EMPLOYMENT TRIBUNALS

Claimant **Respondent**

Mr T Collett v **Chief Constable of Hertfordshire Constabulary**

Heard at: Watford and CVP **On**: 30 November 2020 to 8 December 2020 (7 & 8 December in chambers)

Before: Employment Judge Manley
Mr Bean
Mr Chapman

Appearances

For the Claimant: Mr C Banham, Counsel
For the Respondent: Ms V Von Wachter, Counsel

JUDGMENT

1. The claimant was a disabled person at all material times.

2. The respondent did not fail to make reasonable adjustments under ss 20 and 21 Equality Act 2010.

3. The respondent treated the claimant unfavourably because of something arising in consequence of his disability but it has shown that unfavourable treatment was a proportionate means of achieving a legitimate aim and there is therefore no discrimination arising from disability under s.15 Equality Act 2010.

4. There was no harassment of the claimant related to his disability under s26 Equality Act 2010.

REASONS

1. **Introduction and issues**

    1.1 The claimant brought a claim for disability discrimination. At a preliminary hearing on 28 January 2020 the matter was listed for this seven day hearing and a list of issues which had been agreed between the parties is now set out below:-

"*Disability*

1. *The Respondent accepts that the Claimant was disabled by reason of Type 1 Diabetes at all material times, pursuant to s6 EqA 2010.*

2. *The Respondent accepts knowledge of the Claimant's disability at all material times.*

Failure to Make Reasonable Adjustments pursuant to s20 & s21 Equality Act 2010

3. *Did the Respondent apply to the Claimant a provision criterion or practice ('PCP'), namely:*

    a. *The policy that officers with diabetes are removed/unable to undertake firearms duties;*

    b. *The policy that officers with diabetes are removed/unable to undertake Class 2 driving duties;*

    c. *The requirement for stricter health parameters to undertake firearms duties.*

    d. *The requirement for stricter health parameters to undertake Class 2 driving duties.*

4. *If so, did that PCP put the Claimant at a substantial disadvantage in comparison with persons who are not disabled, namely because the Claimant's disability meant that he is/was:*

    a. *Suffering from Type 1 diabetes;*

    b. *Unable to meet the requirements for stricter health parameters to undertake firearms duties; and/or*

    c. *Unable to meet the requirements for stricter health parameters to undertake Class 2 driving duties.*

5. *If there was such a PCP what adjustments should the Respondent have made to remove the disadvantage placed on the Claimant? The Claimant avers that the following adjustments were reasonable:*

    a. *Test levels before driving;*

    b. *Test blood glucose levels daily and whilst on duty, a minimum of 3 times per day;*

    c. *Test levels before any firearms deployment and if he suspects a hypoglycaemic episode;*

    d. *Carry short and long acting carbohydrates at all times;*

    e. *Given time to eat;*

    f. *Must retire from duty if blood sugar levels fall outside 4-15ml range;*

    g. *Take a snack if blood sugar levels are 5mmol per litre or below;*

    h. *Continue to submit testing readings to occupational health;*

    i. *Partake in independent reviews when requested;*

    j. *Must advise occupational health of any onset of reduced awareness or absence of awareness of hypoglycaemic episodes;*

    k. *Maintain up to date knowledge of diabetes mellitus;*

    l. *Report any changes in status that may have an impact on risk factors in respect of carrying out safety critical duties or driving;*

    m. *Allow occupational health to review all assessments at the department of diabetes and endocrinology.*

6. *If there were such adjustments, were those adjustments reasonable? Did the Respondent fail in its duty to make reasonable adjustments by imposing additional unreasonable requirements?*

Discrimination arising from Disability pursuant to s15 Equality Act 2010

7. *Did the Respondent treat the Claimant unfavourably? The Claimant relies upon the following alleged acts as instances of unfavourable treatment:*

    a. *Removing the Claimant from operational duties;*

    b. *Removing the Claimant from firearms duties; and/or*

c. Removing the Claimant from Class 2 driving duties.

8. If there was found to be such unfavourable treatment was it because of something arising in consequence of the Claimant's disability? The Claimant avers that the following constitutes "something arising in consequence of" disability:

a. The inability to maintain blood glucose levels within a normal range;

b. Impaired judgment (reduced or absence of awareness) as a result of excessively low and/or high glucose sugar levels;

c. The need to maintain a specific diet to manage/control blood glucose levels;

d. The need to take insulin to manage/control blood glucose levels;

e. The need to test his blood regularly.

9. Can the Respondent show that the treatment was a proportionate means of achieving a legitimate aim? The Respondent relies upon the following by way of legitimate aims:

a. To ensure that the Claimant operates safely as a firearms officer and/or rapid response driver. The Respondent asserts that this is a proportionate means of achieving the legitimate aim of ensuring the safety of the Claimant, the Claimant's colleagues and the public.

Harassment pursuant to s 26 Equality Act 2010

10. Did the Respondent engage in unwanted conduct that was connected to the Claimant's disability and if so what?

11. The Claimant relies upon the following alleged incidents of unwanted conduct:

a. Dr Junker's refusal to take into account the Claimant's individual circumstances and her comments that he should stop his outside hobbies.

b. Dr Junker's opposition of the reasonable adjustments recommended in May 2018. In her own words any adjustments are 'about the Force's appetite for risk, what the Force thinks is reasonable and what the Force can manage' (letter to Chief Superintendent Dales 2nd May 2018). Her intervention was after the Claimant had made a complaint about her.

c. Dr Junker's requirement for the Claimant to be monitored 24 hours a day 7 days a week via a CGM. The Claimant considers this to be a breach of his human rights and the right to a private life.

d. Dr Junker's requirement that the Claimant maintain a maximum HbA1c reading if 64mmol/L. This requirement is not a reasonable adjustment. Readings of this nature may affect the Claimant's long term health but do not interfere with his ability to undertake his role as a Firearms Officer.

e. Dr Junker's comments that she 'reserves the right to decide the frequency of my reviews' and 'incomplete testing records or delayed provision of testing records will entail unfitness' means the Claimant will constantly be worried that at any time the parameters for his testing will change and he could be removed from duties instantly without consultation.

12. Did the conduct have the purpose or effect of violating the Claimant's dignity, or creating an intimidating, hostile, degrading, humiliating or offensive environment for the Claimant?

Compensation

13. If unlawful discrimination is established, has the Claimant suffered financial loss as a result of that discrimination?

14. If so what level of compensation is just and equitable?

15. If unlawful discrimination is established, is the Claimant entitled to an award for injury to feelings as a result of that discrimination?

16. If so what level of award is just and equitable?"

1.2 All claims are brought under the Equality Act 2010 (EQA). They are claims for failures to make reasonable adjustments under ss20 and 21; discrimination arising from disability under s15 and disability harassment under s26.

2. **Hearing**

2.1 At the commencement of the hearing on Monday 30 November 2020, there was a preliminary application made by the claimant to adduce documents which attracted legal and/or professional privilege. It was agreed that that was a matter best dealt with by the judge alone and it was therefore considered at the end of the first day. The application was refused because the documents were privileged and had been disclosed as a result of an obvious mistake. Otherwise, the tribunal

spent the rest of that day reading the documents and witness statements.

2.2 The document bundle was extensive. It was over 1700 pages long and there was a further bundle with policy documents, although the only one we were referred to in that bundle was the appendix to the “Blue Light Guidance”. The witness evidence was also fairly detailed. It was agreed that the hearing would be a liability only hearing so we did not need to read or hear from one of the respondent’s witnesses. The bundle contained some photographs of a continuous glucose monitoring device (CGM). We were able to view a short video of someone wearing one and the respondent’s representative held one up for us to view it remotely.

2.3 We heard from four witnesses for the respondent as follows: Dr Andrea Junker, who is the force medical advisor (FMA); Chief Inspector Oliver Warsop; Mr Paul Fullwood (retired Assistant Chief Constable) and Deputy Chief Constable Michelle Dunn. We also heard from the claimant himself and from Mr Wollaston, a Police Federation Representative who attended one of the meetings with the claimant on 8 April 2019.

2.4 The parties both supplied opening skeleton arguments which we also read when we were pre-reading. They had helpfully agreed a cast list, an agreed facts and chronology and an agreed reading list. We therefore began hearing oral evidence on Tuesday 1 December. The tribunal members were present in the tribunal hearing room but the parties and witnesses attended by CVP. This led to some occasional technical difficulties and delays which were usually overcome without too much trouble. The evidence was completed on Thursday 3 December and, as the judge had another matter on 4 December, we agreed that we would hear submissions by CVP on the morning of Monday 7 December. The rest of the time was spent with the tribunal deliberating, given that this was a relatively complex matter.

