EMPLOYMENT TRIBUNALS

Claimant: Ms Vivienne Ward

Respondent: Greater Manchester Mental Health NHS Foundation Trust

Heard at: Manchester Employment Tribunals

On: 3-7 July 2023 and 12 July (In Chambers)

Before: Judge Miller-Varey, Ms A Jackson and Ms E Cadbury

Representation

For the Claimant: Represented herself

For the Respondent: Mr Paul Sangha of Counsel

JUDGMENT

1.The unanimous decision of the Tribunal is that:

a) The proceedings on all bar one of the complaints contained within the claim were not brought before the end of 3 months starting with the date of the acts to which the claim relates in accordance with section 123(1)(a) of the Equality Act 2010.
b) Nevertheless it is just and equitable to permit all of the complaints within the proceedings to be brought out of time in accordance with section 123(1)(b) of the Equality Act 2010.
c) None of the Claimant's complaints of failure to make reasonable adjustments in breach of the Equality Act 2010 are well founded. The claim does not therefore succeed.

REASONS

THE ISSUES

1. This is a claim arises from the Claimant's employment with the Respondent in the role of deputy ward manager. The claim is exclusively concerned with alleged failures to make reasonable adjustments.

2. The Claimant remains employed by the Respondent but now works in a different unit to the one relevant to these proceedings.

3. Prior to the hearing, a draft list of issues (LOI) had been prepared by the Respondent. This drew upon an earlier Case Management Order of Employment Judge Macdonald of 9 February 2022. We spent time at the start of the first day (before hearing any evidence) going through the issues. They required clarification only in respect of the period of time for which the Respondent admits both that the Claimant was disabled and that it had knowledge of her disability.

4. In the course of this process, the Claimant made an application to amend her case to include allegations of whistleblowing detriment. This was declined and oral reasons given. The chief grounds for refusal were that in essence the application was an attack on the decision of Employment Judge Butler who had previously refused the application (both initially and on reconsideration). In the absence of a change of circumstances – and none was identified by the Tribunal – the only route to adding the refused claims was by way of an appeal. The Claimant has not made an appeal.

5. The resulting *final* LOI are set out in the annex to this judgment (Annex A).

THE HEARING

6. The hearing took place in Manchester Employment Tribunal between 3 and 7 July 2023. We spent time deliberating on 12 July 2023.

7. On Friday 7 July 2023 we expressed that the target for delivery of the judgment was 28 days but we hoped it would be sooner. In the event, it was not possible to conclude deliberations on the afternoon of 7 July. We re-convened in Chambers on the earliest possible date of 12 July 2023. The Tribunal Judge in the period since has had to take some leave, unexpectedly. The Tribunal Judge apologises to both parties that there has been a delay. The responsibility for that lies with the Tribunal Judge and not the other members.

8. The Claimant gave evidence and was cross-examined. She asked the Tribunal to rely on statements from six other witnesses none of whom attended. The statements of Martyn Ward, Kevin Ward and Laura Kennedy were identified by the Tribunal as being relevant to the issue of liability. The Respondent did not oppose them being received but made submissions about the weight that could be attached to them.

9. For the Respondent we heard evidence from:

   - Alexandra Davidson
   - Carla Page (whose second name has changed since the time of the relevant events but who for ease we refer to by her then name)

10. We also admitted a statement from Sarah Powell who did not attend. She dealt with a grievance raised by the Claimant; she was not connected to decisions about the claimed reasonable adjustments.

11. There was an agreed bundle of documents (spanning three lever arch files) and numbers in square brackets in these reasons refer to that bundle There was also a separate bundle of witness statements. We use the suffix “WB” to refer to the pages of the witness bundle.

12. We explained our reasons for various case management decisions carefully as we went along and also our commitment to ensure that the Claimant was not legally disadvantaged because she was a litigant in person. We regularly explained the process, visited the issues and explained the law when discussing the relevance of the evidence. During cross-examination the Tribunal Judge helped the Claimant to frame questions about points she wished to challenge.

13. We are grateful to Mr Sangha who, whilst putting his client’s case with appropriate vigour and clarity, never veered from the obligation to co-operate and assist the Tribunal. This extended to putting his submissions together in writing overnight so that the Claimant would have a good opportunity to consider her response.

FINDINGS OF FACT

14. Having considered all the evidence, we find the following facts on a balance of probabilities, and such additional facts as are contained in the analysis and conclusions section below.

15. The parties will note that not all the matters that they told us about are recorded in our findings of fact. That is because we have limited them to points that are relevant to our determination of the issues.

Background

16. The Claimant is employed by the Respondent, a mental health trust. Her current role is at Moorside Hosptial [p.16 of 96WB] as deputy ward manager.

17. At all times relevant to these proceedings she was employed as deputy ward manager at the Woodlands Hospital. This is a community-based facility for older patients located in Salford. It comprises of three wards Holly, Delamere, Hazelwood. We are not concerned particularly with Holly. As to the other two:

- Hazelwood Ward is an 18-bed mixed ward for older people who are living with functional illness such as bipolar, schizophrenia and depression.
- Delamere Ward is 16 bed all female ward for older patients - predominantly those suffering from dementia or functional mental illness.

18. There are 100 staff on three wards [p.80 of 96 WB]. The Delamere ward tended to rely to a greater extent than the other two wards on non-permanent staff. Non-permanent staff were provided from two sources: NHSP (NHS Professionals) which is owned by the Department of Health and agency bank staff i.e., those from privately owned agencies that provided bank staff.

19. The Claimant has conditions of chronic obstructive pulmonary disease (COPD), chronic asthma, anxiety, depression and PTSD. Her respiratory conditions placed her in the category of clinically extremely vulnerable during the Covid-19 pandemic.

20. For context, we pause to say something about the Claimant's history of working across these wards and that also of Ms Davidson. Ms Davidson's inactions on behalf of the Respondent are a key criticism at the heart of the Claimant's case.

21. The Claimant commenced work with the Respondent in 1999. In November 2019 the Claimant was appointed to Band 6 deputy ward manager of Holly Ward.

22. Ms Davidson has worked at Woodlands since 1999. In 2017 she was promoted from Band 6 staff nurse to Band 7 Ward Manager of Hazelwood ward. The Claimant and Ms Davidson have known each other for many years.

23. The Claimant worked from home between the receipt of her letter requiring her to shield as an extremely clinically vulnerable person and 11 August 2020. In this period, she was inevitably unable to provide day-to-day clinical leadership on her ward. Instead, she undertook a range of tasks remotely including providing remote supervision to the clinical team and undertaking remote ward rounds.

24. On the first occasion she returned to the unit she started her first shift on Hazelwood Ward. That was short-lived. She was transferred to Delamere

Ward on 14 September 2020 under the management of Ruth Orwin-Taylor.

25. All subsequent events with which we are concerned relate to the Claimant executing the role of Band 6 deputy ward manager on the Delamere Ward.

26. Following her first return, the Claimant was required to shield again. This happened around 30 December 2020 following the escalation of the northwest into Tier 4.

27. Meanwhile in February 2021 and lasting until August 2021 Ms Davidson was asked by the Respondent to be the ward manager of Delamere Ward. Thus, she became the direct line manager of the Claimant. We set the scene that way as the context of communication between these two people has some bearing on how matters progressed and the claimed PCPs.

28. The Claimant returned to work on Delamere ward 1 April 2021. We will come to the detail of what then happened but it is convenient to record in a single paragraph our findings about the Claimant's attendance at work from that date until 16 September 2021 when the claim was issued. For each period we give information about the Claimant's health which is set out on her GPs fit notes (more commonly referred to as sick notes), where they are available[1]. In any other case we identify the source. Accordingly:

- 26 April – 3 May 2021 inclusive – upper respiratory illness [p.252]
- 10 May – 14 May inclusive - migraines [p.74 of 96 WB]
- 2 June 2021 for four weeks. GP notes "work related stress" and "headache affecting her mental/ physical health
- 30 June 2021 – 1 September 2021 – GP notes "Work related stress/headache affecting mental health"
- 2 September 2021 for 4 weeks - GP notes "work related stress/headache affecting mental health".

29. Thus, the Claimant did not return to the Woodlands unit to work at any point after 2nd June 2021. She remained on sick leave and in October/November 2021 she was redeployed to Safire Ward, Park House, North Manchester General Hospital.

Covid-19 on the Unit and at the time of the Claimant's return in April 2021

30. The greatest acuity of patients with Covid-19 had been in the first wave of the pandemic, i.e., from March 2020. Holly and Delamere had both been badly affected at that time by a high incidence of the virus. When the

[1] These were admitted on 7 July 2023.

Claimant returned on the first occasion (this lasted between 11 August 2020 and 7 December 2020, [p.44of 96 WB], the unit had been Covid-19 free.

31. The Claimant became aware shortly before her return in April 2021 that there were Covid-19 positive patients at Woodlands. This came via another member of staff.

32. In response to the Claimant's email asking if there was anything that she needed to know prior to her return, Ms Davidson telephoned the Claimant. She informed her that there were Covid-19 positive patients on the ward.

33. Ms Davidson instructed the Claimant that pending a Covid-19 risk assessment (for which the Claimant should complete Part A), the Claimant should not enter into the red or amber zones, or isolation units of the hospital.

34. The risk assessment in question is one brought in by the Respondent in reference to those returning from shielding. It harnessed a number of elements including discussion of adjustments and a health and wellbeing plan, that includes reducing the risk of catching Covid.

35. No aspect of the risk assessment (or its completion) features in any of the 5 PCPs. However, the circumstances of its completion are strongly disputed by the Claimant. This is one of three specific factual challenges which she makes to the evidence of Ms Davidson – one other being directly in reference to PCP2. The Claimant places significant weight on these matters as tending to show Ms Davidson is not to be relied upon as an honest witness. We address them in some detail therefore.

The completion of Part B of the Risk Assessment and challenges to Ms Davidson's credibility

36. We find the Claimant, under advice from the RCN or the RCN's solicitor, stalled in returning Part A [p.1118 refers and p.76 of 96 WB].

37. She was reminded by Ms Davidson [p. 216]. She was not on duty at the Unit on the day that she completed it. That day was 14 April 2021 and the Claimant received notification that she had completed her part successfully [p.225]. Part B (the part to be completed by Ms Davidson on behalf of the Respondent in her capacity as the Claimant's manager) was before us and bears the date of 14 April 2021 too [p.219-214]. This has been disclosed close in time to the final hearing. On the balance of probabilities, it was not completed by Ms Davidson in the physical presence of the Claimant.

38. In her witness statement Ms Davidson says [p. 72 of 96 WB, para. 24] that she completed Part B of the assessment "with her [the Claimant] on the same day". Notably though, Ms Davidson did not give any positive account of where or how it was completed. She did not do so in her evidence at the hearing. Rather, her evidence to us was that she could not do that section

without the Claimant and she disputed that she would have done it on her own.

39. In this respect we are satisfied that Ms Davidson when preparing her statement, relied much more on how she expects she *would* have dealt with it, in contrast to relying on any actual, specific memory. That is hardly surprising given the passage of time and what we find were significant additional pressures placed upon the management of the unit.

40. Our finding is that Part B was done without any specific meeting or conversation with the Claimant. We accept that the Claimant is likely to have insisted on having her PTSD condition mentioned which it was not [p.219]. Also that by this time she had developed concerns about a number of different issues that had arisen on her return. She was becoming zealous in her formal dealings with the Respondent, and that brought with it, an eye to detail.

41. From this however, we do ***not*** take either that Ms Davidson attempted to mislead the Tribunal in anyway. Nor do we consider that any lack of adherence to the Respondent's expectations for completion of such a risk assessment is a marker of anything untoward. We exclude that it was not done in person to prejudice the Claimant or because Ms Davidson did not take it seriously. She and the Claimant had met and discussed at length closely related matters just 8 days previously. The Claimant herself in Part A when asked about further concerns relating to safety at work as a result of Covid-19 [p.220], and to detail them, commented only "discussed with my manager in supervision". Realistically, the ground had already been covered and Ms Davidson considered she was able to address Part B as a result.

42. Somewhat out of chronological order, but for the sake of convenience, we also deal with the second (non-PCP related) credibility issue taken against Ms Davidson by the Claimant. We received additional disclosure documents concerning this on the last day of the hearing. Emails of 21 May 2021 were placed before us whereby a trainee advanced clinical practitioner, Ms Hilton, wrote to a consultant psychiatrist at the site in reference to a relative of his who had been admitted. He asked that if visits were restricted, whether the patient could have a video call.

43. Ms Hilton wrote back that Ms Davidson, to whom the email was copied, " is contacting family". It is possible to read this as being a phone call in reference to an in-person visit at 4pm that day. The only evidence of Ms Davidson, given that her evidence concluded before this issue arose, is an email from her within the chain. That says that she [Ms Davidson] had left a message on an answer machine. She was then directed to ring another relative.

44. Ms Davidson was asked by the Claimant whether visitors were allowed to use the back door. Her questions arose against an immediate backdrop of questions relating to mask provision in early April 2021. This was some weeks before the proposed visit on 21 May to which the emails relate. We

say that because the resulting answers of Ms Davidson are not specifically anchored in the same time period as the May 2021 emails.

45. Ms Davidson's evidence to us was that visitors "did not happen" when she was managing the ward, she did not witness it and that she would never have allowed it. We did not have the benefit of her comments on the emails that were later produced. There is no clear evidence of any actions by Ms Davidson after leaving a message for the relative, in what *seems* to be furtherance of a proposed visit. The chain ends.

46. Putting this together, and weighing it alongside other evidence, we are not satisfied this is any sensible basis to discount Ms Davidson's evidence on this point or more generally.

47. We certainly follow how it might be argued that Ms Davidson's answer was incomplete in that, impressionistically at least, it conveyed that in-person visits were anathema to her and by implication, she had no involvement at all with them, at a time when they were not permitted.

48. However, having thought about this closely, these points remain (a) we do not know what actions Ms Davidson took on 21 May 2021 – did she in fact telephone about an in-person visit; there was also a video call to be arranged and her email confirming attempted contact with the family did not delineate the purpose. It was also within 18 minutes of Ms Hilton saying *"a video call was being arranged as we speak"* (b) Ms Davidson had no opportunity to comment on the emails and give her explanation and (c) we formed the very strong view that Ms Davidson was committed deeply to the well-being of staff and patients, is a highly principled professional, took Covid-19 very seriously and was undertaking an important leadership role in very challenging circumstances, over a long period. We have taken particularly positive note of the way that she dealt with the Claimant's supervision on 6 April 2021 (turning around the Claimant's express wish no longer to be managed by her) and the way she dealt with friction that arose between two wards regarding loans of equipment.

49. In the context of a busy unit experiencing lots of novel ways of working with continuous but fluctuating degrees of risks to all, Ms Davidson had to balance competing considerations. Her tone with the Claimant was consistently calm but concerned.

50. Ms Davidson was not complacent about the Claimant nor did she bear any ill will to her or even detectable impatience. Both she and the Claimant have a good knowledge of mental health issues and we find Ms Davidson was genuinely understanding about the Claimant's own mental health conditions. She says she likes to consider herself a compassionate manager. We agree that she is.

51. To this we would add that having had the chance to read the many exchanges between the Claimant and Ms Davidson in this period what is plain to us is that, concurrent with issues reflected in the PCPs, the Claimant felt dissatisfied on a range of matters not the subject of this claim. A number of these she attributed to Ms Davidson. These included what the Claimant saw as the unwarranted removal of her facility to book bank shifts and an incident before the pandemic in December 2019 which (from her perspective) the Claimant freely acknowledged had an irreversibly damaging effect on their relationship [p.212]. She devoted most of a full page of her witness statement to it [p.25 of 28 WB]. No one says (and we certainly do not consider) this was connected to any issue of discrimination.

52. We do not criticise the Claimant. She was managing her own health conditions in April 2021 and concerns about returning to work. She was also quite clearly determined, despite the personal implications, to return to her role. She enjoys her job vastly and finds great occupational rewards in it. Since her promotion in November 2019 she had been thwarted from fulfilling her new role for any extended period. But nevertheless, in attitude we find she was by turns combative and defensive in the period between April and June 2021. This was only partly in reference to Covid-19 concerns or lack of appropriate regard to her disabilities. As well as the matters we have identified in paragraph 51, it was partly in reference to the changed employment landscape.

53. Ms Davidson and the Claimant remained in the early phases of a new professional relationship, with a different hierarchy and challenges that neither of them could ever have foreseen. We find the task of the Claimant's long-standing colleague and former peer, Ms Davidson, in managing the Claimant was not easy. This is relevant because whilst we found the Claimant to be (a) thoroughly transparent in her evidence to us (b) a committed professional (c) to have brought these proceedings based upon an honest belief in the Respondent's legal failings to her as a disabled person, subjectively she has had difficulty in unpicking her legal complaints from what are, objectively analysed, dissatisfactions with non-Equality Act matters. This also means she has a tendency to seek to bring them within its purview, such is her sense of injustice.

54. It follows from the above and what is said in paragraph 87 below, we do not find Ms Davidson's credibility to be undermined in anyway. We deal with the factual challenge in relation to PCP2 separately below.

55. We summarise now the key events of relevance between the period of the Claimant's return to work and 2 June 2021. We make more detailed findings below specific to the individual PCPs. In the case of PCP2 (occupational health) these extend to 7 September 2021, being the final occupational health assessment before the issue of these proceedings on 16 September 2021.

Events between 1April and 2 June 2021

56. The Claimant returned to work on 1 April 2021. She travelled there by car and used her own face covering whilst walking in the car park. The car park was strewn with discarded masks of staff who had removed masks as they left the premises. There was an overflowing bin outside the entrance. The Claimant personally was experiencing raised anxiety because unlike her previous returns to work there were now, to her knowledge, Covid-19 positive patients on the unit. She proceeded to enter the unit, wearing her own face personal face covering and did so using the airlock, in common with other staff who were not wearing any face covering or mask.

57. On 1 April 2021 and on another occasion a few days later when the Claimant entered the unit, there were no masks available in the reception area of the hospital. They had not been replenished. On these occasions the Claimant had to walk, wearing her own personal facemask down a corridor to the bottom where there was the entrance to the three wards. On one occasion only was it necessary for her to enter her own ward before being able to obtain a hospital-provided facemask.

58. On 3 April 2021 the Claimant received information from another member of staff that earlier that morning they had found a plastic bag in the Delamere Ward kitchen containing dirty pots labelled, "Hazlewood Ward Suspect Covid" p.215].

59. Emails from the Claimant to Ms Davidson followed. It was Easter bank holiday weekend. The Claimant recounted the information she had received and asked why staff were bringing suspected Covid dirty pots to a Covid-free ward, also that she had heard that the staff of Hazlewood Ward

were also coming onto Delamere. She referenced her return to work and her need to *"feel safe"* [p.215]. She was instructed to discuss the matter with the nurse in charge as the sending of the email would not assist. Exchanges followed and Ms Davidson assured the Claimant she would ascertain what was going on. She says she would find out where the bag was coming from and speak with staff [p.214]. It was a difficult exchange. The Claimant asked for a referral to occupational health, saying that she felt unsupported on her return to work, would be contacting her GP and also making complaint that she had come to learn Ms Davidson had requested the deletion of bank shifts of the Claimant's [p.213].

60. An important supervision meeting took place on 6 April 2021 [p.1118]. It lasted between one and two hours. This was unusually long. This took place between the Claimant and Ms Davidson with a brief appearance by Trea Simpson, the Unit's Services Manager. The nature of the supervision is a two-way discussion which focuses on the areas of well-being, the employee's role, development and review of appraisal objectives as well as, ordinarily, issues such as annual leave sickness and HR issues. In the context of this supervision, development and review of appraisal objectives was omitted and struck through. The second page comprises 5 points bearing the heading grievance. The notes were written up by Ms Davidson and signed by both parties. We will return to the discussions regarding occupational health in more detail. An important finding is that in the course of the meeting the Claimant identified that she no longer wished to be managed by Ms Davidson but by the end of the supervision, the Claimant was content to remain on the ward, working under Ms Davidson.

61. On 23 April 2021 the Claimant and other staff on the Delamere Ward were informed that there was a Covid 19 patient. The Claimant was placed on alternative arrangements for her shifts which meant that she would be working on Hazlewood Ward and Holly Ward. The purpose was to limit the risk to her.

62. The Claimant began to suffer with migraine which resulted in her absence from work until 14 May 2021. On her return her permanent request for night shifts was declined. The Claimant entered into stage 1 absence management which was a source of concern to her. This was then managed by Ms Davidson. She commenced a further four-week period of sick leave on 2 June 2021.

63. On 11 June 2021 the Claimant raised a formal written grievance. This was substantially concerned with a request for the reasonable adjustment of night shift working because "day shifts are having a detrimental impact on my [the Claimant's] physical and health wellbeing" [p. 302 – 303].

64. This was a request for reasonable adjustments in reference to a disabling condition not pleaded as a condition in these proceedings. Before us the Claimant connected the migraines - factually - to increased anxiety. Even if the admitted disability of anxiety is the root cause (in essence migraine is a symptom of heightened anxiety or potentially "something arising"), it is not necessary for us to consider these. The Claimant had not previously alleged a substantial disadvantage on this basis. We did not suggest or consider an amendment application. Against the backdrop of the renewed, failed amendment issue for whistleblowing and the absence of any available, sufficient medical evidence corroborating the connection with the admitted disabling conditions, that would not be reasonable or proportionate. Our own finding too is that the reason night shift working was not granted was because the role of a Band 6 deputy ward manager carries the expectation of remaining, for the majority of the time, on days where it is possible for them to support the overall ward manager. Band 5 staff were expected to rotate to cover the night shift. The position of the Respondent is not therefore obviously unreasonable and certainly not irrational.

65. From around 9 June 2021 [p.82 of 92 WB], the Claimant's sickness absence was managed by the operational manager of the unit, Ms Carla Page. This was with the Claimant's consent. Since 2017, Ms Page has been matron/operational manager which is a Band 8 role. She has accordingly been, since their respective promotions, the direct line manager of Ms Davidson. Ms Page has responsibility for leadership and governance of the unit and is also responsible for workforce planning, performance and operational oversight.

66. On 11 June 2021 the Claimant raised a further grievance with Ms Page.

67. On 15 July 2021 the Claimant attended an occupational health assessment and a report followed. The Claimant's sickness absence was reviewed by Ms Page.

68. A grievance meeting took place on 25 August 2021 at which the Claimant requested redeployment to another area.

69. On 7 September 2021 the Claimant attended a further occupational health assessment and a report was issued.

70. The Claimant's grievance outcome was provided on 22 September 2021. The Claimant in between times issued proceedings.

Facts around PCP1 – Allowing staff into the airlock without wearing masks

71. Staff access and exit all three wards on the unit by a main entrance which is also used by visitors. There is in addition a large delivery area where it is possible to enter the building. There is also a 2nd side entrance. The side entrance door goes straight onto the Delamere Ward. The Claimant had by this stage had her first vaccination but awaited her 2nd. She was doing regular lateral flow testing as were most of the other staff. The evidence about third-party agency staff doing regular testing was less clear.

72. The main entrance comprises two horizontally parallel automatically opening glass doors. The opening is timed such that they can never both be open simultaneously. Once the front set of sliding glass doors is open, the rear entrance doors are closed. At that point incoming people to the unit experience the sliding doors close behind them. Thereafter for about 7 seconds people remain locked within space between the 2 doors. The inner-most doors then release. The area between these 2 sliding doors has been referred to in the proceedings as the airlock.

73. The purpose of the airlock is to keep vulnerable patients who are being treated on a non-voluntary basis, as safe as possible.

74. The dimensions of the airlock are 2.6m x 3.5m. On the outside door was a sign regarding social distancing but it was not in particular reference to the airlock itself. There were no markings on the floor. They only began in the reception. There was no limit indicated on the number of people who should occupy the airlock.

75. Masks were not provided outside of the airlock but near to reception once through the second internal set of glass doors.

76. We are satisfied that as a matter of policy [pp.568 - 575] everybody working in "all areas or visiting a hospital setting" including clinical staff when using shared corridors, kitchens, bathrooms or travelling to and from other work areas were required to wear a face mask. The policy specifies that trust issued masks will need to be worn in clinical and non-clinical areas, of which one description is an office. The policy drew a distinction

between face coverings and masks which were classified as medical devices. The edition date of the policy is 2/11/20 but we are satisfied it remained in force as at April 2021.

77. The infection control team risk assessed the whole site. The airlock was not classified by the Respondent as a room and accordingly was not subject to a specific risk assessment for covid purposes. This emerged from Ms Page's evidence.

78. We find there were periods when the airlock was used more than others. This was when shifts changed. Relevant here is that all wards operate 4 shifts namely 7:30 AM to 3:30 PM, 1 PM to 9 PM, and 7:30 AM to 7:45 PM and 7:30 PM to 7:45 AM. Consequently, the entrance, and correspondingly the airlock, was busier at the start and end times of these shifts. The Claimant says she had a fear of people running towards the airlock when she was in it. We do not find this reflected any concerning experience that the Claimant had. The higher numbers were a product of arrival and departure times being common to a number of staff.

79. The highest number of people inside airlock was 6 or 7 at one time. Ms Page recalled a maximum of 3 at one time. We find the Claimant's experience was honestly related and that the beginning and end shifts could see as many as 6 or 7 the higher number. Minimum and maximum numbers did not particularly change with the pandemic.

80. People did not wear either a mask or indeed a face covering consistently when in the airlock. Nor did they observe social distancing – this was the Claimant's experience over the days of her return leading up to 6 April 2021 when it was raised at supervision. That is the very reason why she raised it.

81. When the Claimant raised the concerns she felt about the airlock, Trea Simpson suggested the Claimant approach the matter by standing back and waiting until the airlock was empty before entering. The Claimant did not disagree or suggest this would be an inadequate way of addressing her concern. She did not suggest any other steps.

Facts around PCP2 – not making Occupational Health on request/ routinely delaying such requests

82. Following her return to work, the Claimant first requested a referral to occupational therapy in her email of 3 April 2021 to which we have already made reference. This was the subject of further discussion between the Claimant and Ms Davidson during the lengthy supervision of 6 April. The record of the supervision includes boxes for describing, in reference to different criteria, what was discussed and what actions arose. In reference to the Claimant's well-being the form commented, "p*ersonal issues trying to resolve and being defensive when asked or challenged... viv aware and working on it"*. The action in the adjacent box is "*referred to OHIO re-counselling"*. OHIO is the name given to the Occupational Health service.

83. In a lower discussion box the notes record *"discussed recent events leading to discussions about grievance"* the adjacent actions box says "*referred to Ohio re-anxiety re-Covid*". We have seen the resulting referral which employed a standard pro forma [p.1118-1119]. The former gives as the reason for referral:

> *Viv has returned from work after shielding*
>
> *she has high expressed emotions/anxiety around Covid 19*
>
> *she is aware this is affecting her work*
>
> *she also has personal issues she is finding difficult*
>
> *she requires counselling and has requested a referral by myself she is anxious about self referral*

84. Pausing there, although nominally completed by Ms Page, we find these words are those of Ms Davidson. We heard and accept evidence that owing to sheer pressure of work they assisted each other with tasks depending on respective workloads and convenience. The words are likely to have been a cut and paste.

85. The Claimant's case and evidence is that based on the conversation, there ought to have been two occupational health referrals made. She contends that Ms Davidson knew and appreciated that the issues which arose were discrete; on the one hand referral for counselling for her personal issues and consideration of her Covid-19 related anxiety and by extension, consideration of adjustments.

86. The Respondent submits this is disingenuous, and a retrospective attempt to assert that the Respondent unreasonably failed to deal with a request, utilising for this purpose the two references to occupational health which the supervision record, happens to include.

87. Our finding is that there was no agreement or clear consensus between the Claimant and Ms Davidson about the need for two occupational health referrals. Ms Davidson, as the terms of the referral which came from her, demonstrates had understood that the counselling was to address both personal issues and Covid-19 anxiety. There is nothing within the supervision record which we find to be inconsistent with this. The supervision was unusually long and touched on a wide range of subjects, including shared personal reflections on family matters. As we have mentioned, the Claimant appeared to accept a strategy for personal risk management when using the airlock. She did not persist with discussions about other adjustments. In those circumstances Ms Davidson honestly and reasonably emerged from the supervision believing the Claimant's wish was for counselling for two matters.

88. We reject the Respondent's submission that the Claimant has contrived this point after the fact. We consider that in a diffuse conversation involving a mix of professional and personal discussion, it is quite understandable some ambiguity about actions arose. The difference in their understandings is also quite subtle. The fact the Claimant did not later stress "two referrals" on 20 April 2021 when told she needed to self-refer for counselling, does not demonstrate this is somehow all "after the fact".

89. On 20 April 2021 Ms Davidson shared with the Claimant a response received from the occupational health and well-being provider. It said they were unable to process GMMH counselling requests unless made via EAP. Ms Davidson said to the Claimant *"sorry they will not accept a referral from myself as the request is for counselling ect"* [sic,p.241]. She was directed to self-refer and told of a new online app where CBT was available.

90. On 12 May 2021 the Claimant duly confirmed that she had undertaken a self-referral. She commented that she would telephone to see how long the waiting time was.

91. The issue regarding occupational health was not then touched on again until 2 June 2021 in response to the Claimant being unable to attend work as a result of migraines and her saying "*she felt nights would help reduce any further sickness"* [p.281]. Ms Davidson said as follows:

> *"I'm also concerned that it was a night shift you was working and you continue to suffer with your migraine, I don't want to become unwell therefore I will refer you to occy health"*[p.281]

92. The Claimant commenced sick leave the same day and reported to Ms Page on 2 June that she had been signed off for 4 weeks with work-related stress.

93. Ms Page and Ms Davidson discussed the intended occupational health referral. They both had concerns about whether the adjustment of working on night shifts would in fact be of assistance to the Claimant in circumstances where she had recently been unwell due to migraine on a night shift, plus there are less staff meaning less support for those who become unwell. Ms Page arranged the sickness absence review on the 14 June 2021, a time when the Claimant remained off work. The Claimant said she would not be attending. On 14 June 2021 Ms Page enquired of Lisa Quinn, HR adviser, whether occupational health could review the Claimant to see whether or not nights could be recommended as a reasonable adjustment. It is clear from her email [p.305], that an appointment was then already in place for 28 June 2021 to review night working. Ms Davidson had therefore actioned this promptly. Ms Page asked whether in reference to that appointment, the reason for referral could be changed to include a long-term sickness review as well as discussions about adjustment/support that could realistically be implemented to support the Claimant back to work.

94. Ms Page became aware that the consequence of modifying the referral meant the existing appointment was automatically cancelled. We are satisfied entirely that this was a genuine error. Ms Page had no wish to cause delay. Her motivation was to make the assessment which the Claimant had to attend as encompassing and as efficient as possible. She duly made attempts to contact the Claimant directly to update, ultimately reverting to communicating through her RCN representative. She did so promptly on 15 June 2021 which was also the same day as the Claimant got notice of the cancellation. Ms Page also made efforts to retain the original appointment.

95. The Claimant attended the occupational health assessment on 15 July 2021. The report contained advice that ongoing mental health symptoms were a barrier to the Claimant returning to work in any consistent effective capacity. A workplace stress risk assessment was recommended. The Respondent was advised to consider a short period of night working to support recovery and return to work if operationally feasible as a temporary measure. The assessor expressed hope that with psychological support the Claimant would be able to return within the next 6 to 8 weeks.

96. We accept Ms Paige's evidence that because the Claimant remained on sick leave (the most recent fit note of 5 July 2021 signed her off from work between 30 June and 1 September 2021), she did not progress the stress risk assessment nor a short period of nights. This was against the backdrop of the unequivocal assessment, in our view, that the Claimant would not be fit to return at all sooner than 6 weeks from 15 July.

97. Occupational health next arose for consideration at a long-term sickness meeting which took place on 28 July 2021. During this meeting the

Claimant has requested redeployment. Ms Page referred the Claimant to occupational health for consideration of that matter. She did not do so until 16 August 2021 and forwarded details of the resulting appointment almost as soon as they were received on 17 August.

98. The Claimant in between times on the morning of 16 August 2021 exchanged messages with occupation health directly and was told by them that no referral had yet been received.

99. Ms Page did try to bring forward the appointment and the initial appointment planned for 20 September [p.368 – 369] took place earlier by telephone on 7 September 2021. The Claimant remained on sick leave under a new fit note. The assessment that followed [p.375] found that the Claimant was suffering from ongoing anxiety and would require further intervention in order to receive a level of well-being consistent with the return to work. She was found not fit for work in any capacity at present until an alternative role could be found. Permanent redeployment was recommended to an inpatient ward elderly or adult acute at North Manchester which the Claimant considered would be safer.

Facts around PCP3 – not making sure that used face masks were disposed of effectively

100. We find that the Respondent's premises extend to and include the car park. The trust is responsible for management of that area. This was the province of facilities/housekeeping team. There was no written policy regarding collection of PPE refuse from the car park at the time of the Claimant's return to work.

101. There were a number of yellow bins in the car park which could be used for the disposal of PPE including masks.

102. There were a lot of strewn discarded masks in the car park on the day of the Claimant's return. This was acknowledged by Ms Davidson. The Claimant's witness Matthew Harrison also supports this. The abandoned masks were not personal coverings but masks which had discarded having been worn inside the premises. The bins were overflowing on these occasions, a factor which contributed significantly to the strewn masks. We say that because we consider NHS staff highly unlikely to have littered willfully in the hospital grounds. We find the masks were overwhelmingly masks that staff had worn in the green areas. Red areas (i.e. places in which patients who tested positive for Covid 19 were placed) had designated stations for donning and doffing inside the unit .That staff were the culprits of the abandoned masks is a corollary of there being substantially fewer authorised visitors in this period. We find that the Claimant experienced the situation once on her return and again on another occasion shortly after 1 April 2021.

Facts around PCP4 – Not always having masks available for staff

103. When the Claimant returned to work on 1 April and once again a few days later there were no masks available in the reception area of the hospital. There was a specific place for them to be available. There was a nearby store to which the staff had access with their passes, in which stocks of masks were stored. However, at this stage there was no written direction in place for the replenishment of stocks by this means. Not all staff, from the external bank i.e. non-NHSP. bank, would have the facility to obtain access to this.

104. The Claimant's own practice was to use her personal face covering until she got through the airlock when she changed it for one provided by the hospital. She experienced on no more than 2 occasions, walking down the corridor wearing her own personal face covering which she maintained from the airlock, whilst other staff members walked along and/or passed her who were not wearing masks, there being none available. Those staff had not worn their own coverings in the airlock so effectively continued without any barrier from the car park area through to the entrance of their respective wards.

105. The issue of availability of masks was not discussed in the supervision of 6 April 2021. During the hearing, we received by way of additional Respondent disclosure, an email of Trea Simpson of 29 April 2021 to Ms Page and Ms Davidson. This refers to the twice-daily PPE checklist. The attached document, a completed version of this checklist dated 29 April 2021 and timed at 11.15am, indicates a series of standards in reference to stock levels of PPE.

106. These standards extend to PPE stations outside wards. It does not encompass the mask station at reception.

107. We are also satisfied that the PPE checklist was, on 29 April, of very recent origin as an audit tool. The writer indicates how long the task took her and the new place on the network where "these" (in reference to the checklist) could be saved and which had only been set up only the day before.

108. We received no evidence of a lack of masks on the ward.

109. We find the Claimant was aware of PPE in the stock room.

Facts around PCP 5- Allowing staff to move freely from ward to ward

110. The claimed PCP is that of allowing staff to move freely from ward to ward. However, the Claimant acknowledged that movements of qualified staff in medical or other emergencies was not something she challenged as requiring an adjustment. In reality, the PCP is that of allowing staff to move freely from ward to ward *other* than in an emergency.

111. From the beginning of the first wave of the pandemic in spring 2020 the Respondent confined movements between the three wards to limited purposes. We have not found there to be any specific formal written policy to reflect this. Our finding is that, as a matter of practice, permitted movements extended to a number of things over and above lending necessary help in emergencies:

- sharing of patient monitoring medical equipment, including important items such as blood pressure monitors; and
- also movements with dirty crockery (pots), in order that one ward could use the dishwasher of another.

112. Both before and during the pandemic, it was regularly the case that the dishwashers (each ward had its own) were in disrepair. In non-Covid times, the expectation of the unit was that staff would gather used crockery from patients and use their ward's dishwasher to clean them. There was not a practice of returning them to any central kitchen. Correspondingly, when dishwashers were not working, facilities were shared between wards. Again, in non-Covid times, there were no infection control measures surrounding this practice. The same dishwashers were used for the personal crockery of the staff.

113. There was an informal change to this standard practice of free movements implemented following the start of the pandemic. The first was that when intending to use the dishwasher of another ward (there being common meal times to all wards) the unit borrowing the dishwasher of the other ward, would wait until sufficient time had elapsed for the washing of the other wards pots to have taken place. Only then would they attend and deliver their wards pots for washing.

114. In respect of patient monitoring equipment, both before and during the pandemic, there was a reasonably frequent need to share equipment in order to manage and treat patients. Problems about defective equipment were reported but this did not obviate the need and there could be delays. Outside of pandemic times, normal infection control procedures, including the cleansing of the equipment after use by each patient, took place. There was no change to this practice . However over-layering both this and the movements in relation to dishwashers were that masks were provided (and the face covering policy applied), PPE stations were situated outside each ward and green, amber and red zones were

designated and maintained depending on the risk of Covid-19 and these indicated the corresponding level of PPE to worn.

115. The Claimant's own experience of actual movements which caused her concern as being prejudicial to her was not one to which she was directly privy. Rather, it was the incident reported to her by other staff who had encountered potentially Covid infected pots on the morning of 3 April.

116. This was discussed during the supervision of 6 April 2021. Ms Davidson on 7 April, we find, reminded staff of the adjusted movement practice. She said as follows:

Thankyou for all you [sic] hard work especially during this latest COVID-19 outbreak.

I have had many staff concerned from various staff regarding cross contamination across the wards, which is understandable during this pandemic

Just to clarify it is impossible for staff not to attend other wards at times, especially during response to alarms; However please can we keep staff attending other wards to a bare minimum and only go if necessary

If you have to attend another ward please ensure that all infection control and PPE is utilized effectively before entering and leaving another ward

I appreciate it's a difficult time for everyone and very anxiety provoking, but lets all be kind to our colleagues and understand how difficult it is on ALL wards and support

...

Please don't hesitate to contact me if you need to discuss further.

The issue of movements practice was not raised again by the Claimant including in her written grievance of 11 June 2021.

LAW

Jurisdiction

117. The Equality Act 2010 (EqA 2010) provides time limits for bringing claims. The provisions relevant to this case are as follows:

123 Time limits

(1) Subject to section 140B, proceedings on a complaint within section 120 may not be brought after the end of—

(a) the period of 3 months starting with the date of the act to which the complaint relates, or

(b) such other period as the employment tribunal thinks just and equitable

…

(3) For the purposes of this section—

(a) conduct extending over a period is to be treated as done at the end of the period;

(b) failure to do something is to be treated as occurring when the person in question decided on it.

(4) In the absence of evidence to the contrary, a person (P) is to be taken to decide on failure to do something—

(a) when P does an act inconsistent with doing it, or

(b) if P does no inconsistent act, on the expiry of the period in which P might reasonably have been expected to do it"

118. We considered **Lyfar v Brighton and Sussex University Hospitals Trust [2006] EWCA Civ 1548, CA** and **Commissioner of Police of the Metropolis v Hendricks [2003] ICR 530, CA** in respect of the correct approach to continuing acts. The Tribunal should look at the substance of the complaints in question — as opposed to the existence of a policy or regime — and determine whether they can be said to be part of one continuing act by the employer.

Discretion to extend time – just and equitable

119. The tribunal has the discretion to extend the time limit for a discrimination claim to be presented by such further period as it considers just and equitable (section 123(1)(b), EqA 2010). A tribunal has a wide discretion when considering whether it is just and equitable to extend time. The Tribunal also had regard to the cases of **Adedeji v University Hospital Birmingham NHS Foundation Trust [2021] EWCA Civ 23** which

cautioned against over-reliance on the "Keeble factors". The best approach for a tribunal in considering the exercise of the discretion is to assess all the factors in the particular case that it considers relevant, including in particular the length of, and the reasons for, the delay (as per Underhill LJ in Adedeji at paragraph 37) .

Failure to make reasonable adjustments

120. Sections 20, 39(5) Equality Act 2010 (EqA) and Schedule 8 to that Act operate to impose a duty on employers to make reasonable adjustments, as well defining the circumstances in which an employer will not be subject to that duty.

121. Section 20 EqA 2010 provides (so far as material):

"Duty to make adjustments

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

(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.

122. To establish a provision, criterion or practice (PCP), there must be an element of repetition, actual or potential. In **Ishola v Transport for London [2020] ICR 1204**, the Court of Appeal said that all three words "provision", "criterion" and "practice" *"..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."* A genuine on-off decision which is not the application of policy is unlikely to be a practice: **Nottingham City Transport Limited v Harvey [2013] All ER (D) 267**.

123. According to s.212(1) EqA 'substantial' means more than trivial. This is a question of fact to be assessed on an objective basis and is not a high threshold to satisfy.

124. The disadvantage must be linked to the disability however. Simler P said in **Sheikholeslami** that:

"The purpose of the comparison exercise with people who are not disabled is to test whether the PCP has the effect of producing the relevant disadvantage as between those who are and those who are not disabled,

and whether what causes the disadvantage is the PCP. That is not a causation question a...For this reason also, there is no requirement to identify a comparator or comparator group whose circumstances are the same or nearly the same as the disabled person's circumstances.

49. ... The fact that both groups are treated equally and that both may suffer a disadvantage in consequence does not eliminate the claim. Both groups might be disadvantaged but the PCP may bite harder on the disabled or a group of disabled people than it does on those without disability. Whether there is a substantial disadvantage as a result of the application of a PCP in a particular case is a question of fact assessed on an objective basis and measured by comparison with what the position would be if the disabled person in question did not have a disability."

125. Paragraph 20 of Schedule 8 of the EqA 2010 provides:

20(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—

(a)in the case of an applicant or potential applicant, that an interested disabled person is or may be an applicant for the work in question; and

(b) in any case referred to in Part 2 of this Schedule, 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."

126. It follows that under s.20(1)(b) an employer may succeed in defending an RA claim by demonstrating a lack of actual or constructive knowledge of either the employee's disability *or* the likelihood of the employee being placed at a substantial disadvantage by the relevant PCP. The burden of proving a defence of this kind is on the employer.

Reasonable steps

127. For an adjustment to be reasonable, it is sufficient that there is a prospect of it alleviating the disadvantage: **Leeds Teaching Hospital NHS Trust v Foster EAT 0552/10.** In **Griffiths v Secretary of State for Work and Pensions [2017] ICR 160** the Court of Appeal put the matter in this way:

"So far as efficacy is concerned, it may be that it is not clear whether the step proposed will be effective or not. It may still be reasonable to take the step notwithstanding that success is not guaranteed; the uncertainty is one of the factors to weigh up when assessing the question of reasonableness"

128. As for effectiveness, that falls to be determined in the light of the information available at the time of the alleged breach **Brightman v TIAA Limited UKEAT/0318/19**

129. Consulting an employee or arranging for an Occupational Health or other assessment of the employee's needs is not in itself a reasonable adjustment because such steps do not remove any disadvantage: **Tarbuck v Sainsbury's Supermarkets Ltd [2006] IRLR 664, EAT; Project Management Institute v Latif [2007] IRLR 579 EAT**.

Burden of proof

130. The Claimant is required to establish a prima facie case that the duty to make reasonable adjustments has arisen and that there are facts from which it could reasonably be inferred, in the absence of an explanation, that the duty has not been complied with.

131. The employer's defence (which operates by preventing a duty to make adjustment from arising) is set out already in paragraph 126 above.

ANALYSIS AND CONCLUSIONS

132. The Tribunal noted there is a jurisdictional point (i.e., the time limit point) which if determined in favour of the Respondent would mean that the claim could not proceed. Having heard significant evidence on the entire case, however, the Tribunal determined that it would be appropriate to reach its conclusions on the substantive merits of the claim and, in fact, to do so *before* determining the jurisdictional point.

PCP1

133. We are satisfied there was a practice of allowing staff into the airlock without wearing masks. This was technically contrary to the strict written policy but nothing turns on this. There was no clear instruction for mask wearing and as a matter of fact we do not think staff considered it a requirement. That would be reinforced by the absence of masks being provided prior to entry into the airlock. Ms Davidson in her witness statement in paragraph 43 identifies that once a member of staff finished a shift the mask was thrown into one of the allocated bins outside of the internal airlock doors within the hospital, *before* entering the airlock to exit the building. The submission of the Respondent that there was an expectation that staff in the airlock would be wearing masks, is not sound.

134. On the question of substantial disadvantage we considered this both in reference to (a) placing the Claimant at added risk of contracting Covid which for her would have potentially more severe consequences and (b) increasing her anxiety as somebody who already had the conditions of anxiety depression and PTSD.

135. On balance, we are satisfied that the relative disadvantage to the Claimant is made out on both limbs. Allowing staff to not wear masks removes one potential barrier to transmission if the non-wearer is infected. We consider this a matter which we can fairly and safely deduce absent expert scientific or medical evidence. We reflect that the wearing of masks was made compulsory in shops nationally even when social distancing was in use. It was a policy clearly predicated on the hypothesis of physical barriers in both directions being a useful measure.

136. In turn when compared to a non-disabled person wearing a mask in those circumstances, the Claimant must suffer, as a clinically extremely vulnerable person, some elevation in her net risk of very poor health or worse. We call it "net risk" in reference to the fact there are two risks: the risk of contracting Covid and then the risk of serious illness or worse. The latter we expect to be broadly static for the Claimant– but importantly always higher than a non-disabled person - because the Claimant's vulnerability is the greatest driver.

137. A person who is not clinically extremely vulnerable but otherwise experiencing the same situation in the airlock would experience the same increase in the risk of contracting Covid but their net risk of very poor health or worse, as a result of coming through the airlock, would still be *lower* than the Claimant's.

138. When using the airlock in the standard way - without the modification which the Respondent suggested - we do not think the increase in net risk can be characterised as trivial. That is the test we must apply. We are entitled to take into account the seriousness of the consequences if the risk materialises. We discount that the testing process employed by some of the staff undermines this. It was not guaranteed to be accurate.

139. All of that said, we consider the substantial disadvantage is made out in respect of heightened anxiety more readily. A person who did not have anxiety and PTSD as a disability, would not be apt in the Claimant's situation (ie as a mask wearer amongst other non-mask wearers in the airlock) to experience the same levels of stress.

140. We find that the Respondent was on notice for the purposes of the duty to make adjustments as a result of the supervision on 6 April 2021 but not before. Once the Respondent was on notice, it proposed the modification to the Claimant of waiting until the airlock was free before she used it. This was a reasonable adjustment given the airlock was transparent so it could be seen if staff were already in the airlock before the Claimant joined it. It could also be observed who was intending to exit the airlock from the unit. Also relevant here is the short period of time for which the doors are closed. This meant the Claimant was not being asked to wait excessively to enter, even at times of shift changeovers. The total staff was only 100 across all shifts. To the extent the Claimant feared people running through and entering the airlock after she had committed to using it, this was not communicated to the Respondent nor do we find it was something that tended to happen.

141. The fact that the Claimant in the supervision meeting felt able to express openly her grievance and that she wished to be managed other than by Ms Davidson, satisfies us that she would not have been at all reluctant to express any dissatisfaction with the proposed adjustment. This reinforces that subjectively and objectively, the Claimant was content to manage the disadvantage to her, in that way.

142. The Claimant did not at any point after 6 April raised the issue concerning the airlock again. We find therefore this claim fails on the basis that a reasonable adjustment was made to the established PCP. The Respondent's duty was accordingly fulfilled. It did not arise again because it had no actual or constructive basis to consider that the Claimant was being placed at a substantial disadvantage, following the modified practice being adopted.

PCP 2

143. The Claimant's reasonable adjustments claim in relation to occupational health asserts is there is a PCP of not making occupational health referrals on request. That is what is recorded in the list of issues which does not have the status of a pleading but is a document into which she had input. We think however, having had the benefit of hearing the Claimant's evidence and arguments, that the behaviour of the Respondent of which she is really critical is that Ms Davidson declined to make the necessary separate referral to consider Covid-19-related anxiety. Secondly, that there were "delays" in respect of actioning the referral agreed with Ms Davidson on 2 June and in relation to the referral agreed with Ms Page on 28 July 2021.

144. Our analysis is that the PCP actually reflected in the list of issues is a reference to a one-off act. This, even on the Claimant's case cannot constitute a provision criteria or practice for the purposes of her reasonable adjustments claim. As a matter of fact, the Claimant has not shown either that Ms Davidson did not make an occupational health referral requested of her by the Claimant. There was no *request* for a separate and distinct referral.

145. Additionally we accept the Respondent's submission that following the principles in **Tarbuck**, the Claimant is unable to show that she has been placed at a significant disadvantage.

146. The Claimant submits to us that for those working in the health service, a referral to occupational health has a unique and special quality. She says it is a gateway to obtaining things that you, as an employee, consider are of concern or need in the workplace, by reference to your health. We can certainly see that the health service is a place likely to place emphasis on the recommendations of occupational health. It would be ironic and perverse given the line of work of their employees, if that were not so. There is also the importance of staff health to being able to treat patients effectively. We feel we could legitimately take judicial notice of that much.

147. It is also clear from the terms of Ms Page's referral that reasonable adjustments were matters occupational health were used to advising on. However, we have received no evidence to suggest that the assessments are not undertaken independently (in fact, they appear to be outsourced), with the purpose of producing a dispassionate assessment of the employee's fitness or whatever other matter the assessor is asked to comment upon.

148. It follows that neither failing to refer (which we stress we have not found) nor any delay in referring, placed the Claimant at a substantial disadvantage. Put simply, the outcome of the resulting assessment cannot be guaranteed, nor that in all cases it will be acted upon.

149. We see no basis therefore to disapply the principles in **Tarbuck.** The fact of referring to occupational health will serve to better inform the Respondent as to what steps are necessary but of itself would achieve nothing.

150. As a matter of fairness to the Claimant who is unrepresented, and taking into account that the Respondent has dealt with the alleged delaying of referrals (paragraph 37 of the Respondent's closing submissions refers), we consider her case on that basis too.

151. The first issue is whether or not there is an established PCP of delay.

152. We are quite satisfied that Ms Davidson did make her referral of 2 June promptly. That is evident from the fact that on 14 June when Ms Page tried to amend the terms of the instructions, an appointment was already in place. Taking account of likely intervening non-working days and the fact that the Claimant was known to be on sick leave until the end of the month, we do not think this amounts to a period of time that could reasonably be described as a delay.

153. The unintended cancellation of the appointment of 28 June, was just that. Unintended. Clear steps were taken to try to avoid the additional 17 days this meant the Claimant had to wait. This was not a provision criterion or practice or part of one.

154. That leaves the delay of which the Claimant has complained between 28 July and 16 August. We have considered this alongside what is said in paragraph 152 regarding Ms Davidson's alleged delay. Looking at the contextual factors, including that at the time of the meeting on 28 July, the immediately previous assessment had taken place less than 2 weeks before and that the Claimant was not expected to be fit to work at all sooner than beginning of September, we do not find delay is established. There is no PCP therefore.

155. We also accept the Respondent's point that even if the respective "lapses" (at most 12 days for Ms Davidson and 19 for Ms Page), the Respondent has no actual or constructive knowledge of any substantial disadvantage

to the Claimant. That is in accordance with the case law to which we have already made reference.

156. Other than advising on recommendations the only other output the Claimant has been able to identify would flow is that she would have been registered on the redeployment register sooner. We are not satisfied of that; there has been no sufficient evidence that would have been possible at any point where she was unfit for work. So, if the occupational assessments taken place sooner than 15 July 2021 and 7 September 2021, the Claimant's lack of fitness for work is in our view likely to have frustrated that in any event.

157. We follow the Claimant may feel subjectively that it would have been beneficial to her then stress levels to have sooner progress that would put her on the way to reasonable adjustments (in June 2021) or to redeployment (in late July/August 2021). We have not overlooked her independently chasing up occupational health on 16 August 2021. However, the information available to the Respondent through Ms Davidson and Ms Page, was not a cause for it to think that the Claimant would be disadvantaged in her health or otherwise, by proceeding in the timeframe in which they did.

158. In summary therefore this aspect of the claim fails because:

- on the Claimant's own case (which factually we reject) there was only one instance of not referring and therefore no PCP as set out in the LOI;
- the Claimant has not demonstrated a PCP of delay in referrals; and
- even if that were not the case, the Claimant has not demonstrated that she was placed at substantial disadvantage or that the Respondent knew or should have known of the likelihood of that disadvantage as a result of the timeframe in which the referrals were made.

PCP3

159. In respect of PCP 3 we accept there was a practice of not making sure that used masks were disposed of effectively in the hospital grounds. It was not a one-off event.

160. However, we are not satisfied of substantial disadvantage arising to the Claimant as a result of strewn masks in the car park either by reference to net health risks from Covid or exacerbation of her anxiety state.

161. Of significance is that the masks were strewn in an outside area, were visible and were avoidable. They were not masks that had been used in a red zone. The Claimant's own practice was to wear her face covering in the car park. There is no adequate basis for us to infer that there was any realistic increased risk of transmission to the Claimant from this littering.

Her underlying risk of harm – as a result of her clinical vulnerability - remained.

162. We were not satisfied that the Claimant did suffer any heightened anxiety as a result of this PCP. We consider she was dismayed and disgusted. Heightened anxiety set in with her airlock experience.

163. In any event, we do not also follow how the Respondent should have foreseen that the strewn masks would operate to increase the Claimant's anxiety. We are certainly satisfied she did *not* raise it in the meeting of 6 April 2021 or at any other time. Standing back we do not think it could be said that the sight of the masks in these circumstances would obviously lead to heightened anxiety given the overall context. Despite her conditions, the Claimant was aware the night before her return to work that there was Covid on the unit. She nevertheless returned. That is because she wanted to get back to work at the Unit. But from the point of view of the Respondent's knowledge, the Claimant's attitude is not consistent with such a degree of fragility in reference to Covid-19 that she would obviously be made worse by the sight of used masks, contact with which could be wholly avoided.

164. The complaint by reference to this PCP therefore fails on the basis of no substantial disadvantage having been demonstrated and secondly, to the degree there was any disadvantage, the Respondent has satisfied us it had no actual or constructive knowledge of that disadvantage being likely.

PCP4

165. In respect of PCP4, there was a PCP of not always having face masks available for staff at reception. It happened sufficiently for this to be shown not to be a one-off.

166. In terms of substantial disadvantage, we think the process of walking up the corridor in tandem with non-face mask wearers is to be distinguished from the physical health risks from being contained inside an unventilated, confined space such as the airlock. We are not satisfied of an increased net risk to her physical health. The Claimant had full volition over her own movements; she was not contained or forced to enjoy physical proximity. The Claimant always had her own face covered. It was also open to the Claimant as she well appreciated to enter the PPE stockroom and replenish the stock of masks both for her own benefit and for the benefit of staff who did not then mask up because none were available. The Claimant had the means available to her to negate the risks. The staff would not have resisted this because unlike in the airlock, the requirement to wear a mask from reception onwards, was clear. This has not been disputed. Accordingly, the cause of the disadvantage she asserts has not been shown to flow from the PCP.

167. In terms of increased anxiety, we return to our finding that – consistent with all that she actually reported to the Respondent on 6 April 2021 - it

was the airlock and not the corridor or outside spaces where her concerns around infection led to heightened anxiety.

168. We would also add to the degree there was any disadvantage in the form of anxiety, the Respondent succeeds in its defence based on lack of actual or constructive knowledge. The Claimant never mentioned concerns around mask-wearing within the corridor. The Respondent - knowing about the clear policy when fully inside the building (in contrast to the airlock) - could reasonably expect masks to be worn.

PCP5

169. In relation to PCP 5 we are satisfied there was a PCP of allowing staff to move from ward to ward, other than exclusively in medical emergencies. That is not the same as saying there was a PCP of free movement in those circumstances. It is also not the same PCP which appears in the list of issues.

170. In any event, we are also not satisfied of substantial disadvantage by reference to the Claimant's physical health conditions, given the other protections to which we have referred in paragraphs 113 and 114 above.

171. On the other hand we consider that a person with anxiety in the Claimant's position would not be comforted by those things completely and that the PCP by which non-emergency inter-ward movements could happen, increased her anxiety in a way which it would not have done had she not had those conditions. We think that the Respondent had knowledge of this given the terms of the email of 3 April and that the matter was expressly raised by the Claimant on 6 April. Of particular relevance is that the Claimant raised the question of her needing to "feel safe".

172. We have referred already to the email from Ms Davidson which followed on the 7th. We find after this time the Claimant did not again raise the question of staff movements and thus the Respondent succeeds in its knowledge defence. It has established, there is no basis for it infer, acting reasonably, that the Claimant was suffering or likely to suffer heightened anxiety still, despite the reinforcement of the importance of limiting movements.

173. Additionally, and although not strictly necessary, we find that the reasonable adjustment for which the Claimant argues of in essence only allowing staff to move from ward to ward in an emergency, is not a reasonable adjustment. The Respondent had a duty of care to monitor the health and safety of its inpatients. It could not ignore this because the act of sharing equipment would occasion some heightened anxiety to the Claimant. We also consider that leaving pots un-washed, because of a lack of operating dishwashing facilities, would create an unacceptable infection risk and not be reasonable. The Claimant also suggested as a reasonable adjustment that prior attendances could be the subject of an advanced telephone call by members of staff from the visiting ward to the host ward. The Claimant accepted this would involve the need to use 2

phones on the part of senior staff on the ward; the office phone was not always manned and the other "mobile" phone was used to allow patients to speak to relatives.

174. We found this suggested reasonable adjustment to add nothing of value (given pre-existing infection control measures) and to be practically unfeasible. It would create an unjustified and distracting burden on the relevant staff.

175. This claim for reasonable adjustments also fails.

Time Limits

176. We find that any discriminatory act or omission occurring on or after 17 May 2021 is, on its face, within the statutory time limit. Anything on or before 16th of May 2021 is, on its face, outside of the time limit.

177. Applying the principles we have set out above, we find as follows regarding each PCP:

A. PCP1 – We find the end of the period in which the Respondent might reasonably have been expected to make the adjustment in respect of the airlock, is within 7 days of acquiring their knowledge. We think even the Claimant would accept that there needed to be checks conducted first on the viability of what she had suggested. On the Claimant's case therefore (which is what we assume for the purposes of limitation), the alleged failure is to be treated as having occurred on 13 April. It is thus out of time, if not a continuing act. Such a claim would have been needed to be referred to ACAS by 12 July 2021. Instead, it was referred on 16 August 2021

B. PCP2 - dealing with the single alleged non-referral (as opposed to delayed referral), we again consider the failure by reference to the date by which the Respondent, through Ms Davidson, might reasonably have been expected to have made the adjustment. We find the alleged reasonable adjustment of arranging <u>two</u> separate additional health referrals (again for the purposes of limitation we look at matters through the prism of the Claimant's pleaded complaint, rather than what we have found), our view is that Ms Davidson might reasonably have been expected to have undertaken the second, separate referral on the same day she made the referral that she did i.e. 10 April 2021. This means that the failure is to be treated as having occurred on 10 April. Such a claim would have needed to be referred to ACAS by 9 July 2021. (We would add here that we do not demur from our conclusion on the absence of "delay" in respect of the two later referrals; the reason the 10 April 2021 is the correct date here flows

from the fact that Ms Davidson made the referral that day for counselling and it would be inefficient to do any alleged second referral, separately.)

C. The same cannot be said of the extended version of PCP2, of delaying referrals. Looking at the 2 periods of challenge, the Claimant's case can only be that Ms Davidson should have referred her on or after 2 June 2021 (but sooner than 14 June) and Ms Page should have referred her on or after 28 July 2021 (but sooner than 16 August). The alleged failures therefore are in time by reference to the provisional cut-off date of 16 May 2021 (see paragraph 176 above).

D. PCP3 - the Claimant has not in our view asserted that there was a continuing breach of the duty to make reasonable adjustments because strewn masks persisted, so that the Respondent was at fault every day. On the basis that she gave no satisfactory evidence of problems with masks after the early part of April, we find this claim was time-barred because proceedings were not issued or ACAS was not commenced before 9 July 2021 i.e., the last date the Respondent could have been expected to deal with it, would be 10 April 2021.

E. PCP4 – on the same basis as PCP3, and the lack of any claimed problem in these proceedings with non-available masks at reception after early April 2021, we find the Claimant should have approached ACAS by 9 July 2021. This is not affected by the fact the Respondent did not in fact take steps prior to 29 April 2021 to create the checklist. The checklist does not deal with masks at reception and the Respondent is entitled to rely on the earliest date under s.123(4)(b) for limitation purposes.

F. PCP5 - this was identified on 3 and 6 April. Approaching matters from the Claimant's case, her proposed adjustments could have made within 7 days, we find. This means the cut-off date for commencing ACAS was 12 July 2021.

178. The tribunal finds this was conduct extending over a period in accordance with section 123(3)(a) meaning the Claimant would have needed to refer the matter to ACAS by 12 July 2021 for the proceedings to have been brought in time. This does mean that the extent of the delay is slightly shorter than submitted by the Respondent: 35 rather than 38 days late.

179. We then turned to the reasons for the delay. We find the record of the long term sickness absence interview [p.441 - 442] instructive. This took place just 9 days after the date on which the ACAS referral should have taken place and its probative. The Claimant stated that she was in "a dark place". She had completed 3 sessions of talking therapies and had also been referred to healthy minds for CBT and was on a waiting list. Although she indicated that she had support from her union representative, GP family and friends she indicated she was on the maximum dose of anxiety medication. We have also noted that the Claimant was not deemed fit for work by GP in this period by reason of work-related stress/headache

affecting mental health. The Claimant told us that she was jumbled up. These are good, corroborated, positive reasons in favour of exercising the discretion.

180. The Respondent has pointed to the support which the Claimant had from the RCN. The Claimant gave candid evidence about this. She told us that in July and August 2021 she was working with her trade union. She was told that as the prospects were not 51% in reference to constructive dismissal, there would be no support from her union. Against the backdrop of her serious ill-health, we do not find the receipt of the advice, or indeed its negative assessment, undermines the justification for extending time by reference to the Claimant's health.

181. The Claimant was confronted with complex decision-making at a time of acutely poor mental health. The balance of prejudice we find to be in favour of the Claimant. Were all allegations save for alleged delay in relation to occupational health not allowed to proceed because of a 5 week delay, the effect on the Claimant would be a profound sense of injustice. The Respondent has not identified any material way in which its defence of these proceedings has been compromised. We have identified no real forensic prejudice. The Respondent has been able to summon witnesses and relevant documentation. The Respondent also advances a multifaceted defence such that being deprived of its statutory defence does not expose it inevitably to a liability it would not otherwise have. Finally, the taking of appropriate reasonable adjustments – for which Mr Sangha says the Respondent should be rewarded by the upholding of strict time limits – this only effects PCP 1 and 5.

182. Finally, a substantial factor that favours extending time is that the course of conduct complained of was still relatively recent at the time the claim was presented, and that it arose within in a quite compressed timeframe - just 4.5 months - prior to conciliation commencing.

183. It is just and equitable therefore that time be extended to allow the Claimant to bring all of her complaints.

184. None of those complaints succeed however, for the reasons we have given.

Tribunal Judge A Miller-Varey
(acting as an Employment Judge)

21 August 2023

Sent to the parties on:

23 August 2023

For the Tribunals Office

Annex A

Final List of Issues
As agreed on the morning of 3 July 2023

Time Limits

1. Were the complaints presented in time for the purposes of the Equality Act 2010? The tribunal will need to consider the following:

    1.1. Did the acts or allegations referred to in the claim form occur more than three months before the presentation of the claim (in addition to any applicable extension for ACAS early conciliation)?

    1.2. Do the Claimant's claims constitute conduct extending over a period within the meaning of section 123(3)(a) of the Equality Act 2010?

    1.3. Was the Claim made to the Tribunal within three months (in addition to any applicable extension for ACAS early conciliation) of the end of that period?

    1.4. Would be just and equitable to extend time for the Claimant's claims?

Disability

2. The Respondent accepts that the Claimant is a disabled person by reason of COPD, chronic asthma, anxiety, depression and PTSD and that it had knowledge at the relevant time being the period from 1 April 2021 until and including 16 September 2021.

Failure to Make Reasonable Adjustments (Equality Act 2010 sections 20 & 21)

3. A "PCP" is a provision, criterion or practice. Did the respondent have the following PCPs:

3.1 PCP1: Allowing staff into the "airlock"(i.e. the entrance to the building where, as a security measure, the inside door would only open once the outside door was closed) without wearing masks.
3.2 PCP2: Not making Occupational Health referrals on request.
3.3 PCP3: Not making sure that used face masks were disposed of effectively (the claimant says that used face masks were "strewn "everywhere outside the building).
3.4 PCP4: Not always having masks available for staff.
3.5 PCP5: Allowing staff to move freely from ward to ward.

4. Did the PCPs put the claimant at a substantial disadvantage compared to someone without the claimant's disability, in that:

4.1 In relation to her respiratory condition, placing her at added risk of contracting COVID, the consequences of which would be severe for her;

4.2 In relation to anxiety, depression and PTSD, significantly increasing her anxiety?

5. Did the respondent know, or could it reasonably have been expected to know, that the claimant was likely to be placed at the disadvantage?

6. Did the respondent fail in its duty to take such steps as it would have been reasonable to have taken to avoid the disadvantage? The claimant says that the following adjustments to the PCPs would have been reasonable:

6.1 In relation to PCP1:

6.1.1 staggering staff arrival times so that they were not in the airlock together;

6.1.2 Allowing the claimant and other vulnerable staff to use the side entrance/an alternative entrance.

6.2 In relation to PCP2:

6.2.1 to make the referral to Occupational Health on the claimant's request to do so.

6.3 In relation to PCP3:

6.3.1 Ensuring regular checks to make sure that used masks were disposed of safely and taking action if not.

6.4 In relation to PCP4:

6.4.1 Ensuring staff on each shift checked that there were masks available for the next shift;

6.4.2 A system for ensuring that was done:

6.4.3 The masks to be replenished if none were available;

6.4.4 Ensuring there was evidence of that process having been carried out.

6.5 In relation to PCP5

6.5.1 Only allowing staff to move from ward to ward when absolutely necessary;

6.5.2 To ring staff on a ward in advance before moving from one ward to another.

7. By what date should the respondent reasonably have taken those steps?

Remedy

8. If the Claimant's claims are upheld by the Employment Tribunal is it just and equitable to award compensation for:

8.1 Any injury to the Claimant's feelings?