# EMPLOYMENT TRIBUNALS

**Claimant:** Mr R Lohman

**Respondent:** Oxford Health NHS Foundation Trust

**Heard at:** Watford (hybrid) **On:** 5, 6, 7, 8 & 9 September 2022

**Before:** Employment Judge Maxwell
Mr Wharton
Mr Scott

**Appearances**
For the claimant: Mr Betchley, Counsel
For the respondent: Mr Green, Counsel

These reasons are provided pursuant to the Claimant's request.

# REASONS

**Preliminary**

Timetable

1. A timetable was agreed at beginning of the hearing:

   1.1 day one - housekeeping and Tribunal reading;

   1.2 day two - Claimant's evidence (four hours) & Respondent's evidence (one hour);

   1.3 day three - Respondent's evidence;

   1.4 day four - Respondent's evidence (three hours) & closing submissions (two hours);

   1.5 day five - Tribunal deliberation;

   1.6 day six - Tribunal deliberation, judgement and remedy if appropriate.

2. In the event, hearing the evidence, submissions, the Tribunal deliberating and giving judgment took 5 days.

Hearing format

3. Whilst the parties previously disagreed about the appropriate hearing format, they both now wished to proceed on the basis of video ("CVP"). The Claimant in particular would be assisted in caring for his partner if able to participate in the hearing from home. Given both parties were represented and able to take part by video it was in the interests of justice to proceed on the basis of a hybrid hearing. The parties attended by CVP, the Panel were at the Tribunal hearing centre or by video, whichever was more convenient.

Issues

4. The parties had agreed a list of issues, pursuant to the direction made by EJ Tynan at a case management hearing. Since that time, the Claimant had obtained legal representation. The parties were able to engage in a constructive discussion and narrow the issues:

   4.1 the protected disclosure detriment and automatic unfair dismissal claims were withdrawn;

   4.2 the reasonable adjustments claim was only pursued to the following extent:

      4.2.1 the PCP was said to be a failure to provide social-worker led supervision from November 2018;

      4.2.2 the adjustment contended for was the provision of social-worker led supervision.

   4.3 The unfair dismissal claim was pursued on a narrow basis:

      4.3.1 the Claimant does not dispute the Respondent had a reasonable belief, on reasonable grounds, following a reasonable investigation, with respect to the conduct for which he was dismissed;

      4.3.2 his complaint is about the sanction, in particular the Respondent taking into account an earlier final written warning, which he says was invalid on the basis it had been manifestly inappropriate to issue it.

## Facts

Background

5. The Claimant is a qualified and highly experienced social worker. From 2001 he was employed by the Respondent, was based at the Luther Street Surgery in Oxford, which specialises in providing medical care to homeless people and those who are substance misusers.

6. He was employed as a Substance Misuse Support Worker and then from January 2012 became the Homeless Social Practitioner. He was involved in undertaking social assessments of new patients and referring patients to the clinical team.

7. The Claimant was passionate about his work and had a strong personal sense of duty towards his clients. In the years prior to the events with which the claim is concerned, the Claimant and Respondent frequently differed over professional boundaries. In 2014 and 2015 the Claimant was subject to a capability action plan. He was required to attend meetings under the Respondent's capability procedure. The rationale behind these measures included enabling the Claimant to understand the Respondent's view (as his employer) of where the line was to be drawn.

8. In October 2017, sadly, one the Respondent's patients died. The Claimant believed this may have occurred because the individual concerned attended the surgery requesting a replacement methadone prescription and this was not provided. The patient had been told they must first obtain a police report and only after this would a replacement be issued. This response was in accordance with the Respondent's policy at the time, which was intended to avoid patients obtaining excess supplies of controlled drugs. The Claimant's opinion was that the particular patient should have been provided with a replacement script without the need for a police report. He believed the police were no longer providing such reports. The Claimant completed a Significant Event Review form, in which he suggested revising the policy to remove the "go to police station" requirement.

Patient Incident

9. On 9 November 2017, a highly intoxicated patient was brought into the surgery. There is a dispute about precisely what happened. The noise of this incident drew two GPs to the reception area, Dr Schafer and Dr Warren. Both were concerned because they believed the Claimant was behaving inappropriately toward the patient. The commotion also attracted the attention of Mr Moore (albeit he did not witness the material incident) who was Practice Manager and the Claimant's line manager.

10. Following this incident, the Claimant was called into a meeting with Mr Moore and Dr Schafer. The Claimant appeared distressed. Mr Moore advised him to take the afternoon off and instructed that he not see any other patients. The Claimant disobeyed that instruction by meeting with a service user later that afternoon.

Investigation [patient incident]

11. Mr Moore was concerned about the Claimant's behaviour and raised this with his own line manager, Mr Harker. Senior management decided to commission an investigation into the Claimant's conduct and he was suspended whilst this was carried out. A letter of 20 November 2017, included:

> **An Investigating Officer will be commissioned to conduct the investigation in to the following allegations outlined in the Terms of Reference:**
>
> > **• That on the 9th November 2017 you allegedly acted in manner that is outside of your code of professional conduct when you were dealing with a patient in the Luther Street Medical Centre waiting room.**

> **• That you physically touched the patient in an inappropriately forceful manner.**
>
> **• That you attempted to administer medication to a patient who was intoxicated.**
>
> **• That you attempted to administer medication outside of your professional capacity**
>
> **• That your professional conduct was inappropriate when interacting with colleagues following the incident.**
>
> **Such allegations, if upheld, could constitute gross misconduct as defined under the Trusts Disciplinary Policy and Procedure, a copy of which is enclosed. In view of the serious nature of the allegations it is necessary to suspend you from duty whilst a full investigation takes place as it is not appropriate for you to continue to work during this process. If it is found that the allegations against you are unfounded or are less serious than they initially appeared the suspension will be lifted. Suspension itself is not a disciplinary sanction. You will remain on full pay during the period of suspension.**

12. Occupational health advice was sought in light of what the Claimant was saying about his health at this time. A report of 24 November 2017 included:

> **Richard has a back injury that is now recovering. At the time of the incident he was in significant pain from his back, had recently given up smoking, both of which likely exacerbated his feelings of stress and consequent reaction, around the time of the incident.**
>
> **[…]**
>
> **It is my opinion that Richard has been stressed due to a combination of physical pain and work pressures. He is however improving now, and would be fit to attend any management/investigative meetings with appropriate support, such as staff side representation.**
>
> **<u>Future plans & closing comments</u>**
>
> **I strongly recommend that the investigation is concluded as swiftly as possible - the longer the process draws out, the harder and more damaging it is likely to be for Richard.**

13. Before he was interviewed for the investigation, the Claimant produced a lengthy witness statement. Rather than simply addressing the events of 9 November 2017, his narrative started in August of that year when he stopped smoking. He set out various matters which had been stressful or upsetting for him. As far as the material incident is concerned Claimant said:

> **I'm in shock, on autopilot & in fight/flight mode, my intent is to wake the patient and encourage him to take his prescribed medication with water. Most colleagues were either debriefing after the recent incident or back in their offices, I experienced a kind of tunnel vision around the intent, probably fueled by my guilt and didn't think to inform my reception colleagues to get the doctors and nurses to deal with it. I read the doses on the packs and remove one dose of medication which meant taking a**

> **tablet out of each of the four packets, something I sensed the patient would struggle with. I get a plastic cup of water. My intent is to wake the patient and encourage him to take his prescribed medication with the water...**
>
> **I should have clarified what was going to happen and left the medication matters in my colleague's good hands, I was distressed and hungry and it seemed simple enough: just wake him up and encourage him to take his medication. In hindsight my actions were hasty and ill-judged.**
>
> **...I walk over to the patient calling his name loudly to him, I tell the patient in German he needs to wake up and with no response further assess the depth of his slumber by nudging his foot with mine. There's research that shows touching the elbow (when the person is conscious) is best for aiding compliance but the foot's a good second place, especially as I'm standing (my back still isn't 100%) so I didn't want to kneel until I had too, and the patient was having a nap of unknown depth. Both the patient and I were wearing shoes...**
>
> **I hold a diploma in anatomy and physiology and have previously undertaken a diploma in reflexology. I'm a registered and qualified Integrative Yoga Therapist with over 800 hours experience, roughly 500 around the use of yoga in addiction treatment. The second-year work placement during my social work training was spent in Mumbai at 'Kripa', the largest addictions treatment organisation in the country which used Iyengar yoga daily combined with the 12 step Alcoholics/Narcotics anonymous approach. I taught each morning over a 3-month period after passing assessment by the organization's founder, Fr. Joe Pereira, a highly qualified instructor with over 20 years' experience at that point, and tutored personally by BKS Iyengar.**
>
> **...still no response so I kneel next to him putting the tablets and water aside, touch his right elbow and shake his left shoulder whilst repeating the message to him loudly in German, his eyes begin to flicker open.**
>
> **At this point I'm aware Rob, Emma and some nursing colleagues have come into reception. I don't want the medication or water to be knocked over, so I pick them up.**
>
> **Rob asks me if those are tablets in my hand, I say yes, he asks where I got them from, I tell him from the patient's medication packs, he tells me it's a clinical situation and I should put the medication down and leave. I go back into reception and put the tablets and the water down. I look at my watch, its quarter to one. I look over to reception and see my colleagues gently trying to wake the patient but to no apparent avail. I went into my office and tried to digest what had just happened.**

14. Dr Warren was interviewed by Ms Betts on 17 December 2017. She said she had been drawn to this incident by hearing a slapping noise:

> **EW: I went out to reception, the noise was coming from the reception floor, what I could see was the patient lying on the floor. RL was leaning over the patient and slapping the patient's arm. It was so loud I could hear it from my room.**

> **EW: I thought the patient had collapsed, I asked RS to come out and see the patient with me, he was due to see him anyway. RS then told RL to leave the patient as we would take over. RL told us that he needed to give the patient his medication, he repeated this. RL was holding the medications in his hand.**

15. Dr Schafer was interviewed by Miss Betts on 18 December 2017. He said he had been alerted to the incident by hearing the Claimant's voice. He came out of his office and observed the Claimant slapping the patient on the shoulder and speaking to him in German, holding tablets in his outstretched hand. Dr Schafer immediately intervened to prevent any medication being administered. He explained his concerns in following way:

> **RS: I was concerned that we had an employee with no clinical training slapping a semi-conscious person, at this point, we said we'll take over. I took the medications off RL.**
>
> **LB: How many tablets were there?**
>
> **RS: I believe there were 5 or 6.**
>
> **RS: At that point, we asked RL if he had taken the tablets out of their strips. He said yes. Myself, with Emma and Ela, dealt with the patient. The patient wasn't rousable at that point, I understand when he was first brought in, he was in a better condition. In the situation at the time, we ran it clinically in the way that we would normally do, we looked at the ambulance report, established way he had come in and assessed his level of consciousness. At that point he was rousable to verbal commands.**
>
> **LB: You wouldn't have touched the patient in this situation?**
>
> **RS: We would have roused him via verbal commands, we wouldn't have slapped him on the back - he was Intoxicated and not responsive to commands, he did subsequently improve. I was concerned about RL's state. I therefore spoke to SM and asked him to speak to RL.**
>
> **RS: SM agreed, however RL was very reluctant to meet so SM had to insist, RL then agreed.**
>
> **LB: How did the meeting progress?**
>
> **RS: I took the lead, and I felt I had to find a way in. I said we are supportive, and I said it was out of character, however RL does have a track record of acting outside of his role, there Is a pattern of him periodically acting in an odd or unsafe way, but it was intended as a supportive phrase.**
>
> **RS: We asked whether he was too stressed to be at work. We were concerned that RL had been trying to give medication to a patient, this is something even I wouldn't do, I would never hold tablets In hand, we very rarely even observe patients taking medication, less than yearly.**

16. Mr Moore was also interviewed on 18 December 2018. He did not witness the patient interaction. When he attended the scene the Claimant appeared "flustered, agitated and emotionally roused". Mr Moore spoke of previous issues where the Claimant had issues around professional boundaries and received

training on this. As to the meeting with the Claimant and Dr Schafer immediately following the event, he said::

> **SM: RL was agitated about being pulled into this meeting, he said "I'll time you". It was a highly charged meeting, when we had finished the points, I asked him not to go to see the patient RL was dismissive of this. I said to him that I will seek management advice from service manager and HR. When I did this, Aiden said yes you will need him to take the afternoon off. I then phoned RL and told him to go home, he abided by that request.**

17. The Claimant was interviewed by Ms Betts on 8 January 2018. His account of the relevant day included:

> **RL: The ambulance guys came in and the patient was walking beside them, they quickly confirmed what medications were needed, I shot off to the pharmacy. At this point he was being a model patient, he was sat very calmly in reception. I brought it back.**
>
> **RL: Another patient had stormed out of RS' consultation room, he storms out then back into reception area, RS came into reception and he started giving a load of verbal abuse to RS, shouting and swearing at him for not prescribing enough medications. RS explained it was protocol and exited the reception area. The patients' girlfriend comes in to get him and thankfully he does exit. By this time, the staff have heard what is going on.**
>
> **RL: What usually happens after an event such as this would be that SM would shut the surgery down temporarily and ask patients to leave, should they not be in the consultation room, therefore my assumption was that SM was going to send the patient out. At this point, I was aware I had another appointment in 20 minutes time, I was in shock and slightly distressed. Going back over it, I should have handed the medication over to SM and asked the GPs to give the medications, but I was still in shock, I was in 'action mode' trying to sort things out.**
>
> **RL: The patient waiting in reception was a rough sleeper and during this time he had lied down and decided to have a nap on the floor. My intent was to hand him the medication, the medication was in 4 separate packets and my sense was that it would take a long time to open all the medications and take out the required dosage, that was my mistake. I took one out and get some water, my intention was to give him the dose and tell him to leave.**
>
> **RL: I had Injured my back 3 weeks previously, so it was a struggle to bend down. I walked over to patient speaking loudly to wake him up (not sure initially English or German). I nudged him with my foot with a flick motion, I then spoke loudly in German, he didn't respond so I then knelt down. I held one of his elbows with my left hand and shook his shoulder whilst still speaking German, his eyes started to flicker open. Then other staff came into the reception area. I think what I had done was that I had put medications and water on the bench, but at some point they were back in my hands. At this point, RS asked me if I was providing medications, he told me this a clinical situation and that they would take over. I sensed I had done something wrong.**

**[…]**

**LB: Would you administer medications?**

**RL: No. My role is clear, if the patient doesn't have cash, what I will ideally do is give the patient a prepayment prescription, but this is not always possible, sometimes I have to go to the pharmacy. Ideally a nurse would take over. Blister packs can be provided by the reception staff. Generally speaking, my role is limited to delivering or collecting medications.**

**[…]**

**LB: When you were waking client on the floor, the impression from interviews was you were tapping him on the arm?**

**RL: I can't remember. We do have CCTV. My recollection was I was shaking him, I had cupped right elbow in left hands, some research that this area of the body aids compliance which was partially in my mind, then I was shaking his other shoulder**

**LB: So you don't believe you were tapping his arm?**

**RL: Might have been *slapped leg making sound***

**LB: Do you think that is appropriate?**

**RL: Context dependant, I know it wasn't ideal and so it is a question of what is the priority. In terms of the timeframe, him leaving without meds and him being brought in by paramedic. If he had another fit and hit his head. The patient didn't wake up from GP and nurses approach of gentle vocal signals. Didn't feel it would work. At some point later in the afternoon he got up on his own, further indication he was not excessively intoxicated. Think if I had had another 30 secs he would be up and awake. It is all context as to whether it was appropriate or not.**

**LB: You felt it was appropriate?**

**RL: I was in shock, I had just been verbally abused, but it was probably not appropriate. What would have been appropriate for a GP to have been there to have either inflicted pain in a clinical manner to bring a person around, such as the twisting of skin. GP twisted my skin when I was 13 when I fainted. But no it probably wasn't appropriate - certainly wasn't appropriate to take medication out of the case**

**[…]**

**LB: How frequently do you have supervision?**

**RL: Don't have supervision as much as I should with SM. He has no health or social qualifications (should be 6-8 weeks). I have clinical supervision from KS every 6 weeks, I think we have had 3 sessions.**

**RL: My sessions with SM, I have had 3 on time, a cycle of it being put off had started again which was very frustrating. When the next session is not booked after meeting it is set up to fail, had not had a session with SM for about 3 months.**

> **RL: Clinical supervision with KS, roughly every 6 weeks had been regular, we had had 3 sessions.**

18. The Claimant's interview was the first occasion on which CCTV of the reception area had been mentioned to Ms Betts. She did not consider it necessary to obtain this, given the witness accounts she had a already received. It was by then unavailable in any event, as it had long since been overwritten. No one, including the Claimant, had thought to suggest this be retained during the 30 days it would still have been available.

19. Ms Betts prepared an investigation report and this was dated 22 February 2018. She found the Claimant had a case to answer on the following allegations:

> **1. That, on 9th November 2017, RL allegedly acted in a manner outside of his professional conduct when dealing with a patient:**
>
> > **a) That RL physically touched a patient in an inappropriately forceful manner.**
> >
> > **b) That RL attempted to administer medication to a patient who was intoxicated.**
> >
> > **c) That RL attempted to administer medication outside of his professional capacity.**
>
> **2. That, following the incident, RL's professional conduct was inappropriate when interacting with colleagues.**
>
> **3. That this behaviour is in contravention of the requirements placed upon employees of Oxford Health NHS Foundation Trust and falls below the standards expected under the Trust's Code of Conduct.**

Disciplinary [patient incident]

20. The Claimant was required to attend a disciplinary hearing in this regard.

21. The Claimant had a further consultation with occupational health on 6 April 2018. This included he was suffering with anxiety and depression but was well supported by medical colleagues and family.

22. In email correspondence during May 2018, the Claimant requested the CCTV footage and also that one or both of the receptionists be obtained as witnesses. Ms Betts' approach had been to carry out interviews with those suggested to her by HR and this had not included the receptionists. Both were called to give evidence at the disciplinary hearing by the Claimant.

23. The disciplinary hearing took place on 5 June 2018. The panel comprised Mr McGrane, Clinical Director of the Community Directorate and Ms Buckman, Head of Social Care. The Claimant was represented by his trade union. Witnesses gave live evidence, namely Dr Shaffer, Dr Warren and Mr Moore. Along with the two receptionists, Ms Bradley and Ms Liddle.

24. Drs Schaefer's and Warren gave evidence consistent with their statements, the former also saying:

> **RS You've got a patient who has a fluctuating consciousness. Putting it all together, including the fact he had fallen, was intoxicated, he's fluctuating, he was brought in by paramedics. It was obvious to me. It's inappropriate to have a guy without nursing or medical training to intervene. I would expect Richard to say, "can I have a doctor or Nurse to help?" It is unsafe to have a non-medical professional to administer medicine. Then also there is that general agitation and the shouting and slapping.**
>
> **PM You mention you've had previous experience of Richard acting outside of his boundaries of his role. Can you expand on that?**
>
> **RS In the 11 years I've worked here, there's typically two incidents per year where Richard has struggled with knowing the limits of his role; when to seek help; when to recognise what behaviour is safe or practical with patients and others. We've been trying to give relevant training and counselling with Richard on this. Richard's role requires high levels of self awareness, and an awareness of when to seek help; when to involve clinicians, when there are risk issues, when to maintain that relationship with partnership organisations. It's a repeating pattern.**
>
> **PM Finally, during the meeting with Steven, do you think it was a clear instruction he gave to "to take the afternoon off"; was it a clear managerial instruction, or ambiguous and could have been a request?**
>
> **RS No, it was crystal clear.**

25. Mr Moore praised the Claimant, referring to his brilliant work but also said he had "dropped the ball" at times and these concerns had to be raised and addressed with him. He said he had made a management request to the Claimant to leave the premises following this incident.

26. Ms Bradley did not think the Claimant had been forceful with the patient, although she also said her line of vision had been obscured. She said he had been "tapping" the patient. She did not see any slapping. Ms Bradley said it was difficult for her as no-one had asked her to write a statement at the time of these events.

27. Ms Liddle said the Claimant was tapping the patient on the shoulder trying to wake him up. She didn't think the Claimant was being aggressive or forceful and could not recall seeing Dr Schafer attend the scene.

28. The Claimant gave his account. He referred to the earlier abusive patient before going on to speak about his interaction with intoxicated patient, which was the subject of the disciplinary allegations. His account included:

> **I made an executive decision that I shouldn't have done, based on wrong information, I know I shouldn't have taken the tablets out. I was in executive mode in my head, I didn't know what was happening and didn't know the paramedics had done a hand over sheet. I should have stopped and clarified. I was concerned - as everyone had just gone - that he's going to get overlooked. These things happen, and the information I had was that he needed his medication to keep him from having another fit.**

29. During the disciplinary, the Claimant's responses to questions were often lengthy and indirect. He brought in many themes and issues, some of which did not appear to relate to the matters he was being asked about. The Claimant admitted speaking inappropriately to Dr Schaffer and also receiving a clear management instruction to leave the workplace and take the afternoon off.

30. Ms Buckman asked the Claimant about his responsibility as a social worker, to refer himself to the HCPC (at that time the regulatory body for social workers) once he had been suspended from work. The Claimant said he was not aware of that.

31. Ms Buckman emphasised the need for social workers to understand the limitations of their role and asked the Claimant whether he had been trained in medication management. He said he had not.

32. Ms Buckman also asked the Claimant about supervision:

> **MB In regards to supervision, there are two different kinds; firstly there is management supervision, which appears to be problematic in regards to how regularly you have it with Steven. Is that accurate?**
>
> **RL Yes. There are a couple of ways to do meetings and supervision well. Such as you agree when the next session should be, at the end of each one. This was starting to not happen. All the old anxieties about when i can next bring up my issues comes up, as no date has been set. There was that unnecessary patient death I was concerned about, I started filling in my significant events form, only for that to be removed. The learning points were all removed. So then I had to challenge Steven: "Please do not remove these points that I've had to put back in." Do I go above his head when that happens? I sometimes do. A service manager also acknowledging in my last disciplinary, that "Richard was entitled to have a laptop and a trust phone, and has one now"; I had to wait two and half years for those. It took being subjected to disciplinary process for me to get them. How does a practitioner - how does anyone - raise it through the trust? It's difficult when the service manager buys into a picture that's painted, like today, through only one lens and not through others. Thankfully the receptionists provided a bit of another lens, but it is difficult**
>
> **MB You were having sessions with a GP?**
>
> **RL Yes finally, after years and years.**
>
> **MB I'm curious why you are having supervision with a GP and not a social worker?**
>
> **RL Previously I attended social work forum and they were a life blood to me.**
>
> **MB You haven't done this recently?**
>
> **RL Once it finished, there hasn't been anything else since. The group social work things, my friends don't go to.**
>
> **MB There is a regular social work forum at the Warneford.**

33. Whilst the Claimant spoke about the subject of supervision with the decision-maker (who was also the Respondent's Head of Social care) he did not then make the point he does in these proceedings, namely that he was in need of social work led supervision and the absence of this was a factor in his behaviour toward the patient.

34. The Claimant had recently obtained a medico-legal report in connection with a road traffic accident claim. This included a diagnosis of anxiety and depression. He was asked about this:

> **MB […] You referenced the diagnoses you once had. Where did you get the diagnosis from?**
>
> **RL From an expert consultant, via insurance company, after a road traffic accident. Occupational health have a copy. I did inform them about the diagnosis.**
>
> **LBr You did acknowledge that about the diagnosis.**
>
> **MB Are you receiving treatment?**
>
> **RL Yes. Currently Mirtazapine from my GP for nights. Via OH, I am accessing counselling. As a consequence of the road accident happened after my father's death, there is a view that I'm struggling to adjust to both. There is also CBT for long distance driving. I haven't done any long distance driving since the accident, because I feel safer not doing them. I'll be doing some driving lessons.**
>
> **MB Is this a driving instructor that does CBT techniques?**
>
> **RL Yes, my insurance offered it an accepted it. I haven't had the details yet.**
>
> **MB Is this a formal course of counselling sessions- 6 sessions. Are you having that?**
>
> **RL No, that's not the only avenue they have.**
>
> **MB Could you elaborate?**
>
> **RL It's OH's discretion, the counselling.**
>
> **LBr I think OH can extend it**
>
> **PM We are trying to establish whether you are currently being supported by OH ?**
>
> **RL Yes, as a result of this process. Not before. I only became aware of the diagnosis in March this year. My insurers nudged me towards seeing mental health professionals. I didn't want to go down that route, but then I realised that maybe something was there. It's a tough one.**
>
> **MB It's very personal, I only raise it because they are issues you brought up, and so we needed to explore them.**

**RL It would have been inappropriate for me not to have mentioned them during this process. They're a pertinent fact.**

**CW We do advise you to do that in these cases.**

35. Notably, the Claimant did not say that his behaviour toward the patient was caused by his anxiety and depression.

36. The Claimant confirmed he had not spoken to the paramedics. Somewhat confusingly, the Claimant then went on to say the patient had not been with the paramedics and had walked in himself, whereas in his earlier statement he had said the patient walked in with the paramedics.

37. The Claimant then gave an account of the interaction:

**RL It was seven months ago. I was walking to him whilst clapping. I also tweaked his foot with my own.**

**AM Is that normal practise?**

**RL I am a trained reflexologist**

**AM But trust processes wise?**

**RL We're probably told not to do it that way. If it had been a friend or a brother, I would have done it the same way.**

38. The reference to reflexology was somewhat puzzling. The Claimant was not trained or employed by the Respondent as a reflexologist. Returning to Claimant's account of his actions:

**AM Did you consider a risk of him choking on the pills, bearing in mind he wasn't conscious?**

**RL I wasn't aware, but had he been awakened I wouldn't have given the drugs.**

**AM You were aware of that at the time?**

**RL I would have made the decision once he roused ?**

**CW The intention was to hand him the medication, not feed it to him?**

**RL Absolutely.**

**AM You mention holding the patients elbow; when was this?**

**RL He wasn't rousing, so I dropped to his level. He did it then.**

**AM. And the shaking?**

**RL Just on the shoulder.**

39. The Claimant's trade union representative put the position in the following way:

**We agree there is a case to answer for, and Richard has put his hands up for a lot of things today. In terms of forceful contact, we have witnesses with conflicting views, with nearer witnesses in reception contradicting those who came out of the practise rooms, so I think this point is not supported by the evidence. Richard did admit he could have handled it better though. He also admits it was wrong of him to take the medicine out for the patient. He says neither will happen again. In terms of conduct, it was a stressful environment with difficult circumstances, and the witnesses agree to this. Richard is clear that in future, if an instruction is unclear, he will refer it to a higher point. We see this as misconduct, considering the conflict around the main point, rather than gross misconduct.**

40. The Claimant's trade union representative did not rely upon a diagnosis of anxiety and depression as explaining his conduct or say it stemmed from a lack of social worker-led supervision.

Final Written Warning [patient incident]

41. After a lengthy adjournment, the panel returned its decision, which was to impose an 18 month written warning. Oral reasons were given at the time and the decision confirmed in a letter of 11 June 2018, which included:

**Having listened carefully and considered all the evidence, the panel concluded as follows:**

**1. That on the 9th November 2017 you allegedly acted in a manner outside of your professional conduct when dealing with a patient, specifically:**

**• That your physically touched a patient in an inappropriately forceful manner.**

**There is no doubt that you physically touched the patient (referred to as Mr A in the Disciplinary Report) and we heard differing views on whether the contact was considered forceful by the witnesses. The absence of CCTV footage made it difficult to reconcile these differing views. Having said that, the acknowledged 'kicking/ nudging' of your foot and the 'clapping' as you walked towards the patient was wholly inappropriate.**

**• That you attempted to administer medication to a patient who was intoxicated.**

**You attempted to administer medication to a patient who was intoxicated. This is upheld through your own admission. In doing so, you placed this patient at potential risk.**

**• That you attempted to administer medication outside of your professional capacity.**

**In attempting to administer medication by your own admission, you acted outside of your professional capacity. Throughout the Hearing we have heard evidence that makes us fundamentally question your understanding of your professional responsibilities and understanding of regulations applying to your scope of professional practice.**

> **2. That following the incident, it is alleged your professional conduct was inappropriate when interacting with colleagues.**
>
> **Your behaviour following this incident was inappropriate and unprofessional. You suggested that this was due to your 'state of mind' although it was apparent that you failed to recognise that this could also have placed your patients at risk. You did not appreciate that your mind set also applied to your next patient.**
>
> **3. That this alleged behaviour is in contravention of the requirements placed upon employees of Oxford Health NHS Foundation Trust and falls below the standards expected under the Trust's Code of Conduct.**
>
> **Your behaviour does contravene the Trust's Code of Conduct and the requirements placed upon you as a Trust employee and as such is misconduct.**
>
> **Therefore, the panel has concluded that due to the significance of the behaviours demonstrated towards the patient, the potential risk this posed to the patient and in addition your inappropriate interactions with your colleagues, you will receive a Final Written Warning for a period of 18 months with immediate effect. You will also be referred to your professional body, 'the 'Health Care Professions Council' (HCPC). A formal and robust capability process will be put in place on your return to work which will include actions that I expect you to engage with to improve your understanding of your professional responsibilities, your professional role boundaries and communication with colleagues. This actions plan will specifically focus upon areas of work where you may not agree with colleagues or management. This process will be regularly reviewed and will be in place for a period of 6 months to assess your performance in your role.**
>
> **Mary Buckman will conduct a formal review of your job description and will also have oversight of the capability process in her capacity as Head of Social Care.**

42. The Claimant did not appeal against this sanction.

Support and CAP

43. A further occupational health report was produced on 24 September 2018. This provided that the Claimant was still suffering with anxiety and depression, although he was improving. It was recommended that his hours be reduced as a reasonable adjustment and also:

> **It is also really important that Richard has regular & appropriate 1-1 clinical supervision, and a mentor that he can easily access if he has concerns.**

44. On 24 October 2018, the Claimant had a meeting to discuss his return to work. In the course of this, it was agreed that before he began seeing patients again a “clinical supervisor” would be put in place. The Claimant told us that when he used this expression he was referring to social work led supervision. We have some doubt about this. Supervision by a social worker would be professional

rather than clinical. The term clinical, suggests supervision by medical professional. We note that in the period to March 2018, the Claimant was being supervised by Dr Smith and this appeared to be an arrangement with which he was very happy. In an email of 2 December 2019, the Claimant wrote:

> **[…] prior to being diagnosed (03/18) appropriate, professional supervision was in place with Dr Kate Smith and that this was unjustifiably stopped/removed by disciplinary panel decision June 2018 and not replaced. For the record the appropriate, professional supervision Dr Smith gave me was exemplary.**

45. After the disciplinary hearing a capability action plan was implemented, which involved regular meetings with Mr Moore. The focus of this plan was to ensure the Claimant was aware of and adhered to required boundaries. He did not welcome this form of supervision or its objectives. The Claimant's opinion about this process was influenced by his opinion of the supervisor. The Claimant had a poor opinion of Mr Moore and considered him of low status, describing him as an "tea and biscuits" manager. Given that neither Dr Smith nor Mr Moore were social workers, yet the Claimant was happy with supervision by one and not the other, it is clear his objection was based on other considerations. We do not believe the Claimant agreed with the Respondent's objectives (i.e. him being required to adhere to the boundaries it set) or the person tasked with seeking to achieve that.