3. **Facts**

3.1 We now set out the facts which we find are relevant to our consideration of the issues as agreed.

3.2 The claimant became a police constable for the respondent on 30 September 2002. On 1 June 2006 he became an operational firearms officer. This is a safety critical role and attracts some extra payments. On Christmas Eve 2015 the claimant was diagnosed with type 1 diabetes. He was told that he would be insulin dependent for the rest of his life. He was understandably shocked by this news as he was, and still is, a relatively fit person who takes regular exercise and takes part in extreme sports such as ultra-marathons and iron-man challenges. As was required, he informed the respondent of the diagnosis and was removed from operational duties as a firearms

officer. His group 2 driving licence was also suspended. Both these actions were pending further investigation.

3.3 In summary, type 1 diabetes is a condition where the pancreas does not produce sufficient (or any) insulin which is needed to regulate blood sugars of the body. It can lead to long term complications if not treated. It can also cause hyperglycaemia which is when the blood sugar levels are too high or hypoglycaemia which is where the blood sugar is too low. Hyperglycaemia is of less immediate concern and noticing those high readings is more useful to ascertain the medium and long term effects of the condition. Having high blood sugar levels can lead to effects on kidneys, sight or circulatory system. Hypoglycaemia is of much more immediate concern and can lead to confusion, clumsiness and a loss of consciousness. People with type 1 diabetes need to inject insulin, with the person needing to understand how much to inject, taking into account carbohydrate intake, and regularly monitor their blood sugar levels. The level of physical activity will also affect blood sugar levels.

3.4 Various measures of diabetes control are available, the most common being blood sugar levels. Another measure is "*HbA1c"* taken over time, with a healthy measure being below 48mmol/l.

3.5 The claimant understood that he was to be monitored for six months after diagnosis to ascertain the control of the condition. He was to be referred to occupational health for those managing him to have the correct information.

3.6 It is not disputed that the claimant showed excellent control of the condition. He undertook an educational course about managing type 1 diabetes and all the information about his blood sugar levels showed good or excellent control.

3.7 The person at occupational health who was to provide advice to the respondent was Dr Junker. She is a consultant occupational physician and has been for many years. She is the Force Medical Advisor (FMA) for the respondent as well as to some other forces. She is highly qualified in various specialisms including orthopaedics and oncology. She has been a specialist in occupational medicine since January 2002. She has provided occupational health services to a number of corporate clients as well as the MOD and Prison Service. She meets with other occupational health advisors in the Faculty of Occupational Medicine (FOM) and chairs the Southern England Group of FMAs.

3.8 When Dr Junker became aware of the claimant's condition, she considered matters and looked at the FOM "Blue Light" Guidance. This guidance was drawn up in 2013 with respect to diabetic officers in the safety critical role of response driving. Dr Junker's evidence is that the National Police Diabetic Association and the Police Federation were members of the steering group that drew up the guidance.

3.9 There was no national or local guidance with respect to type 1 diabetic officers undertaking firearms duties. Dr Junker's evidence was that she considered that the responsibilities of a firearms officer to be at least as safety critical as those of a response driver. She took the view that the "Blue Light" Guidance should be applied to the claimant in his role as a firearms officer as well as in his role as a response driver.

3.10 That guidance does set strict parameters and Dr Junker accepted that it would only be a minority of officers with type 1 diabetes who would be able to regularly meet the standards. It is the Appendix to the Guidance which relates specifically to "*blue light drivers with diabetes mellitus with treatment regimes that may lead to hypoglycaemia*". The Appendix states there should be a preliminary assessment and then, under "First and Periodic assessment" It asks:

"Is control of diabetes stable within the agreed safe limits? (90% of glucose readings between 4-10mmol/l on regular testing and HBA1C of less than 64mmol/l)".

A number of other questions and matters are then raised in the but it is not necessary for those to be repeated here. The claimant asked the tribunal to pay particular attention to one of the notes at the end of the appendix which reads at

(ii) *"This figure is a pragmatic range. The lower figure is well researched. The upper limit of 10 mmol/l is a working level and minimising diabetic complications and avoiding cognitive impairment while driving".*

The claimant's case is that this note throws doubt on the suggestion that the need for 90% of readings to be between 4-10mmol/l was not as strict as the Dr Junker believed. The tribunal does not accept that the note changes the range which is set down within the Appendix itself.

3.11 Dr Junker had access to the claimant's occupational health records and spoke to Ms Jeffers who is the Head of Occupational Health and Safety as well as some other colleagues within occupational health. At the time the respondent had a Tri-Force and also a Seven Force arrangement with other forces in the local area. It is assumed that this is for efficiency purposes. A separate FMA was based in the north of the region in Norfolk. It was not thought that Dr Junker had spoken to the FMA in that region, but, when cross examined about this, she said she had spoken to him by phone but he was junior to her and had nothing really to add. Dr Junker was well aware of the requirement of the respondent to comply with its statutory duties under Health and Safety Regulations as well as to be concerned about its more general duties of safety to the claimant, his colleagues and the general public.

3.12 The claimant met with Dr Junker in May 2016. He had been seen previously by occupational health but this was the first time that Dr Junker had an opportunity to discuss with the claimant what she considered to be appropriate, namely the application of the "Blue Light" Guidance. She explained to the claimant the standard which he would need to meet to stay within the "agreed safe limits" set out there. The claimant mentioned at that meeting that he undertook ultra-marathons and that that might mean the upper limit of 10 mmol/l might be difficult to maintain. The claimant handed over a report from the hospital treating him which confirmed that he had good day to day management of his diabetes and Dr Junker agreed that his management of it was excellent. The claimant readily admits that he did not question the application of the "Blue Light" Guidance at this point apart from mentioning the possible difficulties of the upper limit. In essence the claimant understood that his blood sugar levels would be assessed within the standards set by the "Blue Light" Guidance.

3.13 Dr Junker sent her report to the claimant's line manager to help with decision making about the claimant's role on 13 June 2016. In that report Dr Junker said that the claimant was fit to return to full duties as a firearms officer. In this relatively detailed document (page 177/8) she set out what she said were adjustments for an officer performing safety critical duties which included the claimant being given opportunity to test blood glucose levels on duty, a minimum of four times per day; must be given time to eat; must carry short-acting and long-acting carbohydrates on his person; must be authorised to self-identify brief periods of time (usually lasting 45-60 minutes) during which he is not fit to perform safety critical duties:

> *"To most people this occurs with a blood glucose level of 4mmol/l or lower but in some individuals this can occur slightly earlier. As a precaution a snack should be taken if blood sugar level is at 5.0mmol/l or lower when tested; the officer must test blood sugar levels prior to driving as per DVLA requirements."*

3.14 The report went on to set out the self-monitoring that the claimant must carry out; that the DVLA Group 2 medical standards were to be applied to his driving and that the claimant was waiting for the DVLA to process his re-application for a Group 2 licence. She says this at page 178:

> *"With regards to blue light driving Mr Collett would have to undertake blood sugar testing prior to any call-out without exemption in line with the Faculty of Occupational Medicines Guidelines and Fitness for Blue Light Driving."*

3.15 The claimant then met with his line manager and Inspector Hands on 1 August in which adjustments based on those recommendations were agreed. These are at page 192 and 193 of the bundle. Although it is not entirely clear from that document, it is not disputed that the claimant understood that the "Blue Light" Guidance was to be applied

to him, namely the blood sugar readings between 4-10mmol/l requirement. He returned to full operational duties on 3 August 2016 and on 6 September 2016 the DVLA re-issued his Group 2 licence.

3.16 The arrangement was that the claimant should send his blood sugar readings to Dr Junker but there was a delay towards the end of 2016. It seems this was caused because the claimant thought they would be sent direct by the hospital which was treating him. Dr Junker looked at those readings and found they were not within the "Blue Light" Guidance parameters. In her witness statement, she said that she considered both the low and high level readings. By letter of 26 January 2017 Dr Junker wrote to Inspector Hands to say: "*Unfortunately Mr Collett no longer meets the requirements that would allow me to confirm his fitness for response driving and operational firearms duties. As 39.6% of his readings are outside the required range, ideally 90% or at least 80% should be within."* She had informed the claimant of this by phone.

