and the needs of the undertaking. It is for the Tribunal to conduct that balancing exercise and make its own assessment of whether the latter outweighs the former; there is no range of reasonable responses test*:* Hardys and Hansons plc v Lax [2005] EWCA Civ 846 at [32-33]

95. Justification need not be conscientiously and contemporaneously featured in the decision making process, so that there is nothing to prevent an employer

relying on 'after the event' justifications not considered at the time: Cadman v HSE [2004] IRLR 971

Failure to Make Reasonable Adjustments: Conclusions

96. We deal first with the issue of the Respondent's knowledge of the IBS. The duty is upon the employer to take reasonable steps to inform itself of any disability.

97. On his own account, the Claimant, had detailed knowledge of his gastrointestinal impairment, its history, its symptoms, their frequency, the effectiveness of medication on those symptoms as well as the medical research he had conducted in order to disagree with his GP's diagnosis of IBS. On his own case, he did not share the details of that knowledge and experience with his employer.

98. After 4 absences for gastrointestinal problems, the referral on that occasion was made by RD not because of information shared by the Clamant, but because, as the absence management policy required her to do, she considered that there was a possible link between the absences.

99. The contents of the resultant report, dated 26 September 2016, do not support the conclusion that the long-standing impairment did cause an adverse effect on day to day activities, only there might be a causal connection between the impairment and the absences. The information the Claimant gave was insufficient to enable Occupational Health to advise the Respondent further, and the Claimant was advised to seek further assistance from his GP. The

Claimant allowed both Occupational Health and RD to believe he would follow that advice and it was reasonable for the Respondent to believe that he would; he certainly did not disabuse it of that belief then, or indeed for much of his employment.

100. We reject the Claimant's contention that the Respondent should be fixed with knowledge of the IBS on or around 26 September 2016 upon receipt of the Occupational Health report.

101. We find that the Respondent took such steps as were reasonable to inform itself of the Claimant's disability for much of the chronology, by taking numerous and varied steps such as conducting return to work interviews, by offering to refer, and subsequently by referring, the Claimant to Occupational Health three times, and by holding review meetings with him.

102. Given the wealth of information that he had acquired about his own impairment, and the fact that he knew, on his own case, the manner in which the impairment was affecting his attendance at work, we find that his response to the considerable efforts of the Respondent to understand his condition and support him, to be opaque and unhelpful to the point of being uncooperative.

103. We find, however, that there was a significant change in the Claimant's attitude at the review meeting on 23 August 2017, perhaps attributable in part by the fact that he enjoyed trade union assistance at that meeting. Unlike previous meetings, the Claimant volunteered a significant amount of detail about his gastrointestinal impairment, as well as other conditions. He disclosed not only the fact that he had an impairment for which he had received a

diagnosis, but further that it was long standing, and, we find, his described his difficulty in identifying medication which, we find, ought to have at least suggested to the Respondent of the presence of an adverse effect on day to day activities. On the basis of that information, we find that the Respondent had acquired knowledge, or alternatively ought reasonably to have known, of the gastrointestinal disability by this date.

104. We have considered the Respondent's case, namely that the advice on the question of disability given by Dr Macherides in his report of 24 July 2018 appears to negative the advice given in his earlier report of 26 September 2017. We do not find that the apparent change in Dr Macherides' advice alters our finding; it is ultimately the Respondent's own duty to take steps to understand the true position, taking into account the advice from Occupational Health, rather than being dictated to by it. The knowledge of the facts that the Respondent had or would have acquired in August 2017 would not have changed on receipt of Dr Macherides' report in July 2018; it remained fixed with that knowledge.

105. We next turn to the causative link that is required between the PCP and the substantial disadvantage. Section 21 requires the PCP to 'put' a claimant to a substantial disadvantage.

106. The first PCP is the requirement 'not to have more than 4 absences in a 12-month period and that those absences must not exceed 10 days in duration'. That PCP does not put the Claimant to the substantial disadvantage of being 'unable to attend work due to his disabilities'. The claim on this basis fails for a lack of causative link between the two.

107. In contrast, the second PCP, being the requirement 'not to attend work in the 48 hours after suffering from diarrhoea' is, we find, at least capable of putting the Claimant to the substantial disadvantage of being 'unable to attend work due to his disabilities'. On the facts as we have found them to be, however, the second PCP did not in fact put the Claimant to that disadvantage at any stage after the Respondent acquired knowledge of his disability. The only potentially relevant absence after August 2017 is that in July 2018, which absence we are not satisfied was caused by the Claimant's disability.

108. Since the second PCP did not put the Claimant to the substantial disadvantage at any time when the Respondent knew or ought reasonably to have known of the disability, the duty to make such adjustments as are reasonable to avoid that disadvantage was not triggered and the Claimant's claim on this alternative basis must also fail.

109. We accept the general proposition put by the Respondent that where adjustments to triggers are considered appropriate, that adjustment might, in appropriate circumstances, be achieved by delaying progression through the stages of the absence management policy, as RD explicitly said she would do on, for example, 4 January 2018 and, we accept, on other occasions that have not been recorded.

110. The Claimant did not rely upon a substantial disadvantage whereby he was placed at increased risk of being subject to formal capability proceedings. We considered whether it would make any difference had done so, and had we had we agreed with the Claimant's case that knowledge was acquired in

September 2016. Taking that case, then at its highest, we consider that the Claimant could have been, under the terms of the absence management policy, referred to an ill health capability panel with respect to the remaining non-disability related absences by July 2017[2].

