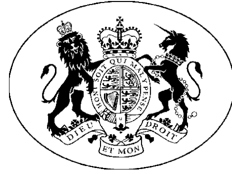
**Case No: 2205225/2019**



# EMPLOYMENT TRIBUNALS

**Claimant:** **Ms. M. Klusmann**
**Respondents: University College London Hospital NHS Foundation Trust**

**London Central Remote Hearing (CVP)** **3,4,5,6, 9 August 2021**
**In chambers 10 August.**

**Before: Employment Judge Goodman**
**Ms S. Brazier**
**Ms S. Plummer**

# JUDGMENT

1. The unfair dismissal claim succeeds.
2. The discrimination claim fails
3. Remedy will be decided at a further hearing on 3-6 January 2022

# REASONS

1. .These are claims for unfair dismissal and disability discrimination.

2. The claimant worked for the respondent as a consultant paediatric radiologist. She was dismissed in July 2019 on capability grounds, after being off sick for two years with anxiety and depression. The context of her illness was an allegation that she had done private work in NHS time, leading to criminal charges being brought against her. Two months after the dismissal she was acquitted, and wanted to return to work. In June 2020 her appeal against dismissal was not upheld, on grounds that it was not practicable to reinstate her.

**Application to Amend Claim**

3. The claims of unfair dismissal and discriminatory dismissal were presented to the tribunal on 6 December 2019. The respondent entered a holding response in January 2020 on the basis that the appeal process had not yet concluded. When the appeal process concluded at the end of June 2020, the respondent filed an amended response on 11 August 2020. This pleading included the

fact of the appeal. There was a case management hearing on 18 August 2021 when Employment Judge Norris approved a list of issues.

4. On 18 November 2020 the claimant applied to amend the grounds of claim in respect of the unfair dismissal, though disputing that an amendment was in fact necessary. Specifically, she added that from January 2020 the panel had occupational health evidence that she was fit to return to work, and, it was alleged, the appeal panel relied on evidence from her former managers that was not known to her or to the dismissing panel. The respondent opposed, and opposes, the application both on grounds of delay, as it was made more than three months after the appeal decision, and because there is no mention of amending the discrimination claim.

5. On the first morning of this hearing the tribunal considered written and oral arguments from each side or whether amendments necessary, and whether amendments should be allowed.

6. We decided it was necessary to amend. Although **Taylor v OCS Group (2006) ICR 836** and **Baldeh v Churches Housing Association UKEAT 0290/18** suggest that an appeal is part of a dismissal, a claim should be pleaded with enough information for the other party to understand what it is about, and as the facts relevant to continued employment had evolved in the year between the dismissal and the appeal decision, as had the respondent's reasons for their decision no longer to employ her, the respondent needed to understand what the claimant said was wrong with the appeal decision. The claimant has had legal representation throughout.

7. On whether to allow the amendment, we have regard to the matters set out in **Selkent Bus Company v Moore 1996 ICR 836**, and **Vaughan v Modality Partnership 2021 ICR 535**. The tribunal must look at such matters as the nature of the amendment, the timing of it, the effect on time limits, and make an overall balance of the prejudice to the respondent of allowing the amendment, and the prejudice to the claimant of refusing it.

8. The amendment itself is not substantial – it not an entirely new claim but elaboration of an existing one. Although it has only been decided at the outset of the final hearing, it was made over 10 months ago. It is also clear from the list of issues that the appeal issue was briefly mentioned in relation to the unfair dismissal claim at the case management hearing, though the list of issues is silent on justification at the appeal stage. Importantly, all the documents about the appeal are in the bundle, and the relevant witnesses have prepared statements. It was made seven weeks out of time, and the delay is currently unexplained, but that is something we can consider when deciding the issues after hearing the evidence.

9. There is no explicit amendment on the section 15 discrimination claim. We have regard to **O'Brien v Bolton Saint Catherine's Academy (2017) EWCA Civ 145**, where it is explained that although the test of justification for the Equality Act claim is more stringent than assessment of the range of reasonable responses in the unfair dismissal claim, both are objective assessments of an employer's reasons, and there is no real distinction in whether the cause of the long term sickness was or was not disability. We concluded that although this is not specifically pleaded, and both parties may

have to clarify their case on the refusal to reinstate the appeal stage, both sides are well aware of the issues, and both sides have the evidence ready for the tribunal. There is no real hardship to the respondent if an amendment is allowed in both claims. There is real hardship to the claimant in refusing the amendment, because of the changes in circumstances (on both sides, hers in relation to a date for return to work, and possibly on other factors such as personal relationships, theirs in relation to effective running of the service) by the time the appeal was decided, and the appeal is part of the dismissal process.

10. So the claimant is permitted to amend both claims to include complaint about the decision not to reinstate at the appeal stage in June 2020, as well as the original decision to dismiss in July 2019.

11. The parties agreed a revised list of issues in the light of this decision. It is appended to these reasons.

**Disability**

12. The respondent admits the claimant was disabled within the meaning of section 6 of the Equality Act by reason of anxiety and depression, and that they knew this when she was dismissed.

**Evidence**

13. To decide the claims the tribunal heard evidence from:

**Dr Maria Klusmann**, the claimant
**Dr Penny Shaw**, consultant radiologist and former colleague
**Mr Hugh Jelley**, Divisional Manger, Imaging. He was the claimant's line manager. He managed her sickness absence for some time, and provided information at the dismissal and appeal stages on service provision without the claimant, and the effect if she returned to work. He was a witness in the criminal trial.
**Dr Kirit Ardeshna**, Divisional Clinical Director, chaired the stage 2 panel which decided to dismiss her.
**Ms Launa Pettigrew**, Employee Relations Manager, provided HR support at the dismissal stage.
**Ms Toni-Dee Downer**, Interim Human Resources Business Partner, prepared the sickness absence management report, and presented the management case at the dismissal meeting
**Ms Naina Arnett**, Head of Employee Relations, provided HR support for the appeal stage.
**Professor Anthony Mundy**, Corporate Medical Director, chaired the appeal panel

14. We also read a short witness statement prepared by the claimant's solicitor about the timing of the application to amend claim, supplied on day four.

15. There was a 1,315 page documents bundle and we read those to which we were directed.

**Findings of Fact**

16. University College London Hospital NHS Foundation Trust (UCLH) is one of the largest NHS Trusts in England, with over 10,000 permanent employees. It provides acute and specialist services. There are 950,000 outpatients and 156,000 admissions annually.

17. The Trust's Imaging Division, Surgery and Cancer Board, where the claimant worked, employed 70 consultants and 28 junior doctors. The clinical director was Dr Samantha Read. The divisional manager, a non-medical role, was Hugh Jelley.