3.17 The claimant was upset by this action arguing that the occupational health department were being "*extremely unrealistic*". It appears the claimant understood that Inspector Hands should take guidance from the occupational health doctor but he was clearly concerned about this action. Inspector Ms Hands replied to the claimant saying: "*You will know that it is the absolute right of the FMA as they are the final arbiter in medical cases such as this to sign you as fit or unfit for the role. As a manager my hands are absolutely tied on this issue."*

3.18 It is not strictly true that Dr Junker was the *"final arbiter*" as the role of the occupational health practitioner in this case was to advise managers and then they must take steps bearing that advice in mind. Of course, it may well be unlikely that a line manager would feel it appropriate to ignore such clear advice as this.

3.19 The claimant attended an appointment with Dr Junker on 7 March 2017. At that meeting the claimant recalls that he mentioned a throat infection but Dr Junker does not recall that, although she does recall discussion about an ankle injury. They did discuss his taking part in ultra marathons. The report from the claimant's diabetologist in October 2016 which Dr Junker saw made reference to the claimant's ability to control his blood sugars and to the fact that his HbA1c was 63 (which is close to the maximum permitted). Inspector Hands attended the meeting with the claimant and they discussed the "Blue Light" Guidance. The claimant argued that a more appropriate parameter would be 4-15mmol/l. Dr Junker disagreed and was clear that she wished to stick to the "Blue Light" Guidance.

3.20 The tribunal heard evidence that different police forces apply different standards and make different decisions about type 1 diabetics officers who have firearms duties within their area. Although we heard no specifics, it was not challenged that some forces do not allow type 1 diabetic officers to be firearms officers. The "Blue Light" Guidance is

what is commonly used for response driving. Other forces do apply different standards and during the discussions that the claimant had with Dr Junker at various points (and with other officers) he mentioned what he had found out about those officers to whom the "Blue Light" Guidance did not appear to be applied for firearms duties. The claimant's evidence was that Dr Junker has suggested that he give up his ultra-marathons. The claimant's witness statement suggests that this was mentioned at the meeting later in May 2017 when in fact he was signed fit for those duties. In any event, Dr Junker does not agree that she told him to stop those activities but that she did suggest that he might want to consider whether he continued. She has no recollection of saying anything about running 5km like normal people which is what the claimant recalled her saying. Even if there was such a discussion, the tribunal cannot see that can be criticised if it was a discussion about how taking part in extreme marathons might lead to the claimant spiking his blood with sugar and this would have an effect on the higher blood sugar levels.

3.21 After the meeting Dr Junker sent a memo to Inspector Hands about the discussion that they had where she said this: *"I would like to stress that his blood sugar control is not poor, it is just not good enough for the standard required for him to be a response driver and a firearms officer, which is not easy to achieve.*" It had been agreed that the claimant would send various pieces of information to Dr Junker for her to consider it again in early May.

3.22 When they did meet again on 9 May 2017 she had the claimant's blood sugar readings and was able to confirm that he could be reinstated for firearms officer and response driver on the same adjustments as before. It is quite clear that the "Blue Light" Guidance parameters still applied at this stage.

3.23 Unfortunately, by the next assessment in August 2017, Dr Junker decided that she would have to recommend that: "*Mr Collett no longer meets requirements that allow me to confirm his fitness for response driving and operational firearms duties.*" She had not been able to speak to him but said she had tried to ring him. The claimant was upset about this course of action. In an email of 10 August 2017 to Inspector Hands he expressed his concern about it and was angry particularly about Dr Junker's stance. Within that fairly lengthy email he said:

> *"You yourself have been present at a meeting when Dr Junker accused me of lying and withholding information from her, completely untrue. You were also present when Dr Junker advised me to do LESS exercise in order to better manage my blood sugar levels. This clearly demonstrates a lack of knowledge around diabetes and how it is effectively controlled."*

3.24 Inspector Hands replied saying that she understood the impact but said that the claimant should meet with herself and Inspector Warsop.

She did not agree or disagree with his suggestion about Dr Junker accusing him of lying or doing less exercise. The tribunal cannot find that Dr Junker lied on the evidence before it. She denies saying the claimant had lied and it is much more likely to have been a misunderstanding of what was said.

3.25 The claimant also sent a report from his dietician to Dr Junker but that really only confirmed that the claimant understood the need for dietary control in the overall control of his diabetes which was not in any dispute. The claimant was on a short period of sick leave between September and October 2017 and returned briefly to non-operational duties before he attended a further occupational health appointment in November 2017.

3.26 By this point it had been decided that Chief Inspector Warsop should have a look at the matter as it was clearly causing some difficulties. Chief Inspector Warsop met with the claimant in November. At this point the claimant was deemed fit to work in a non-operational role after his return from sick leave. Chief Inspector Warsop considered the matter and referred it on to Chief Superintendent Dales to consider towards the end of 2017. Chief Inspector Warsop's evidence was that the claimant would arrange to speak to his specialist diabetologist, Dr Joharatnam. Chief Inspector Warsop thought that the input from that external doctor might be helpful and he then met with the occupational health manager, Ms Jeffers, and Dr Junker in January 2018. He had been hopeful that he might be able to resolve the issue but it seemed that it was getting difficult to resolve. He began to involve Mr Fullwood, who at that point was the Assistant Chief Constable and who was also the designated Chief Officer for Firearms for Bedfordshire, Cambridgeshire and the respondent constabularies. This is known as Joint Protective Services (JPS) from the three forces who deliver operational policing across a number of areas in terms of a governance framework. The individual Chief Constables remain responsible for each separate force.

3.27 Chief Inspector Warsop prepared a report on the matter in April 2018. This was a summary of the position as he understood it. There were one or two errors in the report, which it is not necessary to go into, and there is some dispute about the detail. However, this was not a report which suggested any change to the arrangements. Rather it was a suggestion that it needed to be looked into in a bit more detail including the use of the possible referral to external specialists. Although Dr Junker saw this document, she did not read it all and there was some criticism of the first page of it in an email from Ms Jeffers to the force legal officer (Page 513). It appears that by this point the claimant had suggested that he might well be taking legal action and the legal team had therefore become involved.

3.28 Also, in April 2018 the claimant met with Chief Superintendent Melanie Dales to discuss conditions for him to return to firearms and response

driving. A note of the meeting appears at page 518-522 of the documents. There was considerable discussion about the parameters of 4-10mmol/l, for the percentage of compliance to be either 90 or 80%, questions about a right to a private life and the HbA1c test. Dr Junker had been invited but had been advised not to attend, it seems on legal advice. After the meeting Chief Superintendent Dales said that she wanted there to be a meeting with the OH advisor, Dr Junker (as the FMA) and the claimant's consultant, Dr Joharatnam. The aim was to try and get joint agreement on the issue.

3.29 Chief Superintendent Dales contacted Dr Junker to ask some specific questions, commenting that she had found Dr Junker's report helpful and that there were ongoing discussions with respect to the adjustments to be applied to the claimant's role.

3.30 These were answered by a fairly detailed email of 8 May 2018 (page 593). One question was whether the assessment of blood sugar reading should relate to duty days only. Dr Junker replied that this was a management decision but did not agree that that was appropriate. She said:

> *"The force has a legitimate interest in an individual's overall diabetes control and not only their control when they are on duty. It is important to have an insight and evaluate as far as possible how an individual manages the diabetes on a daily basis in a variety of unexpected and expected situations."*

3.31 She went on:

> *"When it comes to firearms and response driving, we are probably dealing with the most hands-on safety critical tasks within active police work and potentially fatal consequences when things go wrong and with a high reputational risk in such adverse circumstances. My personal understanding is that first and foremost the police has a duty of care to protect the public and that health and safety deliberations ought to outweigh the wishes of an individual to pursue such a career where a risk assessment has concluded that this cannot safely be achieved in all circumstances."*

3.32 On 16 May 2018 the claimant began an extended period of sick leave because of stress at work. Chief Superintendant Dales continued to consider matters and by an email of 22 May 2018 she wrote to the claimant stating that she was confirming her decision about his fitness to remain as a firearms officer. She said that she had looked at the medical records, considered the HR advice, what had been said at meetings and advice from the College of Policing.

3.33 We have not heard from Chief Superintendant Dales so do not have an explanation for why she decided to apply a parameter of 4-10mmol/l for 80% of the time. For reasons the tribunal cannot understand, the claimant in his witness statement suggests that Chief

Superintendent Dales placed a parameter of 4-15mmol/l at that point but that is clearly not the case. In his witness statement, he comments that he did not agree the adjustments were *"reasonable or necessary*" he accepted them - *"I didn't feel that I was ever going to get any better adjustments so reluctantly agreed to them in order to return to work*."