Discrimination Arising in Consequence: Conclusions

111. The Respondent accepts that in dismissing the Claimant, it subjected him to unfavourable treatment. At the time of the dismissal, it knew of the disability relating to the wrist and, for the reasons set out above, we find that it knew or ought to have known of the gastrointestinal disability.

112. The absences caused by the disabilities were self-evidently a significant proportion of the totality of absences; they were more than a trivial influence on the decision to dismiss.

113. We accept that the aim, being managing staff absences in order to maintain an appropriate level of service in respect of patient care as a real need on the part of the Respondent, in order to effectively operate as a provider of medical services.

114. The treatment would in fact achieve the legitimate aim; we accept that dismissal of the Claimant would enable the Respondent to better manage its staff resources in order to provide patient care.

[2] Absence in February 2017 due to injured finger triggering Stage 1 by March 2016, the absence in May 2016 due to 'nausea/bug' triggering Stage 2 by May 2016, successfully completing Stage 2 by November 2016, but retriggering Stage 2 in March 2017 because of the absence due to diarrhoea and vomiting and exceeding the Stage 2 targets by July 2017 because of the stress-related absence.

115. We are satisfied that the treatment was reasonably necessary to achieve the aim; the Respondent had taken many steps over 3 years to support the Claimant.

116. The final matter is the objective, balancing exercise the Tribunal must carry out between on the one hand the reasonable needs of the Respondent and the discriminatory effect of its actions.

117. The need to maintain an appropriate level of patient care by managing staff absences carries, we find, carries a substantial amount of weight in that balancing exercise; for an organisation such as the Respondent, patient care, delivered by its staff is the very purpose of its existence.

118. The Claimant was off work for in excess of 282 days over a period of employment of just in excess of 3 years; he was absent on average 94 days a year or approximately 19 weeks a year. We consider that his absence did have an impact on the Respondent's ability to provide patient care, since the department operated at a margin of 15-20% to cater for 'non-patient facing but patient impacting' activities. In other words, 80% of his time (and therefore his absence) was required to provide direct patient service; his absence needed to be covered by 4 other colleagues in order for patient services not to be directly impacted.

119. There were a significant number of meetings and measures organised to support the Claimant during his employment; the time expended by RD and Human Resources in managing the Claimant's absences were further causes

of indirect cost and therefore impact on the Respondent's ability to deliver an appropriate level of patient care.

120. Approximately half of the Claimant's absences were attributable to the Claimant's disability. The overwhelming majority of those absences were attributable to the right wrist. At the time of dismissal, no further operations or significant absences were envisaged in respect of the wrist. This is a significant factor pointing towards the discriminatory effect of the treatment.

121. It is the treatment that requires justifying, and not the process by which it was arrived at. But the timing of the dismissal is relevant, in our assessment; in particular, we consider it significant that the Respondent dismissed the Claimant in December 2018 some 18 months after it would have been open to it to refer to an absence management panel to consider dismissal (in the artificial circumstances that we set out at paragraph 110 above) in or soon after July 2017. In other words, the fact of the disability related absences had the effect of extending his employment; we considered this to be an important factor suggesting that the discriminatory effect of the decision to dismiss was not substantial.

122. We attach considerable weight to the fact that the decision to dismiss occurred after many steps had been taken to number of steps had been taken in an attempt to support his attendance at work, including adjusted duties, phased return to work, 13 referrals to Occupational Health, three offers of counselling, three offers to complete stress risk assessments and two workplace assessments. In addition, the Respondent supported the stress he

felt as a result of his absence management referral by way of temporary deployment.

123. However, when we considered what alternatives there were open to the absence management panel, one such alternative was to not dismiss him. We considered that the likelihood of absences continuing in future if the Claimant were to remain in employment was not only significant but substantial:

124. First, the Claimant continued to complain of pain and discomfort in his wrist and he had historically failed to engage with the absence management process by, for example, seeking further assistance from his GP, reducing his motorcycle usage, taking his medication in the manner it had been prescribed, rather than creating his own medication plan.

125. In the three months preceding his referral to absence management panel, the Claimant had incurred 33 days absence due to stress i.e. a non-disability related absence. The fact that the stress was, according to Occupational Health, not a medical issue, together with the reluctance on the Claimant's part to explore whether the stress risk assessment might provide him with further insight, or his conviction that it was something for management to complete would indicate that stress related absences were likely to remain a feature had his employment continued.

126. Finally, the fact of the Claimant's continued, non-disability related, absences after the date of his referral to the absence management panel.

127. We considered a further alternative, which was to extend the temporary redeployment, as the Claimant contends. The arrangement was to enable the Claimant to better deal with the stress of the referral to the absence management panel; his stress was not a disability (or even a medical matter), although the referral to panel was, in part, due to his disability related absences. The temporary redeployment was therefore related to his disabilities, but indirectly so, and because of this, together with the factor below, we attach some, but not substantial weight to this prejudicial effect.

128. We consider that the points weighting in the Claimant's favour are significantly outweighed by considerations of the Respondent's need to manage staff absences in order to maintain patient services. Therefore, having considered the Respondent's aim, the means of achieving that aim and the discriminatory effect of the decision to dismiss, we find that the treatment were proportionate to the aim. The dismissal was reasonably necessary, since no less discriminatory means could have achieved the objective of managing staff absences in order to maintain patient services. A continuation of the Claimant's employment could not have occurred without also prolonging the challenge of managing his absences and its impact on its ability to provide patient services; the Claimant's claim fails.

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Employment Judge Jeram
Date 21 January 2021
JUDGMENT SENT TO THE PARTIES ON
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FOR THE TRIBUNAL OFFICE

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