18. Within radiology there are 14 subspecialties, each requiring a one or two year clinical fellowship to gain the relevant expertise. One of these is paediatric radiology. The claimant was one of three paediatric radiology consultants. She was employed on 10 PAs (planned activities, or sessions) per week, meaning she was working full-time, the only paediatric radiologist to do so. One of her PAs was set aside for clerical and administrative work. The rest of her time was split more or less equally between paediatric and adult work. Of the other two paediatric radiologists, Dr Paul Humphreys provided four PAs per week, working another six at Great Ormond Street Hospital, and Dr Penny Shaw worked seven PAs per week. Dr Shaw was the clinical lead. She had retired and returned on reduced hours in 2014, and in September 2018 notified the Trust that she would be retiring for good at the end of January 2019.

19. Cover for paediatric radiology was therefore very tight. On Thursday afternoon and Friday the claimant was the only person in the Department. There was no spare time to cover annual leave, sickness absence, study leave.

20. The time commitment of the work varied. Some radiology could be reviewed and reported on the PACS system in the radiologist's own time. Other scans, for example ultrasound, had to be carried out in clinic. Acute cases required more time than routine work, and the claimant was the first port of call for this as she was full-time and so more likely to be available for an acute case. In cases where a child is brought to A&E and staff suspect non-accidental injury, a skeletal survey has to be reviewed and signed off by two paediatric radiologists.

21. Some NHS doctors also undertake work in the private sector. It is not always easy to rigorously separate the two, because of on-call duties and emergencies in both sectors, and the BMA on behalf of employed doctors, has agreed with Trust employers a system of "time shifts", whereby if the consultant is called away to an urgent private case during NHS time, they will inform their line manager and make the time up. The tribunal was told that the system is very much based on trust, and consultants are expected to manage their own time.

22. Each year a consultant agrees a job plan with a clinical colleague, which is in effect a timetable of when they will be working in the NHS. The job plan will also show when the consultant is engaged in private work.

23. In June 2013 the claimant set up a company, Master Imaging Ltd, for her private work. In the year ending June 2014 she earned £11,937 from private work. In the next three years, ending June 2015, 2016 and 2017, she earned £64,953, £85,060 and £96,250 respectively. By 2017 her NHS salary was £89,856. This suggests she was doing substantial amounts of private work, but does not indicate how much time this involved, as the pay rates are unknown. The company was dissolved in 2019 when she applied for voluntary strike-off.

24. In 2015 financial pressures led to greater Trust scrutiny of consultant activity. Within the Imaging division, Dr Read and Mr Jelley analysed the radiology information system to see when consultants were reporting radiology throughout the week. They detected a number of discrepancies between the claimant's agreed job plan and the claimant's reporting times. They believed there were "frequent unexplained absences from the Department", and also noted that a backlog of ultrasound scans was building up. They also thought she was taking more annual leave than permitted on what would have been a long working day, and that she was sometimes absent from Trust work at short notice without telling Dr Read, and then not making the time up. They held a meeting with the claimant about this in September 2015. Some action points were agreed, but the concern continued. There was some friction, and in June 2016 the claimant spoke to Hugh Jelley about damage to her reputation, a request for reductions in her PAs, and a refusal of carer's leave, but she decided not to pursue a formal complaint. Her job plan was now being set by a senior consultant, not a paediatric radiologist, rather than Dr Read, and her stern approach was part of her complaint.

25. The managers' concern about the claimant's working time was referred to the NHS counter-fraud team in 2016. She was told about this early in June 2017 when she was invited to an interview on 23 June 2017 in connection with investigation under the Trust's conduct procedure.

26. On 28 June 2017 she went sick with work-related stress, later, anxiety and depression. Other than two weeks of booked annual leave then, and four more days at work in the next 2 to 3 weeks, she never returned to work.

27. Dr Read and Mr Jelley had identified three radiologists whom they considered to be working in private practice in NHS time. One of these three resigned when confronted. Another resolved to improve his ways, and is said to have worked satisfactorily since. Mr Jelley said the claimant did not agree that she was failing to make up time, and so her case was referred to the police. In September 2017 the internal conduct investigation into her working patterns was paused because the police were involved.

28. On 18 September 2017, the respondent's occupational health doctor gave an opinion that the claimant would be unfit to work until 'the external situation had resolved'.

29. In February 2018 she was formally charged with fraud by abuse of position. We were told that the agreed opening statement in the eventual trial confirmed that she had done private work in NHS time, and the question for the jury was whether she made the time up, or had acted dishonestly.

30. There was no separate investigation by the police or CPS. The investigation was done by independent investigators working for the Trust. Both Dr Read and Mr Jelley gave evidence for the prosecution at the criminal trial in September 2019.

**Managing the Claimant's Sickness Absence – Stage 1**

31. The Trust has a sickness absence management procedure. At stage 1, investigations are carried out into the reason for absence, when and how the absent employee could return to work, and whether any adjustments are needed to facilitate this. At stage 2, consideration is given to whether the employee should be dismissed on capability grounds.

32. In the claimant's case progress to stage 2 was very prolonged – almost twice the usual period.

33. After the occupational health assessment in September 2017, a stage 1 meeting was set for January 2018. It was twice postponed so that her BMA representative could attend, but when it came to the date set, 2 February 2018, Mr Jelley had to put it off for personal reasons. Given the lapse in time, in March 2018 a further occupational health assessment was arranged. The doctor noted her symptoms had worsened, but said that she would make a full recovery when the "external precipitators" had been resolved. There were no adjustments to be made in the meantime to enable her to work in paediatric radiology, or any other role. The claimant was well enough to participate in the absence management process, if she had a representative present to reduce the risk of a panic attack. The stage 1 meeting was then set for 4 May 2018.

34. Up till now the claimant's absence had been managed by her line manager Mr Jelley. The claimant had however just learned that he was to be a witness for the prosecution in the criminal trial, so her solicitors wrote asking that someone else manage the claimant's absence. Fiona Henderson was substituted.

35. On 26 April 2018 the claimant was told that the internal conduct investigation would recommence. Her solicitors protested, on grounds of prejudice to the criminal proceedings, and the internal disciplinary procedure was paused.

36. On 1 May 2018 the claimant, through solicitors, submitted a grievance (ELC – employee led complaint) about the disciplinary investigation, and about the conduct of Dr Read and Mr Jelley. Much of this was about job plans and private practice arrangements, and described unsympathetic treatment both before and after she went sick. Her grievance also narrated a "significant incident" involving Dr Read in March 2017. On the claimant's account, on the day of the Brexit vote invoking Article 50, Dr Read, she said, brought a box of chocolates to work and said "It's great to have those fuckers out". We do *not* have anyone else's account of this incident. If it *was* said, in the presence of the claimant, a Portuguese national, this was either outstandingly tactless or deliberately offensive. No complaint was made at the time, though the claimant says she did approach ACAS about it, before deciding not to start a tribunal claim. It is not part of these proceedings, but is mentioned here because relationships in the team have to be considered.

37. The stage 1 meeting on 4 May 2018 was conducted by telephone, because the claimant felt unable to attend in person.

38. The position was reviewed after four weeks, according to procedure, on 4 June 2018. The position was unchanged. She would not be able to return to work while the criminal proceedings were pending.

**Managing the Claimant's Absence - Stage 2**

39. By now the claimant was coming to the end of her contractual sick pay, which is full pay for six months, and half pay for another six months. This is usually the point where the sickness absence management process moves to stage 2.

40. It did not, because the criminal trial was expected to take place in September 2018. However, the trial was then postponed to January 2019. Meanwhile she attended an occupational health review in October 2018, still unfit to return to any work. Then in January 2019 the trial was postponed again because the defence objected to inaccuracies in the prosecution opening statement. The new date was 9 September 2019.

41. How was the claimant's work covered in her absence? Routine work on paediatric scans was outsourced to Everlight, but they could not cover work that had to be done on site. Some paediatric ultrasound lists were delegated to the superintendent radiographer. Two radiology clinical fellows (a training grade) from Great Ormond Street Hospital were employed to report out of hours, and to do ultrasound lists at weekends. An agency locum consultant was employed for four months.

42. The strain on the remaining two consultants is shown by the fact that in 2018 they formally asked for the lack of resources to be added to the Trust's risk register.

43. There was a permanent recruitment exercise in January 2019, to replace Dr Shaw on her retirement. Hugh Jelley decided that her seven PA post was to be increased to 10 PAs, a full-time post. This was because there is a nationwide shortage of paediatric radiologists, and it is easier to recruit a whole-timer than a part-timer. The justification was that the Trust was about to add proton beam radiology, used in cancer treatment, to the existing service, and the extra three PAs would be used to cover this, and in the meantime would provide extra flexibility. The candidate they chose however, had just accepted a 12 month clinical fellowship at Great Ormond Street hospital, and so it was agreed he defer his start until February 2020, and in the meantime he was one of the two who provided out of hours cover.

44. In the event, we heard, (it was not mentioned in Mr Jelley's witness statement) the pandemic has delayed the building of the premises required for the proton beam radiology, and there is also some difficulty with water quality. This means there are still an extra three PAs to devote to paediatric radiology.

45. The tribunal notes that both at the time of dismissal, and to some extent now, there was some lack of clarity about how many of the three paediatric radiologists' sessions were actually devoted to paediatric, rather than adult, work. The difficulties with cover related to the paediatric work.

46. A decision was taken to move to stage 2. The claimant's current fit note was due to expire at the end of August. Fiona Henderson, who had stepped into Hugh Jelley's shoes as line manager, was now retiring, and Toni-Dee Downer, a new temporary appointment, was asked to prepare the line manager's report for the stage 2 meeting. Hugh Jelley gave her the information about arrangements for cover during the claimant's absence which went into her report.

47. The next occupational health review was in June 2019, by telephone. The claimant was now on the maximum dose of anti-depressants. She was unlikely to recover until the trial was over. She was too unwell to attend meetings face to face.

**Dismissal**

48. On 2 July 2019 the claimant was invited to the stage 2 meeting, and told that dismissal on grounds of medical incapacity was a potential outcome. She was sent the management long-term sickness absence report, prepared by Mr Downer, with its supporting documents.

49. The stage 2 panel consisted of Dr Kirit Ardeshna, a haematologist, and Oscar Fernandez Sumarit, Divisional Manager for Theatres and Anaesthetics. The meeting was to take place on 19 July. The claimant did not attend, in person or by telephone, as she felt too unwell. Instead she provided written submissions. The panel considered these, and also asked questions of Toni-Dee Downer. Dr Ardeshna's initial response was that they should wait two

months for the outcome of the trial, as they could then better assess when the claimant was returning. Ms Downer said she had already been off for a significant length of time, and there was a need to ensure consistency of approach to sickness absence cases.

50. They then discussed the paediatric radiology service. In the management report it was stated until January 2019 (Dr Shaw's retirement date) there were three consultants providing 15 PAs, the claimant had been long-term sick since June 2017, and they were now down to one part-time consultant providing 4 sessions per week. This left the service very fragile, and there was a concern for patient safety. They were outsourcing work to Everlight Radiology, but they could not provide on-site reporting, or interventions, or complex work which would need a multidisciplinary team discussion. There was a backlog in ultrasound appointments. In addition to what was said in the report, the panel understood that Dr Shaw's replacement had been appointed, but was not going to start work until February 2020. They asked whether the runner-up in the recruitment in February 2019 might be able to provide locum cover. They also asked, given the reported difficulties obtaining cover in paediatric radiology, whether enhanced bank rates were being offered.

51. They also discussed when the claimant might return to work after the criminal trial. It was assumed the trial would last several weeks. It had twice been postponed and might be postponed again. There were "potential appeal rights". The uncertainty could impact on the claimant's health and render her unable to return. The occupational health advice was that her condition was deteriorating rather than improving.

52. Ill health retirement was not recommended, because it was expected that once the trial was out of the way the claimant would recover and be able to return to work.

53. Dr Ardeshna had a more basic concern, namely that they should be investigating her *conduct*, not considering an ill-health dismissal. He asked why the Trust had not pursued the internal investigation; he was concerned that once the trial was over, if there was an internal investigation to follow, her return to work would be delayed because the claimant would remain unfit until it concluded.

54. The panel asked Launa Pettigrew (HR) for more information before they made a decision: a detailed timeline of the sickness period, clarification with the Trust why the internal conduct proceedings and the grievance investigation had been paused, the cost of interim staffing arrangements, clarification of the reasons for delays, and some clarification of the occupational health advice. They were due to meet again on the 25 July.

55. Shortly before that, on 23 July 2019 Dr Ardeshna read Miss Pettigrew's reply to the information request as meaning they could not speak the solicitors about the decision on internal conduct proceedings, and they would not get further information. He then drafted a letter to the claimant saying the Stage 2 meeting

would be postponed until after the criminal trial. When they met Miss Pettigrew on the afternoon of 24 July, she expressed surprise that they had changed their view about making a decision now, explaining that further information was being collected. Information did arrive next day, though not responses from occupational health. The external solicitor did not think it advisable to be seen to intervene in the dismissal process. The Trust could not consider filling the role on a permanent basis while the claimant was in post; the runner-up in the January 2019 appointment was both qualified and appointable, though they did not say whether he was able to act as locum; enhanced bank rates (for casual cover) were still 'under discussion' (i.e. not being offered); there was a more detailed account of cover, including the difficulty of recruiting a locum for a part-time position, there being in any case a shortage of paediatric radiologists nationally.

56. The stage 2 panel met on 26 July 2019 to consider the further information. They were satisfied that the timeline explained why stage 1 had taken so long. They were less satisfied on the timing of the claimant's prospective return to work. The claimant said that if acquitted she would be well enough to return to work once the case concluded. The occupational health doctor said that given the severity of symptoms she would not be well enough to consider a return to work "until sometime after the court case has been concluded". The panel calculated it would be six weeks until the scheduled start of the trial, four weeks for the trial, another two weeks to get favourable medical evidence if acquitted, then six weeks for a phased return to work and formal retraining, so on a 'reasonable best case scenario', she would not return to work full-time for five months, and that assumed a rapid return to normal health. Against that, in their view the service was now "on a knife edge". In their understanding, the service should have 2.5 whole-time equivalent paediatric radiologists, and were barely managing on 0.5. Cover had been patchy. Dr Shaw's replacement had been uplifted from 0.7 to 1. It seems they understood the replacement would not be starting for another 6 months. They also took into account the outstanding grievance and the need to repair working relationships. They decided the claimant should be dismissed. It sems they understood this would clear the way for recruitment of a replacement for the claimant - Dr Ardeshna was surprised to learn in the tribunal hearing that there had in fact been no recruitment.

57. Next day they were given the occupational health response to their further questions. The doctor was unable to predict a return to work until after the outcome of the court proceedings was known. So it did not assist in deciding when the claimant might be fit to return.

58. The final version of the dismissal letter, 8 pages in all, was sent to the claimant on 30 July 2019. She was to be paid three months in lieu of notice. The detail of what had been read and considered was set out. The essential reasoning for dismissing was that she had been off sick for 25 months, and there were no reasonable adjustments to get her back to work until the outcome of the criminal trial. There was no certain prognosis even then, and in the meantime her absence had a "material adverse impact" on the Department, which required a "sustainable long-term solution".

59. The claimant immediately appealed, and an appeal date was promptly set for 19 August (which is too soon under the procedure, and in any case the claimant's representative was unavailable), and then put back to 30 August. Then the start date for the trial was brought forward from the 9 to 2 September. As the claimant would experience undue pressure dealing with two such important events so close together, the appeal hearing was put off.

60. The trial lasted four weeks, and on 2 October 2019 the claimant was acquitted by the jury. It was thought by the Trust's investigation team that this was a majority verdict, but this is unclear: the jury had been given a majority direction, but as it was an acquittal they were not asked whether the verdict was unanimous.

61. On 7 October the claimant's representative asked the Trust to set a new date for the appeal hearing.

62. It was set for 13 November 2019. The meeting was chaired by Professor Tony Mundy, Corporate Medical Director, assisted by Laura Churchward, Director of Strategy, supported by Naina Arnett of HR. Dr Ardeshna prepared a report on the decision of the dismissing body, and commented on the claimant's grounds of appeal. The claimant supplied a fit note stating that she was now fit to resume work subject to occupational health opinion. Hugh Jelley was asked to be ready to attend to explain cover arrangements, though in the event he was not called on.

63. In her letter of appeal the claimant had argued that it was unfair to dismiss with the trial only weeks away; even if they advertised immediately a replacement was unlikely to be in post until November 29 team at the very earliest, meanwhile they could continue current cover arrangements, and in any event, which reduced the service gap. She objected to the hearing being held in the absence, and, referring to Lorna Pettigrew's email says she hopes to persuade the panel there was little value in proceeding with OH questioning, said Miss Pettigrew was biased. She went on that she would need some refresher training, but doctors who had been on a year's maternity leave usually have 3 weeks, but the clinical work during that period. She was in the same position. She added she had said in her representations at the stage II hearing, that it was just semantics that although it was not a disciplinary process, the outcome had been dismissal.

64. The panel had a short pre-meeting. After hearing the claimant, her representative and Dr Ardeshna, the panel decided to adjourn for further information before making a decision. Professor Mundy observed to his colleagues at the time that the claimant was very quiet, and queried whether she had recovered her health. The participants were then informed that the panel's decision was expected to take a week. In fact it took seven and a half months.

65. Nearly three weeks later, on 2 December 2019, there was a brief discussion between Professor Mundy and Naina Arnett. Laura Churchward was unable to attend, but later that morning she emailed Ms Arnett saying: "Tony has updated me, I am happy!! We just need to be quick about it now as we need to get the letter out. Do you have a draft in mind already". This suggests a decision had been made to uphold the dismissal. Ms Arnett however understood they were to get an occupational health opinion, which had presumably been her advice to Professor Mundy, and so cautiously confirmed her understanding of Laura Churchward's email next day: "just to ensure there is no miscommunication, can I confirm your understanding and agreement to the following: that the panel *is minded to uphold the original decision but before making their decision*, would like to follow HR advice to see OH (occupational health) input into the fit note she provided and her fitness to work" (emphasis added). She then listed five questions for OH to answer.

66. Professor Mundy's evidence to the tribunal was that he had reviewed the dismissing panel's decision and could not fault it. Our interpretation, reinforced by reading Ms Churchward's email, is that he thought they should refuse the appeal there and then, but was persuaded by Ms Arnett that in a sickness absence dismissal, where the claimant now said she was fit for work, they ought to get up-to-date information on her health and suitability for return to work before confirming the decision to dismiss.

67. Ms Arnett tasked Hugh Jelley with drafting the letter for occupational health opinion. The panel's questions were: was the claimant now fit for work, would she need a phased return, and if so for how long and with what adjustments, what impact to her health would there be returning to work and interacting with former colleagues, the potential for relapse in mental health, and were there any other adjustments to be made? The question about the impact on her health from interaction with former colleagues arose from the claimant's answer in the appeal hearing to a question from Laura Churchward on whether there would be any issues integrating with colleagues on her return. The claimant had replied: "overwhelming majority of colleagues no, I think we can work constructively and many ways to support". Her representative had then added: "many colleagues would support her but some, one or two, may not, so may need to consider mediation".

68. Hugh Jelley wrote to occupational health on 23 December 2019. There is a suggestion that this otherwise unexplained delay of nearly three weeks may have been due to the Trust's occupational health physician having recently resigned. When writing, Hugh Jelley added to the panel's questions. His first addition concerned the grievance of 1 May 2018. He said the complaint was against her line managers, the divisional clinical director and the divisional manager, and that the complaint had not yet been concluded, and asked: "What impact is this likely to have on her return to work and how should this be addressed from health perspective?". The second addition was that she had mentioned anxiety about not being able to work at the pace of her peers when scanning paediatric and suspected cancer patients – could she now deal with this, and should an adjustment be made? It is not clear where this mention of

anxiety about working at speed came from, as it had not arisen at dismissal, or so far in the appeal. We speculate that it had arisen in discussions in 2015 or 2016 about the claimant's working time.

69. The occupational health doctor proposed a telephone appointment for 16 January , but Hugh Jelley and Ms Arnett wanted a face-to-face consultation, and that took place on 31 January (the claimant returned from Portugal for the purpose). In his report, Dr Asanati said the claimant was currently doing seven PAs of locum radiology work without difficulty, she was no longer on medication, and was fit for work. It would be helpful if she had two weeks to build up from 7 to 10 PAs per week on return. She was able to do on-call as necessary. With respect to relationship difficulties, a stress risk assessment was recommended. The claimant had told him that the relationship difficulty was with "about one colleague". Dr Asanati recommended the stress risk assessment be used to see how interaction with that colleague could be minimised, and if they had to be in contact, "mediation could be an alternative way forward if both parties would be prepared to forget about the past and just focus on the future". A relapse was unlikely as her illness was a reaction to the particular difficulty. On the complaint process, all those involved would find it stressful, but the claimant would not need psychological support. Finally, the claimant had said she was not aware of working at a different pace to colleagues, and she felt able to perform her full range of duties efficiently. No other adjustments were suggested.

70. This report was sent to Professor Mundy on 4 February. He did not reply. At some point in the week 5 to 11 March 2020 Naina Arnett managed to speak to him about it. There are no notes of the discussion, but we understand it was agreed they should now ask Hugh Jelley and Dr Read about the "relationship issues", and also about the need for retraining.

71. Hugh Jelley replied on 18 March 2020. He said that the service no longer had any need for another paediatric radiologist, as Dr Shaw's replacement, Dr Gaunt, was "exceptionally hard-working and… productive". Scans were no longer outsourced. Were the claimant to return, that would be disruptive to the service, as she had lost the trust of her peers and the divisional management team. There would be no service for patient benefit. She could be redeployed outside paediatric radiology, but the mix of work "may not be attractive or rewarding". He then mentioned that they had highlighted a few concerns with her clinical practice when preparing for the trial. On relations with colleagues, he said: "given her disregard for paediatric team colleagues, her consistent absence from the Department during her job planned hours, and her employee led complaint (the grievance) against the divisional management team, it is fair to expect that her return to work would result in her having difficult relationships with a large number of her former peers. He went on: "She has ceased to demonstrate any of the Trust values. I would find it very, very challenging to line-manage and support a colleague who has initiated an employee led complaint against me and whom I believe to have acted fraudulently towards the NHS and whose actions have inconvenienced patients and put some patients at risk".

72. Dr Read's reply on 24 March 2020 was equally forceful. She said they did not need outside support now. On the claimant's return to work she said she no longer trusted her – when challenged about not attending planned sessions she had replied aggressively and given no explanation. She was repeatedly absent without explanation or discussion and had not responded to opportunities to improve. If redeployed to another sub-specialty she would need 1 to 2 years training. If returning to paediatric radiology she would need "a few days of IT training" because new systems had been introduced in the interim. Dr Read did not identify herself as the colleague with whom the claimant had a problem, and said she had problems with "multiple people". As for the wider team, "Dr Klusmann was a consultant who simply did not want to do her job. There is no place for her in a busy department where we need people pulling together, working hard and supporting each other". During the period when she was being encouraged to mend her ways "we were met with aggression and resistance. It was deeply unpleasant. She made false allegations in a vicious employee led complaint that was not upheld in any aspect". She added that analysis of her work in trial preparation showed inappropriate reporting of scans.

73. Dr Read was of course mistaken about the complaint not being upheld, as it has never been decided. The panel has not seen any comment Dr Read or Mr Jelley had made on its content, but evidently they knew what it said.

74. These comments arrived just as the Covid-19 pandemic broke. It is understandable that in a large London hospital, acute respiratory admissions, reorganisation of other work, procurement of protective equipment, ensuring adequate staffing, and so on, meant that employment procedures were put back. On 20 May Naina Arnett asked the appeal panel if they could make time. On 27 May Naina Arnett send Professor Mundy the March material from the managers, and on 28 May the panel had a virtual meeting. The panel held that the decision to dismiss was reasonable based on information available at the time. On reinstatement, they concluded, according to Ms Arnett, that having regard to what was said by Dr Read and Mr Jelley, the claimant could not return without significant adverse impact on the service and working relationships in the team.

75. It should be said that in evidence Professor Mundy denied ever seeing this material from the managers, but he agreed he had reviewed the outcome letter where the content is set out.

76. On 20 June Naina Arnett drafted the letter to the claimant dismissing the appeal. A few days later Laura Churchward returned it with some clarifications. On 30 June Professor Mundy approved it, and it was then sent to the claimant.

77. The letter recited the representations at the appeal meeting, the content of the occupational health report, and gave an explanation and apology for the delay in concluding the appeal. The claimant was sent the additional material from Dr Read and Hugh Jelley, and told that she had not been asked to comment on

this because it arose from her representations at the appeal that she could successfully reintegrate and have the support of the majority of her former colleagues. The appeal panel was satisfied that the original decision was correct. Launa Pettigrew was not biased, and in any case the panel had obtained additional information from occupational health. On reinstatement, the panel held she did not show adequate understanding of the challenges of returning to work after two years, and had troubling lack of insight about the extent of retraining needed. She was told about the concerns with her clinical practice which might need to be investigated were she to return, and about her managers' concerns about her, leading to loss of trust. Nor did they need additional resource. Redeployment outside paediatric radiology would require 1 to 2 years retraining. "Not only is the panel satisfied that the original decision to dismiss you was reasonable and should therefore stand, we consider that the disruption to what is now a well running service would not be reasonable. This is compounded by the relationship difficulties from you former management team and critically, the views expressed about loss of the trust which is essential for a supportive and effective working relationship".

**General Medical Council**

78. When the claimant was formally charged she should have referred herself to the GMC. Professor Mundy used to meet the GMC representative quarterly as he was also the responsible officer for UCLH, and when he learned in June 2018 she had not, he arranged to remind the claimant, and she reported herself at the end of July 2018. The GMC eventually decided in July 2021, after considering the trial transcript, that there was no need to investigate her fitness to practice. Apparently this delay is not unusual - Professor Mundy commented that the GMC's processes "would make a snail look like Mo Farah".

**Relevant Law - Unfair Dismissal**

79. Unfair dismissal is a statutory right. By section 98 of the Employment Rights Act 1996, it is for the employer to show that the reason for dismissal or fair reason.

80. If a potentially fair reason is shown, section 98 (4) provides that it is the employment tribunal to determine:

> "whether the dismissal is fair or unfair (having regard to the reason shown by the employer)—"
> (which)
> (a) depends on whether in the circumstances (including the size and administrative resources of the employer's undertaking) the employer acted reasonably or unreasonably in treating it as a sufficient reason for dismissing the employee, and
> (b) shall be determined in accordance with equity and the substantial merits of the case".

**81.** The tribunal must only take into account what was known to the employer at the time of dismissal – **W. Devis & Son v Atkins (1977) AC 931**- but an

appeal is part of the dismissal process -**Taylor v OCS Group (2006) ICR 1602,** so account can be taken of matters arising on appeal. In a sickness absence capability case, the fact that on appeal the claimant is now fit, which could not have foreseen at the time of dismissal, means that in fairness the medical position when the appeal is decided must be taken into account, even if the appeal procedure only provides for review rather than rehearing – **O'Brien v Bolton St Catherine's Academy (2017) EWCA Civ 145**. Care must be taken where the reason for dismissing at the appeal stage is not the same reason as at dismissal – **Monie v Coral Racing Ltd (1979) ICR 254**, and **National Heart and Chest Hospitals Board of Governors v Nambiar (1981) ICR 441**. It is unfair to dismiss for one reason and rely on a different reason on appeal.

**82.** When a breakdown in trust and confidence is said to be the reason for dismissing, or failing to reinstate, tribunals must be careful if this avoids investigating conduct or a grievance – **Governing Body of Tubbenden Primary School v Sylvester UKEAT/0527/11, A v B (2010) ICR 849, McFarlane v Relate Avon Ltd (2010) ICR 507,** and **Leach v Ofcom (2012) ICR 1269,** in which it was said: "the mutual duty of trust and confidence… is not a convenient label to stick on any situation in which the employer feels let down by an employee or which the employer can use as a valid reason for dismissal whenever the conduct reason is not available or appropriate".

83. In all capability cases, the tribunal must consider whether the respondent can be expected to wait any longer, and if so how much longer, and have regard to the nature of the illness, the length of the absence, and employer's need to have the work done - and be aware that every case will be different – **Spencer v Paragon Wallpapers Ltd (1977) ICR 301.** A more recent case identified the factors to be balanced in assessing fairness as whether other staff could carry out the absent employee's work, and the impact of continuing absence, the nature of the illness and length of absence, the cost of continued employment, the size of the organisation, and the unsatisfactory situation of having an employee on very lengthy sick leave **S v Dundee City Council (2014) IRLR 131.** As noted in O'Brien, "a time comes when an employer is entitled to some finality".

**84.** The tribunal must not substitute its own view for that of the employer, provided the employer's action was within the range of responses of a reasonable employer – **Foley v Post Office (2000) IR LR 82,** which noted that this test does not require "such a high degree of unreasonableness to be shown that nothing short of a perverse decision to dismiss can be held to be unfair within the section".

**Relevant Law – Disability Discrimination**

**85.** The Equality Act 2010 provides at section 15 that it is discrimination to treat a person unfavourably because of something arising from disability. The guidance given on this to tribunals is to find what the unfavourable treatment is and who was responsible for it, then what caused the treatment, focusing on the reason in the mind of the alleged discriminator, considering thought processes, but regardless of motive, and then whether the reason was "something arising in consequence of the claimant's disability". This last is an

objective question, not depending on the thought processes of the alleged discriminator about what occurred "in consequence" of disability– **Pnaiser v NHS England and another (2016) IRLR 170.** As in other discrimination cases, "because" is not a "but for" test **- Robinson v Department of Work and Pensions (2020) IRLR 884.**

86. If discrimination in this way occurred, it is open to an employer to justify it by establishing that the treatment was a proportionate means of achieving a legitimate aim. When deciding whether a provision is a proportionate means of achieving a legitimate aim, the tribunal must consider four points, as analysed in **MacCulloch v ICI (2005) IRLR 846.** The burden of proof is with the respondent. The means chosen must correspond to a real need on the part of the undertaking, and be both appropriate and reasonably necessary with a view to achieving the objective - **Bilka-Kaufhaus GmbH v Weber von Hartz (1986) IRLR 317**. The discriminatory effects of the provision must be balanced against the objective needs of the undertaking, and the more disparate the impact, the greater the weight of the objective needs. Lastly, the tribunal must itself weigh up the needs and make its own assessment, rather than relying on whether the employer's decision was within range of reasonable responses – **Hardy and Hanson plc v Lax (2005) IRLR 720.**

87. This is where the finding to be made by the employment tribunal parts company from unfair dismissal claims. Rather than assessing whether the employer's response was reasonable, the tribunal has to make its own objective assessment of the relevant factors, weighing the real needs of the undertaking against the discriminatory effect of the requirement, in order to decide whether what occurred was reasonable, necessary and proportionate**- Chief Constable of West Yorkshire Police v Homer (2012) UKSC 15**. Where a dismissal is pleaded both as unfair and discriminatory, the same material may have to be considered, and in both cases it is the employer's reasoning that is to be scrutinised. An employer's conduct may be both unreasonable *and* disproportionate, as explained in **O'Brien**, but it is not inconsistent for an employment tribunal to (say) find a fair dismissal but uphold discrimination under section 15, because of the greater latitude given to employers in unfair dismissal – **City of York v Grossett (2018) ICR 1492.**

88. In deciding the discrimination claim, the tribunal must remember the special burden of proof in section 136 of the Equality Act. It is for the claimant to prove facts from which tribunal could conclude, in the absence of explanation, that discrimination occurred, and then consider the explanation.

**Discussion – Unfair Dismissal**

89. The tribunal has approached the unfair dismissal question in two stages, firstly what occurred at dismissal, then on appeal. At dismissal it is clear the reason was lack of capability to work. We must address whether the Trust acted fairly in dismissing her for this reason.

90. Clearly she had been off work a very long time. Most employers would have dismissed long before. The special feature was the consistent occupational health opinion that once the trial was out of the way she could be expected to recover and return, assuming an acquittal, though how promptly was less clear. This will have removed the element of substantial uncertainty that often obtains in long-term sickness absence. What would have happened had she been convicted is another matter – she may not have recovered, she may well have been dismissed for conduct reasons, and there would have been a question on her GMC registration.

91. The claimant urged the tribunal to find that the panel's first draft letter, postponing a decision until the trial was over, was the right one. They had waited two years, and could wait two more months. We were asked to find there was unfairness in Launa Pettigrew seeking to persuade – the word she used in her email to a colleague at the time - the panel not to postpone, and in arranging for a senior colleague to speak to Dr Ardeshna when they meeting on another matter. However we were satisfied with Dr. Ardeshna's explanation that he was annoyed by being denied (as he though,), access to solicitors to discuss what would happen to the conduct investigation, bearing in mind his initial view that sickness was not the correct approach to the problem, and on learning that the enquiries he had wanted were in fact being made, agreed to decide when the information was available, as planned, rather than postponing the whole process until after the trial. We do not think his decision was overturned by HR.

92. The dismissing panel approached their task seriously, getting to grips with the issue of maintaining the service. They seem to have been reluctant to dismiss simply because she had been off a long time, when the trial was so close. There may have been some lack of clarity about whether the establishment was 2.2 or 2.5, or that not all of this was paediatric but adult,, but their genuine belief, based on enquiry, was that the service was "on a knife edge", that this could not continue, and that if not dismissed the situation would continue for at least another 5 months and possibly longer, while if dismissed, there could be a permanent recruitment. They may have been swayed by mention of appeal, without considering that if convicted the claimant was unlikely to be fit to return, but overall their decision was reasonable and the process fair.

93. But we must then consider what happened on appeal. By the time the panel met in November, the claimant had been acquitted, she had a fit note for a return to work, and she had declared she wanted to return. As the fit note was subject to occupational health opinion, it was reasonable to get occupational health opinion on this, though we are less clear why an opinion was not sought for six weeks after the hearing, and why the panel did not then consider it until over a month after the report was available. There is much evidence to suggest that Professor Mundy considered he only had to review the merits of the dismissing panel's decision, and formed his own view had not recovered as she said, which in our finding was unfair when she was represented, so might reasonably leave it to a representative to speak. The evidence from the beginning of December, when Ms Arnett followed up on the hearing, was that

he saw the decision as already made, and occupational health opinion a cosmetic.

94. What then developed, in our view, was a switch from capability as the reason for dismissing to conduct, or loss of trust and confidence. The claimant gave a straightforward answer at the appeal hearing to the integration question. From her point of view, she could work, though her representative alluded to 1 or 2 individuals, who must have been Hugh Jelley and Dr Read. The panel's questions for occupational health concerned whether there would be continued difficulty with the *claimant's* health interacting with former colleagues. Hugh Jelley amplified this by adding in the outstanding grievance, and anxiety about working at speed. The answers in the occupational health report, which must reflect the claimant's view, were that everyone would find a grievance process stressful, but she could be supported, and that she did not recognise the suggestion of anxiety. It told the respondent that she was already working satisfactorily as a locum. It gave firm support to the claimant's immediate return to work. Despite that, but seems to have happened next was an attempt to undermine the view that the claimant could return to work by seeking the opinion managers. The managers' opinions, as they appear in writing, did not concern the claimant's ability to work, but their ability to work with her. They make general allegations about her standard of work. They fiercely resent the grievance having been made ('false', 'vicious'). They allege that numerous colleagues would not want to work with her. They maintain that she was guilty of fraud. These are questions about reintegration which do not concern whether the claimant's mental health would relapse if she returned.

95. These views were not tested or explored, and they were implicitly adopted when the claimant in the appeal was told that her return would disrupt a well-running service. In this hearing Hugh Jelley was asked on what basis he said that numerous colleagues would not want to work for her. His answer was very general. We heard from Dr Shaw, who had worked alongside the claimant for several years, that she was committed and cooperative colleague. It was suggested by the managers that there had been complaints about the claimant, but as it turned out, the only identifiable complaint had been Dr Shaw asking not to have the claimant conduct her annual job plan discussion because of the difference in seniority- she wanted someone of her own seniority to do it. This does not support the view that others would not work with the claimant.

96. Of course, speculatively, the tribunal recognises the possibility that colleagues other than her managers may have held strong views about the claimant's working patterns, knowing that some NHS doctors holds a matter of principle that private work should not be done, though Dr Read will not have been one of them, because we learned that she had shared her own private work with the claimant, but these are not uncommon difficulties in NHS departments, in our experience, and are usually managed by everyone working professionally whatever the differences of opinion. On the evidence, the only colleagues who had difficulty working with her were the managers, Hugh Jelley and Dr Read. As the occupational health doctor had pointed out, a resolution by all concerned to put these matters in the past would have worked. Reference is made in the

hearing to the claimant not being able to avoid casual contact with her managers if back at work, but we could not see why this was an insuperable problem. A mediation meeting to clear the air, both in relation to the grievance, and the fact that they had given evidence in the criminal trial, would have been a common HR procedure to deal with the difficulty of this kind.

97. Nor was there any attempt to explore the allegations of defective clinical practice.

98. As for the assertions of the managers that there was no longer any need for the claimant's services, there was no explanation or exploration of how a service which was "on a knife edge" in July 2019, at a point when it was known that a permanent consultant was due to start at the end of January 2020, did not need to recruit a replacement for the claimant. Had Dr. Ardeshna known at the time of dismissal that the service manager, Hugh Jelley, proposed to stagger on with current cover arrangements for another 6 months, he might have made another decision about the claimant's dismissal, reverting instead to waiting for the end of the trial. It also raises the suspicion that the appeal process, which was initially intended to conclude before the criminal trial, was deliberately prolonged by inaction in getting occupational health opinion, in the expectation that when the new consultant started work, there would be no pressing need for the claimant to resume.

99. What was also briefly expressed in the responses from the managers in March 2020, namely that claimant had been guilty of fraud in a working pattern, was made very clear in Mr Jelley's evidence. We were much struck in tribunal by the evident strength of feeling on his part. He firmly believed the claimant had been guilty of misconduct, short changing the NHS. It mattered to him that the claimant had never acknowledged fault or apologised, or agreed to modify her practices, and it was plain that he did not accept the claimant's argument that she worked more than he believed, and had not failed to make up time, or the verdict of the jury.

100. In our finding, the basis of dismissal moved from the claimant's capability to what amounted to a belief in her misconduct, whether that misconduct was the matter for which she was charged with fraud, or was that she had made a "false" allegation about her managers, which arose from the earlier conflict about her working time. There may well have been difficulty if the claimant returned to work, because of her managers' views, but there are well recognised HR processes for handling interpersonal difficulties, and in any event, the grievance had not been investigated, it would have been hard to investigate because of delay, the claimant may have agreed to withdraw it, and it was unfair to dismiss her (in effect) for allegations of fraud without proper investigation and hearing on that point. The appeal decision was not on her capability for work, but based on other matters of which the claimant had no notice, and no opportunity to dispute, making the process unfair. Apart from that, it is hard to understand why there was so much emphasis on the need for extensive retraining when Dr Read thought she would need "a few days" to become familiar with paediatric radiology systems. Hugh Jelley thought they

could put together a portfolio of work that not involve contact with the paediatric radiology managers, but the claimant would not like it, but she was never asked about ways of working with resentful managers. These were intended to bolster the conviction that she should not return to work for her conduct.

101. At this point it is necessary to note that whatever the outcome letter at the end of June 2020 said were the reasons for not returning her to work, we are not sure that those were Professor Mundy's reasons. There are strong grounds for holding that he made a decision on the day of the hearing that the decision was the correct one, and he was only required to review it, and in any event the claimant was in his view unfit to return. This is confirmed by the email exchanges of early December, his failure to address the occupational health report when it arrived at the beginning of February (when the pandemic was but a rumour), and his lack of any recollection now of the managers' views of March 2020, and it may well be that he approved the eventual letter (after chasing) without giving it close consideration, on the basis that it made the decision he had always thought would be the outcome. If we take the appeal outcome decision as one made by Professor Mundy in November 2019, it was unfair to make that decision without medical opinion on her fitness to return - especially when the opinion concluded she was fit to return in a few days, and she had already returned to work as a locum.

102. The unfair dismissal claim succeeds.

**Discussion and Conclusion- Disability Discrimination.**

103. The unfavourable treatment in the claim under section 15 of the Equality Act 2010 is of course the dismissal, and then the failure to reinstate her on appeal. The reason that unfavourable treatment was the respondent's view that she had been away from work a long time, and at the time of dismissal, it was unclear when she would return to work. At appeal, the reason had shifted to whether it was possible to successfully reintegrate her to the service after her long absence. The long-term absence was because she suffered from depression and anxiety because of the uncertainty of outcome of the charges against her, in other words, it was something arising from her disability.

104. The respondent argues that the decision not to reinstate her on appeal was not because of disability, or because she was not capable of returning to work. The reason not to reinstate her was first that the dismissal was considered to have been fair, and second that what disruption of the team if she returned what not to do with disability.

105. The respondent asserts the decision to dismiss was justified, the legitimate aim being:

> to put a sustainable solution to the Claimant's absence in place (it says she had been absent for 25 months during which time she had been incapable of doing any work for the Respondent and it needed to recruit a new person, cover the impact that the Claimant's absence had had

and ensure stability within the team) and to ensure that patient demand was met.

106. On appeal, if the tribunal finds the reason for not reinstating was her long-term absence, they seek to justify this, the legitimate aim being:

> to ensure that the service operated stably, efficiently and effectively with a complement of staff that reflected the needs of the service at that time.

107. The claimant agrees the aims are legitimate, but disputes that the treatment was proportionate.

108. We start with the dismissal. Here justification is the only issue. Whatever the usual length of time for sickness absence before dismissal, in this case the respondent had been able to wait 2 years, the end was in sight, as occupational health had consistently predicted she would be able to return to work after the trial, though not how soon after, and it is legitimate to ask why they could not wait a little longer on their current arrangements. We reminded ourselves that we have the benefit of hindsight. We now know that the trial did occur on time, even one week early, that the claimant was fit to return to work a few weeks after, and did return to locum work within 6 weeks of the acquittal, and that the respondent was able to carry on with the current arrangements, and did not recruit either then or later. It also seems to be the case that although both Dr Ardeshna and the claimant assumed that she was being dismissed so that they could recruit a permanent replacement for her, that was not the manager's plan, which was to wait and see how things were when Dr Gaunt started, indeed he may not have planned to recruit at all.

109. None of this was known to Dr Ardeshna and his colleague. After their initial response, that this should be a conduct matter, not abut sick leave, or that they should wait and see what happened after the trial, they conscientiously examined what the staff complement was at the time, what arrangements had been made or could still be made for cover, and whether things could continue as they were for a period. They made a realistic estimate of when the claimant could return to work if she recovered she believed she would. They recognised that there was a risk this might take more than 5 months and not at all. In assessing whether the dismissal was a proportionate response to the legitimate aim. Our task is not to review whether the respondent acted reasonably, but to ask for ourselves whether this was a proportionate response. We must do that judging by the facts at the time.

110. It was the case that the trial had twice been postponed, it was not a fanciful risk that it could be delayed again. It was also the case that the occupational health advisor may have been a little more cautious than claimant about how quickly she could return to work, and in supplementary questions could not give a firm answer. Even if all went according to plan we do not disagree that if she was not dismissed, the service would have to make do with patchwork cover arrangements for at least another 5 months. As for the service

risk, they were down to 1 permanent consultant on full sessions, they had outsourced and delegated what they could, they had difficulty recruiting locums. Even when Dr Shaw was still in post, so there were 2 permanent consultants in post, her colleagues had considered paediatric radiology staffing in the absence of the claimant so tight that they had asked for this to be put on the formal risk register for the Trust. The fact that a risk had not materialised did not mean that some serious error might not arise at any time in the next 5 months, or more due, to not having enough paediatric radiology cover. We have to assume it was not then known to Hugh Jelley or others that the proton beam radiology project was running behind schedule, meaning that when Dr Gaunt started at the end of January 2020 3 PAs available for additional paediatric radiology. If it was known, this would have weighed on the side of waiting for the claimant to come back rather than dismissing her, as it would mean there was not the same pressing need to recruit another permanent member of staff. As it was, in our assessment, there were many imponderables about the future - clearly there were risks in the current cover arrangements, just because they had managed so far, there was no reason why any risk might not materialise if the situation ran on, and she was not going to return for at least 5 months and possibly more it was difficult recruiting paediatric radiologists, and recruiting paediatric radiology locums, and if the claimant was dismissed because set about recruiting a permanent member of staff. The legitimate aim was clearly a serious one. In our finding, on the facts at the time the decision was made, it was a proportionate response to the to the aim of stabilising the understaffed service.

111. At the appeal stage, we consider the respondent's argument that the decision to reinstate was not made because she had been away long-term sick. They argue that at that stage it was about whether she could be successfully reintegrated into the department, or whether in fact they had any need for additional resource at all by then. We are not sure that we accept that they had no need for additional resource: the evidence comes from Mr Jelley and at the time he enumerated several very different reasons, many related to his own antipathy to the claimant (belief in her fraud, the outstanding grievance) why the claimant's return to work would not succeed, and nothing to do with service need. There is no evidence that the building delays said to have been caused by the pandemic or the water quality problem which meant Dr Gaunt has spare capacity were known at the time. At the time of the appeal, in our finding, the decision not to reinstate was no longer about her long-term sickness absence and its consequences. It was made for wholly different reasons, which we have found to be unfair, namely a resolute belief that she had committed fraud, assertions made on slender evidence that her colleagues would not work with her and she would disrupt the team, and her managers' fierce resentment of her grievance. Her long-term absence was the context in which a return to work was the decision to be made, but it was not, by the period March to June 2020, the reason why it was made. In our finding, the decision not to reinstate her was not treatment because of something arising from the claimant's disability. In consequence we do not consider justification at this stage. Have we considered that she was not reinstated because of her long-term sickness absence, or any genuine concern that her health might break down again, it is

unlikely we would have considered this a proportionate means of achieving the aim of stabilising the service, as we would have held that mediation, would have adequately achieved enabled the claimant continuing to work in the team, and we doubt there would have been any disruption from the claimants end.

**Time**

112. Strictly speaking the time point is redundant, but had it not been, considered it just and equitable to allow an extension of time to amend the claim to add section 15 discrimination in respect of the appeal. There could well be doubt about whether the treatment complained of was a process which did not end until the appeal was resolved, although amendment was required. The respondent did not plead in full to the claim until after the appeal had been resolved. The solicitors delay in seeking an amendment was reasonably short. In the event the appeal required only a small change to the issues listed, and the time point is only raised in relation to discrimination claim, not the dismissal. Weighing the balance of prejudice to identify whether it is just and equitable, in our view the fault was small, and there has been no prejudice to the respondent.

Employment Judge Goodman
25th August 2021

JUDGMENT and REASONS SENT to the PARTIES ON

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. 26/08/2021

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FOR THE TRIBUNAL OFFICE