3.34 Before the claimant returned to work, Dr Junker, through Ms Jeffers, queried the arrangements made. By email of 5 June to Mr Fullwood Ms Jeffers said (page 731):

> *"Dr Junker has just returned from leave to read this email which has been sent to Trevor Collett by Mel. Dr Junker is extremely concerned about the inaccuracies contained within the email, the exact nature of the advice received from the College of Policing on further investigation, the proposed plan going forward and the complete change to medical standards which have been proposed to Trevor and the implications for BCH going forward."*

3.35 Dr Junker also sent a detailed memorandum to Chief Superintendent Dales on 7 June, cc'd to Mr Fullwood, having spoken to someone at the College of Policing about the conversation which was said to have taken place with Chief Superintendant Dales. She said that she had been told that there had only been a "*short generic conversation with you of less than 2 minutes"* (page 737). She went on to point out that the 80% limit was not in line with the FOM "Blue Light" Guidance which requires 90% and went on to say:

> *"I have applied 80% only once, as an exception, and I have pointed out in my letter to you dated 1 May 2018 that with the benefit of hindsight, it might have been better to stick to the letter of the guidance. I am making this point again today."*

3.36 She reiterated that the 80% is not the "Blue Light" Guidance and concluded:

> *"I can apply whatever standard the force wishes me to but I will have to safeguard my professional integrity by pointing out that these standards are not standards recommended by myself in my capacity as your Force Medical Advisor."*

3.37 This led to the matter being referred again to Mr Fullwood, as the person with the lead on firearms officers. It had been agreed that Dr Junker would try to discuss matters with Dr Joharatnam who was the claimant's consultant diabetologist and Dr Winocour, a consultant physician and medical director of QE2 hospital in Welwyn Garden City. Dr Winocour was also a medical adviser to the DVLA on diabetes. The matter had also been escalated to Deputy Chief Constable Dunn and the suggestion made that the external medical specialists should be asked to make recommendations to allow the claimant to return to firearms and response driving.

3.38 Dr Junker was asked to provide a summary for Deputy Chief Constable Dunn. On 9 July 2018 she sent a memo to the head of occupational health, Ms Jeffers, with a detailed summary of the key facts (page 837-847) over 10 pages with an appendix. She went through the history and background and maintained her recommendation that the "Blue Light" Guidance should be used to assess the claimant's suitability for firearms and response driving duties.

3.39 Mr Fullwood was concerned about the possible risks to the respondent given that authority lay with the Chief Constable and took some HR advice. In July 2018 HR sent a report to Mr Fullwood, which recommended liaising with the College of Policing and, in August, Chief Superintendent Dales sent updated adjustments to the claimant. The claimant believed that they were workable for him although he remained on sick leave.

3.40 Dr Junker sent a memo to Deputy Chief Constable Dunn on 4 September 2018 after a two-hour telephone conference with those two external doctors mentioned above. After providing the background about the history to date, she set out what were said to be the adjustments required for him to manage his diabetes at work and the various pre-requisites. She told Deputy Chief Constable Dunn that the claimant was returned to operational duties as a firearms officer in August 2016 but by January 2017 she found he did not meet the criteria; he was reinstated in May 2017 but then again failed to meet the criteria in August 2017. She says at page 1039, paragraph 13:

> *"I did point out in various correspondence that PC Collett's diabetes control is good that it is just not good enough at all times to meet the criteria the force has agreed to apply to insulin dependent response drivers and firearms officers, ie the FOM's "Blue Light" driving guidance."*

3.41 It was suggested that a panel of diabetologists, occupational physicians, health and safety advisors and operational police officers might be able to consider new guidance, though that would be a substantial piece of work at considerable cost. She went on:

> *"The officer is also a response driver who we will continue to assess him for his driving activities against the FOM "Blue Light" driving guidance which has been applied in the force for many years. This will predictably lead to the bizarre situation of being assessed against two different standards at the same time where he could be fit for firearms duty (your lower standard) but not response driving."*

3.42 She went on to make a recommendation is that the force remains with the FOM "Blue Light" Guidelines and at page 1040 said this:

"Dr Winocour pointed out the FOM "Blue Light" Guidance was outdated, that there were new developments in diabetes management that might aid an officer's ability to work safely in a safety critical environment, that he had concerns regarding the range of readings that had been chosen with no differential waiting regarding the risk of hypo- versus hyperglycaemia and most importantly, that in his professional opinion it was extremely challenging for any insulin dependent diabetic to meet the required standard consistently."

3.43 Dr Junker said she and the external doctors had shared a "*mutual concern about the long term health implications for individuals running their blood sugar higher than they would normally while on duty in order to achieve a certain standard*". They agreed that the guidance should be revised. Dr Junker made reference to health and safety and disability legislation. Finally, she said: "*My recommendation is for Dr Winocour and Dr Joharatnam to look independently at what from their perspective could be a reasonable set of test parameters to be applied to PC Collett. Taking into account the assistive technology available to enable him to safely carry out his activities as a response driver and firearms officer".* She asked that this approach be supported.

3.44 The claimant remained on sick leave and had been informed that his pay would be reduced to half pay and there was an appeal against that decision which was unsuccessful. In September 2018 information was sent to Chief Superintendant Dales in an email from the 7-force firearms instructor in an answer to a query. He said that Norfolk/Suffolk have 2 national firearms instructors who are diabetics. He set out that they had annual OH check-ups and there had been no issues. He raised concerns about the difficulty of recruiting and retaining operational firearms officers.

3.45 A meeting in September 2018 with Deputy Chief Constable Dunn, Chief Superintendent Dales, Ms Jeffers and Mr Fullwood took place although the claimant was not invited. It was agreed that Dr Junker and the external specialists would discuss how to take matters forward.

3.46 A first draft of recommendations for the management of the claimant and his diabetes at work was sent by Dr Joharatnam and Dr Winocour in November 2018. This appears at page 1108 to 1110 of the bundle. It starts with an explanation of the difficulties of someone with type 1 diabetes meeting the FOM guidance.

3.47 It starts "*This guidance is to assist with providing a reasonable set of parameters for PC Collett, to enable him to carry out his duties as a response driver and a firearms officer…..the goals for PC Collett are to ensure safety at work and avoidance of long-term complications of diabetes in the future."* Rather than focussing on a "target window", the doctors said that it is vital to avoid hypoglycaemia. They go on:

"In order to facilitate this continuous glucose monitoring (CGM) would be essential; a continuous subcutaneous insulin infusion pump may also be desirable. CGM will allow detection of trends in glucose levels. This will allow detection of downward trends in glucose and allow early reaction and correction. If for example continuous glucose monitoring shows glucose levels falling from 10mmol/l to 5mmol/l en route to a dangerous situation then an alarm could identify to abort his role in the firearm incident.

PC Collett previously had a CGM funded from a work charity. However he no longer has funding for this and is not eligible on the NHS in Hertfordshire to be given one. The costs are detailed at the end of the recommendation. Standard blood glucose managing should also be continued as set out in the Class 2 driving licence guidance.

The higher glucose ranges should ensure PC Collett is safe and not at risk of emergency complications of hyperglycaemia such as diabetic ketoacidosis."

3.48 The recommendation continued:

"Target glucose levels of 5-15mmol/l are more realistic to account for unexpected excursions and miscalculated carbohydrate counting. The diabetologist and patient need to review how many of the blood glucose levels are over range and optimise during reviews.

In order to achieve the second goal which is avoiding long term complications from diabetes PC Collett should continue to aim for an HbA1c reading under 64mmol/l."

3.49 The recommendation is that this is for use both in and out of work because:

"This is because frequent hypoglycaemia out of work will lower PC Collett's threshold for hypoglycaemic warnings and increase further hypoglycaemia risk. Therefore it is not feasible or appropriate to only rely on blood glucose monitoring whilst at work."

3.50 There was then set out the suggested protocol with the target range of between 5-15 mmol/l; HbA1c 64mmol/l or under and the wearing of a CGM such as Dexcom 6 with some further suggestions of follow up.

3.51 Dr Junker replied to the letter from those doctors with some thoughts and suggestions and stating:-

"(the claimant) is our concern at the moment but there are of course much wider organisational considerations and implications for the constabulary. If they buy into it in all likelihood it will set a precedent

and will have to be applied to other diabetic officers applying for these roles. It is a concept that should then be applicable to both response driving and firearms duties. Unless you suggest that the identified "safe" blood sugar parameters are not safe for both activities."

3.52 In January 2019 the final guidance document was forwarded by Dr Junker to Deputy Chief Constable Dunn. She made some observations on the document about how it might be managed in the workplace including matters such as the officer being given time to eat and carrying short and long-acting carbohydrates and so on as previously agreed.

3.53 A meeting was held on 19 February 2019 with Deputy Chief Constable Dunn and Dr Junker with Mr Fullwood attending by Skype. The claimant was not present but an email from him earlier that morning indicated he was aware of it. Those present discussed the draft protocol and decided to add the offer of a trial period with the CGM. Enquiries were to be made on the funding of the CGM. Dr Junker set out her recollection of the arrangements at the meeting and a return to work protocol was drafted, the claimant having been on long-term sick leave. Again, this repeats the trial period for the CGM.

3.54 The claimant's email sent that morning to Mr Fullwood mentioned other diabetic officers he had been told about. He added this:

"Also worth mentioning is the fact that as of 15th Feb the law has changed with regards to driving, the DVLA now allow the use of a Continuous Glucose Monitoring in terms of driving, this means you can now monitor your blood sugar levels using a CGM instead of having to do a finger prick test, it may sound trivial but it is a massive step forward. Also the government has lifted the postcode lottery when it comes to being issued a CGM on the NHS, this means I should now be able to apply for one (I was previously turned down). They cost somewhere in the region of £1500 to £2000 pa to run."

The claimant was also asked at the tribunal hearing about an email he had sent to Chief Inspector Warsop a year earlier on 6 February 2018 in which he asked about funding for a CGM which he was considering using, stating that he was considering "self-funding". It was put to him that he had moved from being prepared to self-fund for a CGM to refusing to wear one at all. He replied that it was "*being forced to wear one*" which was his concern.

3.55 A meeting was arranged for 8 April 2019. In attendance was Mr Fullwood, the claimant with Mr Wollaston as his representative, the claimant's line manager, someone taking notes and Dr Junker. They went through the protocol. The claimant indicated that he was happy

with most parts but specifically raised concerns about the CGM. The concerns he raised were recorded.

3.56 The claimant said that he had trialled a "Freestyle Libra" which was another CGM and the notes record this:

> *"He advised that he does not want to wear the Dexcom as you have to wear them 24/7. These are very painful/uncomfortable to wear, cause a muscular pain and got knocked off during a triathlon in the past. TC also expressed concern that for each sensor there is significant cost."*

3.57 The claimant also raised concern about where the CGM is positioned and the question of body armour and the notes record: "*He is not prepared to wear it 24/7 on 365 days a year or on workdays only as per the above concerns and there is a potential that he could get called in on a rest day and then have to re-apply the sensor*." He also confirmed that he knew a new Dexcom was out and the sensors are much thinner. It was confirmed to the claimant that the respondent would fund the Dexcom. He took issue with the need to reset the CGM and various questions were raised about the lower level of 5mmol/l rather than 4mmol/l. The claimant said that the range should be changed from 4 to 15mmol/l.

3.58 The claimant had returned to work and Mr Fullwood said that he was pleased that he had done so. He was working on firearms training and was to return to full hours. The notes record this:

> "*A trial period with CGM (once obtained) will be undertaken following PC Trevor Collett's return to work, this will consist of weeks at full hours on restricted duties, in Firearms Training and 4 weeks at full hours on restricted duties, operationally deployed as a responsible officer*"

3.59 When the claimant was cross examined about the trial period, he said he could not recall it being mentioned. He said he understood wearing a CGM was "not negotiable". He was not able to give an explanation for why he did not take up the offer of a trial period. He said he didn't think those who said one should be worn really understood. The claimant made some comments on the minutes of that meeting (page 1349) but did not suggest a trial period had not been offered, which is what the minutes recorded (as above).

3.60 Following on from the points the claimant raised with respect to the CGM, Dr Junker wrote to Drs Joharatnam and Winocour with some questions about blood sugar levels. A reply was sent which answered – "*Blood sugars need to be 5mmol/l or above to drive*" with an explanation of why that was the case. It went on to explain why, in the doctors' view, that was so. This was said about the continuous glucose monitoring:

"Continuous glucose monitoring (CGM) via Dexcom is felt to be the optimum monitoring in terms of allowing early detection of downward trends in blood glucose, especially when deployed. The Freestyle Libra flash glucose monitoring would also be useful in this context. Many Type 1 diabetic people feel it enriches their lives to have the extra information about their blood glucose levels.

However we are aware that to date neither CGM nor Freestyle Libra readings are accepted for Group 2 licence drivers. They still require conjunctive finger prick blood glucose testing."

3.61 Dr Junker responded to some of those points with respect to the matters most of concern she said this:

"I agree that CGM is the optimum means of monitoring blood glucose levels but I am also of the opinion that this is nothing that can be enforced on an individual. We will therefore have to revert to the old fashioned prick test approach."

3.62 The reply from Dr Joharatnam (presumably on behalf of both doctors) on 31 May 2019 said this with respect to that point:

"It has been made quite clear that we feel blood glucose testing is not sufficiently good at detecting trends and some form of continuous glucose monitoring is needed. Although our first preference is Dexcom CGM, the Freestyle Libra flash glucose monitoring is another option for allowing continuous glucose monitoring. It also has arrows indicating and upward or downward trend in glucose but does not have an alarm for hypoglycaemic episodes. I have added a paragraph in the recommendations about this."

3.63 To put it shortly, it is quite clear that the external specialist doctors' view was that a CGM device was needed and should remain in the protocol. Deputy Chief Constable Dunn was advised of this and various discussions followed. The claimant took the view that he should not be forced to wear such a device. He also made the point that he believed those doctors were not the experts on his operational role. He took issue with the fact that they had been sent no documentation about his role.

3.64 Deputy Chief Constable Dunn then needed to prepare a report to the Chief Constable on this matter as, in essence, an impasse had been reached. The claimant was back at work but did not agree to the new protocol. His primary disagreement was with the CGM although there still seemed to be outstanding matters with respect to the lower level reading of 4 or 5mmol/l and indeed the HbA1c reading of 64 mmol/l.

3.65 Mr Fullwood wrote to Deputy Chief Constable Dunn in an email of 19 September 2019 with this recommendation:

"I need to be clear the role of a firearms officer is a high risk role, the increase in threat, whether that be firearms, terrorism, knife crime and/or violence is a serious threat which police officers face daily across the UK, they are highly trained and therefore the medical requirements required are above what we expect from most police officers or members of the public. Firearms officers often have to make quick time decisions, be able to respond to dynamic situations and work as part of a team and ultimately they need to be personally accountable for any decisions they make or not make in dangerous operational police situations."

3.66 He acknowledged there were tensions between the claimant and Dr Junker. He considered the claimant's refusal to agree to the protocol and his responsibilities to ensure that the force act proportionately to achieve a legitimate aim. He concluded:

"It is therefore my professional view that PC Trevor Collett should <u>no longer undertake firearm officer's duties for the reasons</u> I have articulated and we should seek alternative redeployment within JPS or Hertfordshire Constabulary. As much as the organisation I wish to support PC Collett. If there is an element of doubt that his medical condition (without appropriate management requirements) could impact on operational policing, on his own safety, his colleagues or members of the public, then this is a risk I don't believe could be justified and also undermines our ongoing health and safety responsibilities."

3.67 By email of 5 October 2019 to the Chief Constable, Deputy Chief Constable Dunn provided some background on the situation, explained the relevant issues with respect to the lack of national guidance on officers with diabetes undertaking firearms duties and there being no issues being brought before a senior court. She pointed out that there was inconsistency in the way in which various forces dealt with it, giving examples about MOD, Staffordshire and the Metropolitan police having different arrangements.

3.68 She reported that Mr Fullwood, as the firearms lead, had recommended that the claimant should no longer undertake firearms duties. She set out the protocol but said that the claimant objected to the protocol, specifically the off-duty monitoring and the requirement for continuous glucose monitoring. She accepted that the protocol was intrusive but believed that it was necessary and proportionate when balanced against health and safety risks posed and said that for him to continue in his role as a firearms officer and response driver he would have to agree to the protocol and the Group 2 driver requirements.

3.69 On 8 October 2019 the Chief Constable sent an email to Deputy Chief Constable Dunn which contained his decision with respect to the claimant. It is a relatively detailed email but stated that either the

claimant should accept the management arrangements being proposed (the protocol) or his firearms authority would be permanently withdrawn.

3.70 Before this had happened, in September 2019, the claimant had informed the respondent that he was resigning. The claimant commenced work with British Transport Police at the end of October. It seems that his wish to transfer and steps taken to pursue that had been going on for some time. He said that it had been about eight months that this had been in progress. The evidence from the claimant is that the British Transport Police require the claimant to comply with DVLA guidelines, keep his blood sugar levels between 5-15mmol/l when on duty and see OH every three months. He is not required to wear a CGM and is undertaking firearms duties.

4. Law and Submissions

4.1 The relevant legislation is found in Equality Act 2010 (EQA). As stated, this is a disability discrimination claim, where the respondent accepts that the claimant is disabled under the definition in the EQA so there is no need to set that out here. The relevant parts of the relevant sections are as follows:

15 Discrimination arising from disability

(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.

20 Duty to make adjustments

(1) Where this Act imposes a duty to make reasonable adjustments on a person, this section, sections 21 and 22 and the applicable Schedule apply; and for those purposes, a person on whom the duty is imposed is referred to as A.

(2) The duty comprises the following three requirements.

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

(4) –

(5) -

21 Failure to comply with duty

(1) A failure to comply with the first, second or third requirement is a failure to comply with a duty to make reasonable adjustments.

(2) A discriminates against a disabled person if A fails to comply with a duty in relation to that person.

26 Harassment

(1) A person (A) harasses another (B) if—

(a) A engages in unwanted conduct related to a relevant protected characteristic, and

(b) the conduct has the purpose or effect of—

(i) violating B's dignity, or

(ii) creating an intimidating, hostile, degrading, humiliating or offensive environment for B.

(2) -

(3) -

(4) In deciding whether conduct has the effect referred to in subsection (1)(b), each of the following must be taken into account—

(a) the perception of B;

(b) the other circumstances of the case;

(c) whether it is reasonable for the conduct to have that effect.

7.1 Section 136 EQA provides that *"If there are facts from which the court could decide, in the absence of any other explanation, that a person (A) contravened the provision concerned, the court must hold that the contravention occurred, unless A shows that they did not contravene the provision".* This requires the tribunal to consider, on the oral and documentary evidence before it, whether there are facts which point to discrimination under the sections relied upon.

7.2 The complaint of a failure to make reasonable adjustments was central to this claim. The relevant sections are as set out above. The tribunal's task is to first consider the proposed provisions, criteria or practices (PCPs) and determine whether there was a PCP that placed the claimant, as a disabled person, at a substantial disadvantage. The question of whether there was substantial disadvantage requires identification of a non-disabled comparator (usually in these cases, a hypothetical comparator) who would not suffer the disadvantage. If there are one or more such PCPs and the employer has knowledge of the disability and its effects, the tribunal will move to consider whether the respondent can show it has taken such steps as were reasonable to avoid that disadvantage. This requires careful analysis of the

evidence and finding of the relevant facts to which the legal tests should then be applied. In considering what steps would have been reasonable, with the burden of proof resting on the employer, the tribunal looks at all the relevant circumstances and determining that question objectively, may well consider practicability, cost, service delivery and/or business efficiency. The central question is whether the respondent has complied with this legal duty or not (see Tarbuck v Sainsburys Supermarkets Ltd [2006] IRLR 664). Guidance is also provided in Environment Agency v Rowan [2008] IRLR 20 that the tribunal should look at the nature of any substantial disadvantage caused to the claimant by any PCPs before looking at whether there was any failure to make reasonable adjustments. The purpose of such adjustments as are reasonable is to ameliorate the disadvantage as identified.

7.3 The complaint of discrimination arising from a disability needs no comparator but the tribunal needs to consider what facts, if any, show unfavourable treatment linked to the disability. In Basildon and Thurrock NHS Foundation Trust v Weerasinghe [2016] ICR 305, that was said to need two steps. That is that there has to be "something" which is unfavourable and, secondly, that must arise in consequence of the claimant's disability. If that is shown, the employer can seek to show with evidence, that it had a legitimate aim which it used proportionate means to achieve.

7.4 The claimant also complains of harassment. The tests are as set out in section 26 with the burden of proof resting on the claimant to show unwanted conduct related to disability. He also has to show that the unwanted conduct had the purpose or effect of violating his dignity or creating an intimidating etc environment. The question of whether any unwanted conduct related to disability had that effect must be considered objectively taking into account the claimant's subjective perception. In Grant v HM Land Registry and another [2011] IRLR 748, the Court of Appeal reminded tribunals that they should not "*cheapen the significance*" of the words of the harassment section as "*They are an important control to prevent minor upsets being caught by the concept of harassment*".

7.5 There is really no dispute between the parties on the legal tests to be applied in a situation like this, as set out above. Both representatives provided written argument at the start of and at the end of the hearing. We are reminded of the relevant sections of the Code of Practice on Employment (2011) published by the Equality and Human Rights Commission (EHRC), particularly with respect to guidance on what might be reasonable steps in a reasonable adjustment case. Paragraphs 6.23 to 6.29 of the Code reminds us that what is reasonable will depend on all the circumstances of the case.

7.6 In closing submissions, the claimant's representative argued in detail for the PCPs under s20 EQA as suggested in the list of issues. It was argued that they are PCPs and that they clearly disclosed substantial

disadvantage. In essence, the argument is that the reasonable adjustments put forward by the claimant were the ones which should have been taken. The claimant's representative particularly pointed to the failure to obtain specialist's advice or adjust the "Blue Light" Guidance and the failure to properly consult the claimant, show a role profile to the independent medical experts and the imposition of wearing of a CGM as a condition of him returning to firearms and response driving duties.

7.7 As to the respondent's suggested defence about other forces having different arrangements, the claimant's representative reminded us that we must consider this objectively (<u>Morse v Wilsher County Council</u> [1998] RLA 532 and that we must look at the treatment at each stage (<u>Buchanan v Commission of Police of the Metropolis</u> UK EAT/0112/16). In oral submissions Mr Banham dealt with the defences as put forward by the respondent and, particularly, the alleged inflexibility of Dr Junker. It was accepted that health and safety was important but submitted that what the claimant had suggested were reasonable adjustments.

7.8 On behalf of the respondent, it was submitted that it had to take its own decisions on the approach in PC Collett's case, there being no national guidelines and inconsistent approach in other forces. The respondent disputes that the PCPs as suggested by the claimant are in fact PCPs. In particular, it says they say that 3 and b (above) are not PCPs because officers with diabetes were <u>not</u> removed or <u>unable</u> to undertake firearm duties or driving but only had to fulfil various medical requirements. Although it does not accept the other two (3c and d) are PCPs, no specific submissions were made about them. We were referred to <u>Paul v National Probation Service</u> [2004] IRLR 190 which related to getting specialist medical advice but is not directly on point.

7.9 The respondent's representative reminded us of the respondent's duties under the Health & Safety at Work Act as well as various parts of the police regulations although these were matters we had not seen during evidence.

7.10 We were referred to <u>Tarbuck v Sainsbury's Supermarket Stores</u> [2006] IRLR 664 which does not say that reasonable adjustments have to be negotiated. The respondent's representative suggests that the case of <u>R v Chief Constable of Dorset Police Expartie Matthes</u> [1988] CO/1962/87 which is a High Court case might be relevant with respect to an officer with epilepsy.

7.11 As far as the claim for discrimination arising from disability is concerned, the respondent agrees that the matters listed are something arising in consequence of his disability (8 a-e) and accept that the claimant showed good management of his diabetes. The respondent argues that its concerns about public safety and duties under the Health & Safety at Work Act are matters which show a proportionate means of achieving a legitimate aim.

7.12 Finally, with respect to the harassment claim, we are reminded of the statutory provisions as set out above. The unwanted conduct is largely disputed by the respondent, particularly that Dr Junker was herself the person responsible for all those matters, decisions having often been taken by other officers.

8. Conclusions

8.1 It is accepted by the respondent and the tribunal also accepts that the claimant has been a disabled person by reason of his type 1 diabetes from his diagnosis in late December 2015 until the end of his employment with the respondent in October 2019.

The failure to make reasonable adjustments claim

8.2 We therefore turn our attention to considering first the claim of failure to make reasonable adjustments under s.20 and s.21 EQA. The first matter which we must determine is whether the claimant has shown that the respondent applied one or more of the provisions criteria or practices (PCPs) as set out in the list of issues at 3 a to 3 d. The respondent disputes that the claimant has shown those to be PCPs.

8.3 We consider PCPs 3 a and b together as the same principles applied at the time for the respondent's officers with type 1 diabetes in relation to firearms duties and Class 2 driving duties, otherwise known as response driving. The respondent argues that the claimant has not shown those to be PCPs because those officers were not removed from those duties but they had to show that they complied with certain medical standards in order to continue carrying out those duties. As a matter of fact, that is not quite accurate. The claimant was removed from those duties upon diagnosis, albeit not on a permanent basis. He was removed from those duties in December 2015 or January 2016 until arrangements could be made about him undertaking them safely. He was not then allowed to undertake those duties again until August 2016. As set out in the facts, he was removed again in early 2017 and the final decision was he be permanently removed if he did not agree to the protocol arrangements.

8.4 It seems to the tribunal therefore that the claimant has shown that those were PCPs, at least initially. No amended wording was suggested with respect to the PCPs during the tribunal hearing but it may be that those PCPs could be more accurately described as the respondent only allowing officers with diabetes to work as firearms or response drivers if they met a certain medical standard.

8.5 That is what is reflected in the PCPs at 3 c and d. Although they are perhaps not worded as carefully as they might be, the tribunal have formed the view that they do amount to PCPs. The respondent's own case is that they had stricter health parameters for officers with Type 1

diabetes undertaking firearms duties and response driving duties than for other police constables. Those stricter health parameters did apply to the claimant as a type 1 diabetic. He had to show his blood glucose levels were within the parameters as set out in the "Blue Light" Guidance, a matter which other officers without type 1 diabetes did not need to do. The tribunal is satisfied that both PCPs were applied by the respondent.

8.6 Turning then to issue 4 - the question whether any or all of those PCPs put the claimant at a substantial disadvantage in comparison with persons who are not disabled. These disadvantages are said to be that, as he was suffering from type 1 diabetes, he was unable to meet the requirements for firearms duties and driving. Of course, as we know from the facts, the claimant was able to meet some of those requirements some of the time but not consistently. We find that the claimant was put at a substantial disadvantage in comparison with non-disabled people who did not have to provide that information and stay within those parameters. The problem that he had meeting those standards on occasions meant that he could no longer carry out those duties and lost income as a result. It leads, in the tribunal's finding, to substantial disadvantage. We therefore do look to the respondent to see what reasonable adjustments they either put in place or could be expected to put in place.

8.7 Issue 5 is worded in a rather confusing way. What that does is set out, between 5 a. to m, a list of matters which are averred by the claimant to be adjustments which were reasonable. The vast majority of those were in fact put into place. These were adjustments which allowed the claimant, as a type 1 diabetic, to continue to carry out the role of firearms and response driver. There is some minor difference at b. about the number of times he would have to test his blood glucose levels which was not explored at the hearing. All the others were matters which either the claimant volunteered or was happy to accept apart from item 5 f.

8.8 Issue 5 f. is the contentious requirement for adherence to blood sugar levels under the "Blue Light" Guidance during 2016 - 2018. In essence the claimant's case is that an adjustment to the levels stated in the "Blue Light" Guidance to 4-15mmol/l (instead of 4-10mmol/l) before he would "*retire from duty*". Although, again, we did not explore this in detail at the hearing, that suggests a temporary retirement only whereas, as we know from the facts, the decision made by the force on recommendation from Dr Junker, was that if he failed to have readings for 90% of the time in the 4-10 mmol/l range he would be taken off firearms and response driving duties until the next review which would happen three or six months later. Although it was not put quite like this, the tribunal's view is that this has to be looked at rather differently. It is quite clear to us from all we have heard that the claimant was asking that the "Blue Light" Guidance should not be applied to him as a firearms officer, and by implication as a response driver, or if it was applied at all that there be some amendment to the

upper range which was at 10mmol/l and, in the list of issues, suggested to be an upper limit of 15. The reasonable adjustment he appeared to be suggesting the respondent failed to make was to not apply the "Blue Light" Guidance or to amend it.

8.9 The tribunal will first look at the arrangements which were in place from January 2016 until 2019 when the protocol was suggested after the involvement of specialist external medical advisers. This is the consideration that Dr Junker gave to the matter and which is explained in the findings of fact. In her view the FOM "Blue Light" Guidance which already applied to response driving should also be applied to firearms duties. In her view the risks were similar and no less safety critical. In the absence of any other guidance, and in view of the fact that some forces had stricter requirements and other forces appeared to be less strict about how type 1 diabetes officers carried out those duties, this was what she put in place.

8.10 The question for the tribunal is whether there was a failure to make a reasonable adjustment to not follow that "Blue Light" Guidance. There was no significant objection to using the Guidance by the claimant in the early stages. It was not until he was unable to meet that standard that he raised particular concerns about it. So that was in January 2017. If we assess matters at that date, we are satisfied that there was really no possibility of it being a reasonable adjustment to not apply that standard to firearms work at the same time as it was already applying to his response driving. As Dr Junker pointed out, this would lead to the bizarre situation of the claimant having two different standards to meet. We have considered the respondent's explanation which flows directly from concerns about safety, for the claimant, his colleagues and the general public. When considering the claimant's objection to it, some of that relates to his desire to maintain his hobby of taking part in ultra-marathons which, as we understand it, led to him occasionally "carb loading" or spiking his blood for better performance of that activity which could lead to him falling outside the upper range. The claimant argues that the upper range is not a particularly dangerous one and relies on the appendix to the "Blue Light" Guidance for that belief. The tribunal cannot see that that can be right. In the absence of further guidance on this, the tribunal cannot see that the note there which, in any event, refers to "*cognitive impairment while driving*" would lead any reasonable employer to conclude that the higher level suggested was not one which should be considered. We are not satisfied, that, at that time, the respondent failed to make a reasonable adjustment to the tests that they applied to the claimant for him to continue on firearms duty or response driving.

8.11 We then thought that it would be wise to consider the later period of time when it became clearer to the respondent that the claimant would find it difficult to meet that "Blue Light" Guidance standard. This was during 2017 and 2018, although the claimant was on sick leave for a considerable proportion of 2018, so it is not entirely clear to the

tribunal whether he would or would not have been able to meet the standard. The question arises whether Dr Junker, in her advice to the respondent, should have reconsidered the position once problems had begun to arise with the claimant complying with the "Blue Light" standard. The tribunal is satisfied that the respondent attempted to deal with this matter by looking at it in considerable detail. In the absence of other any other advice which could assist them, the tribunal accepts that it would not have been reasonable just to accede to the claimant's request that the upper limit be increased or set to one side. The tribunal appreciates that the upper limit is one which might have fewer immediate risks but it was clear then, and it became even clearer when the specialists gave their advice, that it was still something which should be monitored as it affected the claimant's health more generally and indeed could lead to some serious health difficulties. We find that it was not a reasonable adjustment for the respondent either to set aside the "Blue Light" Guidance entirely or to amend the upper limit contained within it.

8.12 We then turn to the later period of time when the protocol was suggested in 2019. This raises a number of questions which are different from the first period when the "Blue Light" Guidance was applied. It is quite clear from the evidence that the claimant did not accept the parameters set by the "Blue Light" Guidance. In February 2018 and February 2019, the claimant suggested that continuous glucose monitoring might be something which would help them find a way forward. In must have been of some surprise therefore when the independent specialists suggested that this be part of the new protocol that the claimant said that he did not want to wear such a device. The claimant did not adequately explain his change of heart about this, except to say that he had nothing against the devices in principle but he objected to being instructed to wear one. By this time, of course, the parameters which the claimant had mostly been concerned about had been raised at the upper point to 15mmol/l with a suggested lower limit of 5 rather than 4. The claimant also raised an issue about this as well as showing concern about the HbA1c reading of 64, which we heard very little evidence about.

8.13 The question for the tribunal about this period is whether the respondent failed to make a reasonable adjustment when it proposed the protocol drafted by the external medical practitioners rather than agreeing to the suggested parameters that the claimant put forward. The tribunal has had some difficulty fitting in the arguments to the legal tests. It appears that the claimant's case is that he has suggested reasonable adjustments and these are the ones, and the only ones, which the respondent should have implemented. The respondent was not necessarily making adjustments under EQA but had requirements so that a type 1 diabetic officer who might otherwise not be able to undertake these duties at all, could undertake them safely with management and monitoring.

8.14 What is not entirely clear here from the list at issue 5 is what reasonable adjustment the claimant is suggesting at this point. Does it remain the same as it did from when he first discussed matters with Dr Junker, some two or three years earlier? As can be seen from the findings of fact, the claimant was disagreeing with the parameters and arguing for those at Issue 5 f. but also refusing to wear the CGM which is entirely missing from the list of issues (except under harassment).

8.15 In any event, the tribunal finds that that the respondent has not failed to make a reasonable adjustment. It is not a reasonable adjustment to agree to something put forward by the individual concerned, especially in a safety critical role, when, having taken specialist medical advice that is clearly consistent, on the need for CGM and the wider parameters for blood sugar levels. Even though Dr Junker attempted to put the claimant's objections to the independent medical specialists, they were quite clear that that was part of the protocol which otherwise was supportive of the claimant's desire for a higher range for the measurement of his blood glucose level.

8.16 The tribunal was particularly concerned by the claimant's refusal to consider the offer of a trial period. The claimant has failed to give any explanation why he did not agree to a trial period. It is quite possible that that was because he was well into his discussions to join the British Transport Police, or it is possible that he had lost confidence in the respondent and, in particular, in Dr Junker.

8.17 In any event, whatever the claimant's reasons, the tribunal is quite clear that the respondent did not fail to make a reasonable adjustment when it did not set aside the protocol suggested by the specialists who were the claimant's own treating physician and someone who had vast experience with respect to diabetes and driving duties. In considering what is reasonable and what is not, the tribunal must pay attention to the risks to the respondent both in reputational terms, its legal liabilities and specifically, its duties under the Health and Safety at Work Act. We cannot see how it could have made the adjustments suggested by the claimant, it having been considered very carefully by those advising the respondent. Although those advising them were not decision makers, it weighed heavily on the respondent to take advice from them. Their reasons are well set out and there is no failure to make reasonable adjustments.

8.18 We do not agree, as Issue 6 states, that the respondent failed in its duty to make reasonable adjustments by imposing additional unreasonable requirements. The additional requirements were not unreasonable as stated above.

Discrimination arising from disability

8.19 Turning then to the claim of discrimination arising from disability, under issue 7, the first question is whether the respondent treated the claimant unfavourably in removing him from operational duties, firearm

duties or Class 2 driving duties which amount in this case to response driving duties. It may be that some of those amount to the same thing but we are not entirely sure about that. In any event, clearly the claimant did believe, and we accept it was reasonable of him to believe, that it was unfavourable treatment when he was removed from firearms and response driving duties, not least because it led to some reduction in income.

8.20 We turn then to issue 8 between a and e. Although the respondent takes issue with these, it does not matter too much if they are broken down or taken altogether. All these are matters which arise in consequence of the claimant's disability. He needed to maintain his blood glucose levels to avoid impaired judgment, needed to maintain diet and to control blood glucose levels and take insulin and test his blood. All those matters were something arising in consequence of his diabetes and the treatment with respect to his removal from firearms duties and response driving duties was directly linked to his blood glucose levels and other matters concerning his diabetes.

8.21 That takes us to the central question in relation to this which is at issue 9, which is whether the respondent can show that the removal of him from those duties was a proportionate means of achieving a legitimate aim. The legitimate aim relied on by the respondent is the safety of the claimant, his colleagues and the public and the proportionate means is that he would be removed from those safety critical duties if he could not maintain those blood sugar levels, deemed to be safe. We accept that that is a legitimate aim. It is a central role of the respondent to ensure safety of all they have to deal with, as well as specific duties under the Health & Safety at Work Act. It is clearly a central pillar of all policing. Given the inherent risks in blue light driving and carrying firearms which we hardly need to explain, it seems to the tribunal that the respondent can show it is a legitimate aim to ensure that, as far as possible, those safety critical roles are risk free.

8.22 We therefore consider whether the means which the respondent took were proportionate, given that we have found there was unfavourable treatment of the claimant arising from his condition. We are satisfied that the respondent has shown the treatment was such a proportionate means of achieving a legitimate aim. The "Blue Light" Guidance was the clear guidance for the role of response driving and the claimant can hardly argue that it was not proportionate to use that document when deciding to remove him from response driving duties. Although it has been argued that it was commented by Dr Winocour to be outdated, that was some time afterwards, and it was not that outdated as to be an unreasonable tool for managing risk. Clearly things develop over time and some developments have led to things which assist in the treatment and management of diabetes. In this case there was a development with respect to CGM and it was proportionate for the respondent to move towards a position where that development could be used to allow a wider range of readings for

blood glucose levels which would have accommodated the claimant's request for a higher top range.

8.23 Given that the respondent had clear specialist medical advice, not only from their own FMA but also from specialist medical advisers one of them being the claimant's own treating consultant, the tribunal does accept that the treatment was proportionate in the circumstances of this case. The tribunal must balance the needs of the claimant and the fact that he had medical standards imposed upon him to carry out firearms and response driving duties with the ability of the respondent to provide its services to the public safely. This is particularly the case because the claimant wished to be able to carbo load for ultra marathons which led to the possibility of higher blood sugar levels. The steps taken by the respondent took into account that balancing exercise and the tribunal accept it was proportionate.

8.24 Overall, the safety of the claimant, the public and officers in the respondent constabulary must mean that the difficulties for a single disabled officer who could, in any event, either change some parts of his activities to try and be within the lower range when that was the standard or wear a CGM when that was suggested, it must be proportionate to request this standard. The claimant's claim under s15 EQA fails.

<u>Harassment</u>

8.25 Finally, then, we look at harassment claim between issues 10 to 12. We ask whether there was unwanted conduct and, if there was, whether it had the purpose or effect of violating the claimant's dignity etc. Although it is not in the list of issues, s.26 EQA requires us to consider whether, in all the circumstances, including the perception of the claimant, it was reasonable for him to consider that any such conduct had that effect.

8.26 We must consider the matters raised between 11 a and e of the list of issues. First under 11 a, the tribunal do not accept that Dr Junker refused to take into account the claimant's individual circumstances or that she made particularly objectionable comments about his outside hobbies. She did take into account what he told her about those activities and suggested that he might want to consider whether he wished to continue them. There is nothing particularly reprehensible about that given his stated desire to remain as a firearms officer and response driver. He was not pressured in any way to give up that outside activity. There is no unwanted conduct

8.27 Turning then to 11 b, this is not particularly well worded. Dr Junker is said to have "*opposition*" to reasonable adjustments put forward by Chief Superintendent Dales. It is true that Dr Junker raised issues about the adjustment to the requirements which were suggested by Chief Superintendent Dales and queried whether they should proceed. The tribunal accepts that Dr Junker did not know that the claimant "*had*

made a complaint about her" although she almost certainly did know that the claimant was becoming less happy with her because she had from time to time recommended that he be removed from firearms and response driver duties. It was quite proper of her to intervene in the way she did but it could amount to unwanted conduct.

8.28 As far as 11 c is concerned, it was not Dr Junker's requirement but one put forward by the two external medical specialists that the claimant be required to use a CGM device. After she queried it with those doctors, she adopted that provision. Again, it was a reasonable step to take and the tribunal cannot find this amounted to unwanted conduct by Dr Junker.

8.29 As far as 11 d is concerned, it is rather odd that it is here because this is an apparent complaint about the HbA1c level of 64mmol/l which, again, was put forward by the external specialist advisers and was part of the "Blue Light" Guidance previously. It is not unwanted conduct.

8.30 As far as 11 e is concerned, the tribunal do not think that it can amount to unwanted conduct for the FMA to decide frequency of reviews. It must be part of an FMA's job to consider when reviews should take place and indicate that incomplete testing records might lead to a finding of unfitness. Whether it led to the claimant being worried is a different matter. It cannot amount to unwanted conduct.

8.31 In summary then, some of those matters at issue 11 did not take place in quite the way that they are set out there. A number of them are not really matters for which Dr Junker is primarily responsible although she passed on the information to the respondent. We take the view that the claimant cannot show all these matters are unwanted conduct which related to his disability. It is conceivable that Dr Junker's objection to Chief Superintendant Dales' proposals in May 2018 could be unwanted conduct.

8.32 For completeness then, if we are wrong in considering there was no unwanted conduct and for the one possibility of there being such unwanted conduct, we turn to the question of whether any such conduct as found by the tribunal had the purpose or effect of violating the claimant's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for him. Clearly the claimant seems to believe that that is the case. The tribunal has some difficulty with this because of the way in which those individual matters of so-called unwanted conduct are worded.

8.33 Although some of them have some factual basis, they are not quite accurate in the portrayal of them. Many of them are not primarily Dr Junker's proposals. Although the matters did refer to the fact that he was a person with a disability, the tribunal cannot find that they violated his dignity or created the environment complained of.

8.34 Even if that was the claimant's perception, in the circumstances of this case where the claimant is a serving police officer; where he understands the respondent's position as to risk and safety critical element of his role, it cannot have been reasonable for him to consider this was conduct which had that purpose or effect. His claim for harassment must also fail.

8.35 This means all the claimant's claims for disability discrimination must fail and they are dismissed.

Employment Judge Manley

Date: …18/02/2021

Sent to the parties on: .18/02/2021

Jon Marlowe
For the Tribunal Office