46. The Claimant had supervision with Mr Moore on 26 November 2018. They discussed his referral to the HCPC and Mr Moore sought to reassure the Claimant that support would be provided. Mr Moore updated the Claimant as to progress in finding a social worker to provide supervision. Mr Moore had been due to speak with a Mr Mulvaney (a qualified social worker) who it had been hoped could assist. Unfortunately, Mr Mulvaney subsequently advised he did not have the capacity to undertake this role.

47. The Respondent is a provider of healthcare. It employs many medical professionals, administrators and other support workers. The Respondent does not have a large contingent of social workers. There was no other social worker within the Luther Street practice. The Claimant was not part of a social work team, such as one might find in a local authority. Although we were not provided with a precise figure for the number of social workers employed by the Respondent who were more senior than the Claimant (and could, therefore, be considered as potential supervisors) we accepted the evidence there would have been less than 10. Furthermore, the Respondent NHS Trust covers a large geographical area and those who were being looked to for the Claimant's supervision worked in different directorates and were not within his line management chain.

48. Returning to the meeting of 26 November 2018, Mr Moore told the Claimant he would contact Ms Buckman to explore alternatives to Mr Mulvaney. The Claimant was due to take a period of leave shortly. Following this, Mr Moore said that he wanted to meet the Claimant every two weeks. The action plan records that the meeting arranged for 7 January 2019 was postponed because of the Claimant's ill-health. Adherence to the HCPC's standards and the Respondent's policies, along with the need to work within the boundaries and guidelines set for

him, was part of the discussion with the Claimant on this occasion and at each subsequent supervision. Accordingly, the Claimant had the opportunity to raise any concerns or ask for clarity about where the line was drawn, if this was necessary. As part of the action plan, the Claimant was required to revisit and read a number of specified policies, which included information about required professional boundaries. The Claimant assured Mr Moore he had read all of these and several other policies.

49. A further occupational health report of 27 November 2018 repeated the earlier recommendation and included:

> **Richard is fit to work with adjustments (as detailed within introductory paragraph above), further I would support that he does not see patients clinically until he is receiving clinical supervision and has an allocated mentor. Further, in relation to his shoulder, he just needs to be mindful and not lift / move / handle excessive weights / loads.**

50. The adjustment with respect to the Claimant not seeing patients until he had a social work supervisor had already been made, having been discussed and agreed in October. The Claimant appeared satisfied with this arrangement. He did not suggest to his employer that the lack of social work supervision was a bar to undertaking non-patient facing duties.

51. In tandem with the capability action plan (in which the Respondent sought to support the Claimant in complying with its expected standards of behaviour) the Claimant raised a number of his unrelated concerns about the Respondent, including with respect to finance and fundraising (by way of which he sought to have the trust meet his expectations).

52. A further occupational health report was provided on 5 February 2019:

> **As per previous report dated November 2018, I would support that Richard does not see patients clinically until he is receiving clinical supervision and has an allocated mentor.**
>
> **Further, in relation to his shoulder, he just needs to be mindful and not lift / move / handle excessive weights / loads.**
>
> **I would also advise that Richard has a meeting with you and other managers involved, to discuss the concerns he has behind the complaint and to plan how this should be managed going forwards. This is likely to help reduce his anxiety.**

The reference to "the complaint" was the Claimant's concerns about finance and fundraising.

53. Mr Moore sent an email seeking to clarify the latest occupational health report and in reply, on 6 February 2019 he received:

> **The Equality Act legal terminology advises there is an impairment as part of the defining criteria. In relation to RL, it is a shoulder Injury and anxiety, both of which are well managed at present, but not resolved, thus likely inclusion In EA2010.**

> **Adjustments wise, he needs to continue on his reduced hours contract, & shouldn't undertake manual handling, but other than that he doesn't currently require anything else.**

54. In their supervision meeting on 6 February 2019, Mr Moore told the Claimant about a social worker by the name of Lawler, who had been identified as a potential supervisor for him. Mr Moore would be in contact with Ms Buckman to confirm this arrangement. In connection with boundaries, Mr Moore raised a concern with the Claimant that he attended for work on 10 January 2019 when he had not been supposed to. The Claimant said he had not received the email from Mr Moore including the relevant instruction.

55. On 12 February 2019, Mr Moore told the Claimant he was chasing the new potential social work supervisor.

56. On 13 March 2019, Mr Moore told the Claimant he was meeting with a new potential social work supervisor for him.

Police Station Incident

57. Also on 13 March 2019, the Claimant met with Mr Nassar, the Senior Operational manager to whom Mr Moore reported. The Claimant wanted to raise his concern about the Respondent's policy with respect to issuing duplicate scripts for controlled drugs, such as methadone. This was the same issue he had taken up with Mr Moore in 2017. During this conversation, the Claimant disclosed that he had recently attended at a police station and put himself forward as being a drug user who had lost their prescription and needed a replacement. Mr Nassar was very concerned because it appeared the Claimant had lied to the police, which had the potential to damage the practice's relationship with the police and the reputation of the trust more generally. In order to ensure he had correctly captured this disclosure, Mr Nassar sent an email to the Claimant with a summary of the same:

> **You highlighted that in October 2017 a patient reported that they needed a prescription because the one they had was either stolen or lost and that as a consequence of the protocol they were told to visit the police to report it and obtain a police report and come back to the practice. You also reported to me that in this incident the police did not provide the report needed. The patient then returned and was told to come back the following day ( you believe that this is not in line with the protocol). Unfortunately the patient was reported dead over the weekend of 20th - 22nd October 2017 (Suspected possible overdose), which you feel came about as a direct consequence of the current protocol. You reported that you raised several concerns via the practice significant incident review, however it is your opinion that your concerns were not addressed in a satisfactory way.**
>
> **Shortly after the incident you were suspended for an investigation. Now that you are back at work you have revisited the incident mentioned. You expressed to me your continued concerns re the protocol and suggested that the report is not satisfactory. When I asked you if you think this was deliberate you suggested that the way I asked the questions forces you to say yes, as it is the case that the questions were not answered in a satisfactory way. We explored further your concerns we agreed that your**

> **main concern is for patient safety and that you understand that the ultimate responsibility for prescribing lies with the prescriber. As such their opinion is of paramount importance. You also highlighted that you feel that patients are being set to fail when we ask them to obtain a police report as you believe that the police will not provide one as they (the police) have**
>
> **changed their policy on the matter. To verify that patients are being put at risk you informed me that you went to the police station and presented yourself to the police officer as a substance user who had lost their prescription, as a result you were told by the police officer that they no longer provide these reports, and you were given a leaflet re lost stolen property. I challenged your actions as to why you lied to the police officer. You responded by saying to me "do you think they would have told me the truth?" I told you that I have no reason to doubt that they would not tell us the truth and that if we have any concerns regarding any process we would ask directly and if needed we would follow official channels available to us.**

58. As at 18 March 2019, Ms Buckman had found a suitable person to act as the Claimant's social work supervisor.

59. Mr Nassar sent a copy of this email to HR seeking advice about the correct way forward. His concerns were shared by HR and senior managers. A decision was made to suspend the Claimant and commence a disciplinary investigation.

Investigation [police station incident]

60. Given the way in which the Claimant pursues his unfair dismissal claim, in particular because the only criticism made is the fact of the Respondent taking into account his earlier final written warning, it is unnecessary for us to make detailed findings about the investigation, disciplinary and appeal process conducted in connection with the police station incident. Nonetheless, we have made some findings in that regard.

61. The Claimant was suspended on 25 March 2019. A letter sent the following day confirming this decision included:

> **An Investigating Officer will be nominated to conduct the investigation into the following allegations:**
>
> **• That Richard entered a police station and falsely represented himself as a substance user, in order to 'test the system' which could be reputationally damaging to the Trust**
>
> **• That Richard's conduct falls short of the expectations of Oxford Health NHS Foundation Trust and has he contravened the Trusts Code of Conduct (Expectations).**
>
> **Such allegations, if upheld, could constitute gross misconduct as defined under the Trust's Disciplinary Policy and Procedure, a copy of which is enclosed.**
>
> **In view of the nature of the allegations I believe it is appropriate to suspend you from duty whilst an investigation takes place. If it is found**

> **that the allegations against you are unfounded or are less serious than they initially appeared the suspension will be lifted.**

62. An investigation was carried out by Ms Nicklin, Head of Service for Preventative Care.

63. As he had done the last occasion, before being interviewed the Claimant provided his own witness statement. He was then called to an investigatory interview and this took place on 15 April 2019.

64. Ms Nicklin provided her report on 10 May 2019

Disciplinary [police station incident]

65. By letter of 3 June 2019, the Claimant was required to attend a disciplinary hearing:

> **At this hearing you will be given every opportunity to state your case and you will be asked to respond to the allegations:**
>
> **• That you entered a police station and falsely represented yourself as a substance user, in order to 'test the system' which could be reputationally damaging to the Trust.**
>
> **• That your conduct falls short of the expectations of Oxford Health NHS Foundation Trust and that you have contravened the Trusts Code of Conduct (Expectations).**
>
> **[…]**
>
> **At the conclusion of the hearing the panel will decide whether the misconduct allegations against you are upheld. Depending on the facts established at the hearing, there are a number of possible outcomes, including dismissal if the panel upholds an allegation they determine to be Gross Misconduct. However, a decision on this will not be made until you have had a full opportunity to put forward everything you wish to raise, and the hearing has been concluded.**

66. The Claimant provided a further witness statement in advance of the disciplinary hearing.

67. The disciplinary hearing took place on 15 July 2019. The panel comprised Mrs Hewitt, the Head of Urgent and Ambulatory Care and Mr Glover-Wright, Head of Social Care. The Claimant was represented by his trade union. The hearing was adjourned.

68. The disciplinary hearing resumed on 27 September 2019. A decision was made to dismiss the Claimant. This outcome and the reasons for it were confirmed in a letter of 7 October 2019:

> **During the hearing we have heard from the Investigating Officer and yourself that if the same situation occurred you would act in the same way. Therefore, there is little or no evidence that you can reflect on your actions or fully appreciate the implications of your actions.**

**You have stated you have not had clinical or professional supervision for a few years. As a consequence, you claimed you were unable to test out proposed actions and determine whether they might be appropriate. You also stated you felt vulnerable and unable to access relevant support within the team. However, your line manager Stephen Moore has said there were many opportunities to access clinical and management supervision on a daily basis both in a formal and informal context. In addition, Stephen has stated that he has 'an open-door policy' and you accepted this as the case. We have also heard from Stephen that you were not excluded from the Thursday supervision and team activities as you stated, and this could have been facilitated had you requested this. It appears you have not accessed these opportunities to resolve some of the concerns you have described in your personal statement to the panel.**

**You have claimed that the recommended actions from a previous disciplinary process in June 2018 have not been followed. The panel heard from Stephen Moore that actions have been taken to address all the recommendations from the previous process and you did not challenge this account.**

**Stephen Moore described the Luther Street team as open and receptive to practitioner concerns given the intensity of the work undertaken by the team. You have acknowledged you felt vulnerable about disclosing your own mental health needs given the prescribed medication you are receiving and yet found Stephen Moore accessible and receptive to your situation.**

**As a Trust we are not confident that the type of behaviour you have admitted to will not occur again.**

**The Code of Conduct laid out by the Trust requires 'absolute honesty and integrity should be exercised in dealing with NHS patients, assets, staff, suppliers and customers'.**

**The Trust also require that its 'activities should be sufficiently public and transparent to promote confidence between the Trust and its patients, staff and the public'.**

**The panel has concluded that your actions contravene the standards expected and your actions in this respect amount to gross misconduct.**

**The panel considered the sanction carefully. The panel is not sufficiently assured that the type of behaviour you have admitted will not reoccur. The panel believes there is a significant risk of you bringing the Trust into disrepute as your conduct and independent actions have not been carried out with impunity. During the hearing the panel had been made aware of previous disciplinary action, concluded in June 2018. The panel was made aware that you are already subject to a final written warning for acting outside of your professional boundaries. This**

**reinforces our decision that there is a risk of repeated unacceptable and inappropriate behaviour.**

69. Whilst the panel had been aware of a previous history, they did not know the Claimant was then subject to a live final warning at the time of this latest

misconduct. As such, they did not take this into account when deciding to dismiss him.

Appeal [police station incident]

70. The Claimant appealed against his dismissal. The document he prepared included a further account and explanation of his actions. It would be fair to say there were some differences the way the Claimant put matters forward at various different times.

71. His appeal was heard on 28 November 2019. The panel was Mr McEnaney, Head of Finance and Ms Blaylock, Service Manager for Community Services. Once again, the Claimant was represented by his trade union. One of the matters the Claimant sought to rely upon was the absence of "clinical supervision". Attempts were made at the hearing to explore with him, what difference this would have made:

> **MM Have a question, I'm not clinical, but why would clinical supervision make a difference to your decision to go into a police station and do what you did? Isn't this a matter of judgement rather than not receiving professional supervision? And my second question, why wouldn't you raise it with your line manager rather than going to the police station to test the prescriptions protocol?**
>
> **RL In my mind I found a way to allay my own anxieties, losing my prescription, but also to answer the question from a citizen's point of view. I justified it to myself that if I was acting as a citizen who had lost their prescription for mirtazapine, I wasn't doing anything wrong. I went in as a citizen not an employee of the trust.**
>
> **DW I think the question is what is the importance of clinical supervision? and how would this make a difference to your decision to go into the police station, and the second question why not raise it with the manager, to discuss the protocol and ideas around the process.**
>
> **RL The 1st question is difficult, I've not had professional supervision for 4 years, I believe if I had I would have felt more valued, more self-esteem, it would validate me professionally, I would feel accepted, not 2nd rate like I've felt for the past 4 years. The second question it was more around the patient death, I felt that it was part of the reason that the patient died. I didn't feel able to mention it, I had no sense of value in the work place. I have asked repeatedly to see the coroners report to see if there were any omissions in there, but I have never seen it.**
>
> **[…]**
>
> **MM I understand your feelings; however, my particular concern is that you went to the police station to see how the protocol works. I.e. if you lose a prescription you can get a report from the police to get an alternate prescription. To check or change the protocol you should have spoken to your line manager, I want to understand why the influence of professional supervision would influence you in not making this decision and taking this action?**

**RL Can you rephrase the question, do you mean if supervision had been in place?**

**MM My question is how supervision would change your decision to go into the police station and present yourself as someone who has lost a prescription.**

**RL I previously emailed Shafik Nassar with regards to the protocol, I went into the police station in order to gather more information to discuss with Shaffik. Part of me wanted to know what the experience was like, how patients are treated. My experience was positive, the Pc was very friendly, the additional information would be useful to feedback to staff also**

**MM How is the absence of supervision relevant to the action you took?**

**RL It's been a 4-year prolonged process, it's like Chinese torture, I wasn't not thinking straight, not thinking objectively, not felt valued or recognised, the death of the patient was a huge trigger for me, when I came back, I wasn't practicing I was just reviewing old files.**

**[…]**

**How often did you have regular management supervision?**

**RL I was back between November and March, the timing was difficult for meetings, I was on a phased return following sickness absence, I was going home at 2.30/3pm each day. I suppose it wasn't really managed very well, I asked for things and never got them. The whole process has affected me**

**ZM Did you attend team meetings?**

**RL They were once a month, in those 4 months I suppose I attended 3 meetings.**

**ZM And 121 meetings with SM every 4-6 weeks?**

**RL Yes.**

**ZM What was discussed at those meetings?**

**RL Just a list of things.**

**ZM Would there be any time left over to discuss other things, your concerns about anything?**

**RL We would discuss the recommendations and action plan from previous disciplinary outcome, but the recommendations were never really followed through. If they were followed up, maybe I wouldn't be sat here.**

**The allegation is that I went into the police station acting as a drug addict, a patient. There's no evidence of that its purely based on my response to Shaffik. I feel that I've been discriminated against, there have been staff that have disclosed mental health illness and haven't been treated respectfully, so I didn't feel I was able to disclose mine.**

**ZM I'm not clinical, and I'm not familiar with clinical supervision, however the other type (management supervision) I understand that this was available to you, according to the minutes from the last hearing when SM attended, there was an open door policy and management supervision 4-6 weekly, i want to understand what was discussed at those meetings.**

**RL The recommendations of the previous disciplinary panel, there was a list of 1-7 things to discuss. We would discuss those recommendations predominantly. I did raise matters and I emailed the team too, I requested a wording change in the protocol as it undermined the patients. I was raising matters, but didn't feel listened too, I felt I was able to be honest with Shaffik.**

**ZM Why didn't you make reference to testing the protocol with SM?**

**RL I had justified to myself that if I went in as a civilian, which is what I did, that meant I wouldn't have to raise it with SM. I wasn't going in as an employee.**

72. Whilst the appeal outcome included downgrading the conduct from gross misconduct to ordinary misconduct, taking into account his final written warning, the panel decided to reject the Claimant's appeal. This decision was confirmed in a letter of 29 November 2019:

**The trust Code of conduct (C0RP13) is clear on its requirements regarding the conduct of employees and their actions outside of work and states that conduct that may jeopardise the trusts reputation or bring it into disrepute may be dealt with through the Trust Disciplinary Policy. The trust Disciplinary Policy (HR09) describes misconduct outside work which has the capacity to bring the organisation into disrepute or compromise the employee's capacity to operate with impunity on behalf of the trust as Gross Misconduct The panel considered that your behaviour may have been well intentioned but the protocol you were attempting to 'test' is owned by the trust and the team and you made no attempt to involve the team or discuss your plans, despite having the opportunity to do so, before deciding to undertake the 'test'. As a professional member of the Luther Street Team you misrepresented yourself to Thames Valley Police (TVP) which had the potential to compromise the critically important relationship with TVP which could lead to diminished trust of TVP in the Luther Street team and therefore reduced effectiveness of the team for patients. Your action also had the potential for you to have illegally acquired a report to get a repeat prescription.**

**It is the view of the appeal panel that whilst the scope of the risk to the trust in this instance is limited the risk of compromise to the team was high.**

**In mitigation the panel considered the following:**

- **Supervision - Although the specific professional supervision as prescribed in the outcome of the previous disciplinary hearing has not taken place, there has in fact been plenty of opportunity for you to discuss ideas and concerns with the team and managers both formally and informally and on a multi-disciplinary basis.**

**• Your assertion that "you won't do it again".**

**• Recognition that you have been going through a difficult time, particularly in relation to the death of a patient.**

**As a result of these considerations we have concluded that it is appropriate to reduce the outcome of the disciplinary panel from gross misconduct to misconduct. However, since there is a live' final written warning that had nine months to run at the time of this incident and that incident too is one where a panel has questioned your conduct as an employee the panel has agreed that the sanction of dismissal determined by the disciplinary panel is appropriate.**

**Recognising the reduction in the decision from gross misconduct to misconduct and in line with our Disciplinary policy, I have arranged for you to receive pay in lieu of your contractual notice period.**

## Law

Unfair Dismissal

73. Pursuant to section 98(1)(a) of the **Employment Rights Act 1996** ("ERA"), it is for the respondent to show that the reason for the claimant's dismissal was potentially fair and fell within section 98(1)(b).

74. If the reason for dismissal falls within section 98(1)(b), neither party has the burden of proving fairness or unfairness within section 98(4) of ERA, which provides:

> **In any case where the employer has fulfilled the requirements of subsection (1) the determination of the question whether the dismissal is fair or unfair having regard to the reason shown by the employer -**
>
> **(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 sufficient reason for dismissing the employee, and**
>
> **(b) shall be determined in accordance with equity and the substantial merits of the case.**

75. Where the reason for dismissal is conduct the employment tribunal will take into account the guidance of the EAT in **BHS v Burchell [1978] IRLR 379**. The employment tribunal must be satisfied:

    75.1 that the respondent had a genuine belief that the claimant was guilty of the misconduct;

    75.2 that such belief was based on reasonable grounds;

    75.3 that such belief was reached after a reasonable investigation.

76. The employment tribunal must also be satisfied that the misconduct was sufficient to justify dismissing the claimant.

77. The function of the employment tribunal is to review the reasonableness of the employer's decision and not to substitute its own view. The question for the employment tribunal is whether the decision to dismiss fell within the band of reasonable responses, which is to say that a reasonable employer may have considered it sufficient to justify dismissal; see **Iceland Frozen Foods v Jones [1983] IRLR 439 EAT**.

78. The band of reasonable responses test applies as much to the **Burchell** criteria as it does to whether the misconduct was sufficiently serious to justify dismissal; see **Sainsbury's Supermarkets v Hitt [2003] IRLR 23 CA**.

79. Where an appeal hearing is conducted then the **Burchell** criteria must also be applied at that stage, in accordance with the decision of the House of Lords in **West Midlands Co-operative Society v Tipton [1986] IRLR 112** and the speech of Lord Bridge:

> **"A dismissal is unfair if the employer unreasonably treats his real reason as a sufficient reason to dismiss the employee, either when he makes his original decision to dismiss or when he maintains that decision at the conclusion of an internal appeal."**

80. After an appeal, the question is whether the process as a whole was fair ; see **Taylor v OCS Group Limited [2006] IRLR 613 CA**, per Smith LJ:

> **46. […] In our view, it would be quite inappropriate for an ET to attempt such categorisation. What matters is not whether the internal appeal was technically a rehearing or a review but whether the disciplinary process as a whole was fair.**
>
> **47. […] The use of the words 'rehearing' and 'review', albeit only intended by way of illustration, does create a risk that ETs will fall into the trap of deciding whether the dismissal procedure was fair or unfair by reference to their view of whether an appeal hearing was a rehearing or a mere review. This error is avoided if ETs realise that their task is to apply the statutory test. In doing that, they should consider the fairness of the whole of the disciplinary process. If they find that an early stage of the process was defective and unfair in some way, they will want to examine any subsequent proceeding with particular care. But their purpose in so doing will not be to determine whether it amounted to a rehearing or a review but to determine whether, due to the fairness or unfairness of the procedures adopted, the thoroughness or lack of it of the process and the open-mindedness (or not) of the decision-maker, the overall process was fair, notwithstanding any deficiencies at the early stage.**

81. General principles in connection with the approach to earlier disciplinary warnings were discussed in in **Wincanton Group plc v Stone [2013] UKEAT/0011/12/LA**, per Langstaff P:

> **37. We can summarise our view of the law as it stands, for the benefit of Tribunals who may later have to consider the relevance of an earlier warning. A Tribunal must always begin by remembering that it is considering a question of dismissal to which section 98, and in particular section 98(4), applies. Thus the focus, as we have indicated, is upon the reasonableness or otherwise of the employer's act in treating conduct as a reason for the dismissal. If a Tribunal is not satisfied that the first**

**warning was issued for an oblique motive or was manifestly inappropriate or, put another way, was not issued in good faith nor with prima facie grounds for making it, then the earlier warning will be valid. If it is so satisfied, the earlier warning will not be valid and cannot and should not be relied upon subsequently. Where the earlier warning is valid, then:**

**(1) The Tribunal should take into account the fact of that warning.**

**(2) A Tribunal should take into account the fact of any proceedings that may affect the validity of that warning. That will usually be an internal appeal. This case is one in which the internal appeal procedures were exhausted, but an Employment Tribunal was to consider the underlying principles appropriate to the warning. An employer aware of the fact that the validity of a warning is being challenged in other proceedings may be expected to take account of that fact too, and a Tribunal is entitled to give that such weight as it sees appropriate.**

**(3) It will be going behind a warning to hold that it should not have been issued or issued, for instance, as a final written warning where some lesser category of warning would have been appropriate, unless the Tribunal is satisfied as to the invalidity of the warning.**

**(4) It is not to go behind a warning to take into account the factual circumstances giving rise to the warning. There may be a considerable difference between the circumstances giving rise to the first warning and those now being considered. Just as a degree of similarity will tend in favour of a more severe penalty, so a degree of dissimilarity may, in appropriate circumstances, tend the other way. There may be some particular feature related to the conduct or to the individual that may contextualise the earlier warning. An employer, and therefore Tribunal should be alert to give proper value to all those matters.**

**(5) Nor is it wrong for a Tribunal to take account of the employers' treatment of similar matters relating to others in the employer's employment, since the treatment of the employees concerned may show that a more serious or a less serious view has been taken by the employer since the warning was given of circumstances of the sort giving rise to the warning, providing, of course, that was taken prior to the dismissal that falls for consideration.**

**(6) A Tribunal must always remember that it is the employer's act that is to be considered in the light of section 98(4) and that a final written warning always implies, subject only to the individual terms of a contract, that any misconduct of whatever nature will often and usually be met with dismissal, and it is likely to be by way of exception that that will not occur**

Reasonable Adjustments

82. Insofar as material, section 20 of **the Equality Act 2010** ("EqA") provides:

**20 Duty to make adjustments**

> **[…]**
>
> **(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.**

83. Whilst a one-off decision might comprise a provision or criterion, this will not always be so. In **Nottingham City Transport Ltd v Harvey [2012] UKEAT/ 0032/12**, the claimant, who suffered with depression and tended to react adversely to stressors, encountered difficulty when using a new automated gate at his place of work, in particular with closing this behind him. In order to avoid anxiety with the operation of the gate, he left work early on three occasions. The timesheet he handed in, however, represented that he had left at the end of his shift. The claimant was dismissed following a procedure he said was flawed, in that it did not involve an investigation of the contribution made by his disability to this conduct and / or accord sufficient weight to his disability as a mitigating factor. The flawed disciplinary procedure was said to be a PCP. The Tribunal found for the claimant on reasonable adjustments. The EAT overturned this decision, both for the absence of a PCP and also lack of disadvantage, per Langstaff P:

> **21. […] the Tribunal erred in law by identifying the particular flawed disciplinary process that the Claimant underwent as being something that fell within the heading "provision, criterion or practice", and […] as showing that because of his disability those aspects caused a disadvantage over others who were not disabled, when it may seem obvious that a failure to consider mitigating circumstances and a failure reasonably to investigate is likely to cause misery whoever is the victim. […]**

84. A one off step may amount to a PCP where it is indicated that the same approach would be followed in the future; see **Ishola v Transport for London [2020] ICR 1204 CA**, per Simler LJ:

> **38. In context, and having regard to the function and purpose of the PCP in the Equality Act 2010 , all three words carry the connotation of a state of affairs (whether framed positively or negatively and however informal) indicating how similar cases are generally treated or how a similar case would be treated if it occurred again. It seems to me that "practice" here connotes some form of continuum in the sense that it is the way in which things generally are or will be done. That does not mean it is necessary for the PCP or "practice" to have been applied to anyone else in fact. Something may be a practice or done "in practice" if it carries with it an indication that it will or would be done again in future if a hypothetical similar case arises. Like Kerr J, I consider that although a one-off decision or act can be a practice, it is not necessarily one.**

85. Pursuant to EqA schedule 8, paragraph 20(1)(b), a person is not subject to the duty to make reasonable adjustments if they neither knew nor could have been reasonably expected to have know of the claimant's disability and that they were likely to be placed at a disadvantage by the relevant provision, criterion or practice ("PCP"):

> **20 Lack of knowledge of disability, etc.**
>
> **(1) A is not subject to a duty to make reasonable adjustments if A does not know, and could not reasonably be expected to know—**
>
> **[…]**
>
> **(b) [in any case referred to in Part 2 of this Schedule]1 , that an interested disabled person has a disability and is likely to be placed at the disadvantage referred to in the first, second or third requirement.**

86. The Equality and Human Rights Commission ("EHRC") EqA Code of Practice identifies factors which may be relevant to the reasonableness of a proposed step:

> **6.28 The following are some of the factors which might be taken into account when deciding what is a reasonable step for an employer to have to take:**
>
> **• whether taking any particular steps would be effective in preventing the substantial disadvantage;**
>
> **• the practicability of the step;**
>
> **• the financial and other costs of making the adjustment and the extent of any disruption caused;**
>
> **• the extent of the employer's financial or other resources;**
>
> **• the availability to the employer of financial or other assistance to help make an adjustment (such as advice through Access to Work); and**
>
> **• the type and size of the employer.**

87. Pursuant to the decision in **Secretary of State for Work and Pensions v Wilson [2009] UKEAT/0289/09** the Employment Tribunal must have regard to:

87.1 the extent to which it would be practicable for the employer to take the steps proposed;

87.2 the feasibility of the steps proposed.

88. When considering the reasonableness of an adjustment the practical effect, objectively assessed is key; see **Royal Bank of Scotland v Ashton [2011] ICR 632 EAT**, per Langstaff J:

> **24 Thus, so far as reasonable adjustment is concerned, the focus of the tribunal is, and both advocates before us agree, an objective one. The focus is upon the practical result of the measures which can be taken. It is not - and it is an error - for the focus to be upon the process of reasoning by which a possible adjustment was considered. As the cases indicate, and as a careful reading of the statute would show, it is irrelevant to consider the employer's thought processes or other processes leading to the making or failure to make a reasonable adjustment. It is an adjustment which objectively is reasonable, not one**

> **for the making of which, or the failure to make which, the employer had (or did not have) good reasons.**

89. A claimant does not, however, need to go so far as to show a 'good' or 'real' prospect, it is sufficient if there is 'a' prospect the disadvantage will be removed or reduced; **See Leeds Teaching Hospital NHS Trust v Foster [2011] UKEAT/0552/10/JOJ**, per Keith J:

> **[17] In fact, there was no need for the tribunal to go as far as to find that there would have been a good or real prospect of Mr Foster being redeployed if he had been on the redeployment register between January and June 2008. It would have been sufficient for the tribunal to find that there would have been just a prospect of that. That is the effect of what the Employment Appeal Tribunal (Judge McMullen QC presiding) held in Cumbria Probation Board v Collingwood (UKEAT/0079/08/JOJ) at 50. That is not inconsistent with what the Employment Appeal Tribunal (Judge Peter Clark presiding) had previously said in Romec Ltd v Rudham (UKEAT/0069/07/DA) at 39. The Employment Appeal Tribunal was saying that if there was a real prospect of an adjustment removing the disabled employee's disadvantage, that would be sufficient to make the adjustment a reasonable one, but the Employment Appeal Tribunal was not saying that a prospect less than a real prospect would not be sufficient to make the adjustment a reasonable one. When those propositions were put to Mr Boyd, he did not disagree with them.**

## Conclusion

Unfair Dismissal

90. The Claimant's argument on unfair dismissal was a narrow one, namely that his dismissal was unfair because the Respondent took into account an invalid final written warning. Whilst the Claimant accepts that, ordinarily, it is not open to a Tribunal to go behind earlier disciplinary sanction, in this case he says it was unfair for the Respondent to rely upon the warning because it had been manifestly inappropriate. We pause here to note, the Claimant does not argue the earlier warning was issued in bad faith.

91. The various matters relied upon as showing that the final written warning was manifestly inappropriate were set out in the Claimant's written closing submissions. We will address these points.

92. Firstly, the Claimant says there was "a failure by the Respondent to give sufficient weight to the evidence of two key witnesses to the 2018 incident. The two witnesses he refers to are the receptionists, who gave different accounts to those of the doctors, in particular not seeing any slapping. He must also mean the incident in 2017. This criticism appears to overlap substantially if not entirely with the Claimant's third point, which is "the decision by the 2018 disciplinary panel to prefer the evidence of two GPs who were not present for the entire incident, and whose evidence the Claimant considers was tainted, over the evidence of two receptionists who were present throughout". Our conclusion is that neither formulation has any merit. The disciplinary hearing panel did not choose to prefer the evidence of the doctors over that of the receptionists, even though it appears to us they could properly have done so. On the contrary, given conflicting accounts from various witnesses including the receptionists the panel

decided to deal with the Claimant on the basis of his own version of the physical interaction between him and the patient. This was the most generous approach that could have been adopted.

93. The Claimant's second point is that there was "a failure by the Respondent to view CCTV footage of the 2018 incident" (again, this must be 2017). Ms Betts did not become aware of the CCTV until the Claimant told her about it during his interview. The Claimant did not then ask for it to be obtained and Ms Betts did not consider it necessary to do so. We pause to note that even if we were required to apply the band of reasonable responses test to a decision not to obtain the CCTV, it is not obvious that Ms Betts' approach would fall foul of that. She interviewed all of the main participants in this event, save for the patient himself (who was unlikely to have been able to help even if he were available) and she concluded this was sufficient. Whilst more might have been done (to see whether there were additional witnesses or search for video footage), it does not follow that no reasonable employers would have thought what Ms Betts actually did was sufficient. In any event, by the time Ms Betts' became aware of the CCTV it was no longer available and could not, therefore, have been included in her investigation and report or be made available to the disciplinary hearing panel. There is nothing inappropriate, let alone manifestly so, in the Respondent proceeding to a disciplinary hearing notwithstanding the video footage was no longer available.

94. The Claimant's fourth point is "the absence of live warnings". An employee may be dismissed for act of gross misconduct, notwithstanding they have an entirely clean disciplinary record. Similarly, a final written warning may be issued for a first offence where that is of sufficient gravity to merit the same. In this case, whilst it is true the Claimant had no live warning, there was a significant history of him failing to respect the boundaries set by his employer and the conduct in question was easily capable of being found to amount to gross misconduct.

95. The Claimant's fifth point is that he was "acting in good faith with the best of intentions at all times". This is something of a double-edged sword. On the one hand, it might be thought better the Claimant had good intention rather than bad. On the other, his failure to respect professional boundaries and act appropriately because he believed he knew what was best for the patient might, reasonably, appear to be a serious risk factor in terms of the likelihood of future misconduct. Whilst the summing up by his trade union representative emphasised the Claimant making admissions and "holding up his hands", it is clear from the notes of the disciplinary hearing that his concessions were mixed in with a very large measure of self-justification and his own complaints about the Respondent.

96. The Claimant's sixth point is:

> **Taken at its highest, he opened medication but nothing more, he nudged the patient's foot, and did some clapping, purely in attempt to arouse the patient – to help him. The patient suffered no harm, and did not complain. Further, the Claimant was unable to properly comprehend the conversation with his manager afterwards. To his credit, all matters which the Claimant readily accepted during the disciplinary process. In my respectful submission, these are not matters which warranted such a severe disciplinary sanction when viewed in the proper context**

97. We do not accept this is an accurate summary of the evidence or even the Claimant's own account, as set out in his witness statement, interview and during the disciplinary hearing. As far as physical contact is concerned, the Claimant told the disciplinary hearing that he had shaken the patient by the shoulder. Mr McGrane explained in his evidence at the Tribunal the difficulties faced by homeless people on the street, who are often the victims of assault. He believed that contact from another persons foot was degrading and liable to be misconstrued, potentially as a physical threat, if it had the effect of waking the patient suddenly. He also believed the clapping and shaking were highly inappropriate. None of this was any part of an approach in which the Respondent had trained the Claimant. Furthermore, there were doctors nearby who could easily have been called to help this patient.

98. The Claimant also admitted removing the patient's medication from its packaging so he could give it to him. They can be no sensible reason for removing the medication from its packaging other than to give it to the patient. The Claimant also conceded that he had done wrong in this. As far as the lack of harm is concerned, that is very fortunate for all concerned. The doctors were, understandably, very worried about the danger of giving medication to the patient whilst he was intoxicated and not fully conscious. It was no part, whatsoever, of the Claimant's role to administer medication to patients. And yet, it would, reasonably, appear to Drs Schaffer and Warren as though that was what the Claimant was about to do. The absence of harm to the patient is, of course, a better position to arrive at than the opposite one. This does not, however, detract from the inappropriateness and risks inherent in the Claimant's approach, which was entirely outwith his job role and caused the GPs to intervene as they did.

99. The Claimant's seventh point is his "diagnosis of Adjustment Disorder (pages 619 – 639 and page 256), anxiety and depression in early 2018 (page 203) (and his cognitive state at the material time) for which he was receiving counselling and taking medication appears not to have been fully considered as a mitigating factor". The short answer to this argument is that it was not put forward as a mitigating factor at the time. The Claimant's health was explored, including the recent diagnosis he told his employer about. If the Claimant believed his mental health had, wholly or in part, caused him to act inappropriately then he had the opportunity to say this and did not. This was not even mentioned in the closing submission made on his behalf by the trade union. The mitigating factors argued for him were that the situation had been a stressful one, the Claimant recognised he had done wrong and would not do so again. His trade union representative also contended the instruction to go home after this incident was unclear, although this latter point was inconsistent with the Claimant's answers during the disciplinary hearing. It is not for the employer to invent the Claimant's mitigation or seek to justify his actions by reference to matters he did not himself advance.

100. The Claimant's eighth point is "the lack of social work-led supervision for several years appears not to have been fully considered as a mitigating factor". Our conclusion on this is similar to that set out in the previous paragraph. There was a discussion about supervision at the disciplinary and the panel included the Respondent's Head of Social Care. This was an ideal opportunity for the Claimant to raise any concern he had about lack of social worker led supervision, if this was a concern for him at the time and / or say that it was a

factor in his misconduct. He did not do so. It is unfair to criticise the Respondent for failing to take into account a mitigating factor which was not relied upon at the time. Furthermore, it is difficult to see how the absence of social worker led supervision could be relevant to the Claimant's misconduct on this occasion. Waking a comatose patient in the manner the Claimant did on this occasion and removing medication from its packaging to give to that person, were actions well outside the Claimant's duties and would seem unlikely to have arisen during a prior supervision as a hypothetical for the supervisor to express an opinion on the propriety.

101. The Claimant's last point is that no mitigating factors were taken into account. No additional factors (i.e. beyond those discussed in the preceding paragraphs) in this regard were identified by Counsel . Our conclusion is the panel took into account the matters the Claimant did put forward at the time before reaching their decision.

102. None of the factors set out above, whether viewed separately or cumulatively, show the final written warning to have been manifestly inappropriate. Even if the relevant test to be applied had been the lower hurdle of range of reasonable responses, we would not have been persuaded Claimant had shown the Respondent went beyond this.

103. The Claimant's trade union representative conceded at the time the Claimant was guilty of misconduct. During the hearing in the Tribunal, Mr Betchley made a similar concession, accepting that a 12 month warning may have been appropriate. He also accepted a final written warning may have been a possibility. He argued, however, that a final written warning of 18 months duration was a severe and excessive punishment. We are not persuaded in this regard.

104. The Claimant acted in a highly inappropriate manner, creating real risks for the patient concerned. There was no good reason for him to act in this way, it was well outside the scope of his job role. There were GPs nearby who could have been called upon to provide medical assistance to this patient. Notwithstanding this, the Claimant took it upon himself to attempt rouse the patient in a manner he had not been trained to by the Respondent and which risked a highly adverse reaction from the patient. The Claimant's approach to the medication is baffling. Fortunately an intervention by the GPs took place before any harm was done. It was, reasonably, open to the panel on the information before it, to consider this amounted to gross misconduct. The position was compounded by the Claimant then refusing to follow a management instruction he had understood at the time to leave the practice and not see patients. Dismissal might have followed in these circumstances. A final written warning was entirely appropriate. There is nothing improper in an 18 month final written warning. There was an argument at this hearing about whether the sanction was a punishment or not. Warnings of this kind have at least two aspects. There is a punishment, as no employee would wish to be under such a warning. The warning is also intended to support the employee, by underlining the seriousness of their conduct in the hope that they will learn from this and not repeat the same. This is especially important where the employee (as here) has difficulty accepting that it is for their employer to say where the line is drawn. Again, even if the relevant test had been the range of reasonable responses we would have been satisfied the Respondent

acted within this. The Claimant comes nowhere near showing the final written warning was manifestly inappropriate.

105. In the circumstances, there could have been no unfairness in the Respondent taking the Claimant's live final written warning into account when deciding to dismiss. For the sake of completeness, however, we note this was not taken into account at all at the disciplinary stage. The panel at that time were unaware of it. Although we do not need to decide the point had it been relevant, we would have been satisfied the panel could reasonably conclude the Claimant's behaviour at the police station amounted to gross misconduct.

106. On appeal, the panel were persuaded to reduce the severity of the Claimant's conduct from gross to ordinary misconduct. They did so on the basis that professional supervision by a social worker had not been put in place (although they noted the Claimant had plenty of opportunity to discuss his ideas and concerns with his manager) the Claimant said he would not do it again and he had been going through a difficult time. This was a generous approach. Nonetheless the panel upheld the decision to dismiss by taking the final written warning into account. Given both the final written warning and the subsequent misconduct shared a common theme of the Claimant acting outside of boundaries, this approach was well inside the reasonable band.

107. The Claimant's unfair dismissal claim is not well founded and is dismissed.

Reasonable Adjustments

108. The first question we must consider is whether the Respondent applied the PCP contended for, namely:

    108.1 The failure to reinstate social work-led supervision from November 2018.

109. Whilst it is conceded the Trust did not instate social work led supervision from November 2018, the Respondent argues there was no PCP as there was no decision to maintain this position and it was simply something about which the Claimant was unhappy. We do not agree.

110. The arrangement between November 2018 and March 2019 amounted to a requirement the Claimant work (albeit not seeing patients) without supervision by a qualified social worker. Whilst this position may have been arrived at by default, rather than a positive decision to deny him the same, it represented an ongoing state of affairs. This was not a one-off decision capable only of being applied to the Claimant. If a hypothetical non-disabled comparator had been employed in the Claimant's role at Luther Street, that person too would have been expected to work without supervision by qualified social worker. This resulted from there being no other more senior social worker employed at the surgery and the need to go elsewhere within the Respondent, seeking to track down a suitable person.

111. Having found the PCP was applied, we go on to consider whether this put the Claimant at a substantial disadvantage. Our conclusion is that it did not.

112. The way this point was put for Claimant is as follows:

> **It is submitted that, because of the Claimant's anxiety and depression, the impact of the absence of social work-led supervision upon him (given the stressful working environment in which he operated) was greater than an individual who does not suffer from these conditions, therefore placing the Claimant at a substantial disadvantage. In his own words, the Claimant describes the lack of supervision as "riding a horse without a bridle."**

113. In cross-examination, the Claimant was asked whether there was any evidence to show that his need for social work led supervision was greater than would be the case for a non-disabled comparator. His answer merely spoke to the need for this generally, rather than identifying any reason why he as a disabled person had a particular need. In closing submissions, the Judge asked Mr Betchley whether there was any evidence to support the proposition set out above. He said there was not. Mr Betchley argued it was obvious that a person suffering anxiety and depression would be put at a substantial disadvantage if they did not have professional supervision. It is not sufficient to answer this question by way of an assumption, rather it is necessary to look at the evidence.

114. Notwithstanding the Claimant's repeated answer in these proceedings that he had been denied "clinical supervision" for many years, the evidence suggests he was satisfied by the arrangements in the period to March 2018, when he was being supervised by Dr Smith.

115. Subsequent to the final written warning and following his return to work in November 2018, the Claimant was then provided with supervision by Mr Moore. That supervision was regular, robust and structured. In particular, given the Claimant's ongoing difficulty in recognising and respecting boundaries, this was a subject to which they returned. The Claimant referred to this as discussing "just a list of things" at his appeal hearing. That description appears somewhat dismissive. The list included very important matters, such as adhering to the Respondent's policies and respecting professional boundaries. The Claimant's dissatisfaction with supervision at this time appears to have stemmed from his objection to the objectives that had been set in the capability action plan (adherence to boundaries set by the Respondent) and low opinion of his supervisor, rather than the fact of his supervisor not being a social worker (which was true of Dr Smith also).

116. During the appeal hearing in particular, the Claimant was asked repeatedly to explain what difference supervision by a social worker would have made. His answers were indirect and difficult follow. The Claimant did not identify any clear difference. The Claimant was also asked why he did not speak to Mr Moore about his intention to go to the police station and gave an unsatisfactory answer. Mr Moore was the obvious person to ask this question of, if it truly needed to be answered. Professional conduct and boundaries were central to their supervision sessions. We find it difficult to believe the Claimant could not anticipate Mr Moore's response if asked and that it was likely he would be told not to do it. The Claimant was receiving relevant supervision throughout the period preceding his misconduct in March 2019. We are not persuaded that the absence of social work led supervision made a material difference.

117. The Claimant's difficulties in respecting professional boundaries in this case, did not involve nice or nuanced questions of social work practice, rather he dramatically overstepped the line drawn by his employer. The Claimant did not need a social worker to remind him of his employers rules and procedures. If he had any doubt about where the line was drawn, he could have asked Mr Moore, which he did not. The Claimant's apparent difficulty in respecting boundaries stemmed not from a lack of advice but rather his belief that he knew best. More than once, whether the question called for such a response or not, the Claimant's evidence at the Tribunal included his duty to his clients coming before any duty owed to his employer. Unfortunately, the Claimant tended to construe the duty owed to his client in a way which conflicted with the boundaries set by his employer.

118. We also took into account the psychiatric report prepared by Dr Morris of 23 March 2018. Whilst this predates the Claimant's return to work in November 2018, his position at this Tribunal hearing was that the lack of social work led supervision had been an ongoing problem for many years. Dr Morris sets out various matters which had previously or were at that time aggravating the Claimant's mental health. These matters did not include any concern about supervision.

119. During the period immediately before and after he returned to work, the Claimant was assessed by occupational health. He was identified as being disabled person with a need for reasonable adjustments. In particular, a recommendation was made that his hours be reduced in order to assist with his mental health. Whilst a recommendation for "clinical supervision" was also made, in the interim the approach advised was that he not see patients. That adjustment was made. The Claimant was excused from seeing patients until supervision by a social worker had been put in place. This is an arrangement the Claimant himself had requested and the Respondent agreed to it. There was, subsequently, no complaint from the Claimant about it. The conclusion we draw is the Claimant felt any need for social work supervision would arise from his patient interactions and that whilst these were in abeyance, so was the need.

120. Professional supervision by a qualified social worker is plainly something which an employed social worker ought to have access to (we note the LGA standard in this regard). There is, however, no evidence to suggest that the Claimant had a greater need in this regard because of his anxiety and depression or, to answer the statutory question, that he was put at a substantial disadvantage when compared with non-disabled people.

121. Accordingly, the Claimant's reasonable adjustments discrimination claim does not succeed.

122. Notwithstanding our conclusion on the question of substantial disadvantage, in case we are wrong about this we have gone on to consider the other questions which would arise.

123. We were not persuaded the Respondent had knowledge, actual or constructive, that the Claimant was at a substantial disadvantage because of the absence of social work led supervision. Whilst the need for this had been identified in occupational health reports, before the Claimant came back to work it was

agreed he would undertake no patient facing duties until that supervision was in place. This would, reasonably, appear to have fully removed any disadvantage stemming from this particular form of supervision not yet being in place. Furthermore, the Claimant did have regular and robust supervision in connection with the matters which had been a cause of concern for his employer, in particular the adherence to boundaries.

124. Nor would we have found the Respondent failed its duty to make reasonable adjustments by reason of not having implemented social work led supervision sooner than it did. Regular supervision by Mr Moore was put in place. In the absence of the Respondent being able to source a senior social worker to provide supervision to the Claimant on his return, he was then excused from seeing patients. This adjustment was supported by the Claimant at the time and consistent with OH advice. Thereafter, the Respondent attempted to secure a social work supervisor for the Claimant. This was not, however, an easy task. As a set out above, the Claimant was not part of social work team, such as one often finds in local authorities. He was the only social worker employed at the Luther Street surgery. The other social workers working for this Respondent were spread geographically and across many directorates. Few of these were sufficiently senior to be able act as the Claimant's supervisor. It was necessary, therefore, for the Respondent to find someone elsewhere within its organisation, who was able, willing and had capacity to discharge this responsibility. A supervisor appeared to have been found in November, shortly after the Claimant returned to work. Unfortunately the arrangement with that person fell through. The Respondent then sought to find a replacement and was unable to do so immediately. Enquiries went on and when an appropriate person was identified, in March 2019, this was overtaken by events in light of the Claimant's suspension. The Respondent made the reasonable adjustment it could at the time. There was no other step it was reasonable for the Respondent to have to take at this time, given the circumstances.

Time

125. Whilst given our finding, the Claimant's discrimination claim fails on its merits, there was a jurisdictional point with respect to time. The limitation period for the Claimant's claim began to run in November 2018 (this point was agreed). When the claim was eventually presented, it was nine months late.

126. The Claimant's explanation for this delay, as advanced by Counsel, is that he did not know he could bring a claim of any sort until he was advised about this by his trade union. We do not accept that a highly experienced social worker such as the Claimant would be unaware he could bring a claim of discrimination in the Employment Tribunal. As far as the time limits are concerned, it appears the Claimant made no effort whatsoever to investigate how and when he might bring a discrimination claim, following his return to work in November 2018. Our conclusion is the Claimant chose not bring a claim because his employment was continuing. When, however, he was dismissed, he decided to complain not only about that but also earlier events. To that extent, we reject the Claimant's explanation for delay.

127. The absence of a good reason for the late claim does not in and of itself answer the question whether it is just and equitable to extend time. We have gone on to

consider the question of prejudice to the Respondent. Mr Green said there were two elements to this, firstly the Respondent would have to face the discrimination claim and secondly, the recollection of witnesses such as Mr Moore had faded. We were not persuaded by Mr Green in this regard. The first element, having to face the claim, would have been precisely the same if the claim were presented in time and so delay did not change this. As far as the second element is concerned, it is true the witness evidence of Mr Moore was somewhat lacking in detail about the steps taken to find a social work supervisor. This was, however, remedied significantly when in re-examination Mr Green took Mr Moore to the capability action plan, which Mr Moore had completed at the time and this included a number of references to specific steps taken towards finding and securing the supervisor, together with relevant dates. It appeared to us the problem was less the result of a nine-month delay and more Mr Moore not having been required to provide a written account or consider contemporaneous documents until many years later, which was a choice the Respondent made in preparing to contest this litigation. The Respondent could have gone to Mr Moore very much sooner, following receipt of the Claimant's claim and had him address these matters, then confining his recollection into writing. Furthermore, we were in fact satisfied by the evidence Mr Moore gave and so it is difficult to see where the prejudice lies. Whilst we have found against the Claimant on his discrimination claim that has only followed a detailed scrutiny of the evidence. The position on merits of the discrimination claim was not so clear on the face of pleadings, such that it would have been a relevant consideration. In all circumstances it is just and equitable to extend time for the Tribunal to consider the Claimant's late claim. For the reasons already given, however, the reasonable adjustments claim fails on its merits.

Employment Judge Maxwell

Date: 14 November 2022

Sent to the parties on:

15 November 2022

For the Tribunal